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Winter 12-1-1984

## Yale Nurse

Yale School of Nursing

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# Yale Nurse



Sven Martson

Office of the President  
Yale University  
New Haven, Connecticut

November 5, 1984

To the Community of the School of Nursing:

As you know, Dean Diers retires from the Deanship of the School of Nursing and returns to full-time faculty status at the end of this semester. For twelve and a half years, she has been a superb leader of the School of Nursing and citizen of the University. I wish to express the admiration and appreciation of all of us for her splendid work in the Deanship and say how much we have benefited from her innovative and wise guidance.

As you also know, the search for a new Dean of the School of Nursing has been going on for some time, and will continue. While we have had a most diligent search, I am not convinced that the process has fully matured. In order to allow the School to move forward while we continue the search, I am, therefore, delighted to announce that Judith B. Krauss has generously agreed to serve as Acting Dean beginning January 1, 1985 until a new Dean is appointed. I am truly pleased that Dean Krauss has decided to take on this important responsibility and I know that the School will continue to flourish under her guidance.

Sincerely yours,

*Bart Giamatti*  
A. Bartlett Giamatti

DECEMBER 1984



# Yale University School of Nursing

ALUMNAE/I ASSOCIATION

## Newsletter



Published three times a year  
by the YUSNAA

Please address all communications to  
Mrs. Mary C. Colwell, Executive Secretary  
Yale School of Nursing Alumnae/i Association  
855 Howard Avenue, P.O. Box 3333  
New Haven, Connecticut 06510

December 1984

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### From The Dean...

It will come as no surprise to any of you that the theme that is lately on my mind is the theme of transitions. In the life of an organization a transition is that period of time when things are moving and changing in ways that cannot always be apprehended or precisely described. Transitions are often characterized in oppositional terms such as: a time for growth vs. stagnation; a time for opening vs. closing doors; or, a time for building vs. tearing down.

In a place like the School of Nursing transitions make for exciting times. Under the most stable of conditions everyone is in transition anyway! Students are in transition from being the passive recipients of information to active partners in the shaping of a professional mission. Faculty are in transition as they push the boundaries of practice and clinical scholarship closer and closer to our mission of reshaping the health care system. And, the alumnae/i are in transition as they continually realign their past images of the School with our current visions.

As I step into the position of Acting Dean, itself a transitional role between deans, I am reminded that there is a science of "muddling through" which is an integral part of the executive function in organizations that manage complex social problems. The key to muddling through is having a view of the whole rather than a view of the parts, particularly when the parts are always changing anyway.

My view informs me that we have been left a magnificent legacy. Donna left all doors open when she left the deanship. During her tenure we literally built our building and our programs and pushed the boundaries of advanced nursing practice as far as they could be pushed. We are not finished. Our continued growth is virtually assured in the strength of our faculty, our students, and our alumnae/i.

As for me -- I intend to keep the doors open and to explore new views of the School and of nursing. I hope that these doors will encourage contact and interaction with you, the alumnae/i. I look forward to the opportunities to meet with you, speak with you, and write to you concerning the School's present and future directions. Your voice will be an important vehicle as we move through these times of transition. I welcome your company in the process of "muddling through"!

Judith B. Krauss '70  
Acting Dean

ALUMNAE / I WEEKEND

June 6 - 7 - 8, 1985

### THE SOCIAL AND ETHICAL SIGNIFICANCE OF NURSING

A series of addresses  
by

Annie Warburton Goodrich

This book is available at the School!  
Send request with \$6.50 check made out to  
Yale School of Nursing to:  
Reference Room  
Yale School of Nursing  
833 Howard Avenue  
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New Haven, CT 06510



## Mary Jane Kennedy Honored

The Alumni Fund Convocation was held on October 12 and 13. During workshops class agents were able to talk about the plans for the year with Mary Jane Kennedy '68, YSN Chairman, and also the group had an up-date about the School from Donna Diers. Following the dinner that evening, President Giamatti greeted those present, and five Chairman's Awards were presented to Chairpeople who have served their constituencies especially well. Mary Jane was a recipient this year!! How wonderful to have her, her work and her agents' efforts recognized. Her citation read:

"In the fall of 1980 when you took over the chairmanship of the School of Nursing Alumnae Fund, you did so with such enormous energy and enthusiasm that the Fund had to grow and break all previous records.

Two years ago, the Nursing School Alumnae Fund, for the first time, raised over \$100,000 and just last year it succeeded in having 55% participation -- the highest participation figure for all Graduate and Professional Schools.

Last year you originated, organized and ran the first annual five-day, five-evening phonathon. You have also organized an advisory board to coordinate the annual and Bequest and Endowment efforts; to improve communication between the class agents, the School and the Fund; and to broaden the base of leadership for fund raising.

We want to show our gratitude to you by presenting you this Chairman's Award in recognition and appreciation for all your untiring efforts on behalf of the Nursing School Alumnae Fund."

## Ann Slavinsky, Acting Master



Ann Slavinsky '67, Associate Professor, has been asked by the President of the University to serve as Acting Master of Berkeley College at Yale for second semester. This is the first time any faculty member from the School of Nursing has served as Master. Ann has been a Fellow of Berkeley for some time. She will serve the

period of sabbatical leave of Robin Winks, who is currently Master. Ann will continue her teaching responsibilities in the School during this period.

Ann says, "understanding what a Master does depends on understanding what a College is. Yale College is divided into twelve residential units, each with its own student dormitories, faculty living quarters, dining hall, library, meeting rooms, as well as athletic and recreational facilities. They each house from 378 to 460 students. Although most of the colleges look as if they could have been here since Yale was founded, the residential colleges are only 50 years old. The first of these opened in 1933, with the last completed in the 1960's. In order of appearance, there were Davenport, Pierson, Branford, Saybrook, Jonathan Edwards, Trumbull, Calhoun, Berkeley, Timothy Dwight, Silliman, Ezra Stiles and Morse. They are named after places or people important in Yale's history."

"With some variations, Yale's college system was modeled after the college systems at Oxford and Cambridge. Colleges are not intended to be dormitories, although they also serve that function, but as places in which there might be created an intellectual and social environment in which both students and faculty might flourish. The Master is both the educational leader of the college and its chief administrative officer. Robin Winks has characterized the role as one of 'cultural attache,' a person whose main function is to reach out to as many people as possible in 'setting the tone of the college'. This is done by fostering a balance of intellectual, social life and recreation within the college."

"The Master is not alone in this task. Each college also has a Dean and Residential Fellows who, with their families and the family of the Master, live in the college itself with the students. There are also other Fellows who are a mixture of Yale faculty and distinguished individuals not a part of the university community. In addition, there also is a Dining Hall Manager, a Building Foreman, Administrative Assistants, Master's Aides and Graduate Affiliates. All of these individuals contribute to the task of providing an environment in which it is possible to live, eat, sleep, study, attend

(continued on Page 5)





## The Board of Permanent Officers

The School of Nursing now has a new thing: a Board of Permanent Officers. This is a significant achievement which brings the School more in line with the way other schools in the University are organized.

According to the By-Laws of the Yale Corporation,

...The members of the faculty of each school who are Professors on permanent appointment shall be the Permanent Officers of the school and together with the President and the Provost *ex officio* and its Dean, shall constitute its Board of Permanent Officers. The Board shall be the governing board of the school, entrusted with matters relating to the educational policy and government of the school. The Board of Permanent Officers of a school may at its discretion refer to the faculty of the school for action on any matters except recommendations for appointments of Permanent Officers and the assignment of Permanent Officers to the school...

...The Dean shall serve as Chairman of the Board of Permanent Officers and of the faculty of the school...

The members of the B.P.O. as it is known, are the tenured faculty of the school, presently Helen Burst, Donna Diers, Judy Krauss, Dorothy Sexton and Ann Slavinsky.

In the past, until YSN had enough tenured faculty to constitute a BPO, an Executive Committee was the policy making body. The BPO recommended, and the Provost approved, that the Executive Committee remain in place, constituted of the BPO, the Program Chairpersons who are not members of the BPO, three faculty elected for rotating two-year terms, and three students. The BPO felt that the participatory faculty governance that has characterized the School should be preserved, and thus they delegate to the Executive Committee the policy-making functions.

The BPO also function as the Senior Appointments Committee and review requests for promotion to tenure and for reappointment as Associate Professor (the last step in the term of appointments before the tenure review). This now means that there is an internal mechanism for review of tenure appointments within the School. Previously, all recommendations for tenure went to an ad hoc committee chaired by the Provost (since there were no tenured faculty to make the recommendation except the dean). Now, if the Senior Appointments Committee so votes, recommendations will go from that body to the Provost who will convene an ad hoc review committee, which will have the benefit of the prior internal review.

The creation of a BPO has made other changes in the composition of the Standing Appointments Committee, previously elected by the faculty. Now, three BPO members are appointed and four faculty are elected. One BPO member is appointed to serve on the faculty grievance committee and two faculty are elected to it.

The creation of a Board of Permanent Officers represents another way in which the School is supported and reinforced by the University. In addition, the opportunity for school of nursing faculty to serve on central University committees is increased, since those committees almost always require the membership to come from the tenured faculty.

## Grants For Two New Projects

### PERINATAL NURSING

The School of Nursing has received a four-year grant award of \$1,200,000 to continue the preparation of nurse-midwives and to add a new curriculum option in perinatal nursing. The grant, from the Bureau of Health Care Delivery and Assistance, DHHS, will support faculty and provide some student aid.

The nurse-midwifery program at YSN is one of the oldest such programs in schools of nursing in this country, started in 1956. Nurse-midwives are specialists in the care of the essentially normal child-bearing woman. With the growth of knowledge in high-risk perinatal medicine, the faculty believed it was time to add to the curricular offerings a course of study for nurses who wish to specialize in the care of mothers at risk. The resources of the School of Medicine and Hospital's high-risk pregnancy services provide a superior training situation at Yale. Individuals from the School of Medicine and from the obstetrical service of the Hospital serve on the Advisory Committee to the project.

