



Women's Leadership in the Development of Nursing

In her 1976 book on the early origins of nursing in the United States, Jo Ann Ashley noted, "Professional nursing must begin exerting open and public leadership.... Nurses must change their own attitudes toward themselves and their role ... from meeting the needs of hospitals and physicians to meeting those of the patient and the public" (p. 113).

More than 3 decades later, nursing leadership has moved nursing forward in the direction identified by Ashley. These changes are remarkable considering the history of nursing and the obstacles created by both cultural expectations and the health care bureaucracy since modern nursing's inception in the United States. Today's nursing leaders are found in the academy, in hospitals and other health care organizations, in legislatures, and in a wide range of government agencies and voluntary organizations.

The Birth of Nursing Leadership: Florence Nightingale

Nursing is the ultimate academic discipline and practice profession to have been shaped by women's leadership. Nursing was historically viewed as an extension of a woman's role in the home. Organized nursing had its roots in religious orders of women and men, such as the Knights Templar, dating back centuries before the era of Florence Nightingale, considered the mother of professional nursing. Professional nursing, with a planned educational program, began with the work of Nightingale, one of two daughters of an English family of wealth and influence. Born into this aristocratic English family while they were living in Florence, Italy, Nightingale was educated in languages, science, and mathematics, unlike most women of her social class during that era (Kalisch & Kalisch, 1995). Nightingale was a leader not only in nursing but in her country. She set the stage for leadership for the thousands of women across the world who would come behind her to lead nursing into the next 2 centuries.

Nightingale, after observing the Daughters of Charity, a Roman Catholic nursing order from France, studied briefly in a German deaconess's nursing school at Kaiserwerth on the Rhine. Inspired by what she identified as a religious calling and by what she observed in France and Germany, she returned home to develop a new model for nursing education in England.

After returning to England from her studies at Kaiserwerth, Nightingale took her first position as a superintendent of nurses at King's College Hospital. She was recruited by government officials to help the British military in the care of wounded soldiers in the Crimean War. The military had observed that French soldiers recovered from their wounds more often than British soldiers. They attributed this to care the French received from members of the Catholic nursing order, the Daughters of Charity. Nightingale, who was well known to members of the British parliament because of her family's status, was recruited to help the military improve the care in the hospitals in Turkey (Kalisch & Kalisch, 1995).

Despite vigorous opposition from military physicians, Nightingale and her group of 38 nurses arrived in the Crimea in late 1854. Twenty-four of the nurses were nuns; the rest had little or no experience or training as nurses. They found the hospital to be in horrible condition, filled with filth and vermin and absent of basic

equipment such as clean linens. In the face of overt opposition from physicians, Nightingale and her nurses set about cleaning the hospital, securing the help of military wives to wash the linens and obtaining other basic supplies through charitable donations from England and with her own money. The military provided her with no monetary support. When she was satisfied with the changes at the first hospital at Scutari, she went to other British military hospitals in the Crimea to clean and provide care (Beck, 2006; Kalisch & Kalisch, 1995). She became the heroine of the Crimean War, where she dramatically reduced the mortality rate for injured soldiers from 40% to 2.2% by ensuring that they had nursing care, sunshine, and fresh air in a clean environment.

At the end of the war, Nightingale returned to England after becoming ill while in the Crimea. With a donation equivalent to \$220,000 from a grateful British public, she inaugurated the first professional nurses' training school at St. Thomas Hospital. She accomplished this feat despite the opposition of the hospital's medical staff: Only 4 of the 100 physicians approved of her effort. The physicians believed that there was no need to provide a formal education to nurses, whom they equated with housemaids, needing little training beyond the basics of hygiene, environmental cleanliness, and meeting the personal needs of patients (Kalisch & Kalisch, 1995). Nightingale's ill health after the war left her unable to attend to the daily operations of the school, but she was its chief advisor and ensured that the educational program was developed to her satisfaction. It was during this time that she also served as a consultant to the British government on the public health issues in the colony of India. Nightingale is credited with developing the plans for the sanitary sewers of India. She wrote a plan to improve the environment of the cities in a letter to the editor of a London newspaper (Beck, 2006).

