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“The Miracle in Giridih”: A Photographic Documentation of a Plastic Surgery Clinic in India, January 2000

Preserving the recent history of our profession is equally important as preserving that of a hundred or more years ago, and through the generosity of local medical illustrator and photographer Florence Houser, we are privileged to make a photographic collection of images documenting “The Miracle in Giridih”¹ available to students and scholars of international nursing history.

On January 21, 2000, a University of Virginia led team of 18 – including three plastic surgeons, three anesthesiologists, a pediatrician, two dentists, six nurses, a physical therapist, a medical student and a photographer – traveled to Giridih, a small town outside Calcutta in the state of Bihar, India. There the group spent seven 18 hour days treating Indian children with cleft lips and palates (mostly from vitamin B deficiencies), facial scars from burns, and other congenital and traumatic deformities requiring the highly technical skills of plastic surgery. It was the fourth time a group of clinicians of the Virginia Children’s Connection, established in 1989 by UVA surgeons John Persing and John T. Lettieri, had made the trip to the rural town in India where the need for medical care was so great. Under the direction of UVA plastic surgeon Dr. Thomas J. Gampper, the surgical teams worked in sparsely furnished clinic rooms – supplementing the light of a single bulb hanging from the center with their own surgical lamps. School of nursing faculty member, Dr. Audrey Snyder (then a Masters student in acute care) was among the nurses who participated.

When the team



Virginia Children’s Connection clinicians at Bagaria clinic.

The
CENTER for
NURSING
HISTORICAL
INQUIRY

The Center for Nursing Historical Inquiry (CNHI), established at the University of Virginia in 1991 to support historical scholarship in nursing, is dedicated to the preservation and study of nursing history. The development of advanced clinical nursing practice, and the clinical specialty organizations that represent the various practices, is a major focus of the Center. The goals of the Center include the collection of materials, the promotion of scholarship, and the dissemination of historical research findings.

(Continued from page 1)

arrived in Giridih on the evening of January 23, after more than 24 grueling hours of travel, the members immediately began screening the more than 450 patients who had awaited their arrival. The



Tea shop near the clinic.

clinic, located in the heart of South Bihar's mining region, provided care to an underserved population in a part of India that is, according to Professor of South Asian history Walter Hauser, "topographically and economically similar to the Appalachian area" here in the United States.



Local nursing students.

There the need is so great that "for every child you do help, there are thousands upon thousands you can't."² There the need is so great that when the team left, the local people, saddened at their leaving,

"assembled outside the crumbling wall of the Bagheria Hospital with folded hands, their turbans placed on the ground."³

I invite you to visit our Center to view the photographs. I also hope that you will document your own clinical experiences (as best you can given HIPPA regulations) for future historians!

Alex W. Keeley

1. Hasan, Mushirul. "The Miracle in Giridih." *Indian Express*, February 23, 2000.
2. Ibid.
3. Ibid.



Surgical gloves carefully washed and saved by local nurses.

Center News & Events

2009/10 History Forums

McLeod Hall Room #5044

12:00-1:00 PM

October 20, 2009

"In the interests of Halifax sufferers":

Massachusetts Disaster Relief Nurses' Response to the Halifax, Canada Explosion of 1917.

Deborah A. Sampson, PhD, APRN, FNP-BC
Assistant Professor, The University of Michigan
The University of Michigan School of Nursing
2009 Barbara Brodie Nursing History Fellow

November 17, 2009

A "Roar Like a Thousand Niagaras":

The Monongah Mine Disaster and the Care of Victims, Rescuers, and Survivors, December 1907.

John C. Kirchgessner, PhD, RN, PNP
CNHI Assistant Director,
Assistant Professor of Nursing,
University of Virginia School of Nursing

February 9, 2010

"Contrary to Approved Methods of Practice": Massage Therapy, Polio, and Nursing, 1900-1945

Audrey Snyder, PhD, RN, ACNP, CEN, FAANP
Assistant Professor of Nursing,
University of Virginia School of Nursing

Agnes Dillon Randolph Lecture/Award March 16, 2010



Dr. Patricia D'Antonio, PhD, RN, FAAN, Associate Professor of Nursing and the Associate Director of the Barbara Bates Center for the Study of the History of Nursing at the University of Pennsylvania has been selected as the recipient of the Center for Nursing Historical Inquiry's 2010 Agnes Dillon Randolph Award and Lectureship. Dr. D'Antonio was chosen for her sustained contributions to nursing and health care history, particularly with regard to psychiatric nursing, historical methodology, and nursing in the community. In addition, she serves as the editor of the Nursing History Review.

The Agnes Dillon Randolph Award, named in honor of one of Virginia's early nursing leaders, is given to an individual who has contributed significantly to the intellectual rigor and scope of the discipline of nursing history. Dr. D'Antonio's lecture, entitled *"Competence, Coolness, and Control: Rethinking the Trope of Disciplined Obedience in the History of Nursing"* is scheduled for 4:30 p.m. and will be followed by a reception.