The first students will be admitted in the fall of 1985. While they will share some course work with the nurse-midwifery students, they will specialize in high-risk pregnancy and be prepared to work in acute care settings. Full-time study will be required for the first two classes; part-time options may be offered after that.

The nurse-midwifery curriculum will continue to enroll 14 students per year for full-time study. The Master of Science in Nursing degree will be awarded. Professor Helen Burst is Project Director for the Project.

### CARE OF ACUTELY ILL CHILDREN

Under a three-year grant of \$319,308, the School of Nursing will begin to offer a two-year graduate program to prepare nurses for



care of acutely ill children. The grant, from the Division of Nursing, USPHS will support faculty and development of curriculum and clinical practices. The first class will be admitted for fall 1985. Madelon Visintainer, Associate Professor, is Project Director and Chair of the Pediatric Nursing Program.

The Pediatric Nursing Program is one of five clinical programs in the School offering advanced practice concentrations. Started in 1970, the Pediatric Nursing Program has prepared nurses for primary care, as pediatric nurse practitioners. The addition of an acute care emphasis is designed to help fill the needs of hospitals and other inpatient facilities for nurses prepared for clinical leadership in situations in which children are acutely or critically ill. In addition, students will have the opportunity to pursue individual interests in the care of the chronically ill child, or adolescents. The attention to families is a strong component of the curriculum.

The project enjoys the collaboration of Yale New Haven Hospital and the Hospital of St. Raphael. In both institutions, clinical nurse specialist faculty will be appointed to the agency and to the School jointly. The Newington Children's Hospital will also be heavily involved.

Both full- and part-time study will be available. The degree, Master of Science in Nursing, will be awarded upon completion of the clinical and research curriculum, and a research thesis.

### **Connecticut Nurses' Association Award**

Kathleen T. Flynn, Associate Professor, Medical-Surgical Nursing Program was the recipient of the Josephine Dolan award for Excellence in Teaching. The award was presented to Ms. Flynn at the Diamond Jubilee Awards Banquet on October 3, 1984.

### **AJN Book Of The Year Award**

Sherry Shamansky '69, Associate Professor and Chairperson, Community Health Nursing Program has received an AJN Book of the Year Award for the book she and two Indiana colleagues, M. Carolyn Cecer and Evelyn Shellenberger co-edited (PRIMARY HEALTH CARE HANDBOOK: GUIDELINES FOR PATIENT EDUCATION). Chapters in the book were written by Julie Trepeta '77, Susan Molde '76, Associate Professor Dorothy Baker, Associate Professor Kathleen Flynn, Associate Professor Pat McCarthy '79, and former faculty member, Tom Cook.

### **A Change in the Licensure Procedure in Connecticut**

As the result of regulations which were promulgated in 1983, the Board of Examiners for Nursing has been working closely with the Division of Medical Quality Assurance, Department of Health Services to evaluate candidates for

nurse licensure who have not held an active license in the past three (3) years.

Nurses who have been inactive for a considerable length of time may be requested to participate in refresher activities as a condition of relicensure. The refresher activities may range from a formal course to orientation at a health care agency. Official notification of a plan and the successful completion of the educational activities to the Board may also be requested.

To comply with mandatory licensure, each nurse who must obtain a knowledge/skill update is advised that educational activities which include a skill component must be practiced after the license has been issued.

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Ann Slavinsky's article (continued from Pg. 3)

seminars, have good conversation, play at sports and take part in a rich cultural and social schedule of events. The Master oversees it all and is directly responsible to the President. There is also a Master's group, the Council of Masters, which meets regularly to discuss university-wide college concerns and to advise the President about the residential college system."

"I have been a member of the Berkeley College community since September 1980, when I was appointed as a Fellow."

"In thinking about the Master's role, it strikes me that the appointment of a nurse is fitting. Nursing has historically been, not only a nurturing profession, but one that has done so through the creation of environments that promote health, healing, and interpersonal development. Nurses do that by organizing the physical and interpersonal environments in which patients are treated and in which they live. A University based nurse does this for her patients, but also creates that environment for students. It will be my pleasure to attempt to achieve that goal at Berkeley, as our Deans and Faculty have done so successfully here at YSN."

"In the slightly more than 60 years since its creation, YSN is not only flourishing within the University system, but has moved into a new, more intimate relationship with Yale College. We have faculty who are active Fellows in residential colleges, active members of university-wide committees, and instructors in the College Seminar Programs. That number is growing steadily. Somehow, I think that Annie Goodrich would be pleased, but not at all surprised."



# ALUMNAE/I COLLEGE PAPERS

As promised, the following are two papers presented at Alumnae/i College on June 8, 1984.

## Nursing—Its Past, Present and Future

Ingeborg Mauksch

...There are many, very exciting reasons why this is a special day. First, because my assignment of talking about nursing's past, present and future is indeed exciting.

Second, this allows me to observe that today is special also as it gives me the opportunity to look back over my own career in nursing, which is 44 years old. Finally, we are able to express those human feelings that we've always felt, but have been hesitant and at times almost prohibited from sharing. You have done so; thus your introduction was very meaningful to me.

I feel humble to be among the Dean's choice; I have to say that. I am thinking of the large number of people that she made this choice from. Therefore, being here is very special. I also need to say a few words about the Dean which I hope she will accept in the same kind of joy in which I accepted being her choice.

Donna, we are here to honor you. I feel a sense of agreement among us that you are a most

distinguished scholar, researcher, leader, but above all, thinker. I rejoice that we are able to say this while you are here, and able to participate, while we are all here to enjoy it together! To me, you are a nurse par excellence and par elegance! You possess that rare combination of qualities: brilliance, inquiry and leadership which you combine with a significant aristocracy of heart and the humanness of spirit! I'd like to indulge in just one brief nostalgia - a memory that relates to Donna and to Yale. A number of years ago (and I can't remember how long) we talked about Yale, about the School of Nursing and I asked you, Donna, "What is the goal of the school?" I was absolutely astounded at the way you responded, without having to think for one second. You simply said, "To change the health care system." Do you remember that? I've never forgotten it. It has made Yale very special and different. I don't want to use the word "unique" because it's an overworked word, but it has definitely made Yale a one-of-a-kind school. That is what Yale is to me and I believe that it is what Yale is to you. And now, to my task of the day!

It's very difficult to try to talk about nursing's past in an hour. So obviously, I had to make some choices and to be clear what my chief goal is. My decision was to try to convey to you a great urgency to study our history, to know more about it, to use it because it is a significant heritage that must be part of tomorrow's nurse. I am certainly very happy to see so many of THEM here today!

History is a study of the past, and a way of determining our roots. It is a major component of our heritage; in the case of a group as large as we are, 1.7 million of us, engaged in nursing or health care related fields, it is of major import that we understand that our history provides our most significant common bond. History is our major source of self respect and its denial frequently is reflected in low group self esteem. History is essential in understanding the present. Certainly, it is paramount in allowing us to look into the future with any degree of sophistication. It can be interpreted quite variably. Always, there are reconstructionists who attempt to show that events did not occur. But primary sources are invaluable, as are witnesses. We are fortunate to have both. We have good primary sources and we do have witnesses who go back over long periods of time. One of the many advantages of being a woman's profession is that we live longer. Finally, history is a challenge to the student who appreciates the fact that it is never completely written. Always, there are new insights to be gained, new perspectives to be established, new sources to be discovered; perhaps, it is like the ocean, never totally explored. Thus, as we embark on our journey into nursing's past, its very beginnings on these shores, we pose these critical questions: How do we go about understanding what I believe I have to call an "almost profession," which





started out with an identity so very different from its current one? And: what are the issues of significance?

What is it that we need to look at in order to understand? In a society where solemnity is often trivialized, and trivia are solemnified, where athletes are heroes, and those caring about the poor and the hungry are ridiculed, we have to take an inventory of our values, choose carefully what it is we wish to learn, to know, and finally, to understand and to retain.

What I shall do is to share with you the perspectives I have chosen to use, such as the status of women within any given point of time, and nursing obviously will reflect it, the kind of societal mandates to which we responded; the enduring values which nursing adopted at its very beginning and never foresook. Finally, the fact that this resulted in my envisioning a number of themes which consist of opposing points of view: the theme of change and the theme of constancy; of progress and of unaltered adherence to tradition. Some of us smile at that! Then, there is the theme of social involvement and yet a great deal of abstention from participation in deciding significant issues. And finally, the theme of success and retreat!

In 1873, America was already deeply immersed into becoming a pre-industrial society and the status of women is well known to all of you: it was that of being in the home, managing and caring, but having few rights and very few opportunities in the world at large. That is when "professional nursing," so called, began in the United States. At the Connecticut Training School in New Haven, at the Bellevue Hospital in New York and of course, at my own alma mater, The Massachusetts General Hospital in Boston. I took lots of ribbing about that in New Hampshire this weekend, as everyone there disagreed with me; but I know that the Massachusetts General Hospital was the best school in the world, and of course they were wrong. Nursing students, at that time, wore black stockings! Nursing's beginnings had been greatly encouraged by physicians and welcomed by hospitals in this country because it constituted an opportunity to have cheap and controlled labor where previously there had been none. Most hospitals were religiously controlled and thus cast this fledgling occupation of nursing into the context of a labor of love, a sacrifice and certainly an occupation in keeping with what was viewed as "women's work." The nurse was the "physician's assistant" in today's terms: then, she was his handmaiden. There were very few self-initiated nursing actions. Cure was the chief goal of medical care; there was a distinct sense that medical science was at the very edge of a breakthrough that would forever change the world. We now know, it did.

