New Structure of Nursing Organizations

ALMOST 10 years of effort by nurses to simplify and improve the structure of their professional associations culminated last June when more than 6,000 nurses at the 1952 Biennial Nursing Convention voted to consolidate their organizations into two major national groups. Of the five national professional nursing organizations existing in 1952, only one—the group representing industrial nurses—remained outside the new structural plan.

The first national nursing organization was founded in 1893; by 1942 there were six. During World War II and the postwar years, these organizations were coordinated first through the National Nursing Council for War Service and later through a joint board of the six organizations. Considerable effort was required for the coordination of their activities in order to prevent duplications and gaps in services. Moreover, members of related professions and the general public were confused as to the respective functions of the organizations. The nursing profession soon recognized that reorganization was in order and set about finding a new structure.

In 1944 the boards of the American Nurses' Association, the National League of Nursing Education, and the National Organization for Public Health Nursing voted to make a survey of the "organization, structure, administration, functions and facilities" of their groups "to determine whether a more effective means could be found to promote and carry forward the strongest possible program for professional nursing and nurses." The Association of Collegiate Schools of Nursing and the National Association of Colored Graduate Nurses joined in the study during 1945. A formal study and report were made in 1946 by a firm employed for the purpose. From that time until 1952, nurses everywhere, through their local, State, and national committees, worked at designing a new structure for the organization of their profession.

A plan for a single, all-purpose association had some proponents, but the establishment of such an organization presented problems. Nonnurse participation in organizations was recognized as desirable. Certain functions, such as those relating to the setting of standards, however, were considered to be the prerogative of an all-nurse association, and the International Council of Nurses requires that its national constituents be comprised solely of nurse members. Consequently, a plan for two organizations evolved. One, much like the existing American Nurses' Association, would have nurse members only; the other, to be called the National League for Nursing, would have both nurses and other persons as individual members as well as agency and institutional members. The first would be concerned primarily with the individual nurse and her professional welfare and standards; the second, with community nursing services and education to prepare nurses for these services.

At the Biennial Convention of 1952, the National League of Nursing Education, the National Organization for Public Health Nursing, and the Association of Collegiate Schools of Nursing approved an action disbanding their organizations and combining most of their former functions under the new National League for Nursing. Also at this convention, changes were made in the bylaws of the American Nurses' Association, and a means for cooperation between the altered American Nurses' Association and the National League

This summary was prepared by the office of the Chief Nurse Officer, Public Health Service.

for Nursing was formulated. The National Association of Colored Graduate Nurses had gone out of existence several months previously and its functions assimilated in other organizations. The American Association of Industrial Nurses voted not to disband. At present, then, there are three national nursing organizations.

American Nurses' Association

The following are the major activities to be carried on by the American Nurses' Association:

1. Define qualifications for nurse practice in the various occupational groups and for specialities within those groups.
2. Recommend standards for nurse practice in such fields as public health, industrial hygiene, nursing education, private practice, and nursing administration.
3. Promote legislation and speak for nurses on legislative action concerning general health and welfare programs.
4. Take periodic inventories of the Nation's nurse resources.
5. Promote and protect the general welfare (economic, professional, and social) of nurses.
6. Provide professional counseling service regarding employment to individual nurses and to their employers.
7. Act as spokesman for nurses with the public and with official groups (professional, governmental) on a State, national, or international basis.
8. Serve as official representative of American nurses in the International Council of Nurses.

Four sections of the original American Nurses' Association are continued—general duty, private duty, institutional nursing service administrators, and industrial nurses. Three new sections have been added—public health nurses, educators, and special groups, which include nurses who do not come under any other section, such as office nurses and nurse anesthetists. State organizations will be similar to the national organization, and sections will send representatives proportional in number to their membership to the American Nurses' Association House of Delegates, the official voting body which meets every 2 years.

The *American Journal of Nursing* will continue as the official organ of the American Nurses' Association.

