

WINDOWS IN TIME

THE UNIVERSITY OF VIRGINIA SCHOOL OF NURSING ELEANOR CROWDER BJORING CENTER FOR NURSING HISTORICAL INQUIRY

VOLUME 28, ISSUE 2 FALL 2020



FROM THE DIRECTOR

Nursing Contagious Disease

Barbra Mann Wall, PhD, RN, FAAN

Today, as COVID-19 spreads around the world, nurses, once again, are the “essential” workers in hospitals, particularly intensive care units as thousands of desperately ill patients come into these facilities. This does deny that some nurses are caring for family and friends at home. Yet we know that many patients with COVID-19 stay in their homes, alone, isolated from their families, with trays of food left outside their rooms from family members or friends. No one is allowed into the sick room.

Caretakers, however, can learn much from nursing history. In the 19th century, trained nurses brought “care, cleanliness, and character” into the homes of the sick, especially the poor. Much of this nursing was built on the English model, and the story of Florence Nightingale who nursed British soldiers in Crimea is well known. Nightingale went on to establish a nursing school, St. Thomas, in London.¹

Nightingale’s vision conformed to her environmentalist ideas on disease causation that were prevalent at the time. As I have argued elsewhere, in the 19th century, there was a period of competition among many medical systems and theories. Terms such (continued, page 2)

Above: Tending to influenza patients at Walter Reed Hospital in 1918

¹Karen Buhler-Wilkerson, *No Place Like Home: A History of Nursing and Home Care in the United States* (Baltimore: Johns Hopkins University Press, 2001). Quotations are on p. 18.

INSIDE THIS ISSUE:

4

CENTER NEWS

A New Addition to the Archives: Eleanor C. Bjoring’s “201 File”

Arlene W. Keeling, PhD, RN, FAAN

7

FEATURES

Jewish Refugees and the British Hospital World, 1938–1948

Jane Brooks, PhD, RN, SFHEA

Fear and Fortitude: Nursing Practice and the AIDS Epidemic, 1980–1990

Lauren Catlett, RN, MSN, CNL

16

SNIPPETS FROM THE PAST

The Golden Rule(s)

Rebecca Coffin, PhD, RN

18

THE ARCHIVIST

Designing for Contagion

Henry K. Sharp

19

TAKING STOCK



The Eleanor Crowder Bjoring Center for Nursing Historical Inquiry (ECBCNHI), 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.

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FROM THE DIRECTOR

as “contagion,” the vehicle by which disease is transmitted by person to person, and “miasm,” the pathogenic discharge into the atmosphere, were part of this system of causation. Sometimes these terms were not fully distinguished since both involved transmission through the air. At other times, “miasm” was used in a more restricted way as something “arising from stagnant water”

I suggest that analysis of nurses’ work in earlier times to treat and prevent infection can provide greater understanding of how nurses in the past gave meaning to what went on around them and how they prioritized care.

or decomposed “vegetable matter.” A broad framework of disease causation, however, included some common concepts: the centrality of hygiene, and an understanding that the mind and body were mutually interactive, and that the environment could affect both.²

Charles Rosenberg elaborates on how Nightingale stressed good nursing in preventing infections: “Poor planning of windows ... cold and ill-prepared foods, drains and sinks placed where they might contaminate the atmosphere, inadequate ventilation, chamber vessels unemptied for hours” were all remediable, and this gave nurses indispensable roles.³

As Nightingale’s influence spread to the United States, schools of nursing based on her model eventually opened in the 1870s, 1880s, and 1890s, during a time when germ theory was transforming American medicine. Nursing students staffed hospitals, and graduates either went into private duty nursing in homes or became visiting nurses in public health, also going into homes. In all these areas, nurses were responsible for keeping patients clean,

well fed, and comfortable; maintaining fluid balance; giving medications prescribed by physicians but sometimes independently;⁴ keeping order within chaotic hospital units or homes; and particularly, keeping the environment clean, thereby preventing the spread of infection among patients and families.

In the early training schools, nurses studied how to care for those with fever.⁵ If a patient developed an infectious disease, they were put to bed in a restricted area, with their nurses segregated along with them. A perusal of chapters in nursing textbooks reveals teaching on causal organisms and infection; resistance to disease; general and

²Barbra Mann Wall, “Textual Analysis as a Method for Historians of Nursing,” *Nursing History Review* 14 (2006): 234. See also Christopher Hamlin, *Public Health and Social Justice in the Age of Chadwick: Britain, 1800–1854* (New York: Cambridge University Press, 1998), 52–53, 60–61, 61; Michael Worboys, *Spreading Germs: Disease Theories and Medical Practice in Britain, 1865–1900* (Cambridge, UK: Cambridge University Press, 2000); Nancy Tomes, *The Gospel of Germs: Men, Women, and the Microbe in American Life* (Cambridge, MA: Harvard University Press, 1998).

³Charles E. Rosenberg, “Florence Nightingale on Contagion: The Hospital as Moral Universe,” in *Healing and History: Essays for George Rosen*, ed. Charles E. Rosenberg (New York: Science History Publications, 1979), 127.

⁴Arlene Keeling, *Nursing and the Privilege of Prescription: 1893–2000* (Columbus, OH: Ohio State University Press, 2007).

⁵J.C. Wilson, *Practical Lessons in Nursing: Fever Nursing* (Philadelphia: J.B. Lippincott Co., 1915).

specific measures for disinfection of doors, window handles, clothing, utensils, and hands; and after the 1940s, provision of medicines such as sulfa drugs and antibiotics. Nurses learned that the many diseases affecting humans could also be transmitted by animals, either directly or indirectly. Nurses read about carriers of disease even by those who were asymptomatic, and they carried out regulations that the state deemed important to control disease. Nurses also learned how the body defended itself and the sites of infectious agents' entrance such as eyes, skin, mouth, and nasal membranes. Temperature, humidity, and ventilation were all important to prevent transfer of respiratory droplets from being discharged into the air in crowded rooms such as homes, schools, and theaters. One book written in 1952 noted, "Adequate scientific advice should be obtained."⁶ Sound familiar?

Other books on nursing principles included chapters on nursing in the community and creating and maintaining the physical environment.⁷ Nurses also learned how to take precautions and resist disease. As Joan Lynaugh has argued, nurses did face risks via exposure to patients with infectious disease, and they "protected themselves as best they could. But their understanding of the idea of contagion from germs did not ... destroy either nursing or the hospital."⁸

Today nurses' roles have expanded, and they are indispensable in any setting. I suggest that analysis of nurses' work in earlier times to treat and prevent infection can provide greater understanding of how nurses in the past gave meaning to what went on around them and how they prioritized care. They were essential workers then as now, and their efficient and safe bedside care could prevent future hospitalizations and deaths. Nurses today are still present with patients and, in addition to high tech, they bring basic care (yes, even based on the dictums of Nightingale): nourishment, fluid management, comfort, preventing the spread of disease, and care of the environment—especially when no other therapeutic measures work.

Indeed, when we know so little about pharmaceutical therapeutics regarding COVID, it is *nurses* who can be expected to prevent the spread of bacterial and viral infections among themselves and their patients in the community, in homes, in long-term care facilities, or in hospitals. We need to remember this. Nurses are the ones who keep order within the patient-care units, keep their patients safe from harm, well fed, clean, and comfortable.

In the past as well as now, however, nurses themselves have needed assistance. After caring for yellow fever survivors in 1878, one nurse pleaded for help: "I am sick and starving, and in self-defense will have to leave. ... Come at once."⁹ This must not be the case for nurses today; they need the support and protection they have historically deserved. 🌅

Barbra Mann Wall

When we know so little about pharmaceutical therapeutics regarding COVID, it is *nurses* who can be expected to prevent the spread of bacterial and viral infections among themselves and their patients in the community, in homes, in long-term care facilities, or in hospitals. We need to remember this.

⁶M.E. Pillsbury and E.J. Sachs, *Nursing Care of Communicable Diseases* (Philadelphia: J.B. Lippincott Co., 1929, 1931, 1934, 1936, 1938, 1942, 1952). Quotation is in 7th ed., 1952, p. 31.

⁷See, for ex., M. R. Smith and J. Broadhurst, *An Introduction to the Principles of Nursing Care* (Philadelphia: J.B. Lippincott Co., 1937).

