Advances in Nursing Science
Vol. 32, No. 1, pp. 3–18

Defining Nursing Practice
The ANA Social Policy Statement, 1980–1983

Jennifer Lynn Hobbs, PhD, RN

This article examines the initial development of the American Nurses Association's Social Policy Statement (SPS). The methodology used is the Social History of Technology. This approach provided the means to treat the SPS as an information practice or tool that resides within a technological system composed of skills, tools, and knowledge. The data for analysis include archive material and secondary sources. This study concludes that development of the SPS was inherently a local exercise in prioritizing, organizing, and promoting certain skills, tools, and knowledge associated with nursing practice, an exercise that integrated contextual influences with local realities. The study also provides a means to reflect on the development of contemporary information practices. **Key words:** *American Nurses Association*, *history*, *nursing*, *professional organization*, *Social History of Technology*, *Social Policy Statement*

The [American Nurses Association] has historically been responsible for defining nursing.

—American Nurses Association, Board of Directors, December 1987[1(p3)]

NURSING CARE PLANS, classification schemes, admission sheets, datasets, and policy and procedure manuals—all are examples of information practices aimed at placing structure around the complexities of day-to-day patient care. On the surface, these bits and bytes of information seem rather innocuous, but each is inherently a cultural, social, economic, and political entity aimed at reinforcing a particular view of nurses' work. Take, for instance, the subject of this article, the first iteration of the American Nurses Association's (ANA) Social Policy Statement (SPS). The document promoted a specific take on nursing practice that endorsed certain skills and knowledge, while excluding others.

While there were several content areas that garnered significant protest from the ANA's membership, perhaps none was as contested as the definition of nursing practice outlined in the document. The definition declared that nurses treat the symptoms of disease, not the disease itself. These critically important semantics explicated a boundary of nursing practice that was viewed as unduly limiting to some nurses, namely, a growing number of nurse practitioners. The definition disregarded the necessary knowledge of disease and diagnosis integral to current practice conditions and essentially isolated nursing care to symptom management. Moreover, the ANA SPS all but equated the role, and thus the definition of what we now consider advanced practice, with the acquisition of the skill of physical examination.

On the face of it, the SPS may seem like a broad declaration aimed at influencing the

Author Affiliations: *VA San Diego Healthcare System, San Diego, California, and Barbara Bates Center for the Study of the History of Nursing, School of Nursing, University of Pennsylvania, Philadelphia.*

The author thanks Julie Fairman, PhD, RN, Joan Lynaugh, PhD, RN, and Nathan Ensmenger, PhD, for their generous support. This work would not have been possible without the financial support from the VA Pre-Doctoral Nurse Fellowship, the American Association for the History of Nursing, and the Gamma Gamma and Xi Chapters of Sigma Theta Tau International.

Corresponding Author: *Jennifer Lynn Hobbs, PhD, RN, VA San Diego Healthcare System, 3350 La Jolla Village Dr, San Diego, CA 92161 (Jennifer.Hobbs@va.gov).*

whole of the profession. The intent of the document was to issue a statement about nursing's responsibility to the American public, those who use and come in contact with nurses providing a variety of healthcare services. Outlining this responsibility was a significant challenge for the ANA because it entailed summarizing the multitude of roles nurses play, the various educational options, and the profession's and public's beliefs about nurses and the work they do. Furthermore, the ANA's effort was made more difficult by rather rapid and relentless changes in practice that pushed nurses to become more and more specialized. Nurses across the country were taking up a variety of new skills, using different tools and knowledge to adequately meet patients' needs.

However, in a very real sense, the information practice designed by the ANA was a local representation of what a small yet influential group thought about nursing. We can consider the document a situated exercise that integrated contextual influences with local realities. For the ANA, these local realities came in the form of a significant loss in membership that threatened the organization's financial and political viability and was fueled largely by a changing practice environment and specialization of practice. Numerous specialty organizations formed during the time period leading up to the publishing of the SPS, in order to meet the ever-growing educational and support needs of specialist nurses. Thus, despite the organization's national status, issues that arose as the document was created were local and related to the immediate situation faced by the ANA. In other words, the SPS was a document created by ANA members for ANA members, despite the document's larger stated goals of influencing the whole of nursing practice, health policy, and the profession's symbolic relationship with patients.