National League for Nursing

Nurses and other citizens, both as individuals and representatives of community, health, and educational agencies, are members of the new National League for Nursing. This organization will:

1. Work with allied professions and other interested groups to help communities to meet their nursing needs.
2. Promote the organization and improvement of nursing services in communities, including defense areas where services are often woefully inadequate.
3. Study the kind of education nurses need to give good nursing service.
4. Promote the improvement of educational programs in nursing, and provide accreditation of such programs.
5. Give advisory service to community nursing agencies and counseling service to colleges, universities, and communities regarding the establishment of educational programs in nursing.
6. Interest young people in choosing nursing as a career; test and guide those who are interested so that the ones best suited are selected.

The league has two divisions—nursing services and nursing education—each of which has two departments. Public health nursing and hospital nursing are the departments of the first division; baccalaureate and higher degree programs and diploma and associate degree programs are in the second division.

The committees and services in the National League for Nursing include: Committee on Careers in Nursing, which is promoting the recruitment of student nurses; National Committee for the Improvement of Nursing Services; Committee on Nursing in Medical Care Plans; Joint Committee on Practical Nurses and Auxiliary Workers in Nursing Services; National Nursing Accrediting Service (for nursing schools); Advisory Nursing Service for Orthopedics and Poliomyelitis; and Tuberculosis Advisory Nursing Service.

Eligible for individual membership in the league are registered nurses in all fields of nursing; members of allied professions, such as physicians, hospital administrators, public health administrators, and educators; members of boards and committees concerned with nursing; members of boards and staffs of hospitals and public health agencies which have nursing service programs; and others interested in standards for community nursing service and nursing education. Among those eligible for agency membership are visiting nurse associations; public health nursing services in health departments, schools, and other community agencies; nursing services in industries, hospitals, and other institutions; and both basic and advanced nursing schools.

State leagues for nursing are now being formed all over the country. In general, they have the same divisions, departments, and committees as the National League. Individual members join the national organization through the State organization if such exists. Agency members join the national organization directly. Non-nurse members are entitled to membership on boards and committees and are eligible for election to all offices except those of president and first vice president. Individual members join the department of their choice and vote as members of that department for their own and general officers. State leagues may have district or local branches.

Official Publications

Nursing Outlook, which will begin publication sometime next year, will be the official organ of the National League for Nursing. This, the *American Journal of Nursing*, and the new journal *Nursing Research*, which first appeared in June 1952, will comprise the official journals of the new professional organizations. *Nursing Outlook* will absorb *Public Health Nursing*, the journal previously published by the National Organization for Public Health Nursing.

The American Nurses' Association has memberships approximating 180,000. The National League for Nursing has more than 20,000 individual members transferred from other organizations and is gaining membership daily. Those who joined before September 30, 1952, are charter members of the new organization. Most nurse members of the National League for Nursing will probably also be members of the American Nurses' Association. Membership in the league will provide additional opportunity for community service.

The president of the American Nurses' Association elected at the Biennial Convention in 1952 is Elizabeth Porter, and the executive secretary is Ella Best. The president of the National League for Nursing is Ruth Sleeper, and the general director is Anna Fillmore. The address of the headquarters of both organizations is 2 Park Avenue, New York City.

Yellow Fever Vaccine Production

Yellow fever vaccine, produced exclusively by the Public Health Service since 1942 in order to meet emergency wartime needs, will be manufactured in the future by the National Drug Company of Philadelphia, the Public Health Service announced jointly with the Armed Services Medical Procurement Agency in October.

This step, following conferences with many of the major pharmaceutical houses in the United States, is in accordance with Public Health Service policy of withdrawing from the manufacture of biological products in favor of the pharmaceutical industry when large-scale production becomes feasible.

Manufacture of the vaccine by the private firm does not alter the regulations governing distribution. All eligible consumers now receiving the vaccine may continue to do so.

PHS publications

Patients in Mental Institutions, 1949

This report presents statistics on patients in 199 State, 49 county, 1 city, and 225 private hospitals for mental disease; 16 psychopathic hospitals; 111 general hospitals with psychiatric facilities; and 99 public and 125 private institutions for mental defectives and epileptics. It is based on the twenty-fourth Annual Census of Patients in Mental Institutions, the third such census to be conducted by the National Institute of Mental Health.