Center News



Introducing Anne Cockerham Our New Center Associate

We are pleased to announce that Anne Cockerham PhD, CNM, WHNP-BC has joined the Center as a Center Associate. Dr. Cockerham completed a PhD from the University of Virginia in 2008. Her research used historiographic methods to examine a Catholic nurse-midwifery service in Santa Fe, New Mexico that provided care to impoverished Spanish American women from 1943 until 1969. As a nurse historian and nurse midwife, she believes it is critically important to examine the historical antecedents to today's practice to be able to make more informed decisions about the profession's present and future.

Dr. Cockerham practices nurse-midwifery in Leesburg, Virginia and teaches on the faculty of the Frontier School of Midwifery and Family Nursing in Louisville, Kentucky. We are delighted to welcome Anne and look forward to the unique scholarship she will bring to the Center.

Barbara Brodie Nursing History Fellowship 2010

The Center for Nursing Historical Inquiry Barbara Brodie Nursing History Fellowship, a postdoctoral award, is open to nurses engaged in historical scholarship that advances the field of nursing history. This year the application deadline for the \$3000 award has been extended until November 6, 2009, and the recipient will be announced in December, 2009. The selected Barbara Brodie Nursing History Fellow will present a paper from their research in the Center's History Forum series.

Selection of the fellow will be based on the scholarly quality of the investigator's project including: the clarity of the project's purpose, its rationale and significance, the rigor of its methodology and questions posed, and its potential contributions to the field of nursing.

The application and a curriculum vitae should be sent to Dr. Arlene Keeling, Director, Center for Nursing Historical Inquiry, University of Virginia School of Nursing, PO Box 800782, McLeod Hall, Charlottesville, Virginia 22908. Applications are available on the Center's Web site, at:

[www.nursing.virginia.edu/
Research/CNHI/Fellowship](http://www.nursing.virginia.edu/Research/CNHI/Fellowship)

Center News

Staff Externally Funded Research:

Keeling, A. (PI), Kirchgessner, J., and Brodie, B. (January 2007- Aug 2009). American Association for the Colleges of Nursing, RFP: "A History of the AACN."

Staff Awards:

Gibson, M.E. (September 2009) Jeanette Lancaster Faculty Endowment Award, \$2,000, for archival research, Seattle, Washington & Philadelphia, Pennsylvania.

Staff Publications:

Brodie, B. Book Review: *The W. K. Kellogg Foundation and the Nursing Profession: Shared Values, Shared Legacy*, by J. Lynaugh et al, *Nursing History Review*, 18(2010): 236-237.

Brodie, B. Media Review: *History of Nursing: Early Years and History of Nursing: The Development of a Profession*, J. Tannenbaum, Producer, K. Lam, Director. *Nursing History Review*, 18(2010): 204-207.

Cockerham, A.Z., & Keeling, A.W. "Finance and faith at the Catholic Maternity Institute, Santa Fe, New Mexico 1944-1969." *Nursing History Review*. 18 (2010): 151-166.

Keeling, A. "'The Ghetto was a Hotbed of Influenza and Pneumonia': District Nursing during the Influenza Epidemic, 1918-1919." *The Institut fur Geschichte der Medizin der Robert Bosch Stiftung*, Stuttgart, Germany. (in press).

Keeling, A. "'When the City is a Great Field Hospital': The Influenza Pandemic of 1918 and the New York City Nursing Response." *The Journal of Clinical Nursing*. 18(19): 2732-2738.

Wall, B.M. and **Keeling A.** "A History of Disaster Nursing," Chapter 15 in *Public Health Nursing: Applying and Doing*, eds: Marie Truglio-Londrigan and Sandra B. Lewenson. Jones and Bartlett Publishers, Boston, (in press).

Telford, JC, and **Keeling, A.** "The context of Professional Nursing Practice: Historical Development of

Professional Nursing in the United States," In *Conceptual Foundations of Professional Nursing Practice*, edited by J. L. Cresia and E. Friberg. Mosby Yearbook, Inc., (in press).

Staff Presentations

Gibson, M. "'The Best Return for the Money': School Nursing as an Early Focus for Virginia's Bureau of Public Health Nursing." Paper presented at the American Association for the History of Nursing Annual Conference, Minneapolis, Minnesota, September, 2009.

Keeling, A. "When the City is a Great Field Hospital: Lillian Wald and the Nursing Response to Pandemic Influenza, 1918." Paper presented at the American Association for the History of Nursing Annual Conference, Minneapolis, Minnesota, September, 2009.

Staff Research in Progress:

Keeling, A. Nursing during the Influenza Pandemic of 1918.

Gibson, M. Nursing care of crippled children in the twentieth century.