Professionalism as a concept, later described by Abraham Flexner, was interpreted variously by this fledgling profession. There was a disdain of money and everything it represented; a lack of desire towards achieving

autonomy; a tremendous commitment, and a great devotion to the care of the patient and to his needs as a person. There was no understanding of the need for research. Certainly, there was no appreciation of the concept of a science of nursing or of a body of knowledge that was nursing's own. There was a distinct need for self-sacrifice and a primitive understanding of accountability. All of this reflected the status of women in the society.

Our heritage was monastic. There was asceticism, duty and obedience to authority and even though my school pin does not say "1873," it was not all that different in 1940.

At the same time, already then, there were people in nursing who had incredible foresight. I will mention a few: Lillian Wald, and Mary Brewster, who had the deepest social understanding and acted on it, in the community. Adelaide Nutting who appreciated education and who knew in her heart of hearts that nursing must be university-based. Lavinia Dock, suffragist, pacifist, historian, internationalist, the symbol of nursing's future who had a vision, and a dream, reflected in her actions and in her writing. Lavinia, as many of you probably know, was in jail five times. Each time, Miss Lillian had to go down and bail her out, feed her up, and then back on the streets she'd go, to march some more, to get that woman's vote. Sometimes I wonder: who are the Lavinia Docks of today? This was a significant time in the development of nursing; growing, reaching out, trail-blazing. Its entrance into a completely new field of understanding: that there is more to nursing than just taking care of people who are ill; there is health care, illness prevention, and the new field called public health.

Our willingness to do with little or altogether without was another way in which we expressed our virtue and reflected the mentality and ethos of women of the time. And yet, there were giant innovations that came out of coat pockets, like the founding of the American Journal of Nursing in 1900, in the apartment of Miss Palmer and Miss Davis. Our national organizations grew and flourished. The role of the hospital changed; its chief energizer was the introduction of electricity into the world of health care. When you have nothing else to do, sit down and try to write down all the things that happened and could only happen because electricity finally came into our lives.

In 1910, we had Flexner's recommendations for the revamping of the Medical Profession. The American Medical Association read his report carefully, and drew the appropriate lessons. I wish that we had, but we didn't. And so we were in a balance of change and constancy, expressed principally in our extremely poor economic conditions, in our lack of organizational clout. But change did take place through the actions of our leaders who were able to speak up and say it. To answer the



right question, to appeal to the right body, to bring about actions whose consequences, in many ways, are still felt.

World War I allowed American's nurses to participate in extremely significant and major ways. And when it ended, we had made significant contributions, but we had only relative rank, and received none of the Veterans's benefits: in a way we were back where we started. Yet, this also was the time when the 19th Amendment was passed: when insulin became a household word, and when, with the passage of much significant legislation, hospital beds increased by well over 1000 percent. And what happened to the women who had succeeded in getting the 19th Amendment passed? They went home, had babies, and kept house!

At the Massachusetts General Hospital, the nursing students wore black stockings!

The sociology literature of that time does not reflect a change in the status of women, nor had the medical advances, brought about by the war, changed the status of nursing. Nursing picked up its moral tasks. It cared for the sick, chiefly in the home, yet increasingly in the hospital, as we witnessed a rapidly growing explosion of medical science and technology. The entrance into the scientific age of health and illness care!

Finally, clinical diagnosis by laboratory methods was established, the hospital flourished and became a male bastion of physician power and control. Progress in nursing, nevertheless, was tremendous in the '20's. The studies -- Goldmark; the establishment of Collegiate Nursing Education -- the Yale School of Nursing. Increasing sophistication in hospital schools of nursing. 1917 saw the publication of the first Curriculum Guide by the then National League for Nursing Education. Another appeared in 1927 and again another in 1937 -- there were three decadal issues. In 1927, the Curriculum Guide actually introduced the nursing care study, and the fields of sociology and psychology. It proposed looking at patients in a Gestalt way, and directed nurses to the study of the care of a patient.

In the 1937 Guide, this became the nursing care plan, which after all, was a significant realization of nursing's conceptualizations. An approach to working with people in an organized, and subsequently, more scientific way.

I do not know when it started, but I believe it was in 1920 when Isabel Stewart at Columbia's Teachers' College conceptualized standards which then were applied to the performance of nursing procedures; some of you will remember them: safety, comfort, good use of resources, and therapeutic effectiveness. At that time, this was viewed with a great deal of awe; a new perspective on nursing's contribution to the care of people, and a precursor to quality assessment.

There was also regression, principally manifested through a total lack of financial assertiveness. When I interviewed nurses at



Chicago's Cook County Hospital in the '60's, collecting data for my doctoral dissertation, they said: "We were so happy in 1934 to have 3 square meals and a warm room that we did not mind not getting paid for months on end." I know about the depression, though I was not here at the time. I also know that physicians drove taxicabs during the day in order to feed their families; but I don't believe that they would say that they were happy doing this, or doing without. That was the difference between nurses and physicians in their perception of the economic component of professionalism.

The great majority of America's nurses were then engaged in private duty which we might call private practice today. Retrospectively, I believe that this was one of nursing's great opportunities lost. Sometimes, when I read history, I fantasize what might have happened if these private practice nurses had pursued intense competence in clinical specialization. They could have been our first clinical specialists. They were individual entrepreneurs, holding it all in the palm of their hands. They did not see their opportunity. By the time I came into nursing, it was common practice for a head nurse to say to a nursing student at the Massachusetts General Hospital: "Be sure to watch that 'special' in 203, she's not doing too great." And pretty soon it became common knowledge that nursing students "specialized" the "specials."

What is the significance of this? Simply, that there was a total lack of appreciation and understanding on the part of the graduate nurse cadre of the significance of education, of clinical competence, and of the important role of nursing practice. Now, what was the condition of women in America during the Depression? They either went to work in order to support the family, as their husbands were unemployed, or conversely, they were put out of jobs because their husbands were working. The idea that both members of a couple would work was not considered patriotic, since it might prevent another couple from having even one job for either member. If there was a choice, it was the man who got the job, obviously. Nurses barely made a living. The



married ones who worked considered their jobs as "add-on's;" to add to the family income, but not to add competence to a career, nor to make a social contribution to the health of a society. The basic ethos of the society was for women to be at home and to raise their families; yet, the nurse created in Florence Nightingale's image was appreciated and considered essential, particularly in the hospital!

At the Massachusetts General Hospital, nursing students still wore black stockings!

More and more nurses moved into the hospital, either as employees or as private duty nurses. Their relationship with physicians had not changed. Usually, it was the physician who elicited their services, on a personal basis. "She's excellent in the kind of cases I have." This obviously developed into an inequitable dependency relationship, as you so well know. The nurse still initiated very few therapeutic actions, though more than she had initiated previously; principally, she implemented the physician's armamentarium and his regimen. The main nursing function was to follow the doctor's orders.

The public image of nursing reflected in film and in the literature at the time, which the Kalisches write so beautifully, was principally that of the ministering angel and of the caretaker. This was the time when medicine completed the pathologization of obstetrics and, to a large extent, that of well child care. Many, if not all, of nursing's original turfs had thus been preempted by the time we entered World War II.

And at the Massachusetts General Hospital, nurses still wore black stockings!

What is there to tell about the beginning of World War II? We had poor salaries, but we had increasing aspirations to professionalism. We worked hard, and exerted no control over our practice. We expressed ourselves for the first time in our national organization's support for Social Security legislation. But we were sheep, with the rest of the group, in confronting racism -- there were states that were members of the American Nurses' Association that did not admit Negro nurses to their membership. And we knew and understood very well, that this was a world of apartheid. But we did not know until a little later how to change it.

Our recorded history reveals little of the contributions made to health care by the Negro nurse, or by the Spanish-surnamed nurse or for that matter, by the immigrant nurse. Rather, we participated in the myth of the American melting pot, and it took us a while to move out of that fallacious belief system. At the same time, there also was increasing aspiration towards professionalism. Suddenly, our curricula became more humane, they became more scientific, and slowly and gradually there emerged an understanding: nurses had more to offer than waiting on the physician. We began to understand that there was a commitment to the care of people that was outside to the physician's "base." We

weren't quite sure what the object of the commitment was, but we knew it was there. There was substantial increase in nursing's sophistication in public health in a variety of settings -- in industrial nursing, in school nursing. And suddenly we understood that when outside the realm of the hospital, there were panoramas of accountability, though we may not have called them that at the time, that tasted very good and very nice. But we didn't know yet how to make the changes.

At the end of World War II, major and significant changes had occurred. For nurses, legislation had been passed which finally made them officers in the military with absolute rank, accruing the benefits of all veterans. In health care, significant advances had taken place: early ambulation, penicillin, antibiotics, heparin, and many other medical discoveries. Yet, as after the end of World War I, when the nurses came home from this war, they also did not come back to work. Most married and had babies, but some went to school on the "G.I. bill," and then assumed leadership roles. What about all the good things that women had accomplished during the war? Most were forgotten, none were rewarded.

ANA did a number of interesting things, favorable and disadvantageous. It was the first national health professional organization which recognized its racism and thus provided the possibility for black nurses to become members directly, by-passing the discriminating state associations. And we moved, over much objection, to the 44 hour week. The discussion at the 1948 Chicago convention, initiated principally by Directors of Nursing, said that hospitals could not run on a 44 hour week. This was also the convention in which we debated, and unfortunately inappropriately decided, that practical nurses, through licensure legislation, could answer to a professional nurse, or to a physician or a dentist. Retrospectively, this decision was one of the key indicators, of our lack of understanding of nursing practice and of the focus of the decision on: who delivers nursing care? In a nutshell, a new career ladder emerged -- a ladder of management. Not only management of patient care, but also management of the affairs of the hospital. And at each rung of this ladder, the nurse was removed one more step from direct patient care. Now we entered what I consider to be nursing's darkest phase, the era of "nursing the desk," nursing the physician, and the bureaucracy. Not only did we make this erroneous choice, we did the job with hardly any preparation. The new would-be managers could not be good managers. Sometimes of course, it was done well, but mostly it went badly, caused frustration and oppression; it was a very significant step backwards.

