Respectability Politics: The Professionalization of Nursing Practice

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Abstract: Nursing education has evolved through several phases since the origins of the profession. Through leaders like Florence Nightingale and Isabel Hampton Robb, strides were made to establish nurses as highly educated and essential healthcare workers. They worked to widen the sphere women were permitted to operate in within society, while accepting the limitations of their goals. The progression of nursing included such elements as the exaggeration and exploitation of the social perception of the role of women as caretakers, as well as the embellishment of the angelic imagery of nurses. The catering to male preferences for respectable nurses in part motivated the normalization of university education for nursing. As the founder of the bulk of nursing curriculum, Isabel Hampton Robb was determined to professionalize nursing. In the late 1800s, this meant the employment of white, middle class, plain women with good educational backgrounds, a set of parameters that catered to what patients would find most palatable rather than a merit-based system. Organizations like the American Nurses Association contributed to the long-term establishment of the profession, and eventually helped determine the direction education would take for generations to come. How did the conformity of nursing education shape the modern industry?

Introduction

Florence Nightingale stepped into Istanbul's Scutari hospital to the smell of unchanged dressings and the metallic tang of blood. It was 1854 and within the midst of the Crimean War. All around her, men lay dying in cots, injured and ill soldiers side by side, in clothes that had not been changed since their admittance to the hospital. These soldiers had seen battle and sustained serious injuries. Yet, overwhelmingly, they were dying not of these injuries, but of disease and neglect. Nightingale and her small team of nurses tried to implement skills and hygiene practices to remedy the abysmal state of the Scutari hospital. These practices were simple and three-pronged: a clean environment, comfort, and better nutrition. Records kept from 1855 show a drop in mortality rates from 33% to 2% over in the 10 months after Nightingale's arrival (Gill and Gill 2005). Even with their efforts, thousands died of disease.

Nightingale returned to England from Scutari in the summer of 1856, disappointed with what she had seen and the small scope of what she had been able to accomplish. However, it gave her the impetus to set up the first secular nursing school adjacent to St. Thomas hospital in 1860, based on contemporary practices and modern science. Her work established her as the founder of modern nursing, and the highest award in nursing today bears her name. However, her model of nursing education would prove to be one among many. The variance between the multiple methods proved to be the cause for debate over which method was superior for career

preparation. The education of nurses would prove to be instrumental in the shaping and professionalization of nursing as the respected profession it is known as today.

Origins of Modern Nursing

Nursing was known as the practice of caring for a sick or injured person and varied in both location of treatment and methodology before the growth of modern nursing under Nightingale's influence (Egenes 2009a). When the first U.S. hospital was established in 1751, it was publicly regard as an asylum or almshouse, and those who could afford better care would not seek hospitals until around century later (National Women's History Museum 2010).

Before 1840, the modern-day medicinal practice ascribed to nurses was charged to family members, religious orders, and privately organized groups founded out of necessity, like the Free African Society which organized volunteers to help with the Yellow Fever epidemic in 1793 (Penn Nursing 2021). It arose on an as needed basis, through wars and epidemics. In the military, hospitals were predominantly staffed by men.

Prior to Florence Nightingale, the only documented training programs for nurses were both crude and religious in nature. The first of three such programs began in 1840 under the directive of Quaker prison reformist Elizabeth Fry (Huntsman, Bruin and Holttum 2002). She founded the Sisters of Protestant Charity in response to the poor quality of nurses at the time, who were noted by Dickens to be drunk on duty, sleep with their patients, and delight in their patients' deaths (Dolan 1968). Despite Fry's good intentions, the Sisters were only a small step up in education, with their practicum training consisting solely of observing patients at two hospitals in London.

St. John's House was a Protestant sisterhood founded in 1848, setting up a paid two-year program that gave nurses exposure at three different hospitals (Egenes 2009a). These nurses were then bound to a five-year commitment of work at the sisterhood. Further, because of the religious foundations of the program, only a few hours daily were devoted to nursing education, with the remainder to praying and religious activities (Pavey 1953). The last of the pre-Nightingale efforts was spearheaded in Europe by German Pastor Theodore Fliedner, who established a Deaconess Home and Hospital with his wife in 1836 (Huntsman, Bruin and Holttum 2002). This hospital was the first program to have a primary focus in nursing and patient care, along with secondary education in social services and religious instruction (Egenes 2009a). Deaconesses took no vows and carried out their duties as long as they desired to rather than by obligation.