Kirchgessner, J. The care of victims of West Virginia coal mine disasters, 1900 & 1920.

Student Presentations, Posters, & Publications:

Zerull, L.M. "Nursing body and soul: The Baltimore Lutheran deaconess motherhouse and training school in 1898." *American Journal of Nursing*. 109(10): 26-29.

Zerull, LM. "The Baltimore Lutheran Deaconess Motherhouse: Defining a German or American Model in 1895." Paper presented at the American Association for the History of Nursing Annual Conference, Minneapolis, Minnesota, September, 2009.

“Above Average” Nursing Care: The Development of Intensive Care Nursing at the University of Virginia Hospital, 1954-1970

**Sarah White Craig, BSN, RN
UVA School of Nursing MSN Student**

**John C. Kirchgessner, PhD, RN, PNP
CNHI Assistant Director
U.Va. School of Nursing Assistant Professor**

Introduction

The American Association of Critical-Care Nurses (AACN) defines critical care nursing as, “that specialty within nursing that deals specifically with human responses to life-threatening problems. A critical care nurse is a licensed professional nurse who is responsible for ensuring that acutely and critically ill patients and their families receive optimal care.”¹ The development of intensive care units (ICUs) in the mid-1950s and 1960s led to changes in nursing care and professional collaboration. ICU nursing became a bridge to interdisciplinary education and collaboration between nurses and physicians. The unique interdisciplinary relationships at the grass roots level of care ultimately led to improved patient care and survival rates in critically ill patients. The nurses who worked in the newly developed ICUs also began to have greater clinical expectations of

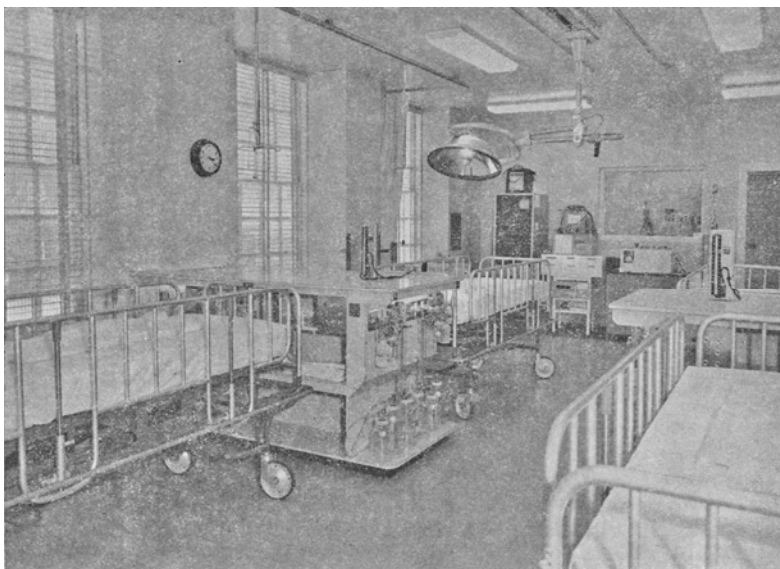
themselves and for their patients. This article focuses on the development of the intensive care units at the University of Virginia Hospital and examines the contributions of nurses to the care and survival of critically ill patients in the mid-twentieth century.

Health Care in Transition

After World War II, numerous changes occurred in medicine, technology, and hospitals. The federal government allocated an abundance of funding for research, technology, and new hospitals. In addition, the development of broad spectrum antibiotic therapy, mechanical ventilation, dialysis, and complex surgical procedures influenced the care being provided in American hospitals.

One aspect of this investment in health care was the Hospital Survey and Reconstruction Act, also known as the Hill-Burton Act. This legislation provided federal funding in the amount of \$75 million annually for five years for building and expansion of hospitals across the nation.² In addition to advances in medical science and an increased number of hospital beds, the number of Americans receiving health insurance benefits from their employers also increased during this time, allowing more Americans to seek and have access to health care. In 1950 an estimated 50% of Americans had private hospital insurance, and that percentage rose to 75% by 1960.³

During the immediate post-war era, the majority of the nation’s industries faced drastic personnel shortages as the post-war economy began to soar and all sectors of the economy prepared to meet American demand for products and ser-



“K” Unit opens as Intensive Care Area, April 25, 1963. *The Draw Sheet*, VIII (5), 1.

vices. The burgeoning hospital industry was no exception. All hospital departments including nursing service were in desperate need of staff. However, many nurses who joined the armed forces during the war showed little interest in returning to hospital nursing or nursing in general. Thus, the skeleton nursing staffs that kept hospitals functioning were forced to care for an increasing number of patients as Americans turned to hospitals for medical and nursing care, surgery and childbirth.⁴ Many critically ill postoperative cardiology, neurosurgery, and plastic surgery patients as well as heart attack and stroke victims were admitted to hospitals' general medicine and surgery wards. These patients required dialysis, intricate wound and dressing care, and skilled respiratory care including labor intensive chest tube systems for which many nurses were not trained. Nurses became increasingly concerned that with minimal staff, they were no longer able to carefully monitor their critically ill patients. In addition, many nurses realized they did not have adequate knowledge or the skills required to care for such patients.