She not only created a model for nursing education in the late 19th century, but she was also an environmentalist, author, statistician, humanitarian, and public health expert. By her efforts, Nightingale moved nursing from the Dickensian image of the nurse as a drunk or prostitute and shaped it into an emerging profession. She was a woman whose ideas would shape nursing and health care into the 21st century. She was the first woman to be recognized as a leader in nursing but certainly not the last woman to exercise leadership in nursing. Nightingale was a woman ahead of her time in Victorian England. Her take-charge approach in the Crimea and her transformational leadership style set the stage for contemporary nurse leaders. To understand women's leadership in nursing, the history of modern nursing must first be examined to see how nurses exercised and failed to exercise leadership in nursing and health care.

From Nightingale to the Origins of Nursing in America: The 19th and Early 20th Centuries

Nightingale, in her model for nursing education, insisted that her school provide real training to the students, both in the classroom and at the bedside, during a year-long educational experience. She held that nurses needed not only to carry out the physician's orders but to understand why those orders were appropriate, which was a revolutionary idea for the time. She planned for lectures by physicians and for bedside training and supervision by the nursing superintendent and her assistants. Nightingale believed that nurses needed to understand the symptoms of the diseases of their patients, what the symptoms and changes in symptoms indicated, and the reason behind the symptoms. Nurses needed to be able to observe the patient for changes that occurred in the absence of the physician and communicate these changes to the physician. She also planned for training the trainers, preparing the nurses who would teach the students. She insisted that the superintendent nurse have ultimate authority about students (Kalisch & Kalisch, 1995).

Origins of Nursing Education in the 19th Century in America

The legal status of women in the late 19th century in America was rather dismal. Once married, a woman was the property of her husband; he also owned any property or wealth she brought to the marriage. She was usually unable to vote, sue, or enter into legal contracts. Generally women who were widowed or divorced had no rights of guardianship to their children. Women, married or not, were also unable to enroll in most colleges and universities (Andrist, 2006). Because of these legal and social constraints, nursing's early educational

programs in the United States logically did not start in institutions of higher education.

Prior to the Civil War, some aspiring nurses were allowed to observe the lectures given to female students in the few medical colleges that admitted women. There were also some brief training programs, organized and administered by physicians, at hospitals in Eastern states that provided a supply of nurses for maternity care (Speakman, 2006). Dr. Elizabeth Blackwell, the first American woman to become a physician, operated a 12-week program to train nurses for the care of soldiers during the Civil War. In the 1860s Bellevue Hospital in New York City used women arrested for nonviolent crimes, especially prostitution and public drunkenness, to serve their short jail sentences as caregivers, not unlike the Sairy Gamp character of Charles Dickens's work. In 1868 the president of the American Medical Association, Samuel Gross, called for the creation of hospital-based nurse training programs to be administered by physicians, unlike Nightingale's schools where nurse superintendents oversaw the educational program (Kalisch & Kalisch, 1995).

During the Civil War, Dorothea Dix, an early advocate for mental health reform, served as the Union supervisor of female nurses (ANA, 2010; Andrist, 2006; Kalisch & Kalisch, 1995). Along with other women such as Clara Barton, Louisa May Alcott, Jane Stuart Woolsey, and Mary Ann (Mother) Bickerdyke, she helped organize and lead the efforts to provide care to the Union's soldiers. Although they lacked formal training in nursing, because few programs existed, they served as early leaders in nursing, joined by the poet Walt Whitman. Along with famed abolitionists Sojourner Truth and Harriet Tubman, these men and women provided care to wounded soldiers and spoke about the need for nursing care during the Civil War (Andrist, 2006; Kalisch & Kalisch, 1995). In the Confederacy, Kate Cummings was inspired by the work of Nightingale and worked as a volunteer nurse, helping to organize nursing care for the Confederate soldiers (Kalisch & Kalisch, 1995). As in the North, women volunteered to provide care with encouragement from women such as Cummings.