⁸Joan Lynaugh, "Rhetoric and Reality in America," in *Notes on Nightingale: The Influence and Legacy of a Nursing Icon*, ed. Sioban Nelson and Anne Marie Rafferty (Ithaca, NY: Cornell University Press, 2010). Quotation is on p. 87.

⁹Deanne Stephens Newer, "The 1878 Yellow Fever Epidemic in Mississippi: 'For God's Sake, Send Us Some Nurses and Doctors,'" *Nurses on the Front Line*, ed. Barbra Mann Wall and Arlene Keeling, (New York: Springer Publishing Co., 2011), p. 10.

A NEW ADDITION TO THE ARCHIVES: Eleanor C. Bjoring's "201 File"

By Arlene W. Keeling, PhD, RN, FAAN

“kept trying to get into Flight Nurse School but never could because of my eyesight. I had a congenital cataract and flight school seemed out of the question. ... Meanwhile, I served as a staff nurse, then as an OR supervisor, in a combat zone in Korea during the war, often accompanying injured airmen on regional emergency air evac flights from Kunsan, Korea, to Tachikawa Air Force Base in Japan.”

During a phone call in September, Eleanor “Memo” C. Bjoring told me the story of how she was finally accepted to train as a flight nurse for aero-medical transport. After returning stateside from Korea, she applied again for admission—to no avail. At an Officers Club happy hour at Langley Air Force Base, she complained to a congressman that she was good enough to fly emergency flights yet could not get into school. She caught the right ear: with the help of that congressman, she was accepted.

Memo completed the six-week flight nursing course in 1955 in Montgomery, AL. She graduated first in her class. (This despite spending many hours helping her colleagues understand “gas laws” and the physiology of flight, an important concept since at the time we flew non-pressurized aircraft.) Shortly after graduation, she got a flight assignment at Brooks Air Force Base in Texas and served there until her discharge in 1957. This squadron was responsible for

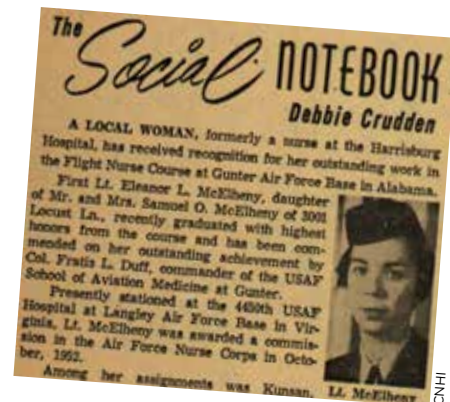
airlifting patients all over the country who required respirators, so it was a constant challenge.

Flight nursing was her favorite area of practice. Even before she became certified, she accompanied sick and injured soldiers to Japan from Korea, alone with a corpsman.

Once, in flight with a misdiagnosed malaria patient, Memo noted that he was retracting his costal muscles to breathe. According to her account, she asked the captain to lower the plane’s altitude if possible, administered oxygen, and requested that the plane be met by someone with a respirator. (The stress was overwhelming and, after landing, Memo admitted that she “sat down under the wing of the airplane and cried.”

Then she “went to the Imperial Hotel with the crew and had a martini!”)

These personal papers—to be catalogued in the Eleanor Crowder Bjoring Collection—are fascinating even to someone without military experience. A researcher with a military background could properly analyze this material, and I encourage someone to do so. However, while there are orders, ranks, and acronyms that make no sense to me, there are records of medicines she carried (morphine and codeine, for example, to be given at the discretion of the AF nurse), various assignments, and comments by her superiors (“energetic, enthusiastic, and keenly interested in her work!”) that do not require a military historian to understand. I encourage you to investigate! 🌈



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The Many Paths of the NP Movement

For the second year in a row, an anonymous donor has generously funded new historical scholarship on nurse practitioners. This year, we have actually expanded the number of grants awarded to outstanding proposals. Recipients of the Nurse Practitioner History Research Scholar Award for 2020 include:

Mary Koslap-Petraco, DNP, PPCNP-BC, CPNP, FAANP and **M. Elayne DeSimone FNP, PhD, NP-C, FAANP**

Topic: Persistence and progress through grassroots nurse practitioner leadership: The New York state story, 1980–1990

They will create a digital archive that memorializes the successful efforts of a small, state-wide coalition of New York nurse practitioners to push through legislation authorizing NP practice. This archive will include primary documents, organizational minutes, letters, conference proceedings, and personal recollections gleaned from interviews.

Mary Koslap-Petraco is a clinical assistant professor at Stony Brook University School of Nursing in Stony Brook, NY. M. Elayne Simone is a clinical professor in the DNP/FNP programs at the Widener University School of Nursing in Chester, PA.

Kim Curry, PhD, APRN, FAANP and **Carolyn Torre, RN, MA, APN, FAANP**
Topic: A video story of early nurse leaders in Florida

This follows a successful pilot project completed in the state of New Jersey in 2019. In this second phase, the researchers will give voice, through videotaping, to the early nurse leaders involved in the evolution of the original state scope of practice laws which enabled the practice of nurse practitioners in Florida.

Kim Curry is a clinical associate professor in the College of Nursing at

the University of Florida in Gainesville. Carolyn Torre is a nursing policy consultant and retired pediatric nurse practitioner in Princeton, NJ.

Marcus D. Henderson, MSN, RN
Topic: Understanding the experiences of male nurse practitioners

Through oral histories, this study seeks to understand the barriers and facilitators for men in nurse practitioner roles, their experiences during educational preparation and clinical practice, their personal and professional development, and overall impact on the profession and NP movement. Interviews will be conducted with male NPs across a variety of specialties who practiced from the 1980s to 2010s—a era of rapid growth in educational programs and practice opportunities.

Marcus D. Henderson is a clinical instructor in the Family and Community Health Department at the University of Pennsylvania School of Nursing, and co-founder and executive director of Up and Running Healthcare Solutions in Philadelphia, PA.



MISSION SUPPORT

In September 2020, the Bjoring Center for Nursing Historical Inquiry kicked off the first (virtual) meeting of the CNHI Advisory Board, an all-volunteer group whose mission is to support and promote the center's educational, research, and engagement activities.

Chaired by Mary Gibson, PhD, RN, who recently retired as the center's associate director, the Advisory Board brings

a wealth of experience and expertise, united by an abiding passion for nursing history. The 10-member group will advise the director in implementing strategic priorities, provide philanthropic support, and serve as advocates for the center in the local community and beyond. Each member will serve a two-year term. We are grateful for their commitment and welcome them aboard!

SELF-QUARANTINE WITH NURSING HISTORY

Our fall 2020 history forums are now online at www.nursing.virginia.edu/cnhi:

“Battles Hard Fought”: A Video Story of Pioneering Advanced Practice Nurses
Carolyn Torre, RN, MA, APN, FAANP and Kim Curry PhD, FNP-C, FAANP

“We shall arrive at the ‘Utopia’ of nursing”: Reconceptualizing Nursing Labour, 1945–1980
Peter Twohig, PhD, St. Mary’s University, Nova Scotia, Canada

Jewish Refugees and the British Hospital World, 1938–1948
Jane Brooks, PhD, University of Manchester

An America-Australia Alliance: Recruiting Australian Nurses as ‘Citizens of World Nursing,’ c. 1885–1900
Madonna Grehan, PhD, University of Melbourne, Australia

Presentations, Publications & Awards

FACULTY/ASSOCIATES

Carhuapoma, L. Publication. Matriarchs of the Operating Room: Nurses, Neurosurgery, and Johns Hopkins Hospital, 1920–1940. *Nursing History Review* 28(1): 133–142.

Coffin, R. Presentation. “The Home Life of the Nurse is Charming: Nurse Residences in the 20th Century.” AAHN Annual Conference (canceled due to COVID-19). Chester, England. September 2020.

Gibson, M. Presentation. “Nurse, Supervise and Educate: Agnes Dillon Randolph’s Contribution to Nursing and Tuberculosis Care.” Southern Association for the History of Medicine and Science Annual Conference. New Orleans, LA. March 6, 2020.

