Nurses make decisions every day that affect the health of the individuals, families, and communities they serve. They make decisions about the use of clinical interventions, the use of their political vote, the education of nurses, the application of new technologies, and a myriad of others as well—yet when nurses make decisions, they often use decision-making frameworks that do not take into account past practices. Nelson and Gordon (2004) write about the “rhetoric of rupture,” stating that nurses often discard and distance themselves from their past, leaving huge gaps in their knowledge. Nurses continually reinvent themselves and their practice at the expense of their history. Without understanding and valuing past contributions to practice or to society, nurses contribute to the “nursism” or bias toward the caring role that pervades this society (Lewenson, 1993). The omission of what nurses do on a day-to-day basis is lost to both current and future generations of nurses and to others who might benefit from such knowledge.

In 1939, nurse historian Mary Roberts wrote that “trends and events of today are the results of past experience as well as of varying
conceptions of both present and future needs” (p. 1). Roberts recognized the need to examine the history of nursing to see how the profession could move forward. Another nurse historian Teresa Christy (1978) explained how she could not “emphasize enough the relevance of an understanding of yesterday’s problems for illumination of today’s issues and concomitant potential for tomorrow’s solutions” (p. 5). Whether nurses choose to use history in their decision-making process, history impacts their decisions. Thus, as part of a reflective decision-making process, nurses need to know their history to make meaningful decisions about their current and future work. This chapter explores why history helps nurses in their decision-making process as well as briefly describes the history of decision-making in nursing.

Historiography provides a way of understanding the past and therefore provides a framework in which to study and apply history to decision-making. Although it is beyond the scope of this chapter to discuss the steps used in historiography, it identifies some of the historical studies that contribute to the evidence used in practice and professional growth. The case study opening this chapter illustrates how graduate nursing students use historical evidence to support the decision-making process in a community health clinical experience. The historiographies presented in this chapter offer examples of how history informs the decision-making efforts of nurses. The case study closing this chapter provides an illustration of how historical knowledge about nursing roles would help current nurses in their practice.

Case Study

A Community Assessment of the Lower East Side of New York City, 1893

What began as a study to look at the Lower East Side of New York City as Lillian Wald may have seen it when she established the Henry Street Settlement became an exciting exercise for students to explore how decisions were made. Nurses need to be able to assess a community and determine the types of services that would most benefit the community. To teach nurses how to assess a community, prioritize primary health care needs of the community, plan and develop an appropriate intervention, and examine the impact of their decisions, a look at historical data was used. In this case study, graduate nursing students interested in community and the Henry Street Settlement in the Lower East Side of New York City joined in doing a historical community assessment as part of their requirement for a master’s project. To complete this requirement, they examined the period of time in which the Henry Street Settlement house was first organized.
The Henry Street Settlement was started in 1893 by two public health nurses, Lillian Wald and her friend, Mary Brewster. Using the demographic data, photographs, and selected writings from 1893 enabled the current students to more fully understand what Wald and Brewster might have seen when they first established the nurses’ settlement house on the Lower East Side of New York. The study helped students learn why Wald and Brewster opened a nurses’ settlement house in the area, the kinds of health care issues that they found, and the impact that their nursing decisions had on the health of that community. In addition, this project enabled students to look at the professional and health care issues over time and see how they compared with those of today. They used history to help them understand the role of the visiting nurse, the political activism that the nurses exhibited, and the obligation to society that nurses continue to maintain now in the twenty-first century. They also used their findings to help them in making decisions about community health initiatives in the same community over 100 years later.

Students studied the Lower East Side community, specifically the area designated as the 7th and 10th Ward. In the late nineteenth century, New York City was divided into wards rather than the present-day census tracts, and data was therefore collected according to ward and sanitary districts. The students examined the demographics; morbidity and mortality rates; immigration patterns; police, fire, and sanitation support services; educational, religious, and social institutions in the community; and the political and nursing issues of that period. Students identified the priority needs in the community and compared their ideas with the actual contributions of the nurses at Henry Street. The students learned about the overcrowded living conditions that so many of the immigrants who populated the Lower East Side found in the tenements. In 1893 the total population in Manhattan (a borough of New York City in which the Lower East Side was a small section) totaled 1,758,000. About 1,332,773 or 69 percent of the total population, however, lived in the tenements of the Lower East Side. There were 180,359 children under the age of 5 (Annual Report, 1909).