Nightingale Model

Florence Nightingale knew early on that she desired to work in a capacity where she could care for the sick, announcing this to the relative shock of her wealthy family. Her passion led her to a two week stay at Kaiserswerth, with Pastor Fliedner's Deaconesses in 1844 (Gallison 1954). Nightingale was captivated and returned for a three month stretch where she learned patient care from the deaconesses and observed the method of teaching instruction (Huntsman, Bruin and Holttum 2002).

When the Crimean War broke out in October of 1853, Nightingale had already collected spates of experience at hospitals throughout Europe, even serving during the cholera epidemic at Middlesex Hospital. With the commencement of the war, mortality rates for deployed British soldiers rose to 41% (Pavey 1953). Nightingale effectively lobbied British administrators for

permission to travel to the front with a team, leveraging her family's status as wealthy British elites by reaching out to family friends in government roles (Cook 1913).

When Nightingale and her nurses arrived, the conditions at Scutari were some of the worst of the pre-20th century. Thousands of sick and wounded soldiers were packed into open hallways, lying on whatever was available—most commonly blood-soaked straw mats left behind by suffering patients (Tye 2010). Many of the men still wore their battlefield uniforms, soaked with blood and other bodily fluids, and infested with vermin (Nightingale and Mundinger 1999). The facilities had no ventilation or freshwater, the food was inedible, and there were virtually no drugs or medical supplies. Amputations were performed without anesthesia in full view of other patients, and most amputees quickly succumbed to gangrene (Tye 2015). The doctors and orderlies dispatched to deal with the crisis were overworked and outmatched by the sheer scale of casualties. In trying to cope with the trauma of the situation, orderlies were often drunk, refusing to empty chamber pots or go near the sickest patients (Terrot and Richardson 1977). Nightingale and her team faced stiff opposition from male chief medical officers (Fee and Garofalo 2010). These officers made it clear that Nightingale and her staff were unwelcome and beneath them, both because they were women and because of their role as aid workers (Cook 1913). Women of the time, especially of Nightingale's station as a member of the British aristocracy, were expected to remain in the home (Reynolds 1988). If they became involved in wartime efforts, it was through fundraising and petitioning friends of the family on behalf of soldiers.

It was out of this cesspool that Florence Nightingale established the profession of nursing and created the modern hospital upon her return to Britain in 1856. Nightingale's wartime credentials were bolstered by positive media coverage, which championed the 'lady with the lamp' as a godsend to Britain's soldiers (Tye 2015, n.p.). Her image was used as positive wartime propaganda back home, as officials championed the decrease in deaths. Nightingale used this acclaim to push for many of the basic health programs that provide a foundation for our hospitals today, like pharmacy, laundry, and nutrition services (Tye 2010). She was not content to limit her progress to the clinical, however, delving into recordkeeping as well. Here, she established a precedent of accountability for healthcare workers and organized patient progress tracking. This tracking system provided the framework for triage of patients and drastically reduced the amount of medication dosing mistakes (Kopf 1978). Nightingale was also the first to break through socio-medical bias, creating the core medical principle that triage should be based on medical need, not status, rank or religion (Tye 2010). This principle was a novel idea in her time, especially coming from a woman of status, wealth, and aristocracy, who stood to benefit from the class-based system. In this way, she started real, unprecedented reform in the field of medicine, all the more impressive given the lack of power given to women of the nineteenth century. Her high social status, and familial connections, aided her in overcoming barriers that would have stymied less advantaged women.

Nightingale was also determined to set up a system of success for the future. Not only advancing standards for a formalized field of nursing, she also personally established the first professional secular school of nursing so that other women could follow her path and achieve an education (Tye 2015). The school existed as a sector of St. Thomas Hospital, establishing the model for nursing as hospital-adjacent, so that all training would occur on-site and in a clinical as opposed to academic setting. She was the first vocal advocate for the healthcare rights of ordinary soldiers and veterans, a sector of society previously left to their own devices in the post war period (Tye 2015).

