Nursing and the Privilege of Prescription, 1893-2000

Keeling, Arlene W.

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Introduction

In January and February 2000, I received numerous e-mails on the subject of new legislation being proposed in the Virginia legislature related to expanding prescriptive authority for nurse practitioners. As director of the Acute Care Nurse Practitioner (ACNP) program at the University of Virginia, I was very interested in the issue. That year, in the Commonwealth of Virginia, nurse-practitioners were restricted to prescribing only one of six categories of drugs (legend drugs), and many of the recent graduates of our program were writing to me about the difficulties the restrictions were causing in their daily practice.

Shortly after receiving the e-mails, I expressed my interest, concern, and hope for change to a colleague in a hallway conversation. The colleague happened to be Ann B. Hamric, PhD, RN, FAAN, who had edited several books on advanced practice nursing and had presented her research data on the safety and efficacy of nurse practitioners’ prescriptive practices in Louisiana to the Louisiana state legislature in 1997.1 Ann’s response was prompt: “Are you going to Richmond to testify on the nurses’ behalf?” I thought for a moment and then replied: “I can’t. I don’t know the whole story. Nurses have been giving medicines—with or without prescriptive authority—for over a century. How can I know where we should go with all this if I don’t know where we’ve been?” Ann’s reply was direct: “Well, if you don’t know and you’re a nurse historian, then I don’t know who does. You’d better find out.”

So I wrote a grant proposal, and in 2002 the National Library of Medicine awarded me funding to research the “History of Prescriptive Authority in Nursing in the Twentieth Century” (G13). This book is the result of that three-year project and another three-year grant (K01) on the “History of Coronary Care Nursing in the United States” funded by the National Institute of Nursing Research (NINR). It is an attempt to tell the story of nurses’ work with medications over the last century—a story that has the potential to shape policy decisions today in the ongoing debates about prescriptive authority for nonphysician health care providers.

The history of nurses’ work with medications is, for the most part, invisible—in fact, it is absent from history books. Despite the fact that nurses administer, dispense, furnish, and/or prescribe medicines every day,
the profession, as a whole, has minimized this aspect of its work, instead advertising itself as the “caring” profession and highlighting the psychosocial aspects of nurses’ responsibilities. To my knowledge, with perhaps the exception of Bonnie Bullough’s work *The Law and the Expanding Nursing Role*, a book on this subject has not been written. Numerous articles have been published on specific aspects of prescriptive privileges for nurses, but most of those begin in 1965 with the formal development of the nurse practitioner role.

This book seeks to make visible nurses’ work related to medical therapeutics. It is a short history of nursing, medicine, and prescriptive authority in the United States in the twentieth century. It is not meant to be the definitive history of twentieth-century prescriptive authority in general; nor is it simply a history of prescriptive authority for nurse anesthetists, nurse-midwives, or nurse practitioners specifically, although it is inextricably linked to those histories. Using a case study approach, the book identifies and describes the informal and formal roles nurses played over the course of the century in dispensing, furnishing, and prescribing medications. (These terms are defined as follows: [1] “to dispense” means to administer a drug from one’s nursing bag or from samples; [2] “to furnish” means to give a drug according to standing orders of a physician; and [3] “to prescribe” is to write or telephone in a prescription for a specific drug to be dispensed by a pharmacist.) The book discusses the nurse’s roles in the social, political, economic, and legal context in which the activities took place and in relationship to the history of nursing and medicine, while occasionally introducing the history of pharmacy (a topic which goes beyond the scope of this work). It addresses the national movement from domestic care toward scientific medical care in the early part of the century and the knowledge needed to give medical and nursing care as that care became increasingly complex.