Hospitals also changed architecturally during the post-war era, thus further transforming hospitals and ultimately changing nurses' responsibilities. These changes were brought about in part by health insurance companies' willingness to pay for semi-private and private accommodations for their patient subscribers. The once large open wards were closed and more private rooms were constructed. This transition affected the delivery of nursing care. As nurse historian Julie Fairman notes, hospital wards allowed nurses to monitor large numbers of patients. With the renovations creating semi-private and private rooms, patients became isolated and the nurses' ability to rapidly assess and respond to their patients' needs was diminished.⁵ In addition when a patient was critically ill, the nurse might be

needed for long periods of time in that patient's room, limiting her ability to care for other patients.

Throughout the 1950s, as the number of complex surgeries increased, post anesthesia care units (PACUs) were established in hospitals to allow for closer monitoring of post-surgical patients. In so doing, nurses were able to prevent or quickly treat adverse events before returning patients to their assigned ward rooms on general medicine wards. These post-operative care units were in close proximity to operating rooms and designed with an open floor plan so that all patients could be readily observed. In addition, the nurse to patient ratio in the early PACUs was generally no greater than one to three. As a result of PACU success in improving post-surgical patient care, physicians, nurses and hospital administrators began to realize the potential such units could have in providing around the clock intensive nursing care to critically ill patients. The nation's first intensive care units (ICUs) were established as early as 1953 in Chestnut Hill, Pennsylvania, Chapel Hill, North Carolina, Albany, New York, Manchester, Connecticut, and Hines, Illinois.⁶ The ICU model was rapidly adopted by hospitals nationally and between 1959 and 1965 the number of ICUs nationwide more than quadrupled from 238 to 1040 units.⁷

The Evolution of Intensive Care Nursing at the University of Virginia Hospital

In keeping with national trends, on July 12, 1954



New coronary care unit with \$10,000 equipment provided by Hospital Auxiliary, 1968. *The Draw Sheet*, 16 (5), p.8.

UVA Hospital's first PACU opened with seven beds and two cribs. Six months later, in the February 1955 issue of the hospital's newsletter *Draw Sheet*, reporter Eleanor Majer wrote about the success of the unit and noted, "Everyone agrees that University Hospital's recovery room has proved its necessity by stepping in as a weapon to beat the unexpected crises that can follow surgery, but, most of all, by preventing those crises." The success of the PACU at UVA with low nurse to patient ratios and therefore an increased level of care caught the attention of many doctors and hospital administrators. To keep pace with the number of post-surgical patients who required intensive care, a 31-bed nursing unit was opened in February 1956. The unit, known as the K-Unit, opened with the intent of providing patients with "above average nursing care."⁸ The unit contained two 4-bed rooms, eleven 2-bed rooms, and one private room with in-wall oxygen and suction, a nurse call system, and air conditioning. Although the unit did not boast advanced technology by today's standards, coordinating the care of the critically ill in a central location with oxygen and suction at the nurse's fingertips was innovative. The K-Unit became the prototype for the hospital's first intensive care unit and became the foundation for the future of intensive care nursing at UVA.

Over the next several years, the growth of medical and surgical subspecialties resulted in an increase in hospital admissions at the University.⁹ As a result, the hospital's physicians and administrators began to plan for the expansion of the hospital. After receiving approval for state and federal funding, including



Arlene Wynbeck and Diane Urrutia with two pacemakers purchased for the CCU, 1970. *The Draw Sheet*, 18 (9), 5.

1961. The new modern hospital complex boasted a total of 682 in-patient adult and pediatric beds.¹⁰ Coinciding with the hospital's expansion, the University also witnessed an increase in the complexity of medical and surgical procedures taking place in the hospital. At the time, physicians and administrators noted that, "Complicated medical and surgical procedures and intricate mechanical and electronic devices used in the care of patients have combined in recent years to produce the need for a highly specialized type of hospital nursing unit."¹¹ As greater numbers of patients were admitted to cardiovascular, nephrology, neurology, and surgical services throughout the early-1960s, it became clear that more highly skilled patient care was required. As a result, the hospital's administrators proposed creating an intensive care unit to better meet the needs of the hospital's patients.