Hundt, B. Publication. Reflections on Nightingale in the Year of the Nurse. *American Nurse Journal*, 15 (5), 26–29.

Hundt, B. Presentation. “Florence Nightingale in Pop Culture: From Santa Filomena to the Simpsons.” AAHN Annual Conference (canceled due to COVID-19). Chester, England. September 2020.

Kumodzi, T. Publication. The Force Behind the Vision: The Significance of Place in Trauma Nursing. *Nursing History Review* 28(1): 170–184.

Wall, B.M. Publication. Seeing Images During Conflict: Then and Now. *The UKAHN Bulletin*, 8 (1). <https://bulletin.ukahn.org/seeing-images-during-conflict-then-and-now/>.

Wall, B.M. Publication. The Role of Place in the History of Nursing: Introduction. *Nursing History Review* 28, 127–132.

Wall, B.M. Invited participant. Second Workshop of the International Research Network in Medicine and Catholicism Since the Late 19th Century. Virtual. September 4, 2020. Leuven, Belgium.

STUDENTS

Brooks, C. H. Presentation. “The History of Prairieview A & M College of Nursing, 1918–1952.” AAHN Annual Conference (canceled due to COVID-19). Chester, England. September 2020.

Capucão, R. Publication. For the Love of Family: The Filipino/o Nurse Diaspora. *Routed Migration & (Im)mobility Magazine*, 8. <https://www.routedmagazine.com/filipino-nurse-diaspora>.

Capucão, R. Publication. Filipino Nurses and the US Navy at Hampton Roads, Virginia: The Importance of Place. *Nursing History Review* 28(1): 158–169.

Tucker, V. Publication. Race and Place in Virginia: The Case of Nursing. *Nursing History Review* 28(1): 143–157.

Jewish Refugees and the British Hospital World, 1938–1948

JANE BROOKS, PHD, RN, SFHEA

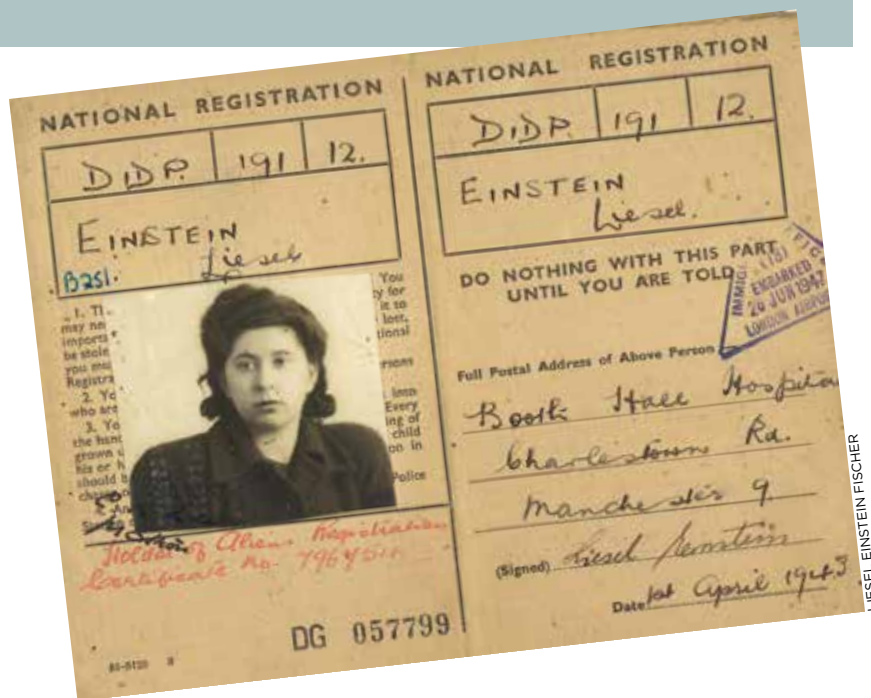
Dr. Jane Brooks received a Barbara Brodie Nursing History Fellowship in 2019. This article is excerpted from her presentation this fall, viewable on our website.

As I write this, the world continues in the thrall of the COVID-19 pandemic. The coronavirus disproportionately affects those from Black and minority ethnic backgrounds and has seen certain sections of the community vilified, as Barbra Mann Wall's warnings against "anti-Asian racism" in the last volume of this newsletter attest.¹ The high death rate amongst Black and Asian health workers compared to their white colleagues has brought racial disparities further into focus.² The migrant workforce in Britain is integral to health-care provision, yet their treatment is a matter for ongoing concern.

In October 2018, *Nursing Standard* published an article decrying racism in British hospitals.³ A year later, on October 2, 2019, *The Nursing Times* published the results of its survey on racism in nursing. Forty-eight percent of respondents said they had personally experienced racial discrimination or disadvantage in their current role over the last twelve months. One respondent stated: "Black and ethnic minorities all across the NHS [National Health Service] are denied

promotions and other opportunities. Sadly, these have been going on for so many years it's

Born in Germany, Liesel Einstein fled on the Kindertransport when she was just 14. We thank her for her permission to reproduce these photos.



¹Barbra Mann Wall, "From the Director: What does History Tell us About Nurses' Roles in Disasters," *Windows in Time: The Newsletter of the University of Virginia School of Nursing Eleanor Crowder Bjoring Center for Historical Nursing Inquiry* 28, no. 1 (2020): 1–2.

²Tony Kirby, "Evidence Mounts on the Disproportionate Effect of Covid-19 on Ethnic Minorities," *The Lancet Respiratory Medicine* 8, no. 6 (2020): 547–48.

³Royal College of Nursing, "London Nurses Experience the Most Racism," *Nursing Standard* 33, no. 8 (2018): 6.



LIESEL EINSTEIN FISCHER

actually become a norm.”⁴ Ambivalence towards those health workers from non-white British backgrounds is not new. The rise of populist politics has created an environment in which the histories of immigration, escape and migration are ever more critical. My research explores the experiences of one particular group of ‘migrant’ nurses in the mid-twentieth century: female Jewish refugees from Nazi Europe who entered the nursing profession in Britain.

“TO TAKE UP NURSING AS A LIFE CAREER”

In 1941, the Committee of the Central Office for Refugees, the organisation established to support Jewish refugees from Nazi Europe, reported on the vision of Florence Horsburgh, Parliamentary Secretary to the Ministry of Health, in which she appealed for young women and girls in Britain “to take up nursing as a life career.”⁵ The Committee agreed that, given the great need for nurses

Liesel Einstein (second row, far right), started children’s nursing training at Booth Hall Children’s Hospital in Manchester, England, in 1943, the same year her parents were sent to Auschwitz.

in a time of war, “Nursing thus offers a special opportunity for following an urgent and present need at the same time of training for the future.”⁶ Female Jewish refugees were to be encouraged to pursue nursing as a career and the practicalities of entering a training school were outlined to the Committee for discussion.

The Committee were clearly hopeful that Horsburgh’s appeal foreshadowed an inclusive recruitment policy for intelligent, female Jewish refugees. In reality, they needed only to look to the attempts to recruit Jewish refugees into the nursing profession three years earlier, in 1938, to determine that neither the government, nor the profession, were as welcoming as was hoped. Indeed, only three months before Horsburgh’s invocation to take up nursing, a Ministry of Health letter outlined the relaxation

of employment regulations for “alien” doctors because of the shortage of medical staff. However, the relaxation did not include nurses, the restrictions for whom “will continue to apply,”⁷ despite the ongoing and severe shortages in the profession. Nevertheless, by the end of 1941, R. Clare Martin, Secretary to the Central Committee for Refugees and E.N. Cooper, of the Home Office, Aliens War Service Department, were corresponding on the value of female refugees’ employment as nurses in British hospitals.⁸ It is this push and pull culture from 1938 and for the first two years of war that this article explores.

Reviewing official documentation from both the government and the nursing profession, letters to the nursing press and personal narratives from refugee nurses themselves, this article exposes the ambiguities of the official responses to female Jewish refugees and the impact of these uncertainties on the refugees themselves. Despite the challenges that these young women faced, I argue that the nation recognised the value of their willingness to enter nursing at a time of war and they realised that in nursing they had a professional future.