At the same time we did understand the need for change; in 1948, we initiated the study that formed nursing's two national organizations. Initially, a good choice, but at



this point in time, hard to justify. Next, we understood the need to finally move the focus of nursing education into academe. The early '60's saw the greatest change for that movement. We also understood then the need to look at scholarship and research, and to provide the necessary preparation to achieve it. In the early '60's, there were fewer than 300 nurses in the United States who had an earned doctoral degree. Great efforts were put forth and still are today, to increase the number of doctoral programs in nursing and to enlarge the pool of doctorally prepared nurses.

At the Massachusetts General Hospital, nurses still wore black stockings!

The '60's also saw nursing's greatest turn about, when it recognized and realized the basic thrust of its societal mandate. Finally we understood that delivery of nursing care, embodied in a conceptualized practice, was the only way to go.

We all remember the '60's as the time of liberation, the era of the "-ism." I know that many of you in this room have tried to study, as have I, the development of the women's movement. So far I have not been able to come up with one piece of literature -- historical, political science, or sociological, which predicted the women's movement. I think this is most significant. It tells us what the boys thought of women and how little we really mattered. I have challenged many of my sociology colleagues to deny that the women's movement was a surprise to them. And then I look them straight in the eye and say, "and now tell me that it isn't an even greater surprise that it has spread and persevered." Most of them, when they're honest, agree. They know that it is not a flash in the pan, and that it was overlooked.

Back to the -ism's. We now had human interactionism, assertiveness-ism, individualism, and for nursing, I believe, care-ism. Nursing finally had become beautiful. By the '70's, nurses were saying, "I practice pediatric nursing," rather than the previous, "I work on pediatrics." Nurses were practicing. The beauty, the fulfillment, the excitement of the practice of their profession had become their identity.

At the same time, many other things had to fall into place, and they did. Too slowly, perhaps, for some of us, but they did happen. Above all, we recognized the need for a change in behavior. The subservience and the dependence of the past changed in favor of autonomy, accountability and advocacy. No more did the nursing student of the '70's call a supervisor and say, as I had to do, "Miss Corcum, it appears as if Mr. Jones is hemorrhaging." She most likely would call and say, "Mr. Jones is hemorrhaging, and this is what I've done about it." Patients could be dead already and I would still have to call the doctor and say: "Come, doctor, and pronounce this person dead." Now, nurses can say, "the patient died at 10:55," and the physician will come and sign the death certificate.

Nursing is able to ascertain its level, and

to continue to elevate it. There was the realization that we had to build a discipline and in order to do this, we had to have the building blocks. They consist of knowing our heritage, and identifying our values. And of knowing how to identify our ethical decision-making processes, how to do research, how to identify the knowledge to accrue, and finally, out of all of this, to develop our practice. That's what we're all about. True, the tools it takes to build a professional practice are not easy to come by; we are still working them out, and they are wearing well.

In the 1960's, the American Nurses' Association organized a committee to develop standards, and to publish them. In 1975, the ANA Congress on Nursing Practice issued a document entitled "The Scope of Nursing Practice." In 1981, the same Congress on Nursing Practice published a significant document, entitled "Nursing - A Social Policy Statement." And only a very few weeks ago, I received a draft copy of the Division of Medical/Surgical Nursing's "Scope of Practice" statement. It is an excellent document. The very evolution of these achievements are spectacular -- unequaled by other professions. And there are others. We adopted a Code of Ethics in 1952, revised it several times, added an interpretative statement, which now makes it a code of which we can be proud. We are in the process of developing a Taxonomy of Nursing Diagnoses. It is in its infant stages, to be sure, but significant as an initial taxonomic endeavor. True, it has its limitations, but it is on the way of becoming.

I believe that the late '60's and particularly the '70's, witnessed gradual societal recognition for the contributions of nursing, in illness and in the health care of the people. Are there barriers? Of course. There is still an exaggerated compliance on the part of too many nurses with the kind of economic constraint, laid upon us in the form of a guilt trip; we might increase the patient's hospital costs, we are told. We are still too bound up in our need to comply with medical dictates. For instance, we still find ourselves in community health care settings, having to accept that a member of another profession approve the plan of nursing care we design for the patient in his home. There is no third party reimbursement for us, if the physician does not sign the order for the delivery of nursing care. In 1977, I represented ANA in testimony before Sen. Kennedy's sub-committee on health and I told him that. He was very surprised but it still is unchanged. In 1983, six years later, Sen. Inouye developed Senate Bill 410, which calls for the establishment of Community Nursing Centers. In the introduction to this legislation (and it will warm the cockles of your soul) Sen. Inouye says that for too long America's nurses have not had the opportunity to truly display their competence. Through his proposal, Community Nursing Centers would



be established, which would share in third party reimbursement through Medicaid and Medicare, provided (among other things), that these centers are owned and/or operated by Registered Nurses. Furthermore, this legislation replaces the currently required Plan of Treatment spelled out in the Medicare legislation with a Nursing Care Plan. The physician will review the plan, may veto it, but his approval is not required. This is a giant step. We are not there yet, but I am most optimistic that it will happen. I have a tremendous amount of appreciation for this, because it shows that a change took place in 20 short years; the Congress of the United States has shown that it now understands, appreciates and values what it is that America's nurses can do for the health care of the people.

Are there regressions? Not really. But there are some fallacious perceptions. One is that power is conveyed, rather than presumed. Another is our custom of going it alone, instead of sharing problems and inviting support. Also, there is a sense of being poor, "crying into our beer," rather than a strong belief in our self-determination, in our ability. We still demonstrate a considerable attitude of non-involvement, a certain denial of accountability. All of which, of course, adds up to low self-esteem. Were it possible to measure self-esteem in a group as large as 1 million 700 thousand, one might find it nowhere as high as our performance and societal contribution would warrant.

As a group, we have come of age regarding our social responsibility. Not only do we oppose racism, we established first a Commission and then a Cabinet on Human Rights. Within the American Nurses' Association we are learning to understand the need of minority members of our profession. We have not solved all of the problems, but we are on the way, and in so far as I can tell, infinitely farther along than other health professions. We understand. We are involved in social issues. We are becoming.

Finally, how to put into context the tremendous change from letting just anyone function as a nurse, to understanding that only nurses nurse. ONLY nurses nurse. This is the realization of the central role of practice. As a student of professions I find, in the persona of our profession, the realization that we are the principal provider in the health care industry. Perhaps we are beginning to understand, though slowly, that we are about to build a significant body of knowledge that is nursing. We understand the need to take the initiative to change the health and illness care delivery system a goal set by the Yale School of Nursing some time ago.

What of the future? What can one say with some certainty? One thing is certain: change is increasing its rate, in speeds that I cannot express mathematically anymore. This allows me to speculate that it will take nowhere as long as we might suspect, for the one million 700 thousand nurses to acquire the behaviors of autonomy and control over practice. Then we

will understand how knowing our past, within the context of professional practice, will contribute to our development of homogeneity, unity of purpose, and to a public image more consistent with our functioning.

It seems to me that we will never feel that we are truly fulfilling the entire range and scope of our professional mandate, but we will always try. There is now a distinct understanding that we will embrace practice models that will increasingly provide for control of practice, and therefore improve it. I believe that nurses will cease to be employees of the hospital: they will be in associations or act as consultants, and will share in the risk as well as in the income of their enterprise. We will continue to specialize, in keeping with medical specialization, including in quaternary specialization (for I believe that "tertiary specialization" does no longer convey the utmost depth of specialty practice that we already see in medical centers). We also will continue to expand nurse specialization in keeping with the nursing model quite distinct from the medical model. I'm talking about areas such as the enterostomy, woman's health, family planning. I proposed a new primary care specialization a year ago at the University of California, with an exclusive on it for three months. They did not take the option, so here it is. I believe we must have a mid-age-span male nurse practitioner role. This has been a significant oversight in the planning of health and illness care in our society.

Hospitals will become one great big intensive care unit. Thus, the kind of sophistication and the kind of competence that will be required of nurses is almost unfathomable. Nurses will have to put a stop to some of the technological gadgetry which continuously invades the privacy and the comfort of our patients; frequently only because it exists. There are hard questions that have to be asked about this avalanche of technology and I do not see any other functionary doing that job. In my brief experience as an executive of a home health agency I have already come up with two technologies that we overuse. One is total parenteral alimentation. I have asked one of our nurses, "Have you tried to see if there is a family member who can apply the seat of her skirt to the seat of the chair and try to feed this patient?" "No," she says. "The doctor ordered it." "You are not a sheep," I told her. "Let's see if a family member can feed the patient one meal a day and then two or three days from now we'll try another, and then another." You'd be surprised how it works. Similarly, with indwelling catheters; already, we overuse them incredibly.

How do I see the future? Nursing education will require the most fundamental change. We must have faculty who is clinically competent. We must have faculty who knows that knowledge known to human kind doubles every two years. Therefore what they must know, in



order to teach students, must greatly increase every two years also. Faculty relevance and clinical competence will be a given -- research, innovation and change will be imperatives, as will be documentable efficaciousness of nursing interventions. Only in this manner can we produce the professional nurse who is autonomous, a critical thinker, a consummate problem solver and a true humanist.

We also know that there never is a problem vacuum -- as we reach these goals, others will already emerge on the horizon. Yet, if nurses want badly enough to command their destiny and to control their practice, they will find that it is in their power to do so, thus achieving the joy and satisfaction of fulfilled clinicians.