The book is built around a series of case studies representing different geographic areas of the United States during different decades of the twentieth century. Although numerous historians have addressed specific aspects of each of the cases presented here, none has analyzed the cases through the specific lens of a history of prescriptive authority in nursing in the twentieth century. For example, much like this book does for nursing, John Warner’s book, *The Therapeutic Perspective: Medical Practice, Knowledge and Identity in America, 1820–1885*, examines the relationship of therapeutic intervention and professional identity for physicians, detailing changes in therapy over time by examining physicians’ work in three cities: Boston, New Orleans, and Cincinnati. And, true to its purpose, Warner’s book is about the medical profession in the nineteenth century. Susan Reverby’s *Ordered to Care* examines the history of the nursing pro-
fession in the late nineteenth and early twentieth centuries, but that book focuses on the caring aspects of the nurse’s role rather than on nursing therapeutics. Rosemary Stevens masterfully documents the history of American hospitals in her book, *In Sickness and in Wealth*, focusing on “medicine, money and power,” and discussing disparities in the health care system, but she clearly does not address the nurse’s role within these institutions nor does she discuss the blurring of the boundaries between medicine and nursing that occurred in intensive care.

Other scholars have covered the topics of each of this book’s chapters in more depth, but they do not address the nurse’s work specific to dispensing, furnishing, or prescribing medications and other therapies. For example, Karen Buhler-Wilkerson’s *No Place like Home* provides a comprehensive account of the work of the Henry Street Settlement Visiting Nurses, but it only touches on the medication aspects of the nurse’s role. Nancy Tomes’s article, “The Great American Medicine Show Revisited,” in the *Bulletin of the History of Medicine*, provides an insightful analysis of the emergence of the modern prescription drug between 1938 and 1951, yet the article makes little mention of the nurse’s role in relation to prescriptions. Likewise, Barbra Mann Wall’s *Unlikely Entrepreneurs* describes Catholic sisters’ work in providing anesthesia during the Civil War, while Virginia Thatcher’s *A History of Anesthesia* and Mariane Bankert’s *Watchful Care: A History of America’s Nurse Anesthetists* both provide a broad overview of the history of nurse anesthesia in the United States, but none of these works specifically analyzes the nurse anesthetist’s role in relationship to prescriptive authority in nursing. The same holds true for the numerous books and articles documenting the history of the Frontier Nursing Service (FNS), including Laura Ettinger’s, “Nurse-Midwives, the Mass Media, and the Politics of Maternal Health Care in the United States, 1925–1955,” in the *Nursing History Review*, and Judith Rooks’s *Midwifery and Childbirth in America*. Breckenridge’s own account of the FNS, *Wide Neighborhoods*, is descriptive and presents the broad picture of the inception and growth of the organization rather than focusing on the legality of the nurse’s work with medications or the nurse’s scope of practice.

As far as nurses’ work with the Bureau of Indian Affairs (BIA) is concerned, historians Emily Abel and Nancy Reifel have done a thorough job of analyzing the cultural aspects of the nurse’s role in addition to describing the nursing activities in chapter 26 of Judith Leavitt’s *Women and Health in America*; nonetheless, their work does not specifically address issues related to nursing’s scope of practice in giving medications to the American Indians. Much the same can be said for Abel’s article, “‘We are left so much alone to work out our own problems’: Nurses on American Indian Reservations during the 1930s,” in *Nursing History Review* and
Mary Ann Ruffing-Rahal’s “The Navajo Experience of Elizabeth Forster, Public Health Nurse,” in another volume of the same journal. Both of these excellent articles provide a broad picture of nurses’ work with the Bureau of Indian Affairs. But despite the fact that both articles reference the field nurse’s use of medicines, neither specifically analyzes this aspect of the nurse’s role.12

Related to the latter half of this book, Julie Fairman’s and Joan E. Lynaugh’s book, Critical Care Nursing: A History and Lynaugh’s and Barbara L. Brush’s American Nursing: From Hospitals to Health Systems are two of the best works analyzing the changes that occurred in nursing practice in the mid-twentieth century, yet medication administration is not their focus.13 In her other works, Fairman’s analyses in “Playing Doctor?: Nurse Practitioners, Physicians, and the Dilemma of Shared Practice,” and “Watchful Vigilance: Nursing Care, Technology and the Development of Intensive Care Units,” 14 support many of my own conclusions. Of particular note, both Margarete Sandelowski’s work, “The Physicians’ Eyes: American Nursing and the Diagnostic Revolution in Medicine,” in Nursing History Review and Davinia Allen’s “Negotiated Boundaries” were foundational to my analysis. Numerous other works influenced my thinking related to Nursing and the Privilege of Prescription. These works are referenced in specific chapters.