Nightingale was not without controversy, however. In her book *Notes on Nursing*, she writes "every woman is a nurse" by nature of her taking care of others at some point in her life (Nightingale 1969, 1). This quote was initially meant to bolster the idea of women being allowed into nursing practice. She intended to assuage worries about women of the era working by framing it as a natural extension of the home rather than a breaking of common gender norms. This created a gendered perception of nursing as a female-only field for centuries. This framing also lent itself to the expectation that in-home nurses would provide other services, like housework. In addition, it also made the journey to public perception of nurses as career professionals as opposed to skilled caretakers more difficult. Another common critique of Nightingale is that she did not support women's suffrage (Selanders 1998). On the contrary, she was a supporter but did not prioritize suffrage in her social activism. She believed the secularization of nursing and expansion of education for women would be more effective at expanding women's rights.

It was Nightingale's approach to nursing that inspired the images of tender, compassionate female nurses. Her iconic image of 'the lady with the lamp,' was coined by a journalist's depiction of the ward of soldiers who she would treat throughout the night, carrying with an oil lamp for visibility (Klugt 2010, n.p.). The popularity of this image led to associations with nurses as angelic or Madonna-esque figures of both aid and purity, which in turn created high moral standards for nurses, both in and out of the workplace (Ford 2019). While the positive public perception of female nurses allowed for an increased acceptance of female nurses into previously unsuitable areas, like field hospitals, it also ostracized men who may have otherwise successfully pursued the profession. Instead, men who wanted to practice direct patient care alongside nurses became orderlies and were paid much less than nurses (Ford 2019).

U.S. Integration of Nightingale Method

The U.S. development of nursing education began with the Civil War, which offered women new opportunities amongst the bloodshed. The medical needs of the Civil War were so great that the American Medical Association (AMA) began recommending the integration of nursing education programs into hospitals to increase the supply of nurses (Carson-Newman University 2018). The sheer volume of men who were coming off the battlefield with traumatic injuries was overwhelming existing medical professionals, and deaths remained high throughout the war (Reilly 2016). Many Civil War nurses who served went on to establish nursing training schools with their wartime experience as credentials (Egenes 2009b). These schools followed the Nightingale model, existing as an arm of the larger hospital rather than standalone institutions.

Class distinctions existed in this labor, as wealthy women who organized the raising of funds and aid for the wounded would not have been found anywhere near military hospitals (National Women's History Museum 2010). Social expectations still labeled this work as lower class because of the gruesome and often filthy conditions in packed hospitals, though the work was important and necessary. The perception of "camp followers" also plagued the reputation of nurses, identifying them as an extension of the roles of wives or mistresses that would follow troops rather than an actual role (D'Antonio 2002, 7). Many nurses performed menial tasks, and some viewed nurses as a drag on resources for the army. This class-based stigma continued after the war, with nursing seen as on par with other menial sanitation roles.

Lack of oversight of hospital practices resulted in varied degrees of education among nurses graduating from the same program (Penn Nursing 2021). The lack of academic accountability drew poor and lower-class applicants who were unable to qualify for work in

other fields, due to a lack of education, criminal record or behavioral issues (Dolan 1968). It was said that in cities where the patient load was higher, nursing care was provided by "drunkards and former convicts," and further reports stated that prostitutes were offered prison or hospital service work at their sentencing (Egenes 2009a, 8).

A pattern soon emerged where men were charged with nursing in the mental health arena while women were associated with general care (Ford 2019). The marginalization of mental health hospitals at the time meant male orderlies were viewed as less qualified and of lower status and received far less training (National Women's History Museum 2010). The further lack of oversight in mental health hospitals also meant that neglect and abuse were pervasive (Kazano 2012). As such, patients suffered a lower standard of care and mental hospitals retained their poor reputation, enforcing the aforementioned cycle. Less male training inspired pay disparities, which is the opposite of today's compensation scale (under which men earn more). Male overrepresentation in mental and behavioral health persists to this day, even though men only make up 13% of nurses overall (Pompilio 2020).

Stereotypes established by female dominance in the nursing field, and males in medicine, placed female nurses as support labor for male doctors, in agreement with social ideas about women in a perpetual subordinate role to men. Defenders of this perspective pointed to a lower standard of education, and lower skilled labor as opposed to medical doctors. Isabel Hampton Robb sought to dispel at the least the former, by sending future female nurses to the baccalaureate degree route.