How does one summarize this journey? In one hundred and eleven years we have travelled from being an "almost" sub-technical occupation to an "almost" pro-active profession, as characterized by the greater prevalence of autonomous practice, research integration, accountability, inquiry and scholarship. Gradually, we have established a discipline and we participate extensively in national decision-making as it affects the health and illness care delivery system. We now are part of a powerful momentum, our might is in ascent -- and as to money -- well, one can't expect it all at once!

## Nursing Research: The Science of Caring

Madelon Visintainer '74



In the book The Rise of Scientific Philosophy, Reichenbach defines the essence of knowledge as the mastery of generalization. Let me read his definition: "The essence of knowledge is generalization. That

fire can be produced by rubbing wood in a certain way is a knowledge derived by generalization from individual experiences; the statement means that rubbing wood in this way will always produce fire. The art of discovery is therefore the art of correct generalization. What is irrelevant, such as the particular shape or size of the piece of wood used, is to be excluded from the generalization, what is relevant, for example, the dryness of the wood, is to be included in it. The meaning of the term "relevant" can thus be defined; that is relevant which must be mentioned for the generalization to be valid. The separation of relevant from irrelevant factors is the beginning of knowledge."

The process of generalizing becomes the basis of science. Separating the chaff from the kernel, the relevant from the irrelevant. And

from these relevancies we construct views of the imperial world -- maps, constructions based on our piece of the relevant.

How can we be certain that our construction of the world is accurate? Bateson has emphasized that the map is not the territory, it is a representation of the territory. Some have sought certainty, but with that goal in mind, science becomes the end purpose of its evolution. Plato was explicit in defining certainty as the goal of science -- as science itself. In the Republic, he admonished thinkers to shun perceptual data.

"Whether a man gazes at the heavens or blinks on the ground, seeking to learn some particular of sense, I would deny that he can learn, for nothing of that sort is matter of science; his soul is looking downwards, not upwards, whether his way to knowledge is by water or by land, whether he floats, or only lies on his back. Instead of observing the stars, we should try to find the laws of their revolution through thinking. The astronomer should 'let the heavens alone' and approach his subject matter by the use of 'the natural gift of reason.'"

By this reason mathematics is identified as the pure science. Why that approach to science, which we consider empirical, that is, the study of what goes on around us?

In mathematics we can have certainty. That is to say in mathematics the map is the territory. The territory in this case is invented. It does not occur in the real world. You never run face to face with a square root. And so a square root, in terms of its relevancy, can be defined certainly.

Most scientists do not consider themselves so divorced from the real world. They would argue that science grows out of and gives order to the empirical. That science explains this real world. But consider: when science studies the empirical world, it brings a piece of the world and studies it in the laboratory -- that piece deemed relevant. It makes a relief map to match the conceptual map.

In my Ph.D. work, I worked with rats. One strain of rats. Why that one strain? Because that one strain was the relevant substance so our theory could be supported or refuted. The "learned helplessness" theory of Martin Seligman calls for a particular strain of rats. You cannot make a wild rat helpless. Does that have to come from this theory? No, no no. Because science comes from the building of maps or theories. It does not necessarily mean that it exists in the real and we may not ever know the real world.

Let me give a practical example of that.

I see a family in which a young man beats his mother. And recently that violence has begun to spill outside the family into the community. How are we going to understand what happens in that family? I begin with several maps, depending on what supervisor I'm sitting with. There's the psychoanalytic map. When



we use the psychoanalytic map what becomes relevant is what goes on in this young man's head and how he reports it to us. What becomes irrelevant is what the family had for breakfast and how they eat it.

In family systems theory, what goes on inside the young man's head becomes irrelevant and what becomes very relevant is what they had for breakfast. We will never know what goes on in that man's head. We will never know reality except as we recreate it according to our theory.

Gregory Bateson, although he was not the first, who knows who the first was, cautions us that the map is not the territory and should not be confused with the territory. There's no danger in creating maps and spinning theories as long as we know that what we may be saying conceptually may have no relevance for what we see empirically.

An example for me comes out of a recent book, written by Donald Griffin called ANIMAL THINKING. In there, he maintains that animals can think, and may even have a conscious. He gives an example of gulls, for example, holding a rock, using it to crack open other eggs. Of a whale taking a board from a ship wreck and using it as a rudder to steer through channels. And he challenges anyone to explain that as either a release of hormones, genetic instinctive released quality, or conditioning, he'll be challenged on that, and the challengers will say that what they are describing in their theories of conditioning, hormonal release and genetic transmission is the essence of the animal's behavior, and these are just isolated examples.

I felt that first hand, talking one time with Richard Solomon, a noted animal theorist who challenged us in class to prove that animals could think. We got out of a seminar and met his dog and he said, "that dog thinks." And I said, "wait a minute, Dr. Solomon, you just told us that animals don't think." And he said, "I'm not talking about this dog, I'm talking about animals."

The laboratory creates the piece of the world that CAN be studied, not the piece of the world from which the initial observation was made. The danger, however, comes when you want to use science to change reality. Because now we have a dilemma. If science is about a piece of reality that we can never see, then when we use it to change the reality, then we're basing it on something that may not have been the foundation from which the change can take place. So we create a new word. That's "basic science" and now we're into "applied science." Applied science merely borrows theories from the basic sciences and then applies them selectively. Well, they have to bend them a little bit.

I maintain it's not the theory at all. What's defined in applied science is a new set of relevancies. When will this work, when won't it, for whom, under what other relevant conditions.

I wonder when we set out as a profession,

to state as our goal to use our science to improve our work, and we make that a goal of our science, what that means to our science. Kuhn would say we have immediately trespassed from science to art. He says that science is merely the "solution of puzzles, for the puzzle's sake." Art is the solution of puzzles in order to create something else. Are we using the solution to create something else, and can that be science?

Science is an invention too, and anything invented can be changed to take in a new aspect, a new perspective.

Let's consider what it means to have the idea that what we see in a particular case we know to be relevant, compared with what someone else sees. Let me use a clinical example.

I spent years watching children recover from tonsillectomy. So I know tonsillectomy recovery well. One day, a nine-year old who had just come back from the OR began resisting the nurse taking vital signs. And I went up to him and said, "your throat hurts, doesn't it." And he croaked in a very hoarse voice, "something's wrong." And I said, "remember, we talked about how much it would hurt." "No, something's wrong." I believed him. Something was wrong. But what? He was agitated, I looked in his mouth, I couldn't see anything, but something was wrong, he was telling me that. So I called upstairs, the attending was doing the next surgery so they sent down the resident who said "what do you think is wrong," and I said, "he might be bleeding." Okay, how are his vital signs. Okay. Did you look in his mouth? Yes. See anything? No. So why do you think he might be bleeding?

Well, it's the most logical thing to be wrong in a healthy kid, they just took out his tonsils, something's wrong back there. The resident said, "he's just having a reaction to anesthesia, give him some Thorazine."

I said, "wait a minute," he's not reacting to the anesthesia. Remember, I'd watched a LOT of kids and I know an anesthesia response. Specifically what it was, that I was able to define later but couldn't tell the resident then, was that in reacting to anesthesia, they flail. He was very purposive. Something was wrong in a particular place. He was very clear.

Finally, in desperation, I put him on a litter and took him upstairs to the OR to the protest of everyone. I thought at least I'll have him there in case anything happens and I'll catch the attending. He came out, after they told him I was there with the kid. He vomited, an incredible amount of blood and said, "I'm okay now." And then they took him in and cauterized it. What he said was never relevant in the whole situation and that was clear.

Now, let's look at this and analyze whether this was creative assessment, or it's coincidental from any hysterical nurse or whatever. I could be hysterical, but that doesn't necessarily mean that nothing is wrong.





Madelon Visintainer '74 and Barbara Geach '69

I think it's more than that. I think it is the essence in the difference in the map that one uses. I was privy to information that the rest of them did not know. What did I know? Well, I had been there the day before when he was admitted, I knew he was the child of a single-parent family, shortly after divorce. I heard his mother say, a number of times, "he is the man of the house now." And he acted like the man of the house. "You can go home now, Mom, I'm okay." And although he was tearful as she left, he understood he was okay. He worked through it and that I could see. That I knew. Even if I had said that to the resident, and I did at one point -- "this isn't a kid that gets upset, that's why I'm believing him" -- it wasn't relevant to the resident's science. Because whether the kid is upset or not isn't relevant to the physiological base of bleeding tonsils, in the way we have abstracted, "bleeding tonsils." And so the resident was correct on two counts: one, he didn't know my basis of collection of information, and I wasn't clear in telling him how I knew something was wrong. And two, we were using different maps. It would be like using a weather map to find your way on a back country road. No communication. And yet we were both involved in the care of the child. No. One of us was involved in the CARE of the child and the other was involved in removal of the tonsils. A specific map, a very important one, but different from the other map.

What would it mean if we were to say that we CAN have a science out of what we do in the larger picture of caring. Lewis Thomas has a notation on nurses in his book, *THE YOUNGEST SCIENCE*, and he says nurses know everything. It's not just a characterological quirk, that we're just busybodies and we make it our business to know. As long as our practice required that we know everything, then our science ought

to give us a framework for knowing everything in a particular way. What would that science look like?

I think it might be an orchestration of maps. Dickoff and James wrote about it as a Theory of Theories. Prescriptive theory is a framework for understanding theories. If we think about how we juggle a map, can that be testable according to scientific principles or criteria. Could we come up with a consistency that science demands. That is, could I explicate what happened with that child so that should it ever happen again, we will have a category system to put that child in because science must have categories. That's what we are saying with generalization.

Next, is it predictive? Well, to the extent that we are dealing with the real world as our laboratory, it's going to be far less predictive than the situation in which the essence of the real world has been extracted according to particular maps. Those of us who have been in other scientific labs know how rarely you get consistency in other labs.