The Lack of Early Nursing Leadership in Nursing Education: The Failure to Embrace the Nightingale Model

The first nursing education programs in the United States failed to use the educational model of the hospital-based schools founded by Nightingale in England to the fullest. Few were under the control of nurses (superintendents); physicians and hospital administrators, almost exclusively male, oversaw the programs (Ashley, 1976). An early program based on Nightingale's model was founded by Dr. Susan Dimock, who had studied medicine in Germany and knew of the nursing programs in Europe. She created a nursing program at the New England Hospital for Women and Children in 1873 after meeting with Nightingale. Linda Richards, recognized as the first nurse to graduate in the United States from a formal nursing program, was an alumna of this school. Unfortunately Dimock died in 1875, and her vision for nursing education using the Nightingale model was lost (Kalisch & Kalisch, 1995).

Most educational programs for nurses in the United States during the last 3 decades of the 19th century were little more than apprenticeship programs in both religious and public hospitals. Students were offered a few lectures by physicians and gave care to patients while being monitored by a few nursing superintendents, usually graduates of the same hospital training program. Care in both religious and public hospitals was provided primarily by students who were paid little and lived under strict guidelines that controlled both their personal and professional lives: Marriage was prohibited, strict adherence to the hospital's rules were demanded, attendance at religious services was often mandated, and style of attire was dictated to the students. Students' lives were totally controlled by the hospital in which the school existed.

Students who failed to live up to the rigid expectations were dropped from the program. The culture of these programs generated cohorts of nurses who were docile, obedient, dedicated to the hospital, and willing to work cheaply (Andrist, 2006). Graduate nurses, except for the nurse superintendents of hospitals and their assistants, tended to work in the homes of the ill or in the community, developing public health systems (Ashley, 1976). Even the superintendents themselves were usually docile and obedient, avoiding confrontation with the medical and administrative hierarchy at all costs (Andrist, 2006). These potential nursing leaders failed

to act on their opportunities to lead the profession, leaving a legacy for others to change for the generations that followed.

The admission of women to colleges and universities was not widely accepted at the time the first nursing schools opened in the United States. Little more than 30 years after the founding of these first post-Nightingale nursing schools, an editorial in the *Journal of the American Medical Association* voiced concerns that infertility was a result of the higher education of women, concerns that first arose in the mid-19th century (Andrist, 2006; Ashley, 1976). The author encouraged physicians to oppose higher education for women, including nurses, because it detracted women from the ability to procreate. Physicians also spoke of their concerns that educated nurses might overtake the role of physicians in health care (Ashley), who often had little formal education themselves.

The First Women in Leadership in Nursing in America

In the 1890s, at the dawn of the Progressive Era and the questioning of many women's roles, the first nursing organizations began to emerge. Nursing leaders from several Western countries, including Lavinia Dock and Isabel Hampton Robb, met in 1893 during the Chicago World's Fair to discuss the need for nursing leadership to shape nursing and its future. Those meetings resulted in the formation of the American Society of Superintendents of Training Schools for Nurses of the United States and Canada (the Superintendents Society), which became the National League for Nursing (NLN) in 1912. The NLN continues today to be a leading organization for nursing education. A corporate arm of the NLN, the National League for Nursing Accrediting Commission, is one of two federally recognized accrediting bodies for nursing education (Andrist, 2006; Kalisch & Kalisch, 1995). Dock wrote several early nursing textbooks and later served as the secretary of the International Council of Nurses, extending her leadership in nursing to an international scope (ANA, 2010).

While the Superintendents Society focused on standardizing nursing curricula, there was concern among the members about the legal status of nursing and nurses and the problems of regulating the profession. There was no regulation at the time, and anyone could call himself or herself a nurse. These concerns resulted in the creation of a second nursing leadership group, the Nurses' Associated Alumnae of the United States and Canada, which became the American Nurses Association (ANA) in 1912 (Andrist, 2006). Robb also help found the organization that became the ANA and served as its first president (ANA, 2010; Kalisch & Kalisch, 1995). The ANA and its constituent state nurses' associations continue to be the major voice for all nurses in policy and legislation in the United States.