Establishment of Modern Nursing Practices: Isabel Hampton Robb

Isabel Hampton Robb took a decidedly different approach from her predecessors. As principal of the nursing school at Johns Hopkins University in Baltimore, Maryland, Robb sought to standardize nursing in an academic setting. She believed this would irreversibly divorce the profession from its designation as a job for uneducated members of the lower class (Robb 1901). Robb therefore began enforcing required exams and certifications in different clinical skills beginning in 1889 (Draper 1902). She believed nurses could and should be held to a higher esteem than the drunk and disorderly reputation that had stained public perception of hospital staffers (Dolan 1968). Her efforts changed the image of nursing and set the foundation for its conversion into a respectable and well-organized profession. In the nineteenth century, that respectability called for the recruitment of white, predominantly middle-class women of plain appearance, a set of standards enumerated by Dorothea Dix in her recruitment of Civil War nurses in July 1862 (Egenes 2009a). The requirement of college education created a barrier to entry that effectively barred both poor and non-white women from the field, as neither would be accepted into university nursing programs (Hine 1989). African American women instead founded their own hospitals and universities, like the program at Spelman College, to train other African American nurses and staff segregated hospitals (Johnson 2008). Today, women of color make up a minority of nursing practice with 80.2% white nurses (AACN 2021). Nurses of color note that making up a minority means there is less ascension to leadership roles across the board, and therefore fewer role models for new nurses to look to, which may increase recruitment to the field (Bennet et al. 2019).

Robb's own nursing education began in a hospital training school that followed the model Nightingale established. After becoming superintendent of the Cook County hospital training school, Robb made one of her lasting contributions to nursing education. She drafted and implemented one of the first standards for nursing grading policy among students (Robb 1898).

This grading policy ensured a metric for measuring the retention of education and produced nurses held to a higher standard (Robb 1898). In 1892, the National Education Association would go on to establish a standardized curriculum for US secondary schools, exhibiting an overall trend of standardization amongst educational institutions (Sass 2021).

Robb's appointment to the Johns Hopkins faculty would prove to be timely for the advancement of nursing education. Johns Hopkins provided status and credibility as one of the first and now oldest nursing schools in the country. The nursing school sought to distinguish itself from the common thread of hospital training schools, and instead exist alongside the higher education institution of Johns Hopkins University. Robb believed this new model would form a stronger pool of graduate nurses, and that the skills of her nurses would spread the model to other schools (Robb 1901). Robb established eight-hour workdays for nurses to prevent exploitation of new staff and to ensure new nurses were not undertrained and overworked (Petiprin 2020). She also extended the education program from two to three years and created an outline for the new three-year curriculum (Petiprin 2020). Her textbook, *Nursing: Its Principles and Practice,* became essential in nursing education and is known for standardizing education for nurses across the US. It outlined three years of coursework and examinations, covering the essentials of running a hospital, like regular cleaning and meals, as well as bacteriology, anatomy, physiology, hospital ethics, and etiquette, among other subjects (Robb 1898). But Robb was not done yet. She then evaluated the economics of hospital wards including ward labor and supply maintenance, established proper hygiene protocols in hospitals, and wrote the protocol for bacteriological notes and proper bed making (Robb 1898). Her books would be distributed at schools and hospitals across the country, becoming the new nursing standard and ushering in a new respect for academia and nursing (Robb 1898).

Academia versus Trade Skill

Internal debates erupted in the 1950s within the American nursing sphere over the type of work in which nurses should engage and the proper way to educate a nurse (Nurse.com 2021). It divided nurses into two main schools of thought. Proponents of two- and four-year degree programs promoted removing nurse education from hospital training schools in favor of an education in universities alongside other professions. Detractors believed in-hospital training offered an irreplaceable bedside care concentration that prioritized patient care and prepared nurses for the work they would be thrown into upon graduation from their training (Nurse.com 2021).

Education disagreements were defined along generational lines. Younger nurses threw their support behind Robb's model of higher education, because it allowed them to seek higher paying positions and enter a field that would earn them social respect as an educated professional (Penn Nursing 2021). The higher education model meant two to four years of formal learning in a university or college, increasing the standard for nursing knowledge as well as practical ability. This process meant it took longer to become a nurse, as well as created barriers to entry for the lower class, who may not have been able to forgo the opportunity to earn wages for the duration of nursing school. The increase in training time soon became a problem for aging nurses, many of whom wanted frequent rotations of fresh, young nurses to take on longer shifts and harder workloads (Whelan 2000). However, newly graduated nurses had less hands-on experience than those with a trade school background. Older nurses believed the emphasis on practical care was more efficient for training self-sufficient new nurses. It had worked as a model for their generation, and they believed higher education could not replicate the skills learned in a

technical setting (Penn Nursing 2021). They also took issue with the length of education and the years that took away from the practicum component.