I was struck recently with the work at Johns Hopkins in support of the antivivisectionists who have said, "look, we have tumor cultures now, we have cell cultures, you don't need to use the animals." All these years those animals have been nothing more than mediums for cells. What does it mean to test a drug on a cell that lies in a test tube, not in the whole animal? Does it mean that we have extracted all the relevancies out of the whole animal and put it in a tissue culture? It's risky enough to use animal models for what is later used in humans. Now we are going to go one system below. I think that is confusing the territory with the map. Science creates the tissue culture to replicate its relief map of reality. It does not define the parameters unless the parameters exist.

Let's consider, maybe, what it would look like if we combined those theories. Dickoff and James came up with a category. Instead of going through those, I'd like to use a clinical example.

At the University of Pennsylvania Hospital, they have a respiratory dependency unit. Children who are respiratory dependent, from birth, or from later accident, stay there and are cared for. The unit is particularly attentive to developmental problems that might come up. There is a young man there, he is now turning six, he was three when I left, and he is called King George (his first name is George). He was born with "Vater's Syndrome" and has been on a respirator since birth. He now has a 20 foot cord and he runs around the unit, getting the cord caught in doors all the time and disconnecting the respirator. It scares you a little bit when the alarm goes off, but you just reconnect it. King George really runs the unit.

When I was down there, a child was evacuated to the unit. His name was Jason. He was about 15 months old and lived in a small town



north of Philadelphia. Around Christmas time, the parents came home from shopping, Jason had been with the baby sitter, and Jason was kind of limp and whiney. The next morning Jason could not move and had gotten cyanotic. They took him into the hospital and they thought maybe it was meningitis. First they ruled out abuse, and finally, by the time he was transported, he was respirator dependent. He came to the University of Pennsylvania for a workup, and a plan. He has a functional complete transection at C-5. The only thing he can do is turn his head, but with the respirator in place, it hurts.

He came and the initial workup was done by virology, of course, because it looked like it was a virus because it didn't look like it was a bacteria. Virology couldn't find anything. So, maybe it was a virus we didn't know anything about yet, so they started looking for treatment plans for viruses. Jason didn't get better. He stabilized, but he didn't get better. Finally, virology said, we can't do anymore, it's not a virus, as far as we know. And I'm glad they added, as far as we know, because we haven't discovered all of them yet. At any rate, they couldn't find any of them in the catalog.

Jason was doing pretty well and his mother and father had actually tried to relocate down to Philadelphia. But they had to get back because the father had taken time off from work for a few months and they had to get back to the rest of the family. After they left, Jason began to lose weight, have apnea spells even on the respirator (he was on blow-by at the time). Jason got worse, so they called virology back and they said, we didn't know what the virus was before, it's probably back again, and we just don't know what it is. Maybe it was an autoimmune response, they couldn't find anything. Finally somebody said, the kid looks depressed, so they called psychiatry in and they said, he IS depressed. It means to me it is an anacletic depression. Whenever his mom comes and stays for a period of time, he perks up a bit. He is suffering from the loss of attachment. So what could we do about that, the loss of attachment?

Not very much, you see. We could get the mother to stay down a lot but that wasn't a workable solution. And furthermore, we really didn't know, just hearing "loss of attachment," how to think to do anything about Jason. This map gave us a way to treat Jason.

One day a nurse said, "we've got to figure out a way to get Jason to eat." He couldn't get tube feedings anymore because he had a kind of dumping syndrome and vagal stimulation, so they were getting him to eat by mouth. And ultimately, that was a good thing to do.

She didn't say, "what's making him sick, how do we get rid of it? What's making him depressed, how do we get rid of it?" She said, "how do we get him to eat?" It's just a body function, she could have asked how to get him to eliminate regularly. But this made sense because THAT'S WHAT HE COULD DO. The one piece

of Jason that was still intact.

Well, how do you get him to eat. We got him his favorite foods -- he had taste and he had preferences. The nurse said, "you know who really gets him to eat well? It's the nurse on evenings." How does she do it? So you ask and she says, "I don't know how I do it, I just feed him like I do every other kid."

So we watched how she fed the other children.

We noticed that when Jason closed his eyes, what she did was to say, "Oh, Jaa-son, Jaa-son" and Jason would open his eyes and she would put another spoonful of food in his mouth. Another nurse, when Jason closed his eyes, would put the spoon up to his mouth and say, "come on, now, Jason, eat." Looking at the two, different perspectives, what we saw was what Brazelton and others have described as "the game." Playing a game. The game is what we have all played and seen in children. The child looks away and the mother INCREASES her activity but doesn't thwart the child's looking away, and then the child looks back. And actually, Brazelton has shown on film that first the mother plays the game and then the baby plays the game. And then the baby will invite others to play the game. Jason was playing the game. The one person who was playing the game was that evening nurse.

Now, suddenly, we knew what to look at. We went over to the psychology department and got the controllability literature. That's the map we wanted to use. Now we could say that his depression was due to his lack of control over ANY part of his world, and the developmentalists said, of course, he is now 18 months old. 18 month olds are manipulators. They run around the world, they get into trouble, moving, always talking. And Jason couldn't do anything. And there was good evidence that there was no cognitive loss in Jason. It made all sorts of sense now.

And the neat outcome of that was first we tried control with food and you could finally get Jason to, in a way, ask for ice cream. He'd ask for it and you'd reinforce it when he blinked twice. And pretty soon there was a pattern. And then the psychologists said, of course, it's conditioning, we're having operant conditioning here.

Then we decided to try to increase Jason's controllability. One afternoon, I was with my brother and sister-in-law at their house, talking about Jason -- he was on my mind a lot in those days. And my brother said, "you know what they use in the cockpit of Navy planes, to give the pilot control when your two hands are busy?" They put reflectors on their heads, and so by gaze direction, the pilot can make a connection with an electric eye and so control other instruments.

Soon, Jason was wearing a little reflector, that completed an electric eye circuit over his crib. When he completed the electric eye circuit, a train on tracks above his head ran



around the crib. And the interesting thing is, we kept making it harder and harder for Jason and he kept mastering the train. And the nurses began to say, "if you don't get that damned train out of here...!" The nurses would say, "Okay, Jason, time to eat and then you can play with your train." And he'd look quick and it would move and jerk.

Well, this did not mean that Jason was not still partly depressed or that Jason did not still have the virus. But we were farther ahead in caring for Jason than if we had stopped with the maps that we were using. Now, is it wrong to say that it was a psychological theory that gave us the idea of conditioning? No. They have done a very good job about operant conditioning. The thing is, we don't know when to use their maps because THEY don't know when to use their maps because they have never seen their maps act in reality. That's kind of a harsh view of basic psychology because applied psychology is working on that particular problem.

Preparing for this today, I called down to see how Jason was doing. He's still on the respirator but he's now learned the language for the deaf. What they have taught him to do is by holding a mouthpiece, he can point to a symbol on a microcomputer. One good thing that has come out of this is the multidisciplinary interest. Every time someone finds something new they go over and try it out with Jason. It may be that Jason will never recover that function. It may also be, and probably is, that we may never know why.

The fact is that we now have a mechanism for capitalizing on what Jason can do. I think that that capitalization began with a particular kind of question that tapped into a care function. I define care as promoting the natural functions, the ones that are intact. So when a nurse asks, "how do we get Jason to eat?", we no longer were bound by the maps of depression, the maps of virology, the maps of immunology.

I think of the use of these maps, and the orchestration of these maps as the crux of nursing science. What it needs to do, it seems to me, to turn its practice into science is be explicit about what it does. And to map those frameworks so that others can understand under what conditions a different focus needs to be taken. Now, one can say that's not science, that is management. That is what they said about computer science -- "it's not science. It's just math and engineering." Computer science right now is a very popular science. I say that by that selective combination, we know more now than we ever could have known with merely the maps of math juxtaposed with the maps of engineering. It was the combination that created a new world, a new reality, a new relief map.

I say that nursing provides a way of knowing about the world that no one else can know. That comes out of the relationship we have with the real world and the patient in the real world. There is a kind of intimacy that occurs in nursing care that is not duplicated in any other kind of care. In talking with a colleague, we

were kind of taking apart the parts of care. A doctor can touch a patient with the same touch but with a different intent. Both the patient and the doctor know that the intent is different. The doctor feels the spine to see if there is a tumor there. The nurse can feel the spine in the same way, the same length of contact, and both the nurse and the patient know that she is giving a backrub. We cannot call intent irrelevant to the effect, because we know all too well that it is the intent that defines the behavior. So it is wrong to say that it is merely feeling the pressure.

In psychology and psychiatry, we sit with patients and hear about emotional intimacy. We never touch them. Is that a difference? I think it might be. I heard a psychiatric nurse remark, "you know that kid back on the unit in the restraints? I fed him this morning. He's not upset when I feed him." He seems better, he's not as disturbed, not as sick. And I think we knew something different about that person when she said that, that we could not tell unless care was given. And what I say about that person was that he was comfortable when his dependency needs were met. And when she was feeding that man, that she was meeting a need, and when she did we knew something we didn't before. That fact probably alters what we should think about what was wrong with him. Through her care, she sees a part of him through the care, in a way, by creating a new world, a new interaction, that none of the rest of us can. That creation of a new reality adds to the perspective of the world and the knowledge about people. It's sad to think that the world will never know the full dimensions of people unless we talk about what it is like for patients when they are cared for, what happens in the exchange of care.