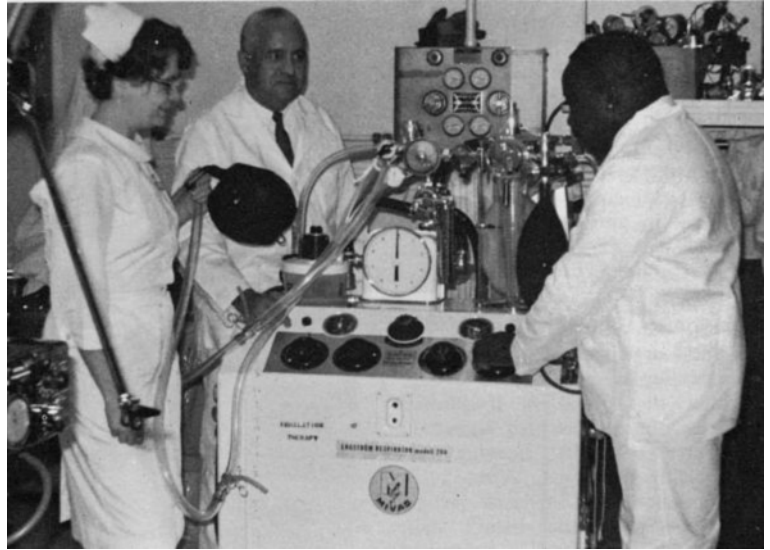
At a cost of \$70,000 the K-Unit was renovated and in the spring of 1963 became UVA Hospital's official nineteen-bed intensive care unit. However, due to the continued shortage of nursing staff and equipment, the PACU and ICU were combined for the first year and a half. The 1963-1964 *Operating Report for UVA Hospital* described the ICU as consisting of thirteen temporary PACU beds and six designated ICU beds. The new PACU/ICU contained the latest technology including: bed side monitors for obtaining vital signs and electrocardiograms; pacemaker and defibrillation capabilities; oxygen; suction and nitric oxide. Operating room lights were also installed over each bed so that emergency surgery could be performed without requiring the transfer of already unstable patients to the operating room.¹² In June 1963, then UVA engineering student Martin Brown described the patient population of the ICU as consisting of those who recently underwent cardiac and head and neck surgeries, as well as patients suffering from strokes, heart attack, and serious injuries.¹³ Throughout this time, the PACU nurses trained the new ICU nurses to care for critically ill patients and helped to develop the nurses' role in the ICU. Persistent nursing shortages prevented the establishment of additional intensive care units over the next several years. However, the demand for intensive nursing care continued to rise, and by 1964, UVA cardiologist Dr. Lockhart B. McGuire negotiated to have three beds in the quietest area of the ICU strictly for the care of cardiac patients.¹⁴

Hill-Burton funds, a new multi-story facility was dedicated in late-1960 and opened in April

Over the next five years, as the number of cardiac surgery patients increased, the demand for coronary intensive care outgrew its three-bed space within the ICU. As a result, in 1968 the next intensive care unit to be opened at UVA was the Coronary Care Unit (CCU). The unit was comprised of four patient rooms and a central nursing station. The hospital's Ladies Auxiliary generously provided \$10,000 for the unit's new equipment. Each room had bedside cardiac monitors with alarms that indicated changes in patients' vital signs and cardiac rhythms. The monitors also had the capability to transmit changes to a large display monitor at the nurses' station. The new CCU was also equipped with new and innovative technology including pace-makers, defibrillators, and medications for the treatment of cardiac arrhythmias. The majority of care and use of this life saving equipment was performed by specially trained nurses.¹⁵ Despite this well equipped modern CCU, Dr. McGuire continued to face a shortage of nursing staff. Nurse historian Arlene Keeling describes McGuire's frustrations with staffing the CCU. According to him, "there was less than vigorous support from nursing administration."¹⁶ Miss Mary Jane Morris, the nursing supervisor for the fourth floor at the time, agreed, stating that she "had to pressure the director of nurses, Miss Roy C. Beazley, to recruit nurses for the unit."¹⁷ Beazley often refused to recommend staff nurses who were qualified for CCU training because she did not want to take them away from the busy and continually short staffed medical and surgical wards.

Education and Professional Collaboration

The ICU and CCU provided an expanded role for nurses. Dr. Lawrence Meltzer, a pioneer in the development of coronary care units nationally wrote, "Until World War II even the recording of blood pressure was considered outside the nursing sphere and was the responsibility of a physician. As late as 1962, when coronary care was introduced, most hospitals did not permit nursing staff to perform venipunctures or start intravenous infusions. That nurses could interpret the electrocardiograms and defibrillate patients indeed represented radical change for all concerned."¹⁸ The ICU at UVA was staffed by an



A. Rutherford, H. Kinnier, & A. W. Brown, with respirator in hospital inhalation therapy equipment room, 1968. *The Draw Sheet*, 16(5), 8.

all professional nursing staff, while a majority of the workforce on the wards remained student nurses. As more and more critically ill patients were admitted to the ICU, nurses identified the need to expand their knowledge and sought understanding in medical technology and pathophysiology. In addition, nurses worked closely with physicians to better comprehend how best to anticipate and identify critical patient situations and act swiftly to prevent or treat emergencies.