THE DEMAND FOR REFUGEE NURSES

In 1938, Miss G.V. Hillyers, matron of the famous St. Thomas’s Hospital in London, was appointed chairman [sic] of the nursing sub-committee of the Co-Ordinating Committee for Refugees. In an open letter to *The Nursing Times*, Hillyers maintained:

⁴ Steve Ford, “Exclusive: High Level of Racial Discrimination Faced by Nurses Revealed,” *The Nursing Times* (2 October 2019). <https://www.nursingtimes.net/news/workforce/exclusive-high-level-of-racial-discrimination-faced-by-nurses-revealed-02-10-2019/>

⁵ Central Office for Refugees, “Circular No. 100. B: Nursing and Medical Auxiliaries: Hospital Nursing” (6 June 1941). The National Archives.

⁶ Central Office for Refugees, “Circular No. 100. B: Nursing and Medical Auxiliaries.”

⁷ Ministry of Health, “Emergency Hospital Scheme: Employment of Alien Doctors of Enemy Alien Nationality” (17 March 1941). HO 213/2093/3 Volume 1: Report on Work of The Aliens War Service Department, 1939–1940. The National Archives.

⁸ Correspondence between R. Clare Martin, Secretary to the Central Committee for Refugees and E.N. Cooper, of the Home Office, Aliens War Services Department (1941), Central Committee for Refugees, Reports HO 215/283, The National Archives.



BILD BUNDESARCHIV/WIKIMEDIA COMMONS

The formation of the nursing sub-committee of the Co-Ordinating Committee in October 1938 was welcomed by the Home Office, who, in conjunction with the Ministry of Health, drew up for our consideration a scheme whereby direct contact with the Home Office was established, to expedite the work of the sub-committee.

The government and one of the most senior matrons in Britain were apparently locked in a scheme to support the employment and training of refugees as nurses. The Central Committee for Refugees also continued to welcome nursing as an opportunity, stating, “A number, also, of well-educated girls and young women are being placed in training for hospital nursing, and meet

a definite need of our hospitals, which was not satisfied by English girls.”⁹ Given that the Jewish Refugees’ Committee had undertaken to support all refugees financially from the first influx in 1933, the provision of a training, accommodation and profession for the most able female refugees would have been a welcome respite from some of their financial obligations.¹⁰ By 1940, the Home Office reported that there were 941 refugee nurses, probationer nurses and midwives working in hospitals across Britain.¹¹

The demand for refugee nurses increased greatly with the declaration of war. The number of applications to the Nursing and Midwifery Committee, chaired by Hillyers, led the Ministry of Health and Home Office to provide

Young Jewish refugees arrive in Great Britain on the Kindertransport in 1939

hospital training places to a considerable

number of female refugees in civilian hospitals across the country.¹² Apart from the caveat that nurses of enemy nationality were not to have any contact with members of the armed forces, refugee nurses were able to seek employment in these hospitals and many did until the fall of France in the spring of 1940, when they were all dismissed.

According to the Nursing and Midwifery Committee of the Central Office for Refugees, only 129 nurses were left in nursing employment after the government order to dismiss all nurses and doctors of German, Austrian, and

⁹Stephany, “Notes for the Home Secretary’s speech.”

¹⁰Susan Cohen, *Rescue the Perishing: Eleanor Rathbone and the Refugees* (London: Vallentine Mitchell, 2015), 105.

¹¹Nursing and Midwifery Department, Central Office for Refugees, “Brief Survey of Situation Regarding Nurse Refugees” (August 29, 1940), 2. Aliens Department – Home Office HO 213/521, The National Archives.

¹²Aliens War Service Department, “Naval, Military And Air Force Hospitals and Any Other Hospital Providing Treatment For H.M. Forces: I: Emergency Medical Services (1) Nurses And Probationers,” 55. HO 213/2093/3: Volume I: Report on the Work Of The Aliens War Service Department, 1939-1944. The National Archives.

Czech nationality.¹³ For those young women and girls who had fled the Nazi terror only to be dismissed from the newly-found safety of their hospital training programme, the decision was traumatic. Lisbeth Hockey, a refugee from Austria, reflected on the personal challenges she faced. She had been expelled from her medical studies at the University of Graz in 1938 and she was now dismissed from her nurse training “and it was the second time that my career had been abruptly broken ... without my intervention and totally beyond my control.”¹⁴ In her oral history interview, Kitty Schafer, who had fled Germany at the age of 18, stated, “the bombshell, a letter came, your contract has been terminated, you cannot stay in the hospital anymore.”¹⁵

By July 1940, requests were being made by the Nursing and Midwifery Committee to relax some of the regulations as to the employment of refugees, especially in relation to Czech nurses.¹⁶ The Aliens War Service Department duly started to relax its restrictions and, by November 1940, under certain circumstances, enemy aliens could once again be employed in hospitals which cared for service personnel.¹⁷ Refugee nurses were invited back to the profession, including Schafer:

And one day a letter came, we need nurses who would like to come back. And I said, “I would love to, but provided I could go back to my matron, and to the hospital.” “No. You cannot.” ... And I said, “if I wasn’t good

enough then, I’m not good enough now,” and that would be the end of my nursing career unfortunately after a year.¹⁸

Although Schafer refused to return to nursing, many did and were glad to be given the opportunity to do so. Nevertheless, this change of fortune did not lessen the challenges they had faced when they were dismissed. Furthermore, the government’s insistence on their dismissal in the spring of 1940 did little to neutralize anti-refugee feelings of some British patients and nurses.¹⁹ According to the Nursing and Midwifery Committee, such antagonism was dealt with “by tactful intervention on the part of the Matron or the Committee.”²⁰ It is clear that in some instances this was the case, but not in all. The ambiguities inherent in the government’s attitude towards refugees could easily be used by those citizens who were anti-alien and not all hospitals were keen to employ continental Jews. Despite the desperate need for nurses to care for the nation’s sick and needy, several of the refugee nurses whose testimonies comprise this research project struggled to be accepted by hospital training schools because they were “foreign”²¹ and Jewish.²²

As the war progressed and the desperate need for nurses amplified, the profession turned more and more to less traditional recruits. Hospitals, even the most prestigious London teaching hospitals, facing dire nursing shortages were happier to accept Jewish refugees.

Charlotte Kratz, who would later become one of Britain’s most influential nurse educators, applied to St. Thomas’s Hospital. In her oral history interview, she recalled:

Thomas’s was pretty selective in those days and pretty choosy. It took me two years to get them to accept me ... they didn’t think I was the sort of person they normally had. But I eventually managed to find a friend of my aunt’s and uncle’s, who in turn was friendly with the senior almoner at St. Thomas’s, and she told them that perhaps I might be the right person after all.²³

From 1938 and during the early months of the Second World War, the nursing profession and British government first courted and then repudiated Jewish refugees’ attempts to become nurses. However, by 1941, with rapidly increasing need for nurses, hospitals became more willing to accept these young women onto their nursing training programmes. The refugees who were willing and able to overlook the sometimes-hostile responses of the profession and government found an increasingly grateful nation and a professional future for themselves. In a time of increasing globalisation of nursing work and within a growing fear of “the other,”²⁴ it is hoped that my research can speak to the vital work of migrant nurses to our health services and the need for them to be supported by the profession and public alike. 🌈

¹³Nursing and Midwifery Department, “Brief Survey of Situation Regarding Nurse Refugees,” 2.

¹⁴Lisbeth Hockey, oral history interview at her home in Edinburgh on 27 December 1987. Interview T26, Royal College of Nursing Oral History Collection, Edinburgh.

¹⁵Kitty Schafer, oral history interview by Jane Brooks on 30 August 2017. Personal archive.

¹⁶Correspondence from A.M. Frey, Secretary to the Nursing and Midwifery Committee to the Ministry of Health (17 July 1940). Aliens War Service Department HO 213/521. The National Archives.

¹⁷Aliens War Service Department, “Naval, Military and Air Force Hospitals and Any Other Hospital Providing Treatment for H.M. Forces,” 56.

¹⁸Schafer, oral history interview.

¹⁹Nursing and Midwifery Department, “Brief Survey of Situation Regarding Nurse Refugees,” 5.

²⁰Nursing and Midwifery Department, “Brief Survey of Situation Regarding Nurse Refugees,” 5.

