To Degree or not to Degree: Women, Nursing and Baccalaureate Education in Twentieth-Century America

Policy Issue: State Proposals for BSN IN TEN

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Statistics released from the 2004 National Sample Survey of Registered Nurses in the United States presents rather straightforward data about the educational backgrounds of American nurses. (FIGURE 1) Today, approximately 25 percent of all registered nurses in the United States receive their initial professional preparation in diploma programs; approximately 42 percent receive associate degrees from community colleges; and a little over 31 percent are awarded the baccalaureate in nursing from four-year colleges and universities.

Initial Education Preparation of All American Registered Nurses
Interestingly, when one shifts the perspective from initial entry preparation to highest educational preparation achieved over a lifetime of practice, a rather different picture emerges. Now (FIGURE 2) for the first time, we see the importance of the baccalaureate degree in nursing, if not for entry into practice, then at least for sustained success in practice. Almost 48 percent of practicing nurses in this country today hold at least a baccalaureate degree in nursing.

Highest Educational Level Achieved over a Lifetime by American Registered Nurses

Finally, looking at the distribution of practicing American nurses with baccalaureate degrees or higher earned over a lifetime by race and ethnic background presents an even more interesting perspective (FIGURE 3). As the National Sample Survey notes, the essential ambiguity of racial and/or ethnic categorization demands caution when interpreting statistics. Still, approximately 47 percent of nurses who identify themselves as white hold at least a baccalaureate degree in nursing as do 53 percent of those reporting African American backgrounds, almost 47 percent of those reporting Hispanic or Latino backgrounds, and 72% of those reporting Asian backgrounds (17-18).

Highest Educational Level Achieved over a Lifetime by American Registered Nurses (by Race and Ethnicity)
What this data means, of course, is a source of sustained debate. Do we celebrate the slow but steady ascendancy of the baccalaureate degree even among those who, for a variety of social, financial, or geographic reasons, had chosen an alternative pathway into nursing practice? Or do we worry that nurses still remain less well educated than colleagues in other health care disciplines? There are no easy answers. But the debate has deep roots in nursing’s history in what the profession has called the “entry into practice” debate.

The Historical Debate

In the opening decades of the twentieth century, at the same moment that medicine was celebrating the conclusions of the Flexner Report, nursing first found itself grappling with issues of education and educational reform. The insatiable demand for student nurses by an ever-increasing number of hospitals had led inexorably to the admission to hospital training schools of almost any willing body regardless of social and educational background (Burgess, 1928). Nursing’s leadership sounded the alarm. Their ostensible language was that of education in the service of the nation’s health (Burgess, 1928; Goldmark, 1923). But their most compelling argument explicitly emphasized the clear slippage of nursing’s educational background relative to that of American women. First the Goldmark Report of 1923 and later the Grading Committee Reports of the later 1920s and the 1930s spelled out the disastrous implications for American’s hard won health care gains if nurses’ educational backgrounds continued to fall behind those of the population at large. “Nursing standards have been rising slowly but steadily,” May Ayres Burgess (1928a), the principle architect of the American Nurses Association Grading Committee’s surveys, acknowledged in a presentation to the American Hospital Association (AHA) in 1928. “But for the general population,” she warned, “they have fairly leaped upward.” Her charted data,
presented to the AHA membership (FIGURE 4), told an important piece of this story: given current trends, the overall educational background of American women would outstrip that of nurses by 1940.

Burgess, 1928: Comparative Distribution of Women and Nurses with High School Degrees (as %)

On the other hand, it does seem historically that the choice of nursing by privileged working class women was a reasonably effective strategy of upward social mobility (Friss, 1994). A number of these women who attended the more prestigious training schools, for example, rose to leadership positions in early twentieth-century American nursing (Bullough, Bullough, and Wu, 1992). More importantly, the markers of learning and culture middle-class women brought to the work of nursing by virtue of their particular place in the social order elevated the status of their working class sisters within their own communities. When one remembers that, historically, “middle class” is as much a sensibility as a social place, one can more easily see how. An identity as a nurse gave these women, often, by virtue of their training, among the more educated of their communities, a socially valued and valuable place as the trusted conveyers of legitimated medical authority (D’Antonio, 1999; D’Antonio, 2007).