The data, based on schedules prepared by these hospitals and institutions, consist of both a bookkeeping account of the flow of patients into and out of the hospitals and institutions and statistics on certain characteristics of first admissions and discharges, overcrowding, personnel, and expenditures.

It also contains discussions of the scope and method of the survey and the classification of reporting units, a definition of terms used, and the limitations of the data presented. There is also a brief historical review of data for the period 1940 through 1949 concerning resident patients, first and all admissions, discharges, and deaths in mental hospitals and institutions.

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Patients in Mental Institutions, 1949. (Public Health Service Publication No. 233.) 1952. 114 pages; charts. 55 cents.

Health Services In the Structure of State Government, 1950

Part I—Administrative Provisions for State Health Services

All State governments consider public health one of their major functions. The States differ, however, in the way they provide services. This publication brings together information regarding health services currently provided by State governments and differences in their public health organizations, methods of administration, scope of activities, policies, and resources.

This is the fourth edition of bulletin 184, containing data on State health organization and administration, each State being surveyed every 10 years. For the 1950 edition, the survey was limited to activity by State governments. No information was sought regarding local services. Therefore, the study does not present a picture of the total services received by the public, but rather it describes the manner in which the participating State agencies function in providing—either directly or through some other organization—health services for which they are responsible. The study constitutes the most complete source of information available on State health organizations.

The entire report is being published in four parts, all carrying the same main title. The second, third, and fourth parts, which will be published later, are subtitled: II—General Services and Construction of Facilities for State Health Programs; III—Personal Health Services Provided by State Government; and IV—Environmental Health and Safety Services Provided by State Government.

Part I—the present publication—gives a general picture of State health services, including the extent of dispersion of responsibility among various agencies of State government, the identity of all State agencies participating in health activities, and major changes occurring since 1940 in program content and in the assignment of responsibility.

The tremendous growth in the kinds and volume of health services provided by State governments can be seen in the increase of funds expended and personnel employed. Almost a billion dollars was spent on health in 1949, an increase of about 250 percent over 1940 expenditures. The average per capita expenditure for the 48 States was over $6, more than three times the corresponding figure for the 1950 survey. The number of personnel, exclusive of part-time and institutional employees, increased more than 100 percent between 1940 and 1950, with State health departments employing by far the greater numbers.

Perhaps the outstanding disclosure made by this study is the high degree of dispersion of health functions throughout the structure of State governments, which is even more pronounced than at the time of the 1940 survey. In 1950 as many as 32 agencies in a single State were participating in some health activity, contrasted to the top figure of 18 a decade ago. On a nation-wide basis, for a single program there may be as many as 14 distinct types of agencies represented. Although there has been some effort toward consolidation within health departments of programs previously scattered among several agencies, new programs still tend to develop under a variety of auspices.

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Mountin, Joseph W., Flook, Evelyn, and Minty, Edward E.: Distribution of Health Services in the Structure of State Government 1950. Part I, Administrative Provisions for State Health Services (Public Health Service Publication No. 184). 1952. 64 pages; tables; charts. 40 cents.

Tie That Knot

This leaflet was designed as a thumbnail-size guide for planning the location of local health units. It illustrates diagrammatically how public health service areas can be delineated, and how hospital facilities and public health units can be integrated to provide health service coverage for all counties. Comparative statistics on present and suggested future health units are given.

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Tie That Knot. (Public Health Service Publication No. 185) 1952. 2-fold leaflet; illustrated. Available upon request from the Public Inquiries Branch, Public Health Service, Washington 25, D. C.

PHS publications

Report of Local Public Health Resources, 1950

Full-time local health services are basically important in maintaining a healthy population to meet the demands of national defense mobilization, but at the same time these demands are seriously handicapping State and local governments in their efforts to expand and strengthen local health services. This annual report, however, indicates that despite inroads upon personnel, it was possible to continue the operation of most local health units and to expand facilities and services slightly during 1950, although a marked gain in the number of organizations or areas covered was impossible to attain.