Nurses who were chosen to work in the University's Intensive Care Unit were required to have at least six months of experience on an internal medicine ward and possess excellent patient assessment skills.¹⁹ The intensive care nurses were taught medical interventions such as cardiopulmonary resuscitation and defibrillation techniques. In addition, they became knowledgeable in cardiac medications and monitored their patients for side effects such as hypovolemia and hypokalemia. Nurse historians Jule Fairman and Joan Lynaugh note that as a result of their additional education and training, intensive care nurses were able to quickly and accurately assess characteristics of congestive heart failure and changes in laboratory values, and report their findings to the physicians.²⁰

In the nation's early intensive care units, nurses and residents learned side by side; such interdisciplinary education reflected a radical change not

only in education, but also in the relationship between nurses and physicians. Nurse historian Arlene Keeling recalls teaching nurses, interns and residents together at UVA in the late 1960s and early 1970s how to read 12-lead EKGs and identify cardiac rhythms. As historians Lynaugh and Fairman noted, nurses and physicians learned from each other and learned to trust one another.²¹

Traditionally, there was a hierarchy of care in hospitals in which physicians directed most aspects of the patients' care, thus leaving nurses and other staff to follow physicians' orders. The ICU became a perfect setting to initiate collaboration between physicians and nurses, and the joint education that took place in the ICUs allowed the traditional hierarchy to evolve over time into a team approach to patient care.

Improving Patient Survival

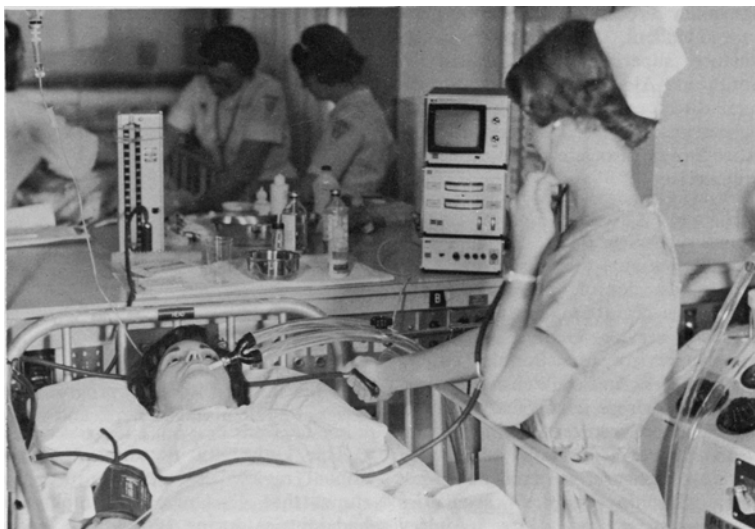
Early intensive care units took the burden of caring for critically ill, complex patients off of busy ward nurses. The goal of the physicians and nurses who worked in the University's intensive care unit was to prevent adverse events in post-surgical and critically ill patients through highly skilled nursing care and new technology. Intensive care nurses influenced patient mortality and morbidity rates through advanced knowledge, skills, and vigilance. The centralization of critically ill patients on one unit facilitated frequent patient assessment, continuous monitoring, and rapid interventions, thereby preventing adverse events. ICU nurses were often allowed to interpret changes in patients' status and treat based on physicians' standing orders. The intensive care unit's low nurse to patient ratios and skilled staff also permitted shorter intervals to treatment and immediate intervention. In February 1967 the coronary care beds within the ICU reported a mortality rate of 24 deaths in 88 patients treated for acute myocardial infarction. During the same reported time period four patients were successfully resuscitated after experiencing a lethal cardiac arrhythmia. Despite a relatively high mortality rate in the ICU, lives were saved through vigilant nursing observation and intervention such as rhythm interpretation and defibrillation.²²

In 1968, Dr. J.H. Hollingsworth, a cardiologist and protégé of McGuire, completed a three year

study at UVA that portrayed successful implementation of cardiopulmonary resuscitation (CPR) and improved patient outcomes especially in areas that were close to trained CPR staff such as the ICU nurses.²³ The general wards had the lowest success rate at 17.6%, the internal medicine wards at 30.1%, and the ICU at 25.3%. The study reported that the internal medicine wards and ICU had little difference in outcomes due to the concentration of house medical staff in internal medicine and trained nurses in the ICU. Hollingsworth further noted that the ICU had more unstable patients and often the ICU nurses ran their own resuscitation attempts until physicians arrived. Although success rates were not high, it is important to note that more patients were being resuscitated due to increased specialization and well trained nursing and medical staff. This report clearly reflected the influence skilled, knowledgeable professional nurses had on patient care. Hollingsworth's findings most likely helped to illustrate the dramatic effect the ICUs and highly skilled nurses had on patient care and supported the need for additional critical care units in the future.