This use of a particular kind of work as a means across the class divide was not, of course, unique to nursing. In ways constantly repeated in the history of women and work, where middle-class women went first, working class women soon followed. Domestic service, for example, was initially the domain of young, “middling,” girls, apprenticed to learn the necessary housekeeping skills; immigrant and African-American labor soon followed. Women of “good Yankee stock” first worked the looms of the early American textile mills; poor, working class labor soon
followed. But when immigrant and African American women entered domestic service, “middling” girls fled. When poor and working class women entered the mills, Yankee women abandoned them (Dublin, 1994). Yet, in ways we have yet to fully appreciate but to the profession's credit, middle-class flight did not occur in nursing. Real opportunities for talented and ambitious persons of all classes and races, regardless of gender, as well as stratified patterns education and practice have kept both groups tied tightly together throughout our history.

Still, it must be noted, Burgess was wrong in her overall predictions. Advances in educational opportunities for American women as a whole stalled during the 1930’s as the ravages of the Great Depression took their toll. By 1940, only approximately 28 percent of American women had a high school diploma. But almost 100 percent of all nurses did. State licensing boards ultimately demanded much more stringent educational criteria to certify graduate nurses as able to manage increasingly complicated medical technologies and treatments, and meet constantly changing expectations about effective symptom management and proper medication administration (Reverby, 1987).

Burgess was, however, correct in her prediction that all too soon, even a high school degree would be a meaningless predictor. “In the old days,” she wrote in 1928, “to say that a girl was a high school graduate was the same thing as saying she was far above the rank and file. Today it means she is only slightly above; and very soon it won’t even mean that” (Burgess, 1928a, 276–77). Burgess's dream, and that of other nursing leaders, including those incorporated into the influential Goldmark Report of 1924, was to move the education of some nurses into institutions of higher learning. As nursing leadership requested, and in keeping with the social equation that connected education with middle-class aspirations, the education of future educators, administrators, and
public health nurses did move into colleges and universities. Only 16 programs of higher education in nursing existed in 1916; and there were only 25 in 1926. But by 1936, there were 70 such programs across the country; and by 1945, there were 138. Most were, to be sure, collegiate degrees earned after nurses had completed standardized hospital-based training. But the ultimate result was that, by 1960, white American nurses had moved ahead of white American women in percent with a baccalaureate degree earned over a lifetime, and they have remained ahead to the present time. (FIGURE 5).

Comparative Population Distribution of white Women and Nurses with at Least a Baccalaureate Degree over their Lifetime (as %)

The way was tortuously slow and incremental. Early-twentieth-century nursing leaders found little social support for their battles to improve the educational preparation of all nurses. The educational needs of most nurses, many Americans believed, were reasonably well addressed by the more practical orientation of the training schools owned and operated by hospitals. Networks of wealthy benefactors and philanthropies did provide generous financial and social support for the stunning achievements of the new practice of public health nursing. However, their educational philanthropy centered on the promise women’s colleges held to enhance the lives of middle-class women. And, as significantly, the American middle class tended to agree with these choices. In the economic prosperity of the early twentieth century, relatively secure middle-class families increasingly insisted that their daughters attend college, while the daughters of the social elite generally passed up such
opportunities, and those of working families were almost always passed over (Solomon, 1985, 71).

While the proportion of American nurses who have earned a baccalaureate degree over their lifetime remains strong among white American women through 2000, the increase in the proportion of those reporting different racial and ethnic backgrounds is even more pronounced (FIGURE 6).

**Comparative Population Distribution of Women and Nurses with at Least a Baccalaureate Degree over their Lifetime (as %)**

Because the numbers of women reporting different African American and Hispanic backgrounds who earned baccalaureate degrees in any field over their lifetime remained relatively low prior to the Civil Rights movement of the 1960’s and 1970’s, such early data need to be treated cautiously. But recent data suggest that the current proportion of African American nurses with baccalaureate degrees earned over a lifetime is greater than that of white nurses; and that African American nurses are substantively more educated vis-à-vis their reference community of African American women than white nurses are vis-à-vis their reference community. Forty-eight percent of practicing African American nurses hold at least a baccalaureate degree, as compared to only approximately 17 percent of all African American women.

Similarly, Hispanic and Asian American nurses currently are also substantively more educated vis-à-vis both white nurses and their particular reference communities. Almost 45 percent of practicing Hispanic nurses hold at least a baccalaureate degree in nursing, as
compared to just 11 percent of Hispanic women overall. Slightly more than 60 percent of practicing Asian American nurses hold at least a baccalaureate degree, as compared to 41.7 percent of all Asian American women.