Nursing in the 20th Century in the United States

Nurses who graduated from the training (diploma) schools around the start of the 20th century began to demand laws to license nurses (registered nurses). Such laws had been passed in some states, including Illinois where the first licensing law was passed in 1907 (Egnes & Burgess, 2007). Hospital-based diploma programs were still tightly controlled by hospital administrators, not nurses, but students began to receive more classroom training than in the earlier programs. After World War I, American hospitals began to employ more nurses for the care of the sick, increasing the demand for nurses. A few baccalaureate programs were initiated in colleges and universities during the first quarter of the 20th century, most notably at Johns Hopkins and Columbia Universities (Speakman, 2006). The programs generally involved 1 or 2 years of college courses and then 2 to 3 years of clinical training in hospitals; many were 5 years long (Kalisch & Kalisch, 1995). The 1923 *Goldmark Report* (Kalisch & Kalisch; Schorr, 1974) called for nursing education to move from the hospital to the university. Hospitals, which benefited from the unpaid labor of nursing students, forcefully opposed this trend and fought to retain their diploma nursing education programs.

During the first decades of the 20th century, nurses made a difference in the health of the poor through the services of public health nursing. Lillian Wald was one of the pioneers of public health nursing, serving the poor who lived in the tenements of NewYork City. With Mary Brewster, she created a Nurses' Settlement House,

which became the Henry Street Settlement House, on the lower East Side, providing a visiting nurse service to the poor. This program evolved into the Visiting Nurse Service of New York, providing health care to thousands every year and served as a model for other community health programs across the United States (ANA, 2010; Kalisch & Kalisch, 1995). The settlement houses emphasized maternal-child health care along with the prevention and treatment of communicable diseases, such as tuberculosis.

Margaret Sanger, a public health nurse in Brooklyn, was a social activist who fought to make birth control legal in the United States after caring for a 28-year-old mother who died from the effects of too many pregnancies too close together. She faced jail and had to flee the country to Europe to continue her work. She founded an organization that later became the Planned Parenthood Federation. She fought both religious and legislative leaders to make safe and effective birth control available to women (ANA, 2010; Kalisch & Kalisch, 1995).

Nursing Education Moves Into Institutions of Higher Education: Mid-20th Century

Over the next 4 decades more colleges and universities initiated schools of nursing, and nursing began to move into the academy under the control of nurse educators, not physicians. At the same time, nursing education moved into the community colleges as associate degree nursing programs were created after World War II. In 1965 the ANA called for all nursing education to move to baccalaureate level education for license by 1985 (Donley & Flaherty, 2002; Kalisch & Kalisch, 1995; Schorr, 1974). This so-called 1985 proposal never came to pass, although as hospital-based diploma schools closed, they were replaced with 2-year associate degree programs in community colleges. Few diploma programs continued to operate at the start of the 21st century.

Graduate programs in nursing began to develop in colleges and universities, primarily to prepare nursing faculty. By the mid-1970s more graduate programs in nursing were preparing nurses for advanced clinical practice. During the 1960s and 1970s a few doctoral programs in nursing were scattered across the country, most in large urban areas along the east and west coasts with few in the central part of the country (Buerhaus, Staiger, & Auerbach, 2009; Kalisch & Kalisch, 1995). Many doctorally prepared nurses seeking faculty positions earned their degrees in related disciplines, such as education and the social sciences, because of the lack of access to doctoral education in nursing. Doctoral education in nursing only became more widely available during the late 1980s and into the 1990s.

The Women's Movement and Nursing

As the first baby boomers entered nursing in the 1960s and early 1970s in record numbers, two changes were notable, both spurred by the women's movement. First, record numbers of women of this generation, supported by the women's movement, entered the workforce through nursing, representing the largest cohort to ever enter nursing. At the same time, the expansion of nursing education into community colleges through associate degree programs increased access to nursing education (Speakman, 2006). Secondly, nurses became more educated. As more nurses attended community colleges and universities to start their careers, unlike earlier generations of nurses, they changed nursing into an academically grounded profession. These baby boomers transformed nursing from a temporary vocation that women left for marriage and motherhood into a lifelong career (Spader, 2008). The women's movement also helped drive this generation of nurses to graduate and doctoral programs in record numbers (Spader).