Conclusion

The early years of intensive care nursing at the University of Virginia proved successful for both patients and nurses. The success of the newly created ICUs exclusively designed to care for critically ill patients was directly related to the innovative, pioneering work of the nurses, despite nursing shortages and some adversity related to the hospital's



Cardiac unit nurse L. Simmons and simulation patient demonstrate bedside monitor for cardiac patients, 1969. *The Draw Sheet*, 17 (3), 1.

professional and social climate. The removal of critically ill patients from the hospital's general medical wards alleviated the stressful demands placed on the overworked ward nurses, who due to the lack of resources and education were often unprepared to care for this patient population. Unique to the new ICU environment was the evolution of a team approach to patient care, an alternative to the traditional medical hierarchy. The new medical-nursing teams resulted in improved communication, the delineation of common goals and values, enhanced care, and the prevention of patient complications. The new ICU setting also allowed nurses to blend their compassion and empathy with expanded knowledge, patient assessment, and technical skills that ultimately led to the improved survival rates of the ever growing critically ill patient population.

Notes:

¹ American Association of Critical Care Nurses, "Definition of Critical Care Nursing" <http://classic.aacn.org/AACN/mrkt.nsf/vwdoc/AboutCriticalCareNursing>, paragraph 1.

² The new medical centers were larger and more complex and by 1957 the nation's supply of new hospital beds had risen to 253,000. Rosemary Stevens, *In Sickness and in Wealth*, (Baltimore: The Johns Hopkins Press, 1989), 230. "Congress sustained its commitment to hospitals by increasing Hill-Burton funds to \$186.2 million in 1959, and \$226.2 million in 1962. By 1963 America had a total of 1,700,000 hospital beds. John C. Kirchgessner " *A Reappraisal of Nursing Services and Shortages: A Case Study of the University of Virginia Hospital, 1945-1965*" (PhD diss., University of Virginia, 2006), 87.

³ Barbara Brush and Joan Lynaugh. *American Nursing: From Hospitals to Health Systems*. (Malden, MA: Blackwell Publishers, 1996). By 1964 there were a total of 972 insurance companies writing health insurance policies, a decade earlier in 1954, that number was 535, representing a 60% increase. The number of subscribers with hospital expense coverage during the same decade increased by 67%. Health Insurance Institute. *Source Book of Health Insurance Data, 1965* (New York: Health Insurance Institute, 1965) 14,51.

⁴ John Kirchgessner, " *A Reappraisal of Nursing Services and Shortages: A Case Study of the University of Virginia Hospital, 1945-1965.*"

⁵ Julie Fairman. "Watchful Vigilance: Nursing Care, Technology, and the Development of Intensive Care Units." *Nursing Research* 41 (1992): 56-58.

⁶ Joan Lynaugh and Julie Fairman. *Critical Care Nursing: A History*. (Philadelphia: University of Pennsylvania Press, 1998).

⁷ Ibid.

⁸ The University of Virginia Hospital. *The Draw Sheet May* (1956): 1. University of Virginia. Claude Moore Health Sciences Library, Historical Collections and Services.

⁹ Between the years 1950 and 1960, the UVA annual patient census grew from 13, 814 to 14, 833 and between 1950 and 1965 the number of in-patient days increased from 140,000 to 160,000. John C. Kirchgessner " *A Reappraisal of Nursing Services and Shortages: A Case Study of the University of Virginia Hospital, 1945-1965.*"

¹⁰ University of Virginia Health System. *UVA Health System Scrapbook, 1960s*. (2009). University of Virginia, Claude Moore Health Sciences Library, Historical Collections and Services.

¹¹ The University of Virginia Hospital. *The Draw Sheet April* (1963): 1. University of Virginia, Claude Moore Health Sciences Library, Historical Collections and Services.

¹² Ibid.

¹³ Martin Brown. *Draw Sheet, June* (1963): 1. University of Virginia, Claude Moore Health Sciences Library, Historical Collections and Services.

¹⁴ Arlene Keeling. "The Human Side of High Tech Care: A History of Nursing in Coronary Care Units, 1941-1970." (masters' thesis, University of Virginia, 1988).

¹⁵ The University of Virginia Hospital. *The Draw Sheet, June* (1968). University of Virginia, Claude Moore Health Sciences Library, Historical Collections and Services.

¹⁶ Arlene Keeling. *The Human Side of High Tech Care: A History of Nursing in Coronary Care Units, 1941-1970*. 35

¹⁷ Ibid.

¹⁸ Keeling, Arlene "Blurring the Boundaries Between Medicine and Nursing: Coronary Care Nursing, Circa the 1960s" *Nursing History Review* 12 (2004):156.

