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Reforming nursing registration: Lessons from pandemics

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ABSTRACT

A nimble and flexible regulatory response regarding the nursing workforce is essential to a fully integrated public health approach to national crises and pandemics. The COVID-19 pandemic has drawn many comparisons to the 1918 Flu Pandemic. Some of them are well-reasoned and grounded in evidence. Other are not. This study provides a historically contextualized analysis of how the 1918 flu pandemic helped shape Pennsylvania nursing’s current regulatory apparatus. We conclude that the state-based solutions that nursing registration represents are inadequate to deal with pandemics and crises with national, if not global, reach. We need to move immediately toward the national COMPACT system, while mindful of how regulatory processes and procedures can reinforce structural inequities.

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nursing registration was still new and highly contested both within and outside of the profession. As with medical and other kinds of relatively new registration processes, each state had the statutory authority to regulate work that affected the public’s interest. The newly organized nursing profession, largely led by leading educators, believed that the process of state registration, similar to what medicine had achieved in the late 19th century, would provide the authority, autonomy, and disciplinary oversight about who could practice nursing (Reverby, 1987).

Pennsylvania nursing leaders began their battle for nursing registration in the opening years of the twentieth century. Furious and powerful opposition came from physicians, directors of specialty hospital training schools (including those of insane asylums) who believed the care of patients in their institutions (and their economic bottom line) would be compromised if they could not tailor nurse training to the specific needs of their institution. Many nurses themselves feared they would be disenfranchised. A compromise solution enacted by Pennsylvania in its first nurse registration act in 1909 and reinforced in a 1915 revision, provided for voluntary registration, protection of only the formal title of “registered nurse,” and a physician-controlled enforcement board (West, n.d.).

The 1918 Flu Pandemic in Philadelphia

Philadelphia’s reactive, highly politicized, and, ultimately, disastrous response to the 1918 pandemic has been well-documented. Politically appointed health officials took few preparations before early September 1918, despite the fact that the morbidity and mortality from the flu in Boston and elsewhere in the country was widely publicized. Philadelphia, more crowded than usual because the city’s industrial base and active port made it integral to the war effort, documented hundreds of ill soldiers by the third week in September. The war effort had already depleted the city’s medical readiness, as more than ¼ of Philadelphia’s physicians and 1/3 of its nurses were in the military (Barry, 2004).

The infection quickly overwhelmed the city’s ability to maintain even basic municipal services such as policing, firefighting, garbage collection, and burials of victims. In keeping with the nation’s volunteer tradition, as the flu epidemic worsened dozens of private groups mobilized to supplement health department personnel. The Philadelphia Chapter of the American Red Cross (ARC), in keeping with its disaster management charter, took charge of furnishing supplies, and mobilizing transportation to be used as ambulances (Jones, 2010). The Philadelphia branch of the federal Council on National Defense, created during WWI to oversee civilian resources and industry to support the war effort coordinated the work of dozens of charities, private hospitals, religious groups, and nursing agencies, (Monthly Bulletin, 1918). Both the ARC and the Council also supplied its own trained nurses, nurses’ aides, and volunteers, as did many of the other private groups in the city.

The Council, along with the Philadelphia and Pennsylvania health departments quickly realized a surprising and unintended benefit of nurse registration. As the only central repository of nursing personnel in Pennsylvania, officials had a record of the numbers of registered nurses in the state. In some places these files also contained information about women who had some nurse training who might be mobilized to serve as aides. The Council used this list of registered nurses as a nucleus around which all volunteer flu-related health care delivery in Philadelphia could occur. As a result of this record, nurses could be quickly deployed to emergency infirmaries, public hospitals, the Visiting Nurse Association, or wherever they were needed to provide direct care and supervise volunteers (Emergency Service, 1918). Yet, despite the unfolding catastrophe, Philadelphia’s segregated social and health care system remained intact. Black Philadelphia flu victims were primarily served by the physicians and nurses trained at the small, black owned Douglass Hospital and the newer Mercy Hospital (Gamble, 2010).

Nurse Regulation in the Wake of the 1918 Flu in Pennsylvania

Over succeeding decades, the increasing sophistication of and necessity for nursing skills, judgments, and specialty practices supported revising registration legislation, not just in Pennsylvania, but in most states. While nursing leaders could claim some accomplishments, they failed to advance in other areas and frankly failed to take up some causes. For example, there was no attention to or mention of Black nurses who provided essential care but continued to practice in tightly segregated systems.

Nursing education and licensure, nonetheless, grew more complex after World War II as health care delivery became more bureaucratic and specialized. By 2020, a nurse seeking state registration, now mandatory for all nursing practice, had to graduate from an accredited nursing program meeting robust curricular requirements and pass a rigorous state-administered, exam. An expensive and complicated process of reciprocity governs the ability to practice across states. This was the framework hospitals and health care systems had to work within when they confronted a serious shortage of skilled registered nurses during the initial COVID-19 crisis. The legacy of state-based registration and registration has left specific areas at a loss when local needs overwhelmed rosters of available clinicians.

A national registration system (the Nurse Licensure COMPACT [NLC] mechanism) has been slowly evolving since 2000 (National Council of State Boards of
This system, sponsored by the National Council of State Boards of Nursing, allows a nurse to have one multistate license that can be used among all states that participate in the COMPACT system. But the slowness and voluntary nature of this process points to the challenges of addressing both processes and entrenched privileges in individual states. Pennsylvania is not a COMPACT state. This dependence on hospital systems and communities to meet their own immediate nursing needs creates significant imbalances in national supply and demand issues that have an impact on crises of national proportions.

Nurse registration legislation arose in a specific historical context. The current state-based system in nurse registration is anachronistic, and all efforts should be made to move immediately toward a national system that is already emerging through the regional COMPACT system and the national examination mechanisms (see https://nurse.org/articles/enhanced-compact-multi-state-license-eNLC/). But history also teaches us to be mindful of one enduring fact. As we look deeper into the process of nursing registration, we need to remain vigilant about how these processes and procedures can reinforce rather than breakdown structural inequities.

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