As the women's movement changed the status of women in the United States in the 1960s and 1970s, the status of nursing and nurses changed as well. In the 1960s one of the founders of the National Organization for Women (NOW) was a nurse, Wilma Scott Heide (Andrist, 2006). Nursing scholars such as Virginia Cleland identified the effects of sex discrimination and called it "nursing's most pervasive problem" (Andrist). She also was among the first to study the economic impact of sex discrimination on nurses' incomes. Ashley (1976) also wrote her book about the origins of nursing in the United States and the impact of sexism on the development of nursing education and practice during this time. At the beginning of the 1980s, Susan Jo Roberts (2006) began her work on oppressed group behavior and nursing. Using social science theory, Roberts looked at

nursing through the same theoretical lens that was used to examine the behavior of politically and economically oppressed women. Based on the assumption that oppressed groups operate out of a learned belief that they are inferior, Roberts applied oppressed group theory to the behavior of nurses to identify behaviors of nurses that were consistent with other oppressed people: lack of self-esteem, horizontal violence, and intergroup rivalry. These nurse leaders challenged the accepted status of nurses and nursing and sought to propel the profession away from sexism and other forms of oppression.

Shortages and Changes at the End of the 20th Century

During the last half of the 20th century, there were cyclical nursing shortages that were generally resolved by the efforts of nurse educators and nurse administrators to recruit more students into programs. Associate degree nursing programs, noted above, were proposed in the 1950s in response to nursing shortages after both World War II and the Korean War (Mahaffey, 2002). During shortages of the late 1980s, some programs reduced their admission or progression requirements or both of these to ensure that more students moved through the pipeline to become graduate nurses (Nelson, 2002). Schools that lowered their admission and retention standards often experienced greater failure rates on the national nursing licensure examination that all graduates take for licensure as registered nurses.

In the late 1980s an acute shortage of nurses resulted in a conflict between the leadership of major nursing organizations (predominantly women) and the leadership of the American Medical Association (AMA) (predominantly men). The AMA proposed the creation of a new category of health care workers, registered care technologists (RCTs), to address this nursing shortage. The AMA proposed that these health care workers would be educated in 9-month training programs designed by physicians because of what the AMA leadership perceived to be an overemphasis on formal, academic education by nursing. Basic RCTs were proposed to provide the same care as existing nursing assistants but could also carry out selected nursing activities under the supervision of RNs, who would be held accountable for the care provided by these RCTs. Advanced RCTs would receive an additional 9 months of training and were proposed to be able to carry out other nursing tasks, again under the supervision of RNs. This proposal unleashed a firestorm of protest from both nursing organizations and other medical associations, including some state chapters of the AMA. The legal implications of care by these unlicensed caregivers were scrutinized by nursing and other health care organizations in what evolved into a turf war between medicine and nursing (Kalisch & Kalisch, 1995).

In the summer of 1988, during the ANA's biennial convention, a summit meeting of the leaders of all major nursing organizations convened to create an organized response from the nursing profession to the AMA's paternalistic proposal. Only one pilot project for implementing the RCT proposal was initiated. That single pilot project, at a nursing home in Kentucky, ended quickly and quietly as a result of the organized opposition to the AMA's proposal (Kalisch & Kalisch, 1995). Nursing leaders from the ANA, the NLN, the American Organization of Nurse Executives, and other specialty nursing organizations rallied their members to bring an end to the RCT proposal within 18 months by lobbying legislators, contacting the media, and talking to physician colleagues to gain their support (Kalisch & Kalisch).

In the early 1990s a new set of forces ended a nursing shortage. The expansion of managed care as the driving force for reimbursement of health care services decreased the lengths of stay and rates of admission for inpatient services. Managed care organizations slashed the reimbursement for these services in hospitals, where about two thirds of nurses were employed. Hospitals reduced the numbers of inpatient beds, used unlicensed assistive personnel to carry out nursing tasks (often at the cost of quality of care and patient well-being), and decreased the size of their registered nurse workforce to save costs. The media featured stories about the reductions in workforces of health care organizations. Such stories noted how changes in health care delivery were resulting in problems related to quality of care and were increasing patient dissatisfaction. This kind of bad press and the explosion of career opportunities for women that had emerged from the women's movement 30 years earlier contributed to the decline in enrollment in nursing programs across the country in both universities

and community colleges (Buerhaus et al., 2009). Nursing leaders tried to stem this tide but were unable to hold it back. Nursing organizations launched media campaigns to encourage interest in nursing, but the response from the public was slow.