The Associate Degree in Nursing (ADN) arose in response to the nursing shortage following World War II, to train beginning technical nurses in a shorter time frame than the four-year baccalaureate (Egenes 2009a). These technical nurses had a narrower scope of practice than the baccalaureate registered nurse, but served to bolster the overall number of nurses, allowing those nurses with a more advanced skill set to focus on the patients that most needed their abilities and others to be taken care of by technical nurses (Egenes 2009a). Endorsement by the American Nursing Association (ANA) meant ADNs would be accepted for decades instead of being phased out, evidenced by their continued existence today despite the preference for BSNs.

The height of the transition to the university degree model was the 1970s, culminating in 1982 when the US National League for Nursing approved a bill requiring all new nurses to earn at minimum an associate degree in nursing (Mahaffey 2002). The US National League for Nursing currently functions to provide research for the education of nurses, and support of nurse educators, through funding, policy initiatives, and networking opportunities. They are the premier source for nursing education requirements and structure (National League for Nursing 2021).

Educational Primacy: Transitions

There was a natural social transition in nursing from care of the home as a wife and mother, to the in-home care of others. The gender stereotyping of women as caretakers opened nursing as a respectable position for women wanting to enter the labor force. Before the rise of hospital or bedside nursing in the late 1930s, nurses worked in the family home of their patients (Penn Nursing2021). This too eased social stigma of women in the labor force, as the profession maintained the perception of a woman's sphere of influence being the home, in domestic labor (Maling 2015). Nursing as an in-home profession was called private duty nursing, where there was a predominant one nurse to one patient ratio and made up the bulk of nursing from the 1860s through the early 1930s (Penn Nursing 2021).

Private duty nursing depended on a roster of graduated nurses that applied to nursing agencies (Whelan 2000). Once their credentials were approved, these agencies would match nurses into private care settings, predominantly in-home for private citizens and sometimes in smaller care homes. This registry system served as a rough credentialing system, checking the qualifications of each nurse who signed on before adding their name to the roster. The registries were highly effective units of nurses, and many of the larger and more successful registries came to be affiliated with the ANA (Whelan 2000). The ANA, initially intended as an organization to petition licensure requirements from nurses, became the foremost association for the lobbying of best practices for nurses and advocacy of working rights (ANA 2020).

Many registries were also run by nursing school graduates. These registries as a conglomerate served to establish conventions of nursing practice like hours of work, fee schedule with hospitals as well as patients, and norms for best professional practice (Whelan 2000). Private duty nurses depended on patient requests and were unpredictable, resulting in a lack of financial security and shortage of positions available for the quantity of nurses willing to work. However, it was a system that offered nurses far more control than the centralized hospital system. Many hospitals employed student nurses from their in-hospital training programs, as they were much cheaper to employ than graduate nurses and could be more easily utilized than experienced nurses in any capacity that the hospital required, even outside the scope of practice

(Whelan 2000). Nurses on the registry were their own agents and could choose whether to take on jobs as independent practitioners. Their experience with in-hospital nursing schools made them capable in a variety of clinical settings and they could switch patient care specialties easily. They also reported to other nurses in many cases, rather than strictly administrators, who were more likely to be understanding of the nature of the work (Whelan 2000).

The creation of the critical care unit was the beginning of the recruitment of nurses to hospital staff, increasing dramatically between 1950 and 1970 (Fairman and Kagan 1999). Critical care patients required round-the-clock personalized care, the kind that could not be covered by general rounds done by doctors or addressed by the night watchmen left at the hospital when all staff went home for the night (Pavey 1953). The need for critical care nurses was evident.

After their introduction, nurses quickly integrated themself into the hospital network and organization. They organized wards based on case complexity and acuity, allowing for many nurses to take on more than one patient without compromising care (Fairman and Lynaugh 1986). Before high tech machines and technology led to the intensive care unit as a permanent fixture, the ideology was that the sickest patients were the most vulnerable and needed acute care. A skilled nurse would be able to monitor, diagnose, and initiate treatment or call for medical help from a senior doctor if necessary. These decision-making skills were invaluable. The increase in nursing care changed the image of hospitals, with higher degrees of patient satisfaction, leading to the popularity and growth of what is recognizable today as the modern hospital (Fairman and Lynaugh 1986).