We could argue, and some people have, that that is not scientific, that's part of the art of description and we are back to the same circle. Science, in the experimental mode, was defined by the map. We have evidence of that. When we do an analysis of variance, we say (if we're doing a complex analysis of variance, let us say we are looking at tumor size by site of the body). What is irrelevant is called "error term." What is included in the error term? Sex of the patient, age, married, whether they have a family, what they think about their illness, what they think about dying, how worried they are. And rightly so, because, see the tumor was grown in the lab. Any variance in tumor was error: the temperature was wrong that day, light fell on this tumor. But we are making an error, a major one, if we think that the individual difference is irrelevant. I think the danger in medicine can sometimes be, there's always a risk if you are using the wrong map for the territory, you may not get very far, and you will waste a lot of time. Like using a map of Massachusetts to get through Connecticut. You may go a long way out of your way if you don't notice it soon enough. It is a risk to the scientist and thus knowledge is a little



slow to come out.

When we use a map to change the world, there's a bigger risk. Because if our map is wrong and we go and we make the Connecticut road system to mimic our map and we are using the wrong map, we have now changed reality. And medicine has the power to do that. If you misdiagnose a tumor and treat it with a carcinogen, you can create cancer. So the error of using the wrong map, a map that comes out of basic science and is applied to the real world, the error is much stronger. And I think what can help decrease the error is to include relevancy -- things that are irrelevant in the laboratory but in the real world are.

I would like to spend the last few minutes talking about that last characteristic of nursing science -- the ability to know people like no one else can. I have come to value that a great deal. Because it was as a nurse that I came to hear how people felt when they knew they were going to die, they were really going to do it. I think I heard it in a different way -- I and other nurses heard it in a different way -- sociologists can write about it, you can go in and say "let's talk about how you feel about dying," that's different from hearing it during a backrub. It doesn't mean it's wrong, it's a different aspect. I can say something about how people are for a 24-hour period, because I have spent a lot of 24-hour periods with people and have seen them change.

This way of knowing has not been all that valued, not so much by the outside world, but by our own. I have two friends, they are both psychologists, who want to work as nurse's aides because they want to know what people are really like. And I have the feeling that if we don't soon get our act together and recognize the wealth of information that we already have, other people will begin to try to create our reality. And there are bright people out there and they probably can come pretty close.

Finally, I would like to talk about the value of feeling that one knows a part of the world. A remote source: Vincent Deithier knows a fly, the blowfly inside and out. There is nothing that you may ever want to know about the blowfly that he doesn't already know. He is a noted biologist and entomologist and one day he got tired of having people ask, "why did you spend your whole life studying a fly?" So he wrote a book about knowing the fly. In one last part, he talks about the rewards of science. He says don't expect money, for one thing, don't expect people to appreciate your work, that's another. There are two rewards that he likes to talk about.

One of the more pleasant ones is a passport, a feeling of belonging to the world, a feeling of belonging to one race without political boundaries and ideologies, religion, or language. It's sort of what brought us together today. It connects us with people who have never set foot at Yale but are interested in the same piece of the world, the same map, that we are.

The second one is one that is closer to the philosophical value that I spoke about earlier, the value of knowing. He says, "man has a hunger to know, and to many a man being endowed with the capacity to know, he has a duty to know. All knowledge however small, however irrelevant to progress and well-being is part of the whole. The instrument of the scientist's destiny may be many things, from the ultimate space of the farthest reaches of the universe to the ultimate particles of matter, and all things in between, including man himself. It is a "myth" to find these things. A fly is just as much in the scheme of things as man."

We can know through our practice, we don't have to collect flies to know something. We can know through our practice a piece of the world that no one else can. And we can try to share that knowledge through our science. That is the basis of the science of caring, is making our practice into our science.

Audience: (Inga Mauksch) I'd like to ask you to tell us a little bit, if you think you can, about how you got this incredible sensitivity, of knowing how to ask the question.

MV: I think a lot of it came from the work that I had here. And from talking to other nurses. You're pointing out something important. The questions I've asked of psychologists are different. I'm a better psychologist for having been a nurse. And I can ask questions that psychology doesn't know yet how to ask. (Psychology as a whole, there are people who know how to ask them.) I can say, "I wonder if her diet is off today, she seems a little jumpy." I have that piece of the plan. From working with a collection of nurses. And maybe it's those long nights working, when you are sitting by a bedside and you begin to wonder about things.

The question I'm researching now is an un-researchable one. And that is, why do people die when they die? Why me, why now? And I think that comes out of knowing that any explanation that we have now is not big enough for capturing what it is we see.

It didn't come from my basic nursing. I don't think basic nursing can be as explicit about the ambivalence that you must feel and the ambiguity that you must deal with when you're always too scared. Our young doctors are too scared to think that there might be another way and that they might be wrong. But that's the best they have, it's the only thing they have. It surely isn't age, though. (laughter).



Our apologies:

The following list of references was omitted from the last issue (Fall 1984) of the Yale Nurse. They should be attached to the copy of Judy Krauss' paper: "Nursing Madness and Mental Health," which was presented at the Alumnae/i College, June 8, 1984.

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## Reva Rubin Gift



Reva Rubin '46 is one of YSN's most distinguished alumnae. We honored her in 1981 with a Distinguished Alumna Award, testifying to her pioneering work in understanding mothering and mother-infant relationships.

Now, Reva has been honored by having her book -- her life's work -- Maternal Identity and the Maternal Experience -- chosen as a Book of the Year by the American Journal of Nursing.

Reva has honored YSN as well. She has chosen to assign a portion of the royalties on her book to us, to be used to increase the "civility" of the place, to make the environment happier. We are deeply grateful to Reva and join in congratulating her.

## ALUMNAE/I ASSOCIATION


### Connecticut Regional Group

At a meeting on November 5th, about 25 alums gathered at Alumni House in New Haven. Donna Diers spoke to the group about Public Policy - and stressed the great need for nurses to be involved in decision-making concerning health delivery and practice.


### Class Notes

Virginia Miles '43, has retired from her teaching duties at the Baptist Hospital School of Nursing in Kediri, Indonesia, and returned home to North Carolina.

Mildred Lafferty '46, travelled with a seminar group (Summer '84) to Tokyo, Hong Kong, Taiwan, Thailand and New Delhi. Lectures by Prime Minister India in her home and by the Vice President of Taiwan.



JUNE 6 7 - 8, 1985



ALUMNAE/I COLLEGE

Theme: High Technology and Humanism

REUNIONS

This is THE year if you belong to one of these classes -

1930	1945W	1965
1935	1950	1970
1940	1955	1975
1945	1960	1980

GIVE YOURSELF A TREAT - RETURN TO YSN IN 1985!



Joan Mennie '46W, School Health Consultant at DuPage County (IL) Health Department, has co-authored an article published in JOSH, April 1984 entitled: "Health Department Services for Preschools and Day Care Centers."

Tina DiMaggio '47, was appointed one of two Associate General Directors of the Massachusetts General Hospital in March 1984. She has worked at MGH since 1968 in administration, and says, "I think I have a thorough understanding of the entire institution and how it can best function for the benefit of the patients." This appointment is a tribute to her personal achievements and recognition of her abilities as nurse and administrator!

Jewel Quimby Patton '47, was honored at a dinner at time of her retirement as Executive Director of the VNA in Salinas, California. She was one of the founders of this agency and has been involved in its tremendous growth and expansion. She has been writing a history of the Salinas Visiting Nurse Association.

Joann Gephart '67, was honored in June by the U.S. Public Health Service by being awarded an Administrator's Award for Excellence. She works at the Rockville MD Health Resources and Services Administration.

Maryann Pranulis '67, earned a Doctor of Nursing Science degree in June from the University of California at San Francisco.

Nancy Koehne Spring '69, had a son Joseph born in July 1984.

Joan Edelstein '75, received a DrPH degree from University of California Berkeley School of Public Health in Maternal/Child Health. She was also granted tenure and promoted to Associate Professor in the Department of Nursing at San Jose State University. In the summer of '84 she was to lead a tour in Russia visiting Maternal/Infant facilities.

Susan Feldman-Gordan '71, and her husband Charles had twin daughters last September - Jacqueline and Rebecca!

Anita Ward Finkelman '71, has completed Post-Masters work in Health Care Administration at George Washington University, and is working for Marilyn Goldwater, Maryland State Delegate, on health legislation.

Catherine Kiene Forrest '71, had a third child in June 1984 - daughter Suzanne.

Linda Vieira '72, wrote in the spring that she and her husband had two babies in 1983! "John was born in February 1983 and we adopted him in April. The second child was Jessica born in December!" Linda continues in private Ob/Gyn practice in Aspen, and also had an



article published, written with Douglas Hershey M.D., "Problems of Pregnancy at High Altitude." See it in Contemporary OB/GYN, Feb. '84, Vol. 23.

Chris Niemyski Nuger '73, has become the Administrator of the Springfield (Massachusetts) Health Center. And she now has three children, 2 boys and a girl (ages 7, 5, and 2).

Margaret Grey '76, completes her Ph.D. in January 1985 and will have an Assistant Professor position at University of Pennsylvania.

Marilyn McHugh Rochester '76, has a daughter born in February '84.

Diana Bransfield '77, received her Ph.D. in September '84 from Yeshiva University in Health Psychology. She has written numerous articles dealing with research in breast and gynecologic cancer. Diane is now Assistant Professor of Psychology at Southwest Texas State University in San Marcos.

Susan Kennedy (formerly Pennington) '77, has left her job at University of Massachusetts School of Nursing, and has moved to the Findhorn Community in Northern Scotland.

Jamie Norris Richardson '77 and husband Londe have a daughter born in February '84. They have moved to San Antonio, Texas where he will do a cardiology fellowship at Wilford Hall Medical Center. Jamie plans to start law school there at St. Mary's University. An article by Jamie was published in the February issue of Nursing '84: "In the Face of Anger."

Dianne Taylor '77, Assistant Professor, Department of Nursing at Towson State University, Maryland presented, during the month of August, day-long seminars through Resource Applications, Inc. on Managing a Crisis Effectively! These were scheduled in Baltimore, Boston, Philadelphia, New York City, Atlanta, Washington, D.C., Fort Lauderdale and Pittsburgh.