The data showed that the residents of the Lower East Side came from Italy, Germany, Hungary, Russia, and other European countries. Once they arrived in the United States and moved to the Lower East Side, they found the tenements waiting for them. They experienced six-floor walk-up apartments, a lack of running water (this was prior to the cold-water flats that evolved following the inclusion of sinks in the tenements), outdoor plumbing until plumbing moved onto the hallway of each floor, as well as poor ventilation and poor lighting. Families, regardless of their size, resided in the two rooms that made up the apartments of the early tenements. Lack of privacy was just one of the many insults to the human condition that existed for those who lived
in the tenements. The Tenement Museum in New York shows what life in the tenements was like and students were able to access the Web site (www.tenement.org/) as well as personally visiting this setting.

The inadequate housing conditions as well as the inhumane work conditions of so many of the immigrants contributed to the poor health conditions that they experienced. Some of the findings showed that infants accounted for 25 percent of all deaths in the community and that children under 5 accounted for 40 percent of all deaths in the community. The top causes of death in 1893 were pneumonia, phthis (pulmonary tuberculosis), digestive organ diseases, heart disease, and diphtheria. Infectious diseases made up 42 percent of the deaths in this community, with pneumonia, phthis, diarrhea, and diphtheria leading the list of these illnesses (Annual Report, 1909; Annual Report, 1897).

Students learned that between 1892 and 1893 there was a 30 percent increase in suicide and that immigrants accounted for 80 percent of these suicides. They further examined how the social, economic, and political factors around 1893 may have affected the suicide rates among the immigrant population. The financial depression of 1893 in the United States surely may have contributed to the increase in the number of suicides during this period. Students explored crime statistics, literacy rates, and houses of worship, social services, and other important community support. They could visualize the effects of—or lack of—these supports by the outcomes they observed in the morbidity and mortality rates (Annual Report, 1897).

Students also read some of Wald’s writings and began to learn about the programs that Wald and Brewster, along with the Henry Street nurses, brought to the community. The Henry Street visiting nurses, the students learned, lived at the settlement house and became neighbors of the families they served. They read about Wald’s famous “baptism by fire” where she meets a young child who led her through the streets of the Lower East Side to visit her mother who had been hemorrhaging for 2 days in bed after a difficult childbirth. Wald’s graphic description provides a stark reality that students could relate to the experience. Wald wrote (1915):

> Through Hester and Division streets we went to the end of Ludlow; past odorous fish-stands, for the streets were a market-place, unregulated, unsupervised, unclean; past evil-smelling, uncovered garbage-cans; and — perhaps worst of all, where so many little children played. . . . The child led me on through a tenement hallway, across a court where open and unscreened closets were promiscuously used by men and women, up into a rear tenement, by slimy steps whose accumulated dirt was augmented that day by the mud of the streets, and finally into the sickroom. . . . Although the family of seven shared their two rooms with boarders . . . and although
the sick woman lay on a wretched, unclean bed, soiled with a hemorrhage two days old, they were not degraded human beings . . . that morning’s experience was a baptism of fire.” (pps. 5-6)

Soon after Wald met the family of seven, she and her friend, Mary Brewster, began the Henry Street Settlement for the expressed purpose of improving the unhealthy living conditions they found in the community. Both nurses were social activists and strove to improve the life of the residents of the Lower East Side through political action and nursing interventions. Wald, especially, felt that nurses had the knowledge and skills to advocate political changes to improve the health of the families in the community. Wald (1900/1991) explained that among the many opportunities for civic and altruistic work pressing on all sides nurses having superior advantages in their practical training should not rest content with being only nurses, but should use their talents wherever possible in reform and civic movements. (p. 318)

Wald’s belief that nurses were poised to advocate for change in the social, economic, and political conditions of the community in which they lived, led to many of the reforms that contributed to the health of the citizens in the community. For example, Wald visited families in their home providing access to nursing care; organized well-baby classes for new mothers; advocated the first school nurse program in New York City which placed a nurse in a city school; established a playground in the community, one of the first of its kind; and fostered an intellectual community of nurses who actively lobbied for social and political changes that supported the health of the citizens in the community.