²¹Gertrud (Trudie) Moos, “I Remember: My Life Story” (printed 1995), 45. A biographical database of European Medical Refugees in Great Britain, 1930s–1950s, Oxford Brookes University, Oxford; Hortense Gordon, oral history interview at her home in London by Jane Brooks on 27 October 2017. Personal archive.

²²Edith (Jacobowitz) Bown, oral history interview by Barbara Mortimer in Maidstone on 24 May 2008. Interview T379, RCN Oral History Collection, Edinburgh.

²³Kratz, oral history interview.

²⁴Rachel Pistol, “Heavy Is the Responsibility for All the Lives That Might Have Been Saved in the Pre-War Years’: British Perceptions of Refugees, 1933–1940”, *European Judaism* 40, no. 2 (2017): 42.

Fear and Fortitude: Nursing Practice and the AIDS Epidemic, 1980-1990

LAUREN CATLETT, RN, MSN, CNL



During the AIDS epidemic in the U.S. in the 1980s, nurses played a crucial role in defining and providing care. Their responses to this unknown and terrifying illness ranged along a spectrum, from fear to fortitude. These attitudes and actions shaped nursing practice in subsequent decades and have important implications for present-day responses to existing and emerging diseases like COVID-19.

The coronavirus pandemic shares many of the same challenges that arose during the AIDS crisis: widespread fear, compulsory quarantine, discrimination, and politicization of the crisis. There are similar issues of burnout among care workers, and concern over the loss of touch and connection with patients. In negotiating these hurdles, nurses today can heed their earlier counterparts. Oral histories from nurses at the time reveal that, despite negative attitudes toward AIDS patients shown by some, the nursing response as a whole illustrated the “culture of caring” that is fundamental to the profession.

The AIDS epidemic was first recognized in 1981 in the Centers for Disease Control (CDC) Morbidity and Mortality Weekly Report, which detailed a rare form of pneumonia contracted by several patients that signaled the compromise of their immune systems. By 1982, the CDC had given a name to the illness: Acquired Immunodeficiency Syndrome (AIDS). Initially, the routes of transmission were not



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known but, in 1983, the CDC had identified blood and sexual transmission and drafted precautionary recommendations for health-care providers. Fending off criticism that his administration was not allocating sufficient funds for AIDS research, President Ronald Reagan publicly announced AIDS as a “top priority” in 1985.¹

The next year, the causative agent of the epidemic was identified and named Human Immunodeficiency Virus (HIV). In 1987, the drug AZT was approved by the FDA for the treatment of AIDS. Highly active anti-retroviral therapy (HAART) became available eight years later, transforming the disease from fatal to chronic.²

Because the majority of cases of this emerging illness were among gay men, AIDS became associated with homosexuality. But it reached far beyond the gay community. It was increasingly common among intravenous drug users, hemophiliacs, and women. This introduced racial undertones to the epidemic: while the majority of gay patients with AIDS were white middle-class males,³ patients outside of the gay community were often poor or homeless Black or Hispanic persons, who

The AIDS Memorial Quilt on display on the National Mall, Washington, D.C., in 1987

especially before the modes of disease transmission had been identified. It was common for providers to wear full protective equipment, including gowns, gloves, and face masks.⁶ Historian Gunter Risse, in his account of the AIDS epidemic in San Francisco, describes “frightened nurses, garbed in caps and gowns, [who] made no pretense about their dislike for these patients.”⁷ These attitudes and practices created an environment of neglect and isolation of patients with AIDS in health-care settings across the U.S.^{8,9}

But the AIDS epidemic also prompted innovative responses from the medical and nursing communities. In 1983, the first AIDS-dedicated inpatient and outpatient units (Ward 5B and Ward 86, respectively) opened at San Francisco General Hospital to accommodate the growing number of patients. A nurse, Cliff Morrison, led the all-volunteer staff of Ward 5B.¹⁰ Upending the hospital’s traditional medical hierarchy, Ward 5B became a community of nurses and other health professionals dedicated to the care of patients dying of AIDS. The prevalent homophobia

were already marginalized apart from their affliction with AIDS.⁴ Given the disease’s association with homosexuality and IV drug use, homophobia and stigma mounted as quickly as HIV spread. Some members of the public supported the discriminatory call to “let AIDS wipe out all of these gays and junkies.”⁵

Health-care providers were not immune to these attitudes, and fear and homophobia manifested themselves in medical and nursing practice. Anxiety and high stress prevailed among health workers,

especially before the modes of disease transmission had been identified. It

was common for providers to wear full protective equipment, including gowns, gloves, and face masks.⁶ Historian Gunter Risse, in his account of the AIDS epidemic in San Francisco, describes “frightened nurses, garbed in caps and gowns, [who] made no pretense about their dislike for these patients.”⁷ These attitudes and practices created an environment of neglect and isolation of patients with AIDS in health-care settings across the U.S.^{8,9}

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¹“A Timeline of HIV and AIDS,” HIV.gov, accessed November 3, 2019, <https://www.hiv.gov/hiv-basics/overview/history/hiv-and-aids-timeline>.

²Diana Austin, “The Unbroken Chain: Three Decades of HIV/AIDS Nursing,” accessed November 17, 2019, <https://scienceofcaring.ucsf.edu/patient-care/unbroken-chain-three-decades-hiv-aids-nursing>.

³Risse, “Caring for the Incurable,” 631.

⁴Ron and Rogers, “AIDS in the United States,” 49.

⁵Ron and Rogers, “AIDS in the United States,” 44.

⁶Risse, “Caring for the Incurable,” 631–32.

⁷Risse, “Caring for the Incurable,” 636.

⁸Gayling Gee, “Head Nurse at the AIDS Clinic, San Francisco General Hospital,” an oral history conducted in 1995 and 1996 by Sally Smith Hughes in *The AIDS Epidemic in San Francisco: The Response of the Nursing Profession, 1981–1984, Volume IV*, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1999.

⁹Diane Jones, “First Wave of the Nursing Staff on the AIDS Ward, San Francisco General Hospital,” an oral history conducted in 1995 and 1996 by Sally Smith Hughes in *The AIDS Epidemic in San Francisco: The Response of the Nursing Profession, 1981–1984, Volume III*, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1999.

¹⁰“A Timeline of HIV and AIDS.”

of the time was notably absent among the staff, many who identified as gay or lesbian themselves.¹¹ By 1989, about 40 American hospitals had dedicated AIDS units, many modeled after 5B.¹²

The AIDS epidemic also spurred social activism within the medical community and beyond. Ward 5B became an example for other hospitals, and the San Francisco community as a whole mobilized financial and political support for patients with AIDS. New York, Los Angeles and other cities hardest hit by the epidemic also saw health-care professionals and Lesbian, Gay, Bisexual and Transgender (LGBT) community activists join forces to advocate for better care and patient rights for persons with AIDS.¹³ However, it was not uncommon for financial and political support for AIDS services to be lacking, even in major urban centers of the epidemic. For example, in New York City, “while there [were] many heroes and heroines—doctors, nurses, public health officials, voluntary organizations, and institutions ... the health-care system [had] moved to a state of crisis.”¹⁴

Using the AIDS crisis as context for the discussion of caring as the “cornerstone and quintessence of [the nursing] profession,” authors Fox, Aiken, and Messikomer identified the 1980s as a renaissance of the core tenets of nursing in the midst of a time of nursing shortages, burnout, and job turnover.¹⁵ Other historians corroborate these observations, noting the severe nursing shortages and lack of hospital beds for patients with AIDS¹⁶ and the paradox that, while the science of medicine (and nursing) struggled, the art of health care flourished.¹⁷ The nursing renaissance involved a holistic approach that emphasized education, advocacy, and the “laying on of hands.”¹⁸ AIDS represented a “nursing disease” because at the time it was a fatal illness, thereby elevating the role of caring over the role of curing.¹⁹ Caring for patients with AIDS required nursing’s multifaceted practice philosophy, including



Nurse advocate Cliff Morrison led the AIDS unit at San Francisco General Hospital.

psychological, social, cultural, educational, and spiritual expertise.²⁰

Certainly these aspects of nursing practice took shape on units such as 5B in the context of the AIDS crisis, but were they widespread and lasting? Fox, Aiken, and Messikomer pose these questions:

“Will the part that nurses have played at this juncture in its history be recalled? And whenever it is that we reach the point of being able to cure, as well as prevent, AIDS, will we continue to appreciate the lessons about the importance of caring that it has taught us, and of the embodiment of the skills, the values, and commitments that it entails in the work and culture of the nursing profession?”²¹

FEAR: HOMOPHOBIA, RACISM, AND SELF-PRESERVATION

Risse notes that the health risks involved in treating patients with AIDS “created tensions among health-care professionals torn between altruism and self interest.”²² Although caring is at the heart of nursing,²³ fear of contracting the disease, especially before modes of transmission were known, was pervasive among nurses. In the words of critical care nurse Helen Miramontes, “inappropriate infection control techniques by health-care providers ... for simple, nontransmissible activities, were the norm rather than the rarity.”²⁴

Diane Jones, founding member and staff nurse on unit 5B at San Francisco General Hospital, reported that contact precautions became a polarizing issue among nurses, with some who feared for their own safety while others believed that these precautions ostracized patients. The result of excessive infection control measures was to create distance from the patient, even to the extent that some nurses would refuse to care for a patient with AIDS for fear of contracting

¹¹ Risse, “Caring for the Incurable,” 638–639.

¹² S. Taravella, “Reserving a Place to Treat AIDS Patients in the Hospital,” *Modern Healthcare* 19 (1989): 32–39.

¹³ Austin, “The Unbroken Chain.”

¹⁴ Ron and Rogers, “AIDS in the United States,” 55.

¹⁵ Renée C. Fox, Linda H. Aiken, and Carla M. Messikomer, “The Culture of Caring: AIDS and the Nursing Profession,” *The Milbank Quarterly* 68 (1990): 226–228.

¹⁶ Ron and Rogers, “AIDS in the United States,” 53.

¹⁷ Risse, “Caring for the Incurable,” 635.

¹⁸ Fox, Aiken, and Messikomer, “The Culture of Caring,” 230–232.

¹⁹ R. Fahmer, “Nursing Interventions,” in *Nursing Care of the Person with AIDS/ARC*, ed. A. Lewis (Rockville: Aspen, 1988), 115.

²⁰ Fox, Aiken, and Messikomer, “The Culture of Caring,” 238.

²¹ Fox, Aiken, and Messikomer, “The Culture of Caring,” 252–253.

²² Risse, “Caring for the Incurable,” 636.

²³ C.H. Jordan, “Caring and Sharing: Spectrums of Practice,” *AORN J* 38 (December 1983): 1003.

²⁴ Helen Miramontes, “Series Introduction,” in *The AIDS Epidemic in San Francisco: The Response of the Nursing Profession, 1981–1984*, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1999.

the disease.²⁵ This runs counter to the “laying on of hands” which Fox, Aiken, and Messikomer identified as central to nursing care of dying patients and demonstrates substandard care for patients with AIDS at the outset of the epidemic.

Homophobia and racism fueled the neglect often experienced by patients with AIDS. Fears for personal safety and stigma around gay culture became enmeshed, so much so that Diane Jones noted, “It was really hard to separate out where the AIDS phobia and the homophobia started and ended.”²⁶ Outside of a functioning AIDS unit (5B), nurses faced personal and cultural clashes with their patients, whose lifestyles some nurses were unwilling to accept. To illustrate these tensions, Diane Jones expounds on the perceptions of Filipino nurses at San Francisco General Hospital during the 1980s epidemic:

“It got racialized really quickly too, because in the hospital the largest ethnic group that was immediately visible was Filipino nurses. It became equated with Filipino nurses, that they are homophobic and AIDS-phobic and will neglect and not provide quality care to people with AIDS. Which was false. There were some absolutely wonderful Filipino nurses and there were some terrible Filipino nurses, and the majority were in the middle, just like it was true of white nurses.”²⁷

Homophobia and racism divided nurses from their patients, and racism also sometimes divided nurses from fellow nurses, according to Jones. All of this resulted in neglect and fragmented care for patients dying of AIDS.

Fear also impacted relationships between providers. Donna Gallagher, a nurse practitioner working at the inception of the AIDS epidemic in Boston, recalled, “Nurses would often walk up and yell at me for bringing this disease to the hospital and putting them at risk. At the time, there wasn’t even a name for the virus, but that didn’t diminish the fear that surrounded it.”²⁸ Moving from oncology into care of patients



Diane Jones at San Francisco General Hospital, 1984

with AIDS, Gallagher described the transition as going “from an honorable sector of nursing to the ‘dirty’ part of health care.”²⁹ She continued, “My own co-workers weren’t supportive, and it was only worse outside the hospital walls.”³⁰

Racial and social conflicts increased as acute care resources were stretched thin. Hospital systems were “overstressed, understaffed, and underfunded.”³¹ Because of nursing shortages, Dorothy Shayan, Director of Nursing at Bellevue Hospital in New York City, observed, “as a result ... everyone gets shortchanged. There is no time for emotional support. It’s the caring functions that are sacrificed.”³²

The life expectancy of a person diagnosed with AIDS was not more than 18 months after the appearance of the first symptoms.³³ Sheila Davis, a nurse working in Boston during the crisis, lamented, “You still went home at the end of the day feeling inadequate.”³⁴ Burnout and compassion fatigue were common. Nurse Diane Jones, who was very active in the care of patients with AIDS, described the toll: “You die with every patient that touches you as a person.”³⁵

Some fears about the disease’s transmission were warranted. As seroconversion of the virus had been reported due to needle stick injuries on the job, nurses were indeed at risk for contracting the illness through exposure to bodily fluids, even if that risk was small.³⁶ Angie Lewis, a nurse educator at the University of California at San Francisco, shows compassion and understanding for nurses who were fearful:

“One of the things that one often did in a presentation was talk about fear, and the fact that we’ve all felt fearful, and that part of living is being fearful at times, and that we need to use fear to keep ourselves safe. You don’t go messing around with needles and sharps and fluids. There are times when it’s reasonable to wear gloves, to wear gowns, to take full precautions.”³⁷

²⁵ Cliff Morrison, “No Peaceful Death,” interview by *Ryan White Voices*, HRSA, n.d., <https://hab.hrsa.gov/livinghistory/voices/morrison.htm>

²⁶ Diane Jones, oral history.

²⁷ Diane Jones, oral history.

²⁸ Donna Gallagher, “Part of a Secret Society,” interview by *Ryan White Voices*, HRSA, n.d., <https://hab.hrsa.gov/livinghistory/voices/gallagher.htm>

²⁹ Donna Gallagher, oral history.

³⁰ Donna Gallagher, oral history.

³¹ Ron and Rogers, “AIDS in the United States,” 53.

³² Ronald Sullivan, “AIDS: Bellevue Tries to Cope with Disease It Cannot Cure,” *The New York Times*, December 23, 1985, <https://www.nytimes.com/1985/12/23/us/aids-bellevue-tries-to-cope-with-disease-it-cannot-cure.html>

³³ Risse, “Caring for the Incurable,” 659.

³⁴ Sheila Davis, “Life’s Too Short,” interview by *Ryan White Voices*, HRSA, n.d., <https://hab.hrsa.gov/livinghistory/voices/davis.htm>

³⁵ Risse, “Caring for the Incurable,” 654

³⁶ “From 1981 to 2010, there have only been 143 possible cases of HIV that were reported among healthcare professionals. Of these only 57 of the exposed workers seroconverted to HIV” K.C. King and R. Strony, “Needlestick,” [Updated 2019 Jun 4] in *StatPearls* [Internet], (Treasure Island (FL): StatPearls Publishing, 2019), available from: <https://www.ncbi-nlm-nih-gov.proxy01.its.virginia.edu/books/NBK493147/>

³⁷ Angie Lewis, “Nurse Educator in the San Francisco AIDS Epidemic,” an oral history conducted in 1995 and 1996 by Sally Smith Hughes in *The AIDS Epidemic in San Francisco: The Response of the Nursing Profession, 1981–1984, Volume II*, Regional Oral History Office, The Bancroft Library, University of California, Berkeley, 1999.