As noted earlier, this book uses case studies to illustrate changes in nursing practice that no doubt were occurring in numerous cities, towns, and villages across the nation during the specific time periods identified. These exemplars were used intentionally to make a complicated and what could have become a lengthy and tedious history one that could be more easily read. The cases were also used to set some boundaries on the project while simultaneously providing a glimpse of nursing practice in different regions of the United States and among different ethnic groups.

The major thesis of the book is that the amount of freedom nurses have had in dispensing, furnishing, and prescribing medications has been dependent on the particular setting in which they practiced, on individual practice negotiations between physicians and nurses at the grassroots level, and on the level of trust that developed between them.15 Even without legal prescriptive authority, nurses safely and effectively administered drugs at various times and places throughout the century. Providing care in underserved areas of the country—in urban slums, in the remote hollows of Appalachia, and on Indian reservations—nurses offered access to care to many to whom it would otherwise have been denied. Meanwhile, in operating rooms, intensive care units, and other areas of the hospital, nurses and physicians cooperated to administer care.
Dispensing drugs when necessary, furnishing drugs according to standing order sets, or de facto prescribing, nurses did what needed to be done in times and places where they were the only ones to do it, and they took responsibility for their actions. Themes that emerge are those of promoting access to care; responsibility for that care; the importance of advanced knowledge for safe practice; economic determinants of care; and interdisciplinary cooperation, collaboration, and conflict.

The struggle between organized medicine and nursing over where, to whom, and in what circumstances a practitioner is licensed to dispense, furnish, or prescribe drugs is the central tension of the book. That struggle is contrasted with what was occurring at the grassroots level, where physicians and nurses worked together on a daily basis, learning to trust each other and their respective areas of expertise.

The book then describes the “elusive and fine line” that separates nursing and medicine and the fluidity of that line. When care was to be provided in remote areas of the country, in the less desirable sections of urban cities, with minority cultures, on nights and weekends, when physicians were not readily available, the boundary moved to accommodate an expanding scope of practice for nursing.

Integrating themes are the fluidity of the line separating medicine and nursing; the influence of social mores; the political and environmental setting; economics, class, race, and cultural heritage in the issue of access to health care; and the ongoing struggle to determine who decides who will govern nursing practice. Another integrating theme is that of safety in health care and who determines the amount of knowledge prerequisite for that care. These themes emerge in each chapter and can be traced throughout the book.

Chapter 1, “Midway between the Pharmacist and the Physician: The Work of the Henry Street Settlement Visiting Nurses, 1893–1944,” represents nursing care provided by the Henry Street Settlement (HSS) visiting nurses in New York City in the urban Northeast at the turn of the twentieth century. From its inception in 1893 until 1944 when the social and nursing activities were separated, the Henry Street Settlement (HSS) visiting nurses linked nursing, social welfare, and the public. The HSS visiting nurses began their work on the Lower East Side of New York during the depression of 1893. Their work extended into the Progressive Era, a period in which there was a growing emphasis on widespread social and economic reform in the United States. During that time, under the rubric of social feminism, educated middle- and upper-class women like Lillian Wald and Mary Brewster participated in the movement to improve living and working conditions for poverty-stricken immigrants in the industrialized cities of the Northeast. Even in America—the land of democracy—class, race, and cultural heritage were issues.
Henry Street Settlement (HSS) Visiting Nurses provided skilled, professional nursing care to the thousands of European immigrants who crowded into ethnic ghettos in Manhattan and the surrounding areas. In addition to promoting comfort, nutrition, psychological support, and education about sanitation and health to patients and families, the HSS nurses dispensed medications from a central medicine chest located at the settlement house. In their work, the visiting nurses practiced in what Lillian Wald’s close friend and colleague, Lavinia Dock, would refer to as the “middle place”—somewhere between professional medical services and unskilled family care-giving—providing skilled nursing care to both middle- and working-class families, particularly to the immigrants who settled in New York City.

The Henry Street nurses practiced at the edges of their disciplinary boundaries, often diagnosing and treating commonly occurring illnesses and referring patients to physicians when necessary. In doing so, the HSS nurses worked cooperatively with local medical societies and independent physicians, but not always without interprofessional conflict. In fact, the reaction of certain divisions of the medical community that occurred in response to the HSS nurses’ work was an early indication of the interprofessional conflicts that would complicate the nurse’s role in relation to medications for most of the twentieth century.