This analysis is based upon the "Report of Public Health Personnel, Facilities, and Services" submitted as of December 31, 1950, by 1,193 full-time health organizations providing local health services in 47 States and the District of Columbia. (Vermont has no full-time local health units.) The definition of a full-time local health unit was changed in 1950 to indicate not only the presence of a full-time health officer but also the provision of full-time services.

The report includes data helpful to health administrators in planning for the expansion of local activities. Personnel and selected facilities and services of local health jurisdictions are summarized in terms of the type of agency sponsoring the service. Information is included for all official health agencies providing service to local areas whether they are officially known as a department, unit, commission, or otherwise. Likewise, the analysis includes data on the public health facilities and services available on a free or part-pay basis through official agencies other than health and through voluntary agencies.

Existing full-time health organizations are exceedingly understaffed. Minimum staffing needs of reporting units approximate an additional 1,000 public health physicians, 10,000 nurses, 16,000 sanitation workers, and 1,400 clerical workers. The small gain (800) in total personnel employed in local health departments as of December 1950, compared to June 1949, is encouraging, but the rate of increase is far below that required to meet the demands of complete coverage.

The availability of adequate public health medical facilities is another important need of local health organizations. Certain facilities and services considered basic by most public health officials are not yet included in the program of many health departments. In several of the newer health fields, the official health agency has not undertaken leadership in sponsoring clinical services and facilities, but has depended upon other official agencies or voluntary agencies to supply services.

With respect to sanitation activities even of the most basic types, too many health departments indicate gaps in essential services. Pasteurization of milk has been widely but not yet universally accepted. Approved community sanitation facilities and services are not available to all nonfarm population. The training of food handlers in proper sanitation techniques is included as a health department function in relatively few areas.

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Report of Local Public Health Resources, 1950. (Public Health Service Publication No. 232) 1952. 75 pages; tables. Limited number of copies available from the Division of State Grants, Public Health Service, Federal Security Agency, Washington 25, D. C.

Fact Book on Aging

This booklet presents 21 charts and 35 tables on the personal characteristics, income, employment, living arrangements, and health of older persons in the population. Facing each chart is a short statement summarizing its essential meaning and linking the data to facts of related significance. The tables contain raw data for the charts plus additional information too detailed to be charted. The Fact Book contains basic information necessary for an understanding of the size, distribution, and characteristics of the aging population.

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Fact Book on Aging. Federal Security Agency, Committee on Aging and Geriatrics. 1952. 62 pages; tables; charts. 30 cents. Single copies available on request from Committee on Aging and Geriatrics, Federal Security Agency, Washington 25, D. C.

Cancer Illness Among Residents of Chicago

The sixth in the series of 10 Cancer Morbidity Reports, this study reveals that the cancer incidence among residents of the Chicago area showed no real change from 1937 to 1947. These results differ from those obtained in five previously published studies, dealing with the metropolitan areas of Atlanta, Denver, New Orleans, Pittsburgh, and San Francisco, where more significant increases in cancer incidence were noted.

The study indicates cancer is primarily a disease of middle and late life. Two-thirds of all cancer patients in the Chicago area are over 55 and cancer occurs 100 times as frequently in persons over 65 as in children under 15. The rates are higher among females than among males from about 20 to 60 years of age, but during the early and later years of life the male rates are higher.

Charts and tables show the incidence, prevalence, and mortality rates; age, sex, and color differences; stage at diagnosis; survival rates; and statistics on hospitalization. Increases in reported illness from cancer were particularly noteworthy for the bronchus and lung sites, pancreas, and brain and nervous system. In contrast, reported incidence of cancer of the stomach, liver and biliary passages, and uterus decreased. In women, the most com-

mon cancers are those of the breasts, genital organs, and digestive system; and in men, the digestive system, respiratory system, genital organs, skin, and urinary tract.

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Cancer Illness Among Residents of Chicago, Ill. Cancer Morbidity Series No. 6 (Public Health Service Publication No. 152) 1952. 49 pages; tables; charts. (Not for sale.)

Cancer Illness Among Residents of Dallas, Tex.