She continued with this caveat: “But that doesn’t apply to going in and holding someone’s hand. It doesn’t apply to sitting on a bed. What a lot of people did was transfer their fear of catching the disease to the person with the disease, and then that’s a way of distancing that person ... It was important to me to demonstrate to the staff, to touch, even though I didn’t quite know what I was doing—maybe it really was dangerous.”³⁸



FORTITUDE: NURSES COME TO THE TABLE

Although fear encumbered some nurses, many exhibited incredible fortitude in the face of a disease that was fatal and steeped in stigma. In fact, this disease became a nursing disease, a “disease of caring” as nurse Angie Lewis put it.³⁹ “I found that for the person living with HIV, it was nursing very often that was part of the key. So I think nurses have been empowered by virtue of this epidemic.”⁴⁰ Nursing empowerment grew particularly in the realms of advocacy, collaboration, and systemic change.

For some nurses, touching patients represented a radical act of advocacy and courage. “I always have felt that skin-to-skin contact is so important,” commented Angie Lewis. “People living with HIV were very eloquent that not being able to touch was just so painful, and that loss of connectedness with people.”⁴¹ This willingness of nurses to touch reduced patient neglect and isolation—and became a show of strength and a symbol of change.

Patient advocacy surged as the epidemic unfolded. Nurse Elisa Chandler on unit 5B evicted the director of public health, Merv Silverman, and his entourage because “the floor was really busy and patients were really sick, and the patients had been complaining that there had been too much activity going

on.”⁴² Knowing full well Silverman’s status, Chandler advocated for her patients, insisting, “this is first and foremost a nursing unit.”⁴³ Other nurses felt the same kind of duty for their patients and their profession. “As it turns out,” recalled Sheila Davis, “Nursing became a type of activist position. I wanted a sense of justice.”⁴⁴ And Donna Gallagher added, “Every nurse has to be an advocate.”⁴⁵ Exercising a vital function of nursing, these and other nurses demonstrated the value of advocacy in improving patient care and protecting patients from discomfort or injustice.

Growing political involvement represented another facet of nurses’ fortitude in the face of entrenched power dynamics in a largely hierarchical system. Physicians typically made the major health policy decisions at the hospital level; the nursing voice was often missing. But because an AIDS cure was not available, physician preeminence in patient care changed as nursing care became central. Cliff Morrison recalled, “I think particularly that the role of nursing changed a lot during that period, in that for the first time we were at the table. We were major contributors to policies, to the decision-making process.”⁴⁶ He continued, “If anybody should be involved in policy-making, it should be nurses. We have an understanding of what people’s needs are.”⁴⁷ Morrison’s pioneering leadership brought unit 5B into being and made it an example of quality AIDS care for the rest of the nation. On this unit, nurses upended traditional hierarchies and entered into more collaborative relationships with their physician colleagues. Nurse practitioner Gary Stephen Carr remembered that “from the first day, I had the authority to talk to patients as an autonomous health-care practitioner,” which was a “big deal” because nurses had not had such autonomy up to this point.⁴⁸ In response to patient needs and gaps in care, nurses were able to assert themselves as leaders, policy-makers, and equals with other providers in the health-care system.

Nurses came to the helm for systemic change, too. “I think nurses as much as doctors had a real role in pulling the systems together, in keeping them going,” said Gayling Gee, “and in developing a lot of integrity around care for people with HIV that I hope has a ripple effect outside HIV.”⁴⁹ In 1987, the Association of Nurses in AIDS Care was established, organizing nurses across the U.S. to address the epidemic. Nurse involvement led to improvements in cultural competency, new nursing models, the implementation of holistic care, better care coordination, and the growth of home care and hospice. All of these significant shifts in nursing care delivery were influenced by the AIDS epidemic.

Nurses did indeed enact a “culture of caring” in response to the AIDS epidemic of the 1980s, and their legacy lives on in the oral histories of those who invested their lives in the care of patients in need of the fundamentals of nursing care. 🌸

³⁸ Angie Lewis, oral history.

³⁹ Angie Lewis, oral history.

⁴⁰ Angie Lewis, oral history.

⁴¹ Angie Lewis, oral history.

⁴² Diane Jones, oral history.

⁴³ Diane Jones, oral history.

⁴⁴ Sheila Davis, oral history.

⁴⁵ Donna Gallagher, oral history.

⁴⁶ Cliff Morrison, The Bancroft Library, oral history.

⁴⁷ Cliff Morrison, The Bancroft Library, oral history.

⁴⁸ Gary Stephen Carr, oral history.

⁴⁹ Gayling Gee, oral history.

SNIPPETS FROM THE PAST



The Golden Rule(s)

Rebecca Coffin, PhD, RN

Students this year have many new rules to follow to keep themselves and their communities safe. No doubt nursing students have always had more rules to follow than other undergraduates. In 1943, student nurses had to adapt to conditions imposed by the outbreak of World War II. Some rules from the UVA Hospital School of Nursing 1943–44 Handbook:

Laundry: Our machines are badly worn and cannot be replaced. Your cooperation in adhering strictly to laundry regulations is imperative.

Kitchen: Such foods as are procurable under the present system of rationing will be provided the students for intermediate nourishment.

Meals: The Federal law requires any individual who eats eight meals or more per week in an institution to file her

ration books with the administration. Every resident must turn in her ration books to the housemother.

Blackouts: Never leave your room at night without turning out the lights. When a blackout occurs those residents in the house are responsible for assisting the housemother in the discharge of warden duties. Cooperation in observing strictly all blackout regulations of the community is your duty as a citizen. Any willful violation of blackout regulation, should such occur, will be handled by the house committee. If radios are used during blackout, cover with dark cloth as light shows distinctly to the outside.

Nursing students today must attend hospital orientation, complete a CPR class, provide proof of immunizations, complete online training modules, submit to a background check and fingerprinting, and sign on the dotted line before they can set foot in a clinic. During the COVID-19 pandemic, they face even more restrictions when doing clinical sessions. By comparison, the rules of the 1964 Nursing Students Health Program at St. Elizabeth's Hospital suddenly seem far less imposing:

Illness: Students requesting medical care are to report to instructor or to the secretary in room 33 in W.W.E. Building by 8:30 A.M. Obtain health record and take to clinic for all visits.... Student returns her health record immediately following treatment to



Nursing Education office—room 33, W.W.E. Building.

Injuries: All injuries are treated and evaluated in Minor Surgery Clinic. Civil Service Forms CA-1 and CA-2 and the health record are to be completed following evaluation.

Outpatient Care: Students who have been given permission by the physician to rest in Barton Hall because of illness, must return to Minor Surgery for a check-up in twenty-four hours. Late leave and overnight permissions are automatically cancelled during this period.

Tuberculosis Prevention and Follow-Up: All students who have contact with patients who have active tuberculosis will give in writing to the instructor the patient's name, case number, ward and dates of contacts. This is reported at the time tuberculosis is discovered in the patient.

Monthly Weights: All students shall weigh themselves monthly and enter their weights on weight sheet in Barton Hall.

Nursing faculty have long attempted to instill in their students the ideal characteristics of a nurse. Student Estey Crim's lecture notes identify these characteristics as "graces." The graces, or "beauties," included courage, calmness,



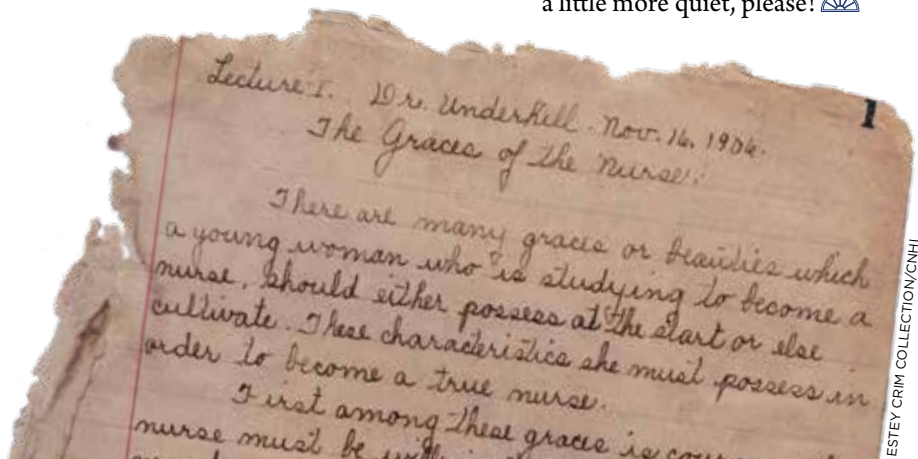
and cleanliness. Some students had self-imposed rules: scheduled times to study, eat, exercise, and have fun with friends. Dora Cline Fechtmann, a nursing student in the 1930s, was strict with herself:

I shall endeavor to refrain from doing the following:

1. using slang expressions
2. making other persons' business my business
3. living in little faith
4. forgetting to pray
5. reading the Bible too little
6. forgetting others

The UVA Nursing Student Handbook of 1943 closed with advice under the heading "It Goes Without Saying." These pearls of wisdom included:

- Courtesy and strict adherence to the Golden Rule is the only basis for successful group life under self-government.
- We adapt our personal plans graciously to necessary changes in schedule.
- All students will rise in the presence of any doctor, graduate or upper-classman.
- Living room doors are to be left open when entertaining.
- Oral hygiene after smoking prevents offending; cigarette stubs in the ash TRAYS and not on the steps prevents untidiness.
- Some people don't go on duty at 7:00 in the morning ... a little less noise and a little more quiet, please! ☺



Recent Acquisitions

Mary Gibson—Student notebooks and syllabi from UVA School of Nursing courses: Nursing the Childbearing Family (1973-1974), Graduate Pathophysiology (1989), and Medical Genetics (2001)

Sylvia Rinker—Books on community health, women's health, and nursing history

Clare Houseman—Papers documenting passage of Virginia House Bill 1024 (1989) allowing for the registration of Clinical Nurse Specialists (CNS) in the state and direct third-party

reimbursement for CNSs in psychiatric and mental health care

Jennifer Matthews—personal library of nursing, medical and related health-science books, from the 1850s to 2010

Albert A. Acena—Family photo albums belonging to his mother, Felicidad Acena, recording her public health service nursing career in the Philippines and in the U.S.

Md Farid Uddin and Mosfika Yeasmin—Oral history recounting their educational journey in the U.S. to train as nurses after careers as doctors in their native Bangladesh

THE ARCHIVIST

Designing for Contagion

by Henry K. Sharp

The challenges of contagion and infection control are nothing new for nurses, yet the global spread of SARS-CoV-2 has brought these issues to the forefront of public consciousness. And in fact, since we're curators of contemporary history, too, the Bjoring Center is collecting COVID-19 pandemic stories from the nurses on the front lines today. This is history as it is happening, and will form a critical body of evidence for scholars to come.

For students of the past, understanding how prior generations of medical professionals and the public confronted these topics is a challenge of a different nature. Our UVA Hospital history project has brought to light evidence of attitudes toward infection and contagion in the era around 1900. Two local examples that speak to the larger context of the campaign against infection are informative.

An early stage in the establishment of the hospital actually concerns a purpose-built facility called the Dispensary. When it opened on UVA's Corner in 1892, a reporter for *The Times of Richmond* lauded its "advantage and convenience" over "the old hospital" located in an old city-owned house on Vinegar Hill. That "old hospital" refused to take contagious patients—one way to address the problem—and the Dispensary, likewise, since neither building had room for isolation. Yet by 1905, other debilitating infectious issues had developed. The Dispensary was, the physician in charge reported, "a disgrace to the University.... The flooring of the amphitheater is wood, partially decayed. In it is soaked the accumulated filthy

discharges for a number of years," a "repugnant" condition that did not safeguard patient health or provide an effective learning environment.

Contagious disease did strike the community, too, and nurse Charlotte Martin, who became manager of UVA Hospital when it opened, was also responsible for the Infirmary, which provided clinics and inpatient services for sick students, and had been designed in the 1850s with a sophisticated ventilation system through a cupola on the rooftop. In February 1901, she had to manage the effects of a smallpox outbreak. "Your duties are very trying at this time," wrote Dr. Paul Barringer, chairman of the faculty, urging her to take "utmost care to see that all clothing and other material is not sent out without thorough and absolute disinfection." Ms. Martin also sought the hire of immune staff, and Barringer complied, arranging for an immune cook and others. Later, the Rector of the Board of Visitors opined to Barringer, "I feel that if the City and County authorities had adopted measures for the suppression of this disease in any sense as practical as those that you have put into effect that the whole situation would have long since been relieved."

It is no surprise, then, that issues of infection control influenced the design of the new University Hospital from the very beginning. Architect Paul J. Pelz chose the "pavilion form" in which freestanding wards or wings are linked by corridors, instead of concentrating activities in a single structure. Florence Nightingale had been the earliest and



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The University Dispensary in 1910. Located on West Main Street, the building was torn down about 10 years later.

most vocal advocate for this type of design

that allowed for ample, independent ventilation of the wards and other interior spaces. Although we lack the original working drawings for the hospital, early photographs reveal a pattern of small, horizontal slots beneath most of the windows in the ward buildings, which would have linked to conduits opening behind the radiators to provide constant fresh airflow to the interior, heated in wintertime. Whether there were exhaust ducts that led to the cupola on the roof of each wing, as in the Infirmary, is unknown but likely, since the cupolas had louvered vents to allow air to escape. The availability of rooms apart from the wards allowed separation of contagious cases, too. In a similar mode, Pelz's design of the surgical amphitheater corrected the worst problems of the Dispensary. Instead of wood, this main hospital operating room had waterproof terrazzo floors with drains, a sink operated with foot treadles, and ready access to in-house sanitizing and laundry facilities.

There will be more to report as this project proceeds, but the University's century-old concerns for sanitary facilities, adequate ventilation, and sufficient space for potentially contagious patients seem altogether modern, today! 🌞

TAKING STOCK

A SNAPSHOT OF FISCAL YEAR 2020



CAROLYN TORRE AND KIM CURRY

Center Goals & How We Met Them

1 Ensure the future growth of CNHI by financial endowment and building a team of nurse faculty historians

- Center endowment: \$2,085,948
- New gifts: \$49,248
- Gifts to the endowment: \$74,949
- New grant: The Nurse Practitioner History Research Scholar Award
- Formed a Bjoring Center Advisory Board to support our initiatives

2 Enhance processing capabilities to make collections available to scholars

- We continue to provide resources for scholars to engage with the center's collections
- New acquisitions include the papers of Dorrie Fontaine, retired Dean of the UVA School of Nursing
- Our "Hidden Nurses" repository continues to grow

3 Build scholarship in local, regional, national, and international nursing history

- The Brodie Historical Research Fellowship was awarded to three historians: Dr. Gwyneth Mibrath (Chicago), Dr. Madonna Grehan (Melbourne, Australia), and Dr. Jane Brooks (Manchester, UK)
- We enhanced mentoring of undergraduates and graduates doing historical scholarship through conferences, history projects, and interdisciplinary research programs.

4 Increase the number of presentations and publications from Center faculty and students

- Four PhD students published in *Nursing History Review*
- Four students had presentations accepted to the Canadian Association for the History of Nursing meeting in 2020 (cancelled due to COVID-19)
- Faculty presentations included in-person and virtual meetings in New Orleans, Chicago, Indiana, Belgium, and Italy
- Our students garnered significant media coverage for our "Hidden Nurses" project

5 Increase diversity in our holdings

- New oral histories of nurses of color (audio and video of 11 nurses)
- Acquisition of items relating to Black and Cherokee nurses of North Carolina
- Beginning to collect oral histories of Filipino nurses
- Launched a pandemic nursing archive to collect first-person accounts of health-care workers on the front lines

Filming of the 2019 documentary, "Battles Hard Fought"

"This past year, Dr. Kim Curry and I were the fortunate recipients of the first Advanced Practice History Research Scholar Award. This award made possible the creation and production of "Battles Hard Fought," the video story of the development and passage of the first nurse practitioner/clinical nurse specialist law in New Jersey, told through the voices of pioneer nursing leaders."

—Carolyn T. Torre, RN, MA, APN, FAANP



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An airman braces for a flu shot from a U.S. Army Nurse at Tempelhof Central Airport, West Berlin, Germany, in 1980.

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