Chapter 2, “Practicing Medicine without a License?: Nurse Anesthetists 1900–1938,” describes and analyzes the role of nurse anesthetists during the first half of the twentieth century, particularly noting the legal complications they faced while pursuing their right to practice this specialty. In California in 1934, the Los Angeles County Medical Association, represented by William Chalmers-Francis, MD, sued nurse anesthetist Dagmar Nelson for the “illegal practice of medicine in violation of the state’s medical practice act.” Given the fact that nurses had been administering anesthesia since the Civil War almost seventy-five years earlier, it is interesting to speculate on how and why this lawsuit happened.

This chapter examines the history of nurse anesthesia in the United States from the late nineteenth century to 1938, identifying issues related to their scope of practice and the reaction of both organized nursing and organized medicine. During the late nineteenth and early twentieth centuries, nurses practiced the art of anesthesia unopposed—often trusted and supported by the physicians for whom they worked. However, as the practice of anesthesia became increasingly complicated and technology based, physicians began to claim ownership of the specialty. At the same time the science was advancing, World War I increased the demand for nurse anesthetists. Later, when the Great Depression created economic difficulties for physicians, further tensions would surface about the nurse anesthetist’s role.
In response to each legal challenge to the nurse anesthetist’s role, the Kentucky, Missouri, and California courts upheld the practice of nurse anesthesia—as long as it was the surgeon who was doing the prescribing of the anesthetic agent. These court decisions would affect the practice of nurse anesthesia for the remainder of the century. They would also influence other decisions on nursing’s scope of practice. By 1938 the nursing profession had a legal precedent on which to base its tentative hold on this specialty practice. In some respects, the practice of nurse anesthesia went far beyond the boundaries of the discipline. These nurses were giving drugs that physician anesthesiologist Isabella Herb referred to as possessing “greater power for harm” than all others, while other nurses working during the same period were not allowed to give an aspirin without a physician’s order. Several themes emerge in this chapter: (1) specialized knowledge attained in postgraduate training programs was essential to nurse anesthetists’ abilities to practice safely; (2) clinical competence in the delivery of the life-threatening anesthetic agents was prerequisite to having surgeons trust their work; and (3) publishing the results of their work enhanced nurse anesthetists’ credibility.

Chapter 3, “Providing Care in the ‘Hoot Owl Hollers’: Nursing, Medicine, and the Law in the Frontier Nursing Service, 1925–1950,” highlights the care that the Frontier Nursing Service nurses provided to inhabitants of Leslie County, Kentucky during the early twentieth century. The chapter addresses one aspect of the Frontier Nurses’ work—that of furnishing medications to patients—particularly noting the intersection of these nursing activities with medicine and the law. Two research questions are addressed: (1) how and why did the FNS obtain the support of the Kentucky medical community for their expanded role? and (2) how did the nurses’ activities intersect with the federal laws regulating narcotics and the state laws regulating nursing, pharmacy, and medicine?

The answers are clear. From the late 1920s through the 1950s, nurses in the Frontier Nursing Services furnished medicines to patients in a remote, rural area of Appalachia. The time was right for the acceptance of their services on the part of the local medical community. Maternal and infant mortality in Leslie County had to be reduced.

The isolated highland region was short of physicians. There were inconsistencies in the safety and efficacy of the care provided by granny midwives, and local physicians were aware of the federal and state mandates for change. Physicians were also cognizant of the fact that the FNS nurses would not be an economic threat to them. Mary Breckenridge’s Frontier Nursing Service offered a solution—one in which the physicians could take some control of obstetric care by delegating authority to educated nurse-midwives who would be under the direction of a trusted leader and friend, Mary Breckenridge.
For her part, Breckenridge was politically astute and cognizant of the law. By establishing a physician advisory committee, Breckenridge clearly acknowledged the physician’s legal authority in the area of diagnosis and medical therapeutics. Rather than challenge that authority, she simply obtained physician-generated standing order sets that would enable the Frontier nurses to provide comprehensive health services in the “Hoot Owl Hollers.” Practicing according to these order sets, the nurses made clinical assessments, diagnosed illnesses, and furnished medications. According to an early report by Breckenridge:

One of the best things we have been able to do has been to effect a liaison between many of our patients and the specialists and hospitals of Lexington and Louisville. Through the kindness of the Louisville and Nashville Railroad and the generosity of the doctors, nine of whom have given their services, we were able, in the first 10 months, to give the best Kentucky has to offer to fifteen of her isolated people and this second summer several specialists have come up to hold clinics: diagnostic, gynecological and prenatal, eye, ear, nose and throat.¹⁹

Supported by the local medical community and the law, the Frontier nurses had unprecedented autonomy to practice nursing in an expanded role, providing holistic, culturally sensitive nursing and medical care to the people of Leslie County, Kentucky.

Chapter 4, “My Treatment Was Castor Oil and Aspirin: Field Nursing in the Indian Health Service, 1925–1955,” analyzes the care provided by field nurses working with the Navajo Indians in Arizona and New Mexico from the 1930s to the 1950s. Their work under the BIA was part of a major federal government initiative to provide health care to American Indians²⁰ on reservations throughout the United States. There, the intersection of federal bureaucracy; meager Congressional appropriations; and professional, geographic, and environmental factors shaped the nurses’ work. Bound by bureaucratic red tape and regulations, but expected to teach health promotion and disease prevention as well as transport sick patients to hospitals, visit patients at home, and care for Indian children in boarding schools, BIA nurses increased their scope of practice to do what needed to be done. They diagnosed everything from trachoma to ruptured appendices, transported critically ill patients to hospitals, taught mothers how to feed and clothe their infants, and furnished medications according to standing orders.

The BIA nurses stretched the boundaries of their professional work, making independent clinical decisions when necessary and at other times collaborating with physicians. Those nurses who were culturally sensitive
and respectful of the Navajos’ traditional beliefs and ceremonies for healing the sick frequently collaborated with the medicine men, as well, using their own treatments (like aspirin and cough medicine) as adjunct therapies when they were requested to do so.

Technically, the BIA nurses worked under physician supervision, but in reality the nurses often worked on their own—sometimes in telephone consultation with physicians. In their work, the field nurses made clinical decisions based on their advanced training in public health nursing and their experience in clinical practice. Clearly, much of their work stretched the traditional boundaries of nursing.

Chapter 5, “Verbal Orders and Hospital Nursing: Expanding Nurses’ Scope of Practice in the Mid-Twentieth Century,” addresses the changes that occurred in hospital nursing during the mid-twentieth century. Beginning with hospital nursing in the 1930s, this chapter discusses the medication nurse’s responsibilities and role in administering drugs. The chapter focuses on the requirement that hospital nurses were to practice only under written physician orders. Later, with the development of intensive coronary care units, a new role for nurses emerged, and nurses expanded their scope of practice. Using cutting-edge, space-age cardiac monitoring equipment, coronary care unit (CCU) nurses interpreted cardiac arrhythmias and made clinical decisions on which they based their care. Indeed, CCU nurses shared medical knowledge with cardiologists, often surpassing the skills of general practitioners in the area of cardiac arrhythmia interpretation and management.

The chapter includes information about the creation of the Hartford CCU at Bethany Hospital in Kansas City in 1962, and the research project in the coronary care unit at Presbyterian Hospital in Philadelphia, where Dr. Lawrence E. Meltzer, Dr. J. Roderick Kitchell, and registered nurse Rose Pinneo worked collaboratively to develop a new role for nursing. In one section, called “After Midnight,” the chapter explores time as place, and demonstrates how the life-saving medical treatment of cardiac defibrillation and the administration of emergency intravenous cardiac medications were rapidly delegated to nurses. Doctors shared knowledge because it made sense to do so to accomplish a greater goal, to decrease deaths from heart attacks (referred to as myocardial infarction, or MI) but also because it was more convenient for nurses to do more, especially at night. Viewed from either the nurse’s or the physician’s perspective, what the nurse could diagnose and treat “after midnight” was remarkably different from what she was responsible for during the day when the physician was present in the unit. Themes that emerge are physician-nurse cooperation and trust at a grassroots level, barriers to expanding scope of practice, and the emergence of specialty knowledge for advanced nursing practice.
Chapter 6, “Nurse Practitioners and the Prescription Pad, 1965–1980,” reviews the inception and development of the idea of the pediatric nurse-practitioner in Colorado under the leadership of Loretta Ford, RN and Henry Silver, MD, and the subsequent spread of nurse-practitioner programs throughout the United States. It opens with an example of the employment of a nurse practitioner by the Indian Health Service and discusses the influence of physician shortages, particularly in rural areas, on the growth of the nurse-practitioner role. The chapter also addresses the movement toward integrating nurse-practitioner programs into master’s programs in nursing. It emphasizes the importance of both public and private funding on nursing education and the growth of nurse-practitioner programs, as well as the intraprofessional and interprofessional conflict over the developing nurse-practitioner role. These issues are contrasted with the collaboration that was occurring between physicians and nurse practitioners at the grassroots level.