The Dawn of the 21st Century: A Historic Nursing Shortage

Shortages from the 1970s into the early 1990s resulted in waiting lists of students seeking admission to nursing programs, but in the mid-1990s nursing programs began to experience massive enrollment declines. Schools of nursing watched as enrollments plummeted from the mid-1990s into 2001 (American Association of Colleges of Nursing [AACN], 2008d). This drop in enrollment was attributed to many factors, including (a) the availability of other professions, including medicine, to women; (b) the turmoil in the health care system that was reported in the media, including the lay-offs of nurses and the failure of new nurse graduates to find jobs; and (c) the perception of nursing as a low-paying career. Then suddenly another nursing shortage began at the dawn of the new century. The mass media began to carry stories of the new and unprecedented demand for nurses. Johnson & Johnson launched a Web site to educate the public about careers in nursing (www.discovernursing.com, which now includes links to nursing videos on YouTube.com). The professional and lay literature began to speak about the new demand for nurses resulting from a growing population of elderly persons, a growing incidence of chronic illnesses, new roles for nurses, and the emergence of new health care services and new employers who needed nurses, requiring more nurses than schools could produce. The tight grip of managed care had been loosened, the explosion of technology and scientific knowledge were creating new treatments and cures, new venues for health care delivery were opening, and old venues were again expanding.

By 2002 schools were suddenly experiencing a surplus of qualified applicants (AACN, 2008d). At the same time great concerns were being expressed by government bodies, regulatory agencies, health care organizations, and professional organizations in nursing related to the dire predictions of an unprecedented nursing shortage with its threats to patient safety and quality of patient care, especially in acute care (hospital) settings (Kany, 2004). Numerous nursing and health care organizations, foundations, government agencies, and health services researchers began to study how to address this shortage and its impact on patient safety and quality of care. The implications of the shortage related to the safety and the quality of patient care were identified by many studies as a cause for concern (AACN, 2008d). The leaders of major nursing organizations lobbied for federal funding to support the growth of nursing education. That resulted in the creation of the Nursing Reinvestment Act in 2002, which has been underfunded since its passage throughout the years of the Bush administration.

Many anticipate changes in federal funding for nursing education with a new administration in Washington starting in 2009. For example, President Obama's 2010 budget proposal included expanded funding for the Health Resources and Services Administration (HRSA) to \$263 million for programs to address the nursing shortage, an increase of \$92 million from the last budget of the previous administration. The budget proposal also sought a 235% increase in the funding for support of nurses in critical shortage facilities, scholarships and loans repayment awards, and for scholarships to prepare 550 additional nursing faculty (ANA, 2009).

The American Association of Colleges of Nursing (2007) noted the dramatic increase in enrollment in baccalaureate programs, including the number of qualified applicants who were denied admission to programs because of insufficient numbers of nursing faculty, classroom space, and access to clinical facilities for practicum experiences. In 2002, 3,600 qualified applicants were denied admission to baccalaureate nursing programs; by 2006 that number had exceeded 32,000 (AACN, 2007). The AACN also reported that during 2007, enrollment in baccalaureate nursing programs was beginning to slow while the number of qualified applicants turned away remained at 30,000. Although interest in nursing as a career remains high, there are insufficient human, physical, and fiscal resources to support the needed expansion of nursing programs. The federal government's Health Resources and Services Administration (2004) projected that by the year 2020 there will be a need for one million additional registered nurses. HRSA noted that schools of nursing would have to increase enrollments by 90% to meet this demand.

The shortage of nursing faculty has been identified as a major reason for turning away qualified applicants, despite a growing nursing shortage. The salary differential between clinical and faculty positions is a major factor related to the inability of many schools to recruit faculty. For example, the AACN (2008c) noted a 2007 survey that demonstrated that a nurse practitioner with a master's degree in nursing (M.S.N.) earned an average of \$81,517 in clinical practice; a faculty member holding the M.S.N. earned an average of \$66,588, controlling for 12-month employment as opposed to a 9-month academic appointment. Although deans and directors of nursing education programs argue for salary equity in comparison with health care organizations, most colleges and universities benchmark faculty salaries in comparison with other educational institutions, continuing the cycle of underpayment of nursing faculty compared with their clinical colleagues. The AACN (2007) noted that 71% of baccalaureate nursing programs reported turning away qualified students in 2006, in large part because of faculty shortages.