Given the data that the students collected in their community assessment, they felt that there was synergy between the programs that Wald established and the data they collected. Through the data, they witnessed the sights that Wald and Brewster saw as they made decisions to provide primary health care in the community. Students also saw the similarities between 1893 and the current period of time. What seemed to exist in 1893 continued to exist in a different (but similar) form. Access to care, a rise in tuberculosis, women as primary caregivers, a close relationship between poverty and access to care, large groups of immigrant populations, the need for social and political activism to support health care initiatives, and environmental factors affecting the health of children and adults in the community continue to be concerns in the same community in the twenty-first century. While variations exist today on the particular environmental concerns, patterns of immigration, and political climate, what continues to be a constant is the need for nurses to make decisions about care and provide leadership in improving the health of individual, families, and the communities they serve.
The graduate students’ use of history to learn about community assessments, community action, and nursing’s role in political activism helped decide the kinds of health-promoting interventions they could use in their own community clinical experience. Understanding the history of Henry Street offers a way for students to see how decisions were made in the past and to value the remarkable outcomes that these decisions rendered in the nursing profession and the health of the community. They used some of the ideas of the past and introduced them with the ideas that they learned about primary health care in the twenty-first century. Teaching parenting skills, like Wald did in the 1893, were one of the projects students initiated at Henry Street’s abused women’s shelter. Classes in parenting, nutrition, and other health promotion-type activities, which reflected current thinking of the nursing students, continued in the kinds of programming that the original public health nurses of the settlement house offered to the community. Students also saw the leadership displayed by Wald and other public health nurses in the late nineteenth century and how their activism continued to be a model for them today.

Nursing History Informs the Decision-Making Process

History provides a knowledge base that allows nurses to better understand their practice and profession. Knowing the evolution of nursing care, or the reasons why nurses for almost 100 years debate the educational level into practice, or why each state requires separate licensing of nursing professionals, affords nurses a way to understand the challenges that the profession has faced over time. Historical understanding allows for thoughtful decisions that facilitate innovation and change. Sometimes, however, tradition is mistaken for historical knowledge and thus, confounds the decision-making process. Pape (2003) states that an organization’s valuing of tradition may cause an organization to oppose changes in practice (p. 156). While tradition is part of history, understanding the origins of tradition through historical research allows a basis for comparison, critique, and ultimately decisions that allow for change. Historical research rather than tradition should be the key element used in providing evidence to support decision-making efforts of nursing professionals.

Historical evidence provides depth and context to issues nurses face today and as a result, the American Association for the History of Nursing (AAHN) supports the inclusion of nursing history in the curriculum. Keeling (2001) writes in an AAHN position paper, that “nurses in the 21st century will need more than sheer information; they will need a greater sensitivity to contextual variables and ambiguity if they
are to critically evaluate the information they receive” (Keeling, 2001). Nurses need the ability to study, understand, and value history. Integrating nursing history into nursing curricular at all levels is essential to help nurses identify their history; obtain the necessary skills to explore, study, and understand their history; and to ultimately use history in their decision-making process (Lewenson, 2004; Keeling, 2001).