One section of the chapter revisits the Frontier Nursing Service and focuses on the procedures that the FNS put in place to facilitate nurse practitioners writing prescriptions in the 1970s. That section emphasizes the fact that nurse practitioners in the Frontier service were doing everything necessary to prescribe a medication except signing the prescription. (Of note, nurse midwives, introduced in chapter 3 in the Frontier Nursing Service, are dropped from follow-up because their requirements for educational preparation and certification have been outside mainstream nursing.)

Chapter 7, “Prescriptive Authority for Advanced Practice Nurses, 1980–2000,” traces selected nurse practitioner and nurse anesthetist developments through the 1980s and 1990s, highlighting important legislation and issues related to the distribution of medications, and including an example of how nurse practitioners gained the right to prescribe in the Commonwealth of Virginia in 2000. The chapter opens with an e-mail I received in February 2000 about what was occurring in the Virginia state legislature regarding nurses and prescriptive authority. The chapter then reviews the scheduling of drugs by the federal government, the challenge to nurse practitioner practice that occurred in Missouri in the 1980s, the Nursing Diagnosis movement, American Medical Association (AMA) opposition in 1984, and nurse practitioners’ gradual success in changing state nurse practice acts. Also included in this chapter are brief overviews of the rise of acute care nurse practitioners (ACNPs), a discussion of the implications of managed care on nursing and medical practice in the 1990s, law professor Barbara Safriet’s commentary on the issues, and a challenge to nurse practitioner practice published in the New England Journal of Medicine. The chapter also documents the outcome of the vote
in Virginia in 2000, when nurses won the vote for expanded prescriptive authority in the Commonwealth.

The chapter ends with one sentence summarizing the major point of the book: advanced practice nurses are professionals who can be trusted to manage their own practice at both the individual and organizational levels. That trust developed between individual doctors and nurses working at the grassroots level throughout the course of the twentieth century. It is time that this same level of trust is developed at the organizational level and that the realities of advanced practice nursing be reflected in state laws. Hopefully, this book is a step in that direction.

**Research Methods and Sources**

A social history framework was used to conduct this research. Primary sources included the Lillian Wald collections at the New York Public Library and Columbia University; the Frontier Nursing Service (FNS) collection at the University of Kentucky; the FNS photographic collection at the Ekstrom Library, the University of Louisville; the Works Progress Administration (WPA) papers at the Kornhauser Library at the University of Louisville; the Virginia Brown, Ida Bahl, and Lillian Watson collection at Northern Arizona University; the Bureau of Indian Affairs papers housed at the National Archives and Records Administration in Washington, DC.; the American Association of Nurse Anesthetists papers in Chicago; and medical and nursing journals of the particular decades. In addition, the following collections were also consulted: the Bethany Hospital Coronary Care Unit (CCU) collection, Kansas City; the Joan E. Lynaugh photographic collection, The Center for the Study of the History of Nursing, and the Main Presbyterian Hospital collection, University of Pennsylvania; the National Association of Pediatric Nurse Associates and Practitioners (NAPNAP) papers, the National Certification Board of Pediatric Nurse Practitioner’s collection, the Rose Pinneo collection, the Joanne Peach collection, the Barbara Brodie Collection, and the Arlene Keeling collection, all at the Center for Nursing Historical Inquiry (CNHI), the University of Virginia. Oral histories with several nurse practitioners were also done, the transcripts of which are located in the Keeling Collection, CNHI.