In sum, given the link between class, education, and middle-class community status first forged in nineteenth century America, nurses seem relatively privileged in comparison with other women of their racial and ethnic backgrounds. This perception, I would argue, makes the explicit linkage between scientific knowledge and nursing practice in the service of educational reform particularly problematic: it just does not match social perception. The technologies of health care are, today, moving out of the hospital and into the home, and the transfer of skills from nurses to non-nurse women (still families’ primary caretakers) has intensified, confounding the issue of how much more education all nurses need than those nursing sick family members at home.

But this social perception that nurses are already relatively well-educated rests on quite tenuous footings. As Jerome Lysaught first pointed out in 1973, success in terms of baccalaureate degrees earned over a lifetime for both groups of nurses has come at an enormously high personal, emotional, social, and financial cost to individual nurses (140–41). Moreover, given the numbers of returning students who depend on employer-based tuition assistance, one may be looking at the single largest inefficiency remaining in the restructured American health care system. But even this route to a baccalaureate degree may today be compromised. Recent data suggests that the numbers of nurses receiving employer-based tuition assistance has dropped from a high of 54 percent in 1992 to 39 percent in 2000. (The Registered Nurse Population, March 2000).
More alarmingly, to paraphrase May Ayres Burgess, saying one has a baccalaureate degree in this day and age does not mean much of import. Indeed, when one compares American white nurses and white women using the initial baccalaureate academic degree as a relevant measure (FIGURE 7), it becomes clear that nursing’s status has been slipping since the 1970’s. The slight up tick in 2000 is likely to prove short-lived: more men and women are now enrolling in baccalaureate programs since the federal tax credit passed during the Clinton administration has made college almost the equivalent of a middle-class entitlement (Klein, 2002). As we look to more recent 2003 data we see that the good news is that there has been no change. But the bad news is that: even though the numbers of nurses enrolling in baccalaureate programs have increased since 2000, the numbers of American women enrolling in such programs have increased every bit as much. Nurses have made no gains.

What might all this mean? First, I would suggest: despite the public perception that nursing are better educated that most people of their gender and ethnic background, the perceived social status that draws diverse men and women into the profession is in clear danger of eroding. And second, nurses may be asking the wrong questions in the debate over the best credentials for entry into practice. Rather than wondering if they are doing better or worse in their quest for baccalaureate education, they
might be wondering: why they always scrambling to “catch-up” to relative reference groups? And, why has the burden of playing such “catch-up” been assumed by individual nurses, rather than by the society as a whole? Nurses—regardless of their original educational backgrounds—clearly want more education. Individual by individual, course by course, they return to school and earn their credits toward higher degrees. Some want to learn new ways about caring for their patients; others want to broaden their occupational options; and some others want the sense of accomplishment and prestige a baccalaureate degree brings. State proposals, popularly known as the growing movement for the “BSN IN TEN”—for mandating that all nurses earn a baccalaureate degree within ten years of graduating from diploma or associate degree nursing programs—can be seen as formalizing that which most nurses already want. But how can we increase social and financial support to make such ideals a reality?

History may provide one answer. Certainly, as historians who have studied communities of nurses in countries with more centralized national governments have long argued, interest in and support for nursing’s educational initiatives have often been motivated by reasons that have little to do with ensuring improvements in health care services. In France, for example, the government of the Third Republic promoted reforms in nursing education and practice as part of a policy to diminish the influence of the Roman Catholic Church, in general, and the religious nursing sisterhoods, in particular (Schultheiss, 2001). Likewise, the South African state championed the professionalizing aspirations of nursing as a remarkably effective tool to create a stable, bourgeois middle class that might support the policies of the apartheid government (Marks, 1994).
Thus, within the particularly American, decentralized, state, we may be observing the social role of nursing education in supporting both the class aspirations and the genuine mobility of diverse social groups. We may, in fact, be seeing the role of nursing in the creation of what journalists and sociologists increasingly describe as the “new” middle class of African Americans, Hispanics, and Asian Americans. Unlike most other professions, nursing has provided real opportunities to those seeking upward mobility through socially respected and well-paid work. Nurses have also always been in and of their particularly diverse communities, returning to them in marriage and parenthood, working within them as part of an informal system of health care and service, and ultimately drawing upon them to consistently lead the American public’s list of trusted professionals (D’Antonio, 1999).

But supporting increased educational standards that contribute to social status as well as patient care needs also acknowledges the need for the American state’s political commitment to more opportunity for those without access to substantive material resources. In the end, capitalizing on the social as well as the clinical advantages of baccalaureate education increases the support necessary for nursing to continue a mission of both care for the sick and care for practitioners as diverse as the patients they treat.
References


Burgess, M. A. (1928). *Nurses, patients, and pocketbooks* (New York: Committee on the Grading of Nursing Schools).