The Expansion of Doctoral Education: Educating for New Leadership Roles

In the fall of 2008, 158 doctoral programs in nursing were offered in universities across the United States, with dozens more schools reporting doctoral programs in planning stages (AACN, 2008b). Doctoral education in nursing began a dramatic transformation after 2005 through the introduction of a new degree, the doctor of nursing practice (D.N.P.). The D.N.P. is a practice degree, not unlike an Ed.D. in education or a D.S.W. in social work. The D.N.P. replaced other nursing practice doctoral degrees (e.g., the D.N.S. and D.N. Sc.) and was developed through the efforts of AACN to emphasize the expansion of advanced roles for nurses, radically increasing the number of nursing programs to offer doctoral education (AACN, 2006a). The D.N.P. was not created to eliminate the need for the research doctoral degree in nursing (the Ph.D.) but to provide a more appropriate path for doctoral education for clinical leaders. The creation of this practice degree was consistent with a series of recommendations from the National Academy of Sciences (AACN, 2005), which included increasing the number of nurses who can serve as clinical faculty and doctorally prepared practitioners.

The AACN, an organization of deans and other administrators of baccalaureate and higher degree programs in nursing, is led by a board dominated by women (AACN, 2008a). The AACN, along with other nursing organizations such as the ANA, has faced opposition from the AMA (representing a traditionally male discipline) to the creation of D.N.P. programs and the use of the title "doctor" by nurses in advanced clinical practice (e.g., nurse practitioners, nurse midwives, certified registered nurse anesthetists, and clinical nurse specialists) (ANA, 2008). Although many traditional male-female role divisions have faded in the last 40 years in American culture, elements of the division between nursing (female) and medicine (male) lingers on.

The promise of D.N.P. programs is to create a new generation of nurse leaders. With a strong focus on organizational and system leadership and shaping public policy, D.N.P. programs seek to offer nurses an advanced skill set to prepare them for leadership positions in clinical practice, policy formation, or administration (AACN, 2006b).

Summary and Future Directions

The American Nurses Association's (2003) *Nursing's Social Policy Statement* observed that nurses and nursing influence numerous factors that shape health care policy and delivery, with nurses leading in an ever-changing health care system. Within the policy statement, nursing's definition of itself has reshaped the role of nurses far beyond the stereotype of caregivers in hospitals and nursing homes: "Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations" (p. 6). This contemporary definition of nursing identifies the many and complex roles that nurses fulfill in the health care system. These roles for nursing leadership rest on a foundation of undergraduate, graduate, and doctoral education in nursing.

Nursing leaders can be found in many venues. Nurse leaders serve in obvious positions such as deans of nursing

programs and chief nursing officers and CEOs in hospitals and other health care organizations. Diana J. Mason, former editor of the *American Journal of Nursing*, has hosted a radio talk show on health care and policy issues in New York City since 1986. In early 2009 President Barack Obama named Mary Wakefield, a nurse who served as chief of staff to two members of the U.S. Senate, to lead HRSA, an agency of the Department of Health and Human Services. Nurses not only serve as leaders of nursing organizations but also in diverse organizations such as AARP and the Robert Wood Johnson Foundation.

Lois J. Capps was a school nurse whose husband, Walter Capps, served in Congress. When he died suddenly, Ms. Capps was appointed to fill his term and has since been elected to Congress three times. She serves in Congress with two other nurses, Eddie Berniece Johnson of Texas, the first nurse elected to Congress in 1992, and Carolyn McCarthy, an LPN. Representative McCarthy won election to Congress after her husband was killed and her son wounded by a gunman on the Long Island Railroad. She challenged the incumbent representative who rejected her efforts to encourage him to support gun control legislation, switching her political party affiliation to run.

The leadership of contemporary nursing is influenced strongly by the restrictions of the past and opportunities of the future. Moving into leadership requires a high degree of commitment to the profession of nursing. Nurses can begin the path to leadership roles by becoming active members of professional organizations, including the many nursing specialty organizations, where they can be mentored by other women in nursing leadership positions. Gaining political savvy in the workplace and in professional organizations can be achieved through active membership in organizations, running for office in these organizations, serving on committees in the workplace or in professional organizations, and networking with other women in leadership positions (Kelly, 2007a, 2007b). Women in leadership are thriving in nursing with great opportunities for continuing growth.

—Karen Kelly

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