The transition to hospital staff meant there was a drastic increase in the desire for highly educated and competent nurses. Hospitals needed to depend on the uniform education of nurses, something that higher education ensured, especially when paired with clinical rotations in a hospital. Nursing training schools that relied on practical care prepared nurses for the care environment but produced dramatically different levels of academic education (Egenes 2009a). Trade skill nurses recognized the variable manifestations of disease but were limited to what they had personally experienced and lacked experience with more rare scenarios that may have otherwise been outlined in textbooks and university lectures. Critical care patients required highly educated medical professionals who had the knowledge base and experience to make life-saving calls without physicians present. Critical care units cropped up in hospitals around the U.S., and demand for college-educated nurses rose in tandem (Egenes 2009a). For the degree of illness these patients experienced, higher degrees of education provided both administrators and patients with assurances of a certified skill set and base standard for nursing skill to try to address disparities in care.

Hospital work began the process of shifting the perception of nursing away from the previous conception of it being a “trade skill.” Through increased use of nurses in hospital work, the traditionally female-dominated field was quickly being considered a position that required a high degree of education. It also provided the basis for unionization among nurses, as better education gave the grounds and reasoning to make arguments for better conditions and treatment as essential hospital staff (D’Antonio et al. 2010). The sheer number of nurses working in private duty and later hospital care made their labor essential to the functioning of the medical system, a powerful negotiating position for better treatment and pay.

The Path to Professionalization: The Role of the ANA and Government

Nursing education takes its current form as a result of national organization and support for standardization of care. Amassing the numbers and permanence of organizational backing was Isabel Hampton Robb's manner of ensuring the continuity of education in nursing practice. It also ensured the long-term efficacy of her earlier successful training program, which produced an arguably higher standard of nursing graduates than traditional methods.

Robb went on to become one of the founders for what would eventually become the ANA in 1896. Today the ANA is a non-profit organization for the representation of nurses which promotes standards of nursing practice, workplace rights, and economic and general welfare (Egenes 2009a). In its initial stages, their main platform was advocacy for nursing licensure in each state to achieve professional legitimacy (Egenes 2009a). They also pushed for the establishment of a code of ethics, attention to the financial and professional needs of nursing, and a renewed image of nursing as a well-trained and well-respected position critical to the function of a hospital and essential to ensuring adequate patient care.

Nursing licenses were first established in all states by 1921, with North Carolina leading and implementing their exam in 1903 (Penn Nursing 2021). Nursing knowledge increased dramatically, and nurses began to be trusted with more medically complex cases, alleviating pressure in the medical system off of doctors (Egenes 2009a).

The ANA used its public platform to give nursing a reputation as a major professional career field in the 1950s (D'Antonio et al. 2010). This came after the merging of male and female nursing units in World War II, which showed that male orderlies and female nurses could be efficient as a medical unit (D'Antonio 2002). Their professional recommendation as an organization was four years of study, with a two-year technical component. Organizational backing helped to strengthen the idea that completion of higher education was to become at least the implicit standard for hiring nurses, if not explicit. Yet even as the educational standard was raised for the profession, social perceptions of nurse behavior and expertise remained rooted in sexist perceptions.

Development of Uniforms

For much of nursing history, the traditional uniform was a floor to tea-length dress with a protective apron, and often an accompanying hat or bonnet (South University 2016). This continued as the major form of dress up until the 1990s when a general transition was made to scrubs, a set of pants and open neck shirt, that were deemed more hygienic and gender-neutral in accordance with the entry of more men into the profession (South University 2016). The predominance of dresses in hospitals prior to this point, despite the mainstream social support of women in pants and other non-dress apparel, reinforced the idea of ideal femininity in nurses.

The idea of the "sexy nurse" pervaded social consciousness in the form of a dress-clad caretaker. This dated from nursing roles on military bases, sexualized as the only female-dominated role in a male space, and continued with a string of films through the 1970s to 1990s that portrayed nurses as scantily-clad sex objects (Gentile 2015). This hyper femininity made it more difficult for female nurses to be taken seriously for their expertise as professionals, despite advanced degrees and training.