¹⁹ Arlene Keeling interview by Sarah White, July 28, 2009, transcript, University of Virginia School of Nursing, Center for Nursing Historical Inquiry, Charlottesville, VA.

²⁰ Joan Lynaugh and Julie Fairman. 1998

²¹ Ibid.

²² The University of Virginia Hospital. *Preliminary C.C.U. Report February 1, 1967*. University of Virginia, Claude Moore Health Sciences Library, Historical Collections and Services..

²³ J.H. Hollingsworth. "The Results of Cardiopulmonary Resuscitation: A 3 Year University Hospital Experience." *Annals of Internal Medicine*, 71(1968): 459-466.

Snippets from the Past

In the early years of the nursing profession most graduate nurses worked as independent private duty nurses contracted by families to care for their loved ones in their homes or in a hospital. However, when people were traveling and became ill other arrangements had to be made. To aid such travelers, large city hotels retained the services of private physicians and graduate nurses to care for their ill guests. The following are some observations and advice given to graduate nurses to prepare them to care for sick patients in a hotel room.

“A case in a hotel is in some respects easier and in others harder than in a house. ... easier because there are no household complications, no family to consider, and no extra work. The nurse can devote herself wholly to her patient. A bell boy or maid can bring her what she might need. On the other hand, hotel rooms are not planned for sickness ... Bedding is apt to be poorly ironed and damp and it needs to be aired and sunned before using. It is wise for the nurse to ask for extra sheets, pillow cases and towels, if they can be spared.

Hotel food, though of great abundance and variety, has not the appetizing or nutritious qualities of ... [food needed by the sick]. Many nurses have had to cook their patients' food on a chafing dish in order to have something suited for their needs.

It is necessary to keep all sights, sounds and suggestions of illness from other guests. If a nurse is alone with a critical case, it is impossible for her to be relieved for exercise or meals. She must eat from a tray in the patient's room and will not get a change of scene that is so restful. Even if ... relief is available ... the process of dressing for the dining room, order-



Private duty nurse, ca. 1920s. CNHI Brodie Collection.

ing and eating her meal ... is too long (to be away from the patient). She will, of course, not appear in her uniform. A nurse with good taste and sense will make herself little observed as possible in so public a place.

If a death occurs in a hotel, and a nurse is alone ... she will need all her resources to make arrangements for the care of the body, send notices to her patient's friends/family, and care for their belongings. It will necessary to have the body removed to an undertaker within two to three hours of the death. One nurse who cared ... for the

distress of her patient's wife, accompanied the body to an undertaker in the middle of the night and stayed there till relatives were summoned and other arrangements made.”

Katharine DeWitt. (1913) **Private Duty Nursing**, “*Hotel Life and Traveling*”, Philadelphia: J. B. Lippincott. 217- 219. (Reprint) 1984. Susan Reverby, Editor, (New York: Garland Press).

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Nursing and Medical History Opportunities

Medical History Conferences

Southern Association for the History of
Medicine & Science
Louisville, Kentucky, March 5-6, 2010
Additional information: www.sahms.net

Calls for Abstracts

Society for the Social History of Medicine
Durham and Newcastle, United Kingdom
July 8-11, 2010

Abstracts due November 1, 2009
Additional information: www.sshm.org

American Association for the History of Nursing, Inc.
London, England, September 14-16, 2010
Abstracts due February 15, 2010

Additional information:
www.nursesvoices.org.uk/conference .

Medical History Grants

Jack D. Pressman-Burroughs Wellcome Fund Career
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Award of \$1,000 for outstanding work in 20th century
history of medicine or medicinal science, as demon-
strated by the completion of the Ph.D. and a proposal
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Application due December 31, 2009.

Additional information: www.histmed.org

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Complete information: www.histmed.org

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Recent Acquisitions

Theresa Drought – Nursing texts, Royal College of Nurses fact sheets, and miscellaneous documents.
Col. Janet Graham, Ret. – books, personal papers, & memorabilia from career as Army nurse and professor.
Lucie Kelly – booklet: *Hôtel-Dieu: The Beaune Hospices*.
Donald Macintyre – Nancy Macintyre papers related to the Nurse Practitioner Association of New York State.
Mary Ann Petty Morgan – Yearbook & Student uniforms, University of Virginia School of Nursing Class of 1956 (Diploma).
JoAnne H. Peach – nurse practitioner files and texts.
John Moritz Library, Nebraska Methodist College – ANA & other miscellaneous booklets.
Audrey Snyder – DVD: *A Paralyzing Fear*
Sharon Utz – Nursing texts.
Jacqueline J. Whitfield – photographs, artifacts, papers, and books of Jacqueline Mae Rutledge, University of Virginia School of Nursing Class of 1948 (Diploma).

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Rose Pinneo defibrillating patient, 1963. Photography by Leet-Melbrook Inc. CNHI Rose Pinneo Collection.