Number 7 of the Cancer Morbidity Series reveals that cancer incidence among Dallas City and County residents increased 18 percent from 1938 to 1948, but during the same period cancer mortality for all residents increased only 2 percent. Among men there was an 8-percent increase in mortality and among women a 3-percent decrease.

The importance of early diagnosis is pointed up in the fact that when all cancer sites are considered, 65 percent of the cancer patients in Dallas County were diagnosed while the disease was still localized. When skin cancers are excluded from the total, only half of the remaining cancers were diagnosed while still localized. Ninety-three percent of these patients survived one year or longer. When diagnosis was made after regional involvement, 73 percent survived. Only 35 percent survived, however, when the disease was discovered after remote metastasis had occurred.

As in the previous survey, the Dallas report notes a relationship between cancer and aging. Cancer occurs 100 times as frequently in persons over 65 as in children under 15. On the other hand, 10 percent of all cancer patients in Dallas are under 35. Most common cancers in these younger persons are the leukemias and cancers of the brain and bone.

Following the pattern established in the first six reports, this publication presents charts and tables showing the incidence, prevalence, and mortality rates; age, sex, and color differences; stage at diagnosis; survival rates; and statistics on hospitalization and cases seen for check-up.

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Cancer Illness Among Residents of Dallas, Tex. Cancer Morbidity Series No. 7 (Public Health Service Publication No. 178) 1952. 46 pages; tables; charts. (Not for sale.)

Safe Water

Designed for those living on farms and in small communities which do not have a municipal water supply, this leaflet discusses three types of water systems (well, cistern, and stream), the ways in which they can become polluted, and how such pollution can be prevented. The reader is advised to consult his local health department to learn how he can protect his water supply from dangerous disease germs.

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Safe Water. Community Health Series, No. 2 (Public Health Service Publication No. 71) 1951. 3-fold leaflet. Illustrated. 5 cents; $1.50 per 100.

A Healthy Personality for Your Child

Written for parents to give them an understanding of the stages through which children grow emotionally from infancy to adulthood, this new publication of the Children's Bureau, Federal Security Agency, is a popular version of a part of the fact finding report prepared for the Midcentury White House Conference on Children and Youth.

The original report was the product of a committee which included doctors, psychologists, anthropologists, social workers, clergymen, delinquency experts, lawyers, educators, and specialists in youth employment, recreation, and child development. The popular version was written by Dr. James L. Hymes, Jr., professor of education, George Peabody College for Teachers, Nashville, Tenn.

"A Healthy Personality for Your Child" puts together what is generally accepted by authorities on how personality grows and how it is shaped. Beginning with infancy, it discusses the emotional needs of children, their attitudes and reactions, and the changes they go through during the years up to postadolescence. It is agreed that parents are the most important influence in their children's lives. Their role in shaping the children's personalities is discussed in relation to the various stages of development.

NOTE: A discussion aid, based on this pamphlet, for use of parents groups interested in exploring problems of emotional growth is available from the Children's Bureau without charge.

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A Healthy Personality for Your Child. Children's Bureau, Federal Security Agency. Publication No. 337. 1952. 28 pages. Illustrated. Single copies available without charge, so long as the supply lasts, on request to the Children's Bureau, Federal Security Agency, Washington 25, D. C.

Safe and Sanitary Home Refuse Storage

As noted in the article "Refuse-Can Holders" in the August issue of *Public Health Reports*, this leaflet contains recommendations concerning the proper storage of home refuse. Stressing the protection to be gained against disease, accident, fires, and vermin, it outlines five simple steps for the householder. They are: (1) providing and using proper containers; (2) maintaining the containers in a sanitary condition; (3) placing the containers in the right place at the right time; (4) draining garbage and bundling bulky rubbish; and (5) where required, separating garbage, ashes, and rubbish. These steps are further amplified, with suggestions on types of storage cans and stands to set them on.

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Safe and Sanitary Home Refuse Storage. (Public Health Service Publication No. 183) 1952. 2-fold leaflet, illustrated. 5 cents; $1.00 per 100 copies.

Health Manpower Source Book

Section I—Physicians

To meet the frequent requests for information on medical manpower, the Division of Public Health Methods, in cooperation with the Divisions of Dental, Nursing, and Engineering Resources, is preparing a comprehensive source book on health manpower. The first section of the source book, issued as a preliminary report, is concerned with physicians. It is based on material published periodically by the American Medical Association and upon various special surveys. The final report on physicians and about 18 other occupations in the health industry will include 1950 census data which are not yet available.

The preliminary report is composed almost exclusively of statistical tables on the country's physicians — geographic distribution, type of specialty, licensure information, graduates over a period of years, income, average patient load, data on group practice. There are 66 tables and the bibliography lists 132 references.

The estimated number of physicians in the continental United States at the end of 1951 was about 211,000, according to the American Medical Association and reported in the Source Book. In 1949 there were 121 active non-Federal physicians for every 100,000 civilian population. This is a slight decrease from the 1940 rate of 122 physicians per 100,000 population. There has been an increase in the numbers of physicians who reported a practice limited to a specialty. The Source Book points out that in 1949, nearly 63,000 (31 percent) reported that they were full-time specialists, in contrast to 11 percent in 1923 and 21 percent in 1940. Internal medicine, surgery, and ophthalmology-otorhinolaryngology accounted for more than half of the total specialists.

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Health Manpower Source Book, Section I, Physicians, Preliminary. (Public Health Service Publication No. 263) May 1952. 70 pages, tables. 40 cents.

for the general public

Smallpox

The emphasis in this health information leaflet is on vaccination. The story of early epidemics and the development of our present form of immunization are reviewed. Facts about the disease include how it is spread, symptoms, and medical care. The list of precautions gives details on vaccination, when it should be done, and how often it should be repeated. Prompt reporting of cases of chickenpox is urged, as smallpox is often mistaken for the more mild disease.

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Smallpox. Health Information Series, No. 27 (Public Health Service Publication No. 230). Reprinted 1952. 1-fold leaflet. 5 cents; $1.25 per 100.

Sunstroke, Heatstroke, Heat Prostration

Because of the number of people who succumb to so-called thermic fever, this leaflet is of particular importance during the summer months. It describes the three illnesses, their causes, and symptoms. First-aid instructions are given, stressing the importance of calling a doctor at once. Common-sense precautions for hot weather are given and the need for extra water and salt is discussed.

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Sunstroke, Heatstroke, Heat Prostration. Health Information Series, No. 4 (Public Health Service Publication No. 176). Revised 1952. 1-fold leaflet. 5 cents; $1.25 per 100.

Home Care of the Sick

Since a majority of the persons who are sick in the United States today are cared for in the home, this leaflet presents valuable general information for the person giving home care. It covers the selection of the patient's room, the furnishings, sickroom equipment, bed and bed clothing. Instructions are given for changing patient's bed linen and for the preparation of the patient for the day. The leaflet also discusses the handling of communicable disease cases, and ways in which the attendant can be of help to the physician. Organizations and individuals who can give instructions in nursing care are suggested.

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Home Care of the Sick. Health Information Series, No. 21 (Public Health Service Publication No. 70). Third printing, May 1952. 2-fold leaflet. 5 cents; $1.50 per 100.

Hay Fever

Hay fever is more than just an annoyance—it can be serious. This health information leaflet describes hay fever, its symptoms, and the various types of seasonal hay fevers. It discusses the diagnosis of hay fever by means of allergy tests, and treatment with injections and medicines. Other means of obtaining relief suggested are the removal of pollens from the air of the victim's room or a change of location. However, the reader is advised that a doctor should be consulted lest the patient leave one type of pollen only to encounter another to which he is sensitive.

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Hay Fever. Health Information Series, No. 17 (Public Health Service Publication No. 208). Revised 1952. 1-fold leaflet. 5 cents; $1.75 per 100.

Publications for which prices are quoted are for sale by the Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C. Orders should be accompanied by cash, check, or money order and should fully identify the publication (including its Public Health Service publication number). Single copies of most Public Health Service publications can be obtained without charge from the Public Inquiries Branch, Public Health Service, Washington 25, D. C.

U. S. GOVERNMENT PRINTING OFFICE: 1952