OVERVIEW

The purpose of this article is to explore how nurses involved in the creation of the ANA SPS prioritized, organized, and promoted certain skills and knowledge associated with nursing practice while excluding others. Moreover, this article seeks to explore if, and if so how, the ANA SPS shaped nursing. The analysis arises from experiences of the ANA members who worked on the SPS, ANA staff, and nurses who responded to the content of the SPS after its initial release. The Social History of Technology (SHOT) is the methodology used to frame this analysis, and the historical evidence is drawn from primary and secondary sources. The University of Wisconsin–Milwaukee provided the bulk of primary source material for this case and was augmented by the Irma Lou Hirsch papers, a collection currently held by the author. In the near future, the Irma Lou Hirsch papers will reside at the Barbara Bates Center for the Study of the History of Nursing at the University of Pennsylvania School of Nursing. This examination reveals that the process of gathering and organizing information incorporates the social, political, cultural, and economic contexts that simultaneously reside within and externally influence nursing.

FRAMEWORK

Before proceeding into the historical case examining the ANA SPS, a brief introduction to the SHOT framework is needed. The SHOT framework offers a unique perspective on the creation and development of information practices like the SPS. SHOT allows for the SPS to be considered a tool—a technology—one that organizes information and provides some sort of structure around a given set of activities.[2] We can think of numerous examples of information practices or tools used in daily practice, like a software program that organizes the collection of admission data or paper forms used to guide blood administration.

However, attempting to analyze blood administration by looking solely at the forms used fails to capture the complexity of the practice of giving blood. The analysis is far too narrow and fails to represent the

intricacy of the process. This is where the SHOT framework provides an approach that encompasses analysis of the skills, tools, and knowledge needed for a given activity.[3] Basically, a tool is not fully understood separately of the skills or knowledge needed to participate in and understand the work at hand. This compilation of skills, tools, and knowledge is the element that comprises a technological system.

We can think of examples of such systems in landscaping, construction, and even in recreational activities like surfing. The skills of a landscaper involve things like pruning and planting. The tools of a construction worker are nails, hammer, and saw. The knowledge of a surfer is illustrated by recognition of surf conditions and choosing the right board for the waves.

The SHOT framework centrally considers the skills, tools, and knowledge associated with a given activity and is ideally suited for a historical analysis of nursing, work that is anchored to the doing of patient care, as much as it is to the thinking and writing about it. For nursing, the technological system is composed of the skills, tools, and knowledge needed for patient care. In using SHOT as a framework, the narrative or story of the SPS is purposefully complicated by considering the document as part of a technological system rather than in isolation. The SPS can then be interpreted through the historical contingencies of practice. This means that through the lens of SHOT and via analysis of the SPS, a very vibrant, messy, technological system emerges—one that is subject to bias, heavily influenced by individual personalities and political will.

As we will see in the pages that follow, when the nurses involved with the SPS made choices about the information to include or leave out, their choices prioritized different aspects of the system, highlighting, if you will, certain skills and knowledge in an effort to promote the ANA's take on what practice was or should be. The ANA attempted to develop this tool in order to shape practice and the work of nurses, but in the end, developed a tool that was useful only to the organization itself.

Contextual Overview

Changes in healthcare during the 1960s, 1970s, and 1980s prompted significant shifts in nursing practice. These changes included an increase in access for specific patient populations, influx of new drugs, and monitoring technologies. Even those elements of nursing care as seemingly basic as bed baths and mattresses were being revamped into strategic interventions aimed at improving various patient issues. Patients, as a result of these new interventions, were surviving previously life-ending illnesses, resulting in altogether different health conditions that were chronic in nature. Patients began to expect access to not just services, but the latest technologies promising cure.

In the decades leading up to the publishing of the SPS, specialized practice was fast becoming a necessity. The introduction of the various technologies mentioned above necessitated the development of specialized skills and knowledge if nurses were to function successfully in this environment. Areas dedicated to specialized practice emerged like critical care and oncology units, and were set up to better support the care delivery required. Nurses learned largely by trial and error the various skills necessary to administer treatments, use monitoring equipment, and intervene when patient conditions warranted.

In addition, in the early 1960s, the role of the nurse practitioner (NP) had emerged in pockets across the country. This new role expanded nursing practice in ways not previously considered. Controversial to some, NPs diagnosed and treated patient problems, often, but not always, in collaboration with physicians. In many instances, these NPs were the only provider available to patients who lived in rural or underserved areas. The NP was often on her own as she determined what treatment was necessary.

For nurses who were practicing as NPs and in the care areas mentioned above, there

was a growing need to share their experiences with each other and find ways to expand their knowledge base. Specialty organizations provided education as well as opportunities to discuss the issues facing nurses in these new roles, whereas the ANA did not.[4] The ANA's dwindling ranks translated into noteworthy financial trouble and resulted in a cyclical problem for the organization.[5] As the ANA attempted to pursue these specialty groups, it drained the budget, and as the budget drained, the organization was less and less able to respond to the emerging needs of its members.

The ANA SPS was in large part a reaction to extensive losses in both the organization's prestige and, more important, membership (revenue) during the 1970s and early 1980s, as practice changes shifted member demands at such a high rate that the organization could not keep pace. The ANA was losing membership to emerging specialty organizations poised to meet the needs of very specific sections of ANA's membership like critical care nurses, nephrology nurses, and oncology nurses, to name a few. These membership blocks were composed of both nurse practitioners and nurses who worked in areas that required specialized skills and knowledge. As each area of specialization grew, the ANA's struggle to maintain responsibility over the scope, standards, and certification of nursing practice intensified. The ANA attempted to regain some semblance of relevancy and control in and over nursing through the SPS and the logical extensions of the statement that included taxonomy development, a revisiting of standards of practice and certification.

THE ANA SOCIAL POLICY STATEMENT, 1980–1984

During the 1978–1980 biennium, the Congress for Nursing Practice, chaired by Norma Lang, appointed the Task Force on the Nature and Scope of Practice—Characteristics of Specialization in Nursing. The ANA board charged the group with developing a definition of nursing practice.[6,7] Lang agreed to oversee this task force as part of her term as chair of the Congress for Nursing Practice, but only under the condition that the document be created, reviewed, and distributed within a year (N. Lang, oral communication, March 21, 2008). Lang stressed the importance of keeping the time limit tight because she felt that if the process were any longer, nurses would never come to a consensus. Moreover, there was a sense of urgency to complete the task by the 1982 convention because there was a pending resolution to consider reorganizing the ANA's structure that would include a division for NPs.[7]

The charge of the task force was first and foremost to develop a definition of the nature and scope of nursing practice that included delineation of the characteristics of specialization.[7] The ANA had evaluated various aspects of specialization because it was under an acute sense of pressure from the American Hospital Association and other groups like the Joint Commission on Accreditation of Hospitals (JCAH), who were concerned over the regulation and management of emerging specialty practice areas—areas like critical care, obstetrics, and neurology.[8,9] These "characteristics"[10] of specialization were things such as determining the educational preparation required for entrance into specialty practice and identifying specific areas for certification. The ANA felt that once these criteria were established, they could then be used to organize the ANA's clinical units and, with application of the definition, support either existing or changes to licensure statutes.

The task force was composed of ANA members who had "[the] ability to think, articulate orally and in writing, listen, [and] compromise, [as well as] previous experience with statement development, and an in-depth understanding of the practice of nursing."[11(p1)] The first meeting, held on January 9, 1980, was attended by 6 ANA members and 1 linguistic consultant.[12] The task force comprised 2 clinicians (NPs), Jean Steel, an NP from the Boston area, and Nina Argondizzo, an NP

from the New York area, and 4 faculty, Norma Lang, dean at the University of Wisconsin–Milwaukee, Kathryn Barnard, from the University of Washington, Hildegard Peplau, retired faculty and former president of ANA, and Maria Phaneuf, from San Diego State University. In addition, Ruth Lewis and Kathryn Goldring were ANA staff who assisted the task force. Each member was asked to prepare a paper prior to the first meeting that addressed definitions of nursing and issues concerning specialization and credentialing.

The task force, under the facilitation of Lang, produced a draft document of the SPS rather quickly. This document was released to ANA staff and division heads, many of whom were not pleased with the initial work completed by the task force. The Division on Community Health Nursing Practice raised concerns about the lack of clinician representation, specifically staff nurses, both in terms of task force membership and in the document in general.[13] Moreover, the division felt that the plan to review the document was limited—one draft and then a final version—without review by ANA constituents.

Despite this early protest in late April 1980, the task force formally released a draft to the structural units, and then in June, during the convention, to members of the ANA.[11] The responses began to come in during late May to both ANA staff member Ruth Lewis and task force chair Norma Lang. The majority of the comments from within the ANA generally focused on the language used in the document. Comments like "too wordy," "too long," "doesn't read well," "lots of rhetoric," and "too general" were common.[14–16] In addition, in light of the language choices in the statement, many wondered who the intended audience was.[17] Was it nurses? Patients? Both? The questions were legitimate. By the committee's own account, stated in the first section of the April draft, the intent of the SPS was to clarify nursing's commitment to patients.[11] Yet, the document was much more reflective of the ANA's current ills such as declining membership brought about by specialization, and little consideration was given to the patients as a potential audience. By the task force's own account, the SPS was intended to "bring coherence to the policies and programs of the association."[11(p1)]

The draft attempted to deal with the issue of specialization in each of its 3 sections. In the first section, The Social Context of Nursing, the task force outlined the content on the interaction between a society and a profession, identified some of the current trends in healthcare spending, summarized nursing's claim to a unique focus on health, and outlined what now was a long-standing call for collaboration with "other health professions,"[11(p1)] a generic reference to physicians. Of the 5 subsections in the SPS, the first 4 reflected the professional centricities of the organization, while the last one addressed the need for exercising authority over nursing practice, the position ANA felt was its role.

The Social Context of Nursing section comprised 4 fairly clear subsections, with the last section, "Authority for Nursing Practice,"[11(p5)] addressing the 5 functions of the ANA. If the task force had stopped at the first 3 functions—establish a code of ethics and standards of clinical practice, establish minimal education standards for entry into practice, and certify clinicians in specialized areas—the remaining portion of the SPS could have gone on to simply outline how these elements supported nursing's social contract to the public.

However, 2 remaining functions were identified. The first, "fostering development of nursing theory, derived from nursing research into those conditions that are the focus of practice, so as to explain and guide nursing actions,"[11(p5)] was a rather odd addition to a document that was largely tasked with representing how nursing served the interests of the public. Such an addition was especially problematic given that the task force failed to include a description of what nursing does for the public, how that is accomplished through educational preparation, and how, through the general regulations proposed earlier in the document, the ANA ensures the public's safety through both ethical and

clinical standards. Task force chair Norma Lang and member Jean Steel recall that this section was something Peplau had wanted in the document (J. Steel, oral communication, March 17, 2008; N. Lang, oral communication, March 21, 2008). Peplau's insistence that theory be included in the discussion was reflective of her own understanding of specialization, an understanding that was based on advanced education in a traditional university setting. This addition supported by the task force later became problematic as the statement made its way to more and more nurses.

The task force defined the final function as "other development work directed toward making more specific nursing's accountability to society."[11(p5)] The vagueness of this last statement left room for interpretation, and in doing so, delineated no clear direction for the organization with regard to its many programs. Apparently, this nondescript approach was intentional; Lang, the chair of the task force, cautioned the group to manage the specificity expressed in the document by being as nondescript as possible in order to avoid further marginalization of the specialty organizations.[18,19] The key here is that "other development work" was to be determined by the ANA, not any other group.

Despite hitting a measurable generic approach that was intended to satisfy internal expectations, the draft did not contain elements that many individuals within the organization anticipated. Connie Holleran, Director of ANA's Government Relations, in a memo forwarded to the task force, expressed her concern over the focus on providers rather than on outlining what nurses do for patients in the form of increased access to healthcare, affordability, and individualized services.[20] She was also concerned over the lack of recognition of the specialties and how these expert nurses were being equated to "special interest groups," something she thought was "problematic" (Holleran was referring to page 12 of the draft SPS). For Holleran, whose work responsibilities extended to lobbying and other forms of influence on policy matters, identifying what services were available and being provided by particular types of nurses was paramount. Designating the specialties as "interest groups" had the potential to lessen her ability to lobby effectively, primarily because the ANA was a political interest group itself. The designation of "interest group" split the membership into even smaller sections, thus lessening the lobbying power, part of Holleran's job at the ANA. Compounding this difficulty, she commented about her "[constant] embarrassment by the lack of specific information in this area."[20] Holleran essentially had no data to illustrate the extent of specialization or what it accomplished, and therefore found it difficult to answer legislative inquiries or develop coherent political strategies.

Unfortunately, the type of political challenges the ANA was concerned with were largely internal ones. In a memo, Francis Waddle, coordinator of the Ethical and Legal Aspects of Nursing Practice Council, raised objections to portions of the statement that equated specialization with advanced education above the associate and diploma level. Waddle was concerned because many nurses' self-selected specialization through informal routes such as job affiliation rather than through formal education.[15] The issue was raised because many of the core constituencies of the ANA were staff nurses, some of whom were in the very jobs Waddle described, and the statement might alienate them. The ANA could not risk upsetting this group, for even though the SPS was about specialization, the bread and butter of their membership—the financial solvency of the organization—was tied to the staff nurse.[4]