Gendered Labor and Pay Gaps

Nursing's bachelor's degree requirements have made it far more class-restricted than its origins as a profession accessible by the poor and criminally associated. It is still a heavily female-dominated field however, with the association as a care worker far more prevalent among

conceptions of nursing than physician's work (Regis College 2021). This stigma prevents many men from going into the profession, an influx that would likely raise salary rates, as it has in other fields (Yavorsky and Dill 2020).

In fact, 70% of respondents to a recent study identifying challenges in nursing said stereotypes deterred men from the profession, including the lack of representation in media, with men occupying the role of doctors and making male nurses a punchline (Pompilio 2020). Male nurses face more stereotypes but also earn $6,000 more on average than their female counterparts in the same specialty (Pompilio 2020). Others suggest the gap may a yearly salary of $60,700 for male nurses versus $51,100 for female nurses (Lotts 2019). However, male nurses who do enter the field are more likely to be found in higher paying specialties, like nurse anesthetists.

Nurses today face many hurdles in the practice of their profession. Gender stereotyping still works against nurses even at the highest level, where nurses who have achieved the highest education, a Doctor of Nursing Practice (DNP), struggle to be taken seriously by patients as capable clinicians. Three out of four patients prefer to see a physician over a nurse practitioner, even if the cost is higher and wait times are longer (Greenhaigh and Melaney 2013). Nurses are also at risk for sexual harassment from patients and other staff members. With patients, nurses are encouraged to brush much of the behavior off, attributing it to illness, medication, or just an uncomfortable byproduct of the role as caretaker (Draucker 2019). With staff members, it can often be intimidating to either confront or report, as this can threaten advancement in the hospital or create a reputation as a 'problem' in the workplace (Draucker 2019).

Conclusion

Nightingale and Robb are venerated as the pioneers of the nursing profession. Their impact on nursing education cannot be overstated as it contributed directly to the extensive labor force of nurses present in hospitals around the world today, making up the backbone of hospital, facility, and care home work.

Documented higher standards for current and continuing education led nursing to become more respected as a formal career choice for the well-educated. The academic component was emphasized, making it less of a trade school-type job field, and adding prestige to the position with the development of highly educated positions like Nurse Practitioner (NP).

The conflict presented throughout nursing educational history is how far to lean into femininity for the expansion of female autonomy. For Nightingale, this meant framing nursing as an already present and prepared aspect of home life. Robb believed in a focus on earning respect, in the form of college education, despite the derision women in higher education may receive as they were still perceived as homemakers not scholars. With expanding specialty, licensing, and degree options, up to a DNP, women who have both respect and options for growth, now have to decide how to organize their career, families, and advancement. As more men enter the field, femininity again comes into play, as second-lowest compensated specialty of pediatrics has fewer than 2% male nurses while the highest earning field of Nurse Anesthetists has almost 40% male nurses (ACLS 2020).

Epilogue

Today's nurses overwhelmingly have completed bachelor's degrees, and many have additional certification or even masters degrees (AACN 2021). Holding a degree enables them to be more competitive for leadership positions and advancement. Continuing studies have

indicated that increased formal education of individual nurses is correlated to lower patient mortality (NIH 2014). A Bachelor of Science in Nursing (BSN) versus Associates in Nursing (ASN) today convey different degrees of academic respect and therefore job opportunities, with a BSN being considered a more favorable and competitive candidate (AACN 2021). The preference for a four-year BSN over the two-year ASN is a current manifestation of the moving bar for nursing education, as this would not have been the case 30 years ago, when only 25,000 nurses held advanced degrees (ASN or BSN) out of 722,000 (Aiken 1983).

New debates may be emerging in the field. Nurses are still fighting for the right to practice with a degree of autonomy as NPs with certification, battling both state differences in practice as well as social perceptions of the superiority of physicians for patient care (Greenhaigh and Melaney 2013). Labor holes have already been exposed through the recent COVID-19 pandemic that left nurses understaffed, overworked, and lacking the personal protective equipment required to feel safe on the job, leading them to direct their ire at out of touch administrators (Morley 2020). Nurses are leaving bedside work in high numbers, preferring the hours, staffing ratio, and salary of outpatient work, setting up a future confrontation on how hospital administration can retain their staff nurses and continue aiding the consistent quantity of patients to come (MacKusick and Minick 2010). With the bar for education consistently moving, for all graduates as well as nurses, the nursing profession will likely have a reckoning with exactly how much education they can require before ensuring employment at the current salary and demand level.

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