Mary Hatton Gibson '78, had a baby in the summer of 1984.

Susan Kalma '78, Director of Health Center at Middlebury College, presented a paper for the World Federation of Public Health Associations in February 1984 in Tel Aviv. She's chair of the Committee on International Health for the American College Health Association.

Judy Shindul '78, was elected President of the Massachusetts Nurses Association in April '84.

Janet Taft '78, earned her MPPM degree at SOM 1984.

Debi Welch-McCaffrey '79, was a speaker at the Third International Conference on Cancer Nursing in Australia in March. She's had three more articles published recently: "When It Comes To Cancer - Think Family," Nursing '83, December 1983; "Promoting the Empathetic Development of Nursing Students in the Care of the Patient with Cancer," Journal of Nursing Education, February '84; "Oncology Nurses as Cancer Patients - An Investigative Questionnaire," Oncology Nursing Forum, March/April 1984.



Robert Woodcock '79, is Assistant Professor of Nursing in the baccalaureate program at Western Connecticut State University (Danbury) Connecticut.

Judy Fardig '79, had a daughter, Erika Linn, in March 1984.

Margaret Flintner '80, had a son on October 27th.

Nancy Loomis-Stewart '80, was married in March 1984.

Danuta Bujak '81, is Hypertension Program Coordinator at the Comprehensive Family Care Center of A. Einstein College of Medicine. In May she presented results of a study conducted there to the Regional Conference on High Blood Pressure Control held at Atlantic City. Her title: "Effectiveness of a Medication Assistance Fund in improving compliance and blood pressure control in hypertensive patients."

Chris Conforti '81, has moved to the nation's capitol -- to be a Clinical Specialist at the V.A. Hospital in Washington, D.C. and she will begin doctoral study at Catholic University.

Rachel Frazin '81, has a daughter, Danielle, born at home in August 1984.

Annabel Ching '82, is working labor and delivery at Harbor - UCLA Medical Center - "getting some OB experience before going on to midwifery!"

Amy Hecht '82, has a son born September 10, 1984.

Kate Schwob '82, is working as nurse-midwife at D.C. General Hospital and teaching nurse-midwifery at Georgetown School of Nursing.

Four grads of the Med-Surg Neurological Specialty program presented papers at the 10th anniversary meeting of the Rehabilitation Nurses Association in October in Cincinnati...Chris O'Dell '84, Deb Garfield '84, Kathryn Barry '81, and Eileen Sherburne '83.

Donna Diers is our super alumnae/i "net worker" -- she reported on folks she's met at meetings.

...Seen at the NPACE (Nurse Practitioner Associates for Continuing Education) Conference in Albany, New York, in late September: Susan Molde '76, Ann Williams '81, Pat McCarthy '79, Ed Branson '80, Catherine Surette-Worthley '80, Candis Danielson '81, Anne Hutchinson '84, Deb Holdeman '83. Donna Diers gave the keynote address, on nurse practitioner skirmishes and successes and strategies.

At the Third New England Cancer Nursing Conference in Waterville Valley, New Hampshire, on a beautiful peak-fall weekend: Carol Curtiss '81 led a discussion on graduate education in oncology nursing; Joan Moore, Clinical Instructor, YSN, on advanced nursing research issues; Maria Quindlen '82 on how a staff nurse does research; Deborah Mayer '85 on nursing participation in research protocols; Peggy Plunkett '81 on the stress of initial diagnosis; Tish Knobf '82 on breast cancer - helping patients make decisions (and Tish also participated on a

panel discussing nutritional status); Debbie Stephens Mills, Assistant Professor, YSN, on patient compliance; Bonny Johnson '80 spoke on considerations in handling cytotoxic agents; Marion Morra, Clinical Instructor, YSN, presented on prevention, and Donna Diers gave the final address on issues of power in nursing. In the audience also were Janet Hine '47W, Brenda Gypson '84, Carmella Lattizori '58, Pat Trotta '78 and a number of our present med/surg students who snuck in at the last minute!

## AROUND THE SCHOOL...

### Student Affairs Office Staff



Elizabeth "Tinker" Barnett, Financial Affairs Officer; Sandra Ferraiuolo, Senior Administrative Assistant; Barbara Reif, Registrar

Bettie Feeley, who worked in the Student Affairs Office for nearly 17 years, has retired. She and her husband have moved to a new home in Maine. Address: R.R. 3, Friendship Road, Waldoboro, Maine 04572.

### In Memoriam

Myrtie Carpenter, age 90, died in a nursing home in West Haven on Wednesday, November 21, 1984. She was secretary to the first four deans at YSN - from 1927 to 1962 - and a much loved friend to many generations of students. Friends may wish to send contributions to the Yale School of Nursing Alumnae Fund in her name. This is a Dean's discretionary fund and is used in large part for student aid - a need which Myrtie would heartily support. A check should be made out to Yale University School of Nursing and sent with a note indicating that it is a gift in Myrtie's name to: The Dean, Yale University School of Nursing, 855 Howard Avenue, P.O. Box 3333, New Haven, CT 06510.

Marion E. Russell '29 died December 12, 1983.

Yvonne Yonick Sherwood '36 died summer 1984.

Ellen Boyd Bigelow '40 died July 24, 1984.

Marcia Creecy Haberlin '44 died February 19, 1983.

Jessie G. Alexander '45W died January 15, 1984.



## YSN Celebrates Donna's Deanship

The faculty, staff, student, and university colleagues of Dean Donna Diers gathered on Thursday, November 29th at an elegant reception to celebrate and acknowledge the twelve and a half year period of her YSN Deanship. Hundreds of people attended not only to take note of the past years of accomplishment but to wish Donna well as she makes the transition from Dean to faculty member. Fortunately for YSN, what we lose in a Dean we will gain in a faculty member as Donna concentrates her efforts on the contributions of nursing to health policy planning and analysis.

A. Bartlett Giamatti, President of the University, reflected on his 8 year relationship with Donna as a part of the University administration as did The Honorable Jose Cabranes, former General Counsel to the University. Donna's brother Jim brought greetings and best wishes from her family and David Whitehorn, President of the Student Government Organization reflected on Donna's influence on students past and present.

The YSN faculty, staff, and students presented Donna with a check to furnish her new office. A silkscreen of Harkness Tower and the three churches on The Green was added to com-

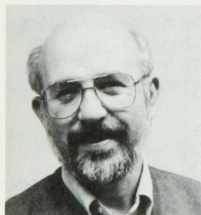


pliment the office furnishings. Virginia Henderson passed on an antique silver loving cup with the hope that Donna would continue the tradition. The Program Chairs and Judy Krauss, the Associate Dean presented Donna with a shadow-box miniature of her current Dean's Office. Much was said about Donna's contributions to the School and to Nursing. The sentiments are perhaps best summed up in a quote from President Giamatti's remarks: "Donna brings honor to nursing on behalf of Yale not because she is of Yale."

## S.G.O.

### In The Middle of The Strike of '84

by David Whitehorn '85  
President, S.G.O.



Being a student at YSN has always been difficult. There are new roles to learn, clinical expertise to develop, and the thesis to write. Our lives are in transition. This year there is an additional stressor.

Clerical and technical workers are on strike. Pickets circle on Park Street. The medical library closes early. Feelings run strong both for and against the union.

Whatever our views, everyone at YSN has been touched by the strike. We have been confronted by questions that go beyond our usual academic scope.

Like many others, I feel very much caught in the middle by the strike. I respect the clerical staff of YSN who have never supported the union and remain at work. Yet I have friends from other departments who believe strongly in the union, strongly enough to carry out civil disobedience.

And there is the issue of Comparable Worth. The clerical workers are nearly all women and their pay is significantly less than tradition-

ally male positions provide. As a nurse I oppose the lack of respect and monetary reward for traditionally female roles in this society. If this strike makes that issue more clear and visible, does it not deserve my support? Yet I came to YSN to learn. I want to make the most of my educational opportunity and get the most return on my substantial monetary investment in my education. Caught in the middle again.

For the S.G.O., further questions arise. Should a student government group take sides when there is a diversity of student opinion? Yet to remain neutral, to conduct business as usual, represents some kind of statement. Once again I find myself in the uncomfortable middle.

Reflecting on the situation suggests that being caught in the middle is nothing new to Nursing, particularly to a Clinical Nurse Specialist. Nursing has always been in the middle between the system (the doctor, the hospital) on one side and the patient on the other. Are we advocates for the patient, or the reliable extension of the doctor, or somewhere in the middle, an independent professional?

The Clinical Nurse Specialist (CNS) often is placed in a lonely, uncertain middle position. Is the CNS a nurse, or some new breed, part nurse, part doctor and part magician? Is the CNS part of the nursing administration or part of the clinical staff?

A CNS is also often confronted with human suffering, that of the patient and their family,



and the staff. And quite often there is very little we can do about it. Certainly there is a great deal of suffering with this strike. More than anger, the mood of campus is sadness. So we are caught in the middle. The situation is ambiguous, dangerous and uncertain. In the 'multidisciplinary team' that is the Yale community, the group dynamics are frightening, communication has broken down. Does nursing have anything to contribute to the healing? What is unique about what a CNS brings to the clinical team?

I came to Nursing because it represents

an attitude of caring and cooperation, a concern for the whole. We know that this often involves an active and assertive application of intelligence tempered with knowledge. Yet there is always a respect for, and an empathy with, all aspects of the situation, all parties involved. This kind of wholistic, synthesizing stance places nursing in the middle, in touch. So perhaps we are where we should be, in the middle. Perhaps we can, in some way, bring our professional understanding to our encounter with the strike of '84.

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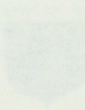
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