No changes were made to the draft version of the SPS that was then presented at the ANA convention held June 8 to 13, 1980, in Houston, Texas. Chairperson Lang presented this first and only draft of the SPS to the House of Delegates.[6] After the presentation, Elaine Beletz of New York drew attention to the ANA's Model Nurse Practice Act and suggested that ANA stop publication and dissemination of the SPS.[21] Beletz believed that

the definition of practice used in the SPS unnecessarily hindered the pursuit of legislation that would be free of unwarranted supervision by physicians. The initial definition offered in the SPS draft limited nurses' treatment of patients to "human responses to actual or potential health problems,"[11(p6)] rather than diseases. This was a major issue for many of the NPs who were pursuing changes in their state nurse practice act that would allow them to diagnose, and logically, they looked to their professional organization for assistance and support. Chairperson Lang assured Beletz and other nurses concerned about practice legislation that the Congress would consider these concerns, but offered no specific changes to the SPS.

At the convention, Lang had requested that conference attendees submit written comments on the SPS, and these came in during the weeks and months to follow. Many of the nurses cited dissatisfaction with the time crunch to provide feedback to the task force; all comments were to be received by the end of July, just 6 weeks after the SPS initial introduction, if they were to be given any consideration before production of the final version of the document.[22] Just as the ANA staff had commented on the language during the internal review, so too did the general membership. Jane Ulsafer of Rush Presbyterian Medical Center urged "clear writing and direct wording."[23] The Professional Advisory Committee of the Association of Operating Room Nurses objected to the language choices, which they described as confusing, and stressed the need to specify various terms.[24] Shirley Bird, another delegate, also emphasized the need to clarify terminology, especially in the document's third section, which addressed specialization.[25]

The third section of the draft, Specialization in Nursing Practice, discussed the role and functions of "specialists in nursing practice."[11(p10)] Because this designation was given only to nurses who had graduate education, the section seemed to directly challenge staff nurses in specialized roles and was interpreted as such. Many of the attendees voiced their concern that delineating the definition of specialist and anchoring it to a degree would alienate staff nurses in critical care and similar areas. Kathryn Hall from the University of Maryland Hospital and chairperson of the Clinical Nurse Specialists Group questioned how the task force was going to "differentiate nurses who are specialized but do not hold master's degrees, from those who do [hold master's degrees]."[26] Catherine Dodd, Alternate Commissioner, Region 12, California Nurses Association (CNA), concurred with Hall. Dodd was concerned with how, for example, intensive care nurses would fit into this outline of specialized practice, as "they don't need [an] MSN."[14] Rosemary Dale, a nurse administrator in Vermont, circulated the SPS to her assistant head nurses, head nurses, and clinical coordinators (managers), all of whom responded by pointing out that specialization was not necessarily tied to advanced education.[27] This debate was the result of task force member Hildegard Paplau's views on specialization, and in particular, her belief that an advanced education should provide the only means for nurses to specialize (Jean Steel, oral communication, March 17, 2008).

However reflective these comments were of the content of the SPS, they represented concerns about the document from nurses who were not NPs, who in many ways were the target audience of the SPS. While the ANA was certainly troubled by the general effects of specialization, it saw the role of NPs and organizations that represented these nurses as politically powerful and therefore more threatening. The NP was a central focus of the ANA's definition of specialization that was tied to a new, politically powerful constituency that the ANA was quickly losing, if it had not already lost. Unfortunately for the ANA, NPs also responded unfavorably to the draft SPS.

The second section, The Nature and Scope of Nursing Practice, received the most criticism from a variety of nurses involved with the NP movement. Mary Crane, a family NP who had attended the forum in Houston,

reiterated her criticisms in a memo to task force chair Norma Lang.[28] She objected to the way in which section 2 equated the acquisition of the skill of physical assessment with achievement of the role of NP. So did the members of the CNA, Catherine Dodd, Marilyn Chow, and Jo Anne Powell; Margaret Hicks and Barbara Dunn of the National Association of Pediatric Nurse Associates and Practitioners (NAPNAP); and Ernestine Kotthoff, chairperson, Council of Primary Health Care Nurse Practitioners.[14,22,29,30] All thought that the skills of assessment alone did not make an NP. The role represented a compilation of skills and knowledge and a willingness to cooperate and negotiate with physicians about how specific responsibilities were shared.

This went along with the task force's coopting of the term "nurse practitioner"[11(p8)] and defining it as the title for all professional nurses. This was a throw back to pre-1965 when any nurse who practiced was labeled as such. This was a poor decision made by the task force because the context of when, where, and by whom the term was used had changed. It had a different, commonly understood connection to this new type of nurse. *Professional nurses* were defined in the SPS draft as any nurse possessing at least a baccalaureate degree. Kartthoff urged the task force not to say that all professional nurses were NPs.[30] However, Margaret Hicks and Barbara Dunn of NAPNAP voiced the strongest objection, arguing that "the term nurse practitioner is not now and will not be 'recognized as an appropriate designation for all professional nurses.' "[22]

NAPNAP was displeased with the ANA, the task force, and the document. In its letter to Lang dated July 9, 1980, the group questioned the assumption that the "ANA alone should and does speak for all of nursing."[22] The group stressed that the SPS document was not one born out of "political feasibility."[22] NAPNAP was referring to the limited number of individuals able to contribute to the document, the short time span allotted for submitting feedback, and the task force's failure to invite other groups such as NAPNAP to contribute. It went further, stating that the ANA's lack of cooperation and the disregard to the "customary [need] to gain support by involving those groups in initial development of the policy . . . is apparent in the draft."[22] The group concluded with the following statement: "NAPNAP believes others who would be affected by and expected to implement this policy should have been involved."[22] As you might expect, NAPNAP and the ANA had, by 1980, what could be considered a long-standing adversarial relationship, particularly over the issue of who spoke for nursing.[4]

Soon after the Houston meeting, Jean Steel, a task force member and an NP, had already started to rewrite, in its entirety, the section on the NP. Steel sent it to Lang in early July, along with her comments on the section. She stressed that the "[nurse practitioner] movement was accomplished by expanding [the nurse practitioner's] assessment skills and then implementing, by the use of guidelines, . . . care. The scope of [the nurse practitioner is] more appropriately defined by patient care responsibilities."[31]

The task force received comments on the draft that largely centered around 2 issues. The first issue was that the authors of the SPS equated specialization with the NP movement. The NP's role required unique skills and knowledge, but that role alone did not make up the totality of the specialization trend in healthcare, which extended to many care areas necessitating refined and focused nursing care. For example, medical-surgical units required a different set of skills and knowledge than did critical care, but not necessarily the skills and knowledge of an NP. The second category of responses focused on the ANA's assertion that the acquisition of the skill of physical assessment defined the NP role. However, for the ANA's purposes, differentiation between the staff nurse role and the NP role had to be based on something. Assessment was a logical choice because the changes occurring in practice demanded that nurses execute the skill and because the ANA was equating acquisition of the skill with specialization. Specialization of nursing work

by skill type and level was similar to what was occurring in medicine.[32] It is unclear whether this differentiation represented the ANA's fundamental lack of understanding of the changes occurring in the practice of the staff nurse or whether such a definition was merely an expedient, although misdirected, way to define the NP's role. Despite the possible motives, the task force conveyed a lack of understanding of practice specialization in general, and the role of NPs in particular.

REVISION OF THE SPS

The task force took many of the comments into consideration as it proceeded to revise the document in the remaining 5 months of 1980. The end result was a 32-page, single-spaced booklet outlining nursing's relationship with the public. The introduction, less 1 paragraph, was new. The changes to this section were reasonable, as the draft explained the process of generating the statement and outlined the statement's purpose. Interestingly, the introduction contained a paragraph that stated the following: "Attempts to . . . delimit nursing more clearly . . . would have been potentially harmful."[33] This insertion was likely included in response to the critique the task force received over the definition of nursing practice. Moreover, the task force recognized the care needed in defining nursing practice, for if it stated the scope of practice for some nurses such as NPs, the ANA could be seen as directly challenging medical practice. So, the task force sought to strike a general tone with its descriptions, rather than specifically identify each and every aspect of nursing practice.

The document's first section, titled "The Social Context of Nursing," remained virtually the same. The task force added to the second section, The Nature and Scope of Nursing Practice, extensive new material detailing the nursing process, complete with diagrams and illustrations detailing the interaction between nursing theory, nursing process, and standards of practice. It was here that the task force made some of the more controversial changes. Although the group had received feedback about the definition of nursing practice, the definition was virtually unchanged.[33] However, the group added a paragraph that aimed to explain the definition, a section that would come to be known as paragraph 1, page 10. The explanation stated clearly and overtly that nurses did not treat diseases. So, despite intentions not to unduly limit nursing practice, the ANA declared that nursing practice did not include the treatment of disease, something NPs performed on a daily basis.

In the third