Studying history provides nurses a conceptualization of the modern nursing movement from 1873 to the present day and affords a continuity between the past and present. This continuity allows for nurses to avoid the familiar adage: “Those who do not study history are doomed to repeat it.” For nurses, not using history in the decision-making process may waste valuable time and resources in reinventing what was already previously discovered to work (or not work). Not using history also may deny the success of decisions made in nursing education, practice, research, or administration. Nurses need to know what worked and what did not work, and how they can seek the data to support decisions that need to be made by nurses. History is a valuable resource as a knowledge base and allows for its use as a form of evidence. The graduate students in the case study “saw” the conditions the newly immigrated families experienced in 1893 and some of the primary health care needs that Wald and her colleagues at the Henry Street Settlement met. Without understanding the historical significance of the Lower East Side, the graduate students would miss the origins of some of the socially minded programs and ideology of the settlement houses that continue to exist in this area today.

Strumpf and Tomes (1993) examined the historical use of restraints in “troublesome patients” in the United States during the nineteenth century. They observed a difference between the common use of restraints in the United States versus the infrequent use of such devices in Great Britain. The cultural beliefs about the kind of care that these patients, including the mentally ill and the elderly, differed historically in both countries and the outcomes of care varied as well. Strumpf and Tomes recognized the need to study history in order for nurse administrators and nurses to examine their decisions about the use of restraints and to give them a better understanding of why they continue to use them with the elderly when evidence does not support the use of these devices.

Contemporary observers often assume that this modern restraint crisis is a peculiar product of the late twentieth century, with its large population of aged and chronically ill, fiscal crisis, institutional overcrowding, and staff turnover. . . . Many of the contemporary dilemmas involving physical restraint can be traced back to an earlier “restraint crisis” that occurred during the middle of the nineteenth century. (Strumpf & Tomes, 1993, p. 4)
Like Strumpf and Tomes, historians search for reasons why things occurred and do so in the hope of informing contemporary issues that need thoughtful decisions. When nurses do a nursing assessment on a patient, they start with a nursing history. Nurses would not be able to appropriately assess their patients or develop plans of action without one. If that is the case, why would nursing leaders, educators, practitioners, researchers, and the like attempt to make decisions without getting the history first?

A Historical Look at Decision-Making in Nursing

In exploring the use of nursing history in decision-making, it would be important to look at the history of decision-making in nursing or when and how nurses made decisions. Questions arise such as whether nurses actually made decisions overtly or did they “downplay” their own reasoning abilities to avoid alienating physicians if they assumed a more autonomous role? Did nurses always make decisions about care and about the profession? If so, what kinds of evidence did they use to make these decisions? How did they document these decisions? Were nurses more autonomous in their roles as nurses, such as the ones that Hallet, Abendstern, and Wade (2006) or that Keeling (2006) describe in their work or were nurses merely following physician orders as they cared for their patients? How did nursing’s close ties with the women’s movement in the late 1800s and early 1900s affect the way nurses made decisions? Were nurses afraid of alienating politicians who could possibly assist the nursing profession obtain nursing registration laws as Lewenson (1993) suggests or did they speak out in favor of women suffrage, regardless of how it affected these politicians? Did Wald and Brewster use the same available demographic data as in the case study about the Lower East Side when determining the need for health care programs in the community? Have nurses historically used “evidence” to support their practice? If so, what kind of evidence did they use and how did find the evidence?

Nursing research, important to the decision-making process, evolved in the profession as nursing educators and leaders called for nurses to base their clinical decisions on empirical evidence. Nursing educator R. Louise McManus (1961) asked the question: “What is the place of nursing research—yesterday, today, and tomorrow” (p. 76) and examined the evolution of nursing research. She understood the need to look at how research influenced the decisions of nursing leaders in order to plan for the future in nursing. McManus explained that nursing research—or the “methodological search for nursing knowledge”—differed from other professional groups because early studies focused more on nursing education and service rather than on practice.
She reasoned that interest in nursing research differed from other professions because of the different “pressures upon the profession as a whole by social, political, and economic forces and the impact on nursing advances in scientific knowledge” (p. 76).

McManus (1961) highlights the early research efforts of Nightingale, and the later studies of M. Adelaide Nutting, Isabel Stewart, and others who examined nursing education and the status of the profession. The studies, McManus said, usually were implemented by the professional organizations, like the American Society of Superintendents of Training Schools for Nurses (which was renamed the National League of Nursing Education in 1912, and then the National League for Nursing in 1952), and as a result focused more on the issues related to education. Nurse educators, like Stewart, valued research and participated in and led many such endeavors such as her noted time-and-motion studies. Another noted nursing leader, Virginia Henderson, published early scientific studies such as the one McManus includes on “Medical and Surgical Asepsis” in 1939. Structure studies of how the professional organizations should look also were done and dramatically influenced the change in nursing organizations in the early 1950s.

McManus’s (1961) examination of history provides a view of the development of nursing research prior to the early 1960s that explains as well as raises questions about nursing’s interest in research and the subsequent culture of research. She noted that the way nursing organized around issues of practice and service as well as one of the first graduate educational programs situated in Teachers College Columbia University (a college for teachers), was indicative of the kinds of studies and research of early nursing. McManus (1961) wrote that: “This happenstance of teachers pushing toward education and toward a teacher training institution for the first graduate programs may well have affected the course of nursing’s development considerably” (p. 79).

Many in nursing were interested in knowledge building to support decisions in nursing. In her 1934 article in the American Journal of Nursing, Sister M. Bernice Beck called for nurses to base their practice on scientific principles rather than on outdated models that supported a paternalistic hierarchy. Nurses, especially educators and administrators, needed to have a “scientific attitude,” which Beck described as being... openminded, ready to learn the truth and accept it; observant, keen, clear-minded, cautious, alert, vigorous, original, and independent in thinking; she carefully weighs all the evidence and overlooks no factor which may influence the results; allows no personal preferences to influence decisions; holds only tentative scientific convictions, because aware that we have not yet arrived at the end of knowledge, but are constantly wresting more secrets from the hidden depths of Nature.” (p. 580)
The early move toward basing practice on nursing research required that nurses examine the way they carried out procedures and not just accept what they did without first examining the outcomes of their actions. Beck wrote that the teacher of nursing arts never insists that procedures, as taught, are the last word; that the unfounded statements of textbooks must be accepted without question, and that the ordering physician must be looked upon as an infallible authority. On the contrary, she urges her students to find out why things are done as they are; whether there are not better ways of doing them; to challenge statements, to ask for proofs, to think for themselves, to make individual contributions.

Students were expected to learn to question and to make decisions based on the response to their questions. Decisions were not to be made by rote; rather they needed to be made using research data. Harmer and Henderson (1940) in their noted text, *The Principles and Practice of Nursing*, included a section on the “Professional Responsibilities in Relation to Method.” Nurses were to “accept the responsibility for studying its procedures and designing its method” (p. 469).

In order to understand how decisions in nursing are made and the kinds of decision-making models or frameworks available, it is important to remember to place decisions within a context that looks at the particular period in which those decisions are made. The students in the case study presented earlier in this chapter examined the demographic data and the morbidity and mortality rates of the Lower East Side within the context of the late nineteenth century United States. They explored the meaning of immigration within the social, political, and economic period of the day. In this way, they could compare and contrast the health care decisions that were made by nurses during that period with the more contemporary decisions made today in the same community. This may be beyond the scope of this chapter, but it is something to consider when looking at history and decision-making in nursing.

**Historical Critiques Assist Decision-Making in Nursing**

Historiography provides the data and the necessary critique that nurses require in their decision-making process. Lewenson (2007) shows how studies in nursing education, practice, and administration provide historical evidence that nurses may use when making decisions on such issues as appropriate educational levels in nursing, the role of the nurse practitioner, and resolving the nursing shortage. Studies like the one that Whelan (2005) did on exploring the demise of private duty nursing
in the United States provides data for a discussion about nursing shortage, staffing issues, and changes in the hospital settings. R.A. Seeger Jablonski’s (2003) study examines the history of the nurse practitioner movement and the effect on nursing education at the Virginia Commonwealth University (VCU). The historical account at VCU serves as a way of knowing what happened to this particular program and serves as an example of how other programs may have fared during the same time period.

Historical studies provide explanations, connections, and relationships among variables in the past and can be used to assist today’s nurses in the decision-making process. For example, understanding the history of nursing’s clinical practice provides knowledge of what worked in the past and perhaps how it can improve. Historical studies, such as Keeling’s (2006) “Medicines in the Work of Henry Street Settlement Visiting Nurses,” explores the role the settlement nurses played in giving medications and nursing interventions, thus, illuminating questions about the work of visiting nurses, autonomy, prescriptive privileges, and legal boundaries of practice today. These visiting nurses in the late nineteenth and early twentieth century gave medications that were sometimes prescribed, as well as gave medications that were not. These nurses sought the over-the-counter treatments that both nurses and laypeople often used to heal a wound or cure a cold.

Keeling describes how these treatments fell somewhere in the middle, using Lavinia Dock’s (author of the 1898 Materia Medica for Nurses) term describing the role of the nurse as being in the “middle place” or somewhere between “professional medical service and unskilled family caregiving” (2006, p. 9). Keeling also noted that nurses did not write about their administration of medications, frequently taking this part of their work for granted as well as trying to minimize it. The research showed how the Henry Street Settlement House (HHS) visiting nurses challenged the boundaries of the early nurse practice acts and sought to provide access to care, often diagnosing, prescribing, and carrying out treatments, without the direct supervision as was required by law of the physician.

Why Keeling’s 2006 research is important to decision-making is found in any number of contemporary discussions addressing the role of nurses, autonomy of practice, nurse practitioner licensure, the move toward a doctor of nursing practice, changes in licensure for health care professionals, and other issues affecting nursing education, practice, and research. Keeling uncovers how little is known of the work of the HHS visiting nurses. This group of professionals often has been studied from a social-political perspective about their activities and the effect they had on improving the environment for the families and individuals they served in the Lower East Side community in New York City rather than on their actual clinical practice.
Nurses today who work with families in the home may also struggle with dispensing advice about medications and offering information about health care interventions typically found in the home. Families today have greater access and knowledge about these medications, but may be hampered by restrictions set by nurse practice acts that prohibit nurses prescribing medications. Given the greater access to the Internet, television, newspapers, or magazines, consumer levels of understanding have been raised and with that their expectations about care.

This “middle place” that Dock describes in her 1898 book and Keeling refers to in her 2006 article is specifically directed toward nurses. Dock wrote her book for nurses to learn about drugs and their administration from the standpoint of what nurses needed to know rather than from what physicians needed to know. Until 1890, when Dock first published her book, the medical perspective was the only one available. Nurses learned about pharmacology from the books available at the time, and not until Dock wrote hers specifically for nurses was the nursing intervention and role of the nurse addressed.

Another historical study by Hallett, Abendstern, and Wade (2006) examines the autonomous clinical practice of the industrial nurse in England around the mid-twentieth century. In the cotton factories, concern for the health of the workers, mostly women, was in the hands of the “welfare officer.” The welfare officer usually had formal nurse’s training or in some instances they were not nurses, but had first-aid training. Hallett, Abendstern and Wade conclude that little is known about the clinical side of industrial nursing and the history of this specialty has been overlooked in general by nursing. Hallett, Abendstern, and Wade used oral histories of cotton factory workers as well as three of the welfare officers to gain insight into the autonomous nature of this role and how it shaped the care of a group of cotton workers in middle of the twentieth century. The outcome of the study describes the values that these particular nurses ascribed to in the fulfillment of their responsibilities. The welfare officers who were nurses worked autonomously providing nursing interventions, that like Keeling’s study, revealed they dispensed medications and nursing treatments that relied on their own nursing assessment and diagnosis. Hallett, Abendstern, and Wade (2006) say that these nurses were imbued “with a sense of autonomy and a consciousness of the ‘expert’ nature of their role. They were not willing to be ‘told their job’ by mill owners” (p. 103). The interventions were mostly first aid in nature and did not seem to cover preventative, screening-type interventions that would have promoted health care of employees. The written record is more limited and the history of this period is captured mostly through oral history, without which, the knowledge would no longer be accessible (Hallett Abendstern & Wade, 2006, p. 103).
Both Keeling (2006) and Hallet, Abendstern, and Wade (2006) provide today’s nurses with data of what was done in the past. They uncover the history of working nurses and make connections between then and now. Keeler, for example, links the work of the Henry Street nurses in the early twentieth century and the role of nurse practitioners today. Contemporary nurses struggle with decisions about advanced practice, nurse practice acts, and collaborating partnerships with physicians that would all benefit in the knowledge that these two historiographies presented. Uncovering of the history informs not only the practice, but the education and research as well and thus affects nursing outcomes today and in the future. Today’s professionals can learn from the wisdom, knowledge, mistakes, and vision of those earlier nurses.

Another Case Study

In 1996 when I was an instructor in a community health course on the Lower East Side in New York City, one of the students, who was a registered nurse returning to school for a baccalaureate degree in nursing, was visiting a “client” of the Henry Street Settlement Home Health Care agency in the home. The student professionally worked as a cardiac care nurse and was proficient in providing high-level care using the latest technology in cardiac care. However, when she entered this client’s home during the community clinical rotation, she said she was shocked at the odor emanating from the client’s feet and had difficulty knowing what her responsibilities were in this case. She wanted to know what could be done for this client, because there were no medical orders and she felt she could not do anything without them.

The goal of the community experience at the Henry Street Settlement (where the visiting nursing service separated from the agency in 1944) was to visit clients who received homemaking services in the home. Students were expected to develop a nursing plan of care after completing a nursing assessment of the client, the client’s concerns, the homemaker’s concern, and an assessment of the home and community resources. When I visited the client’s home with the student nurse and saw the caked-on dirt and smelled the odor from the feet, I asked the homemaker to prepare a basin of warm water so that we could soak the client’s feet. We instituted a nursing intervention, bathing of the feet, so that we could further assess the skin color, the temperature, and the integrity of the skin. As we bathed the feet, the student spoke with the client and began to build trust with him and develop a rapport with the homemaker. Following the simple “nursing” procedure, the student patted the feet dry, continued to assess the feet, and began to teach the client about proper foot care.
The student said on the walk back to Henry Street that while she could operate efficiently in the hospital setting, the home-care setting created new challenges to her perceived role of the nurse. She was unaware of what visiting nurses did or had done in the past. She lacked historical perspective that might have assisted her in understanding this middle ground where nurses provide nursing care autonomously. The autonomous role that she was learning in the community clinical experience had ties with earlier nurses in the same community. Yet not knowing the past creates challenges for her and all nurses who make decisions in their practice.

Conclusion

History provides today’s nurses with an “overarching conceptual framework that allows us to more fully understand the disparate meaning of nursing and the different experiences of nurses” (D’Antonio, 2003, p.1). Lynaugh and Reverby (1987) said that history “provides us with the tools to examine the full range of human existence and to assess the constraints under which decisions are made” (Lynaugh & Reverby, 1987, p. 4). Without understanding nursing history, decisions are at risk of failing and repeating past errors. Historiography provides a way of knowing and understanding of what has gone on before, what is happening now, and what may be expected in the future. If all knowledge has a historical dimension, then nurses need to take this dimension into account whenever a decision is made. All decisions, regardless of the decision-making approach that nurses may use, also must include an historical dimension in the matrix. Like the case studies presented and the historiographies identified, nurses can learn from understanding the past and using this understanding to support the kinds of decisions that they make today.

History is alive, and the search for answers in history is useful for solving present difficulties, directing behavior, and accomplishing the objectives of the nursing profession. When the answers are found, it is not the end. It is the beginning (Austin, 1978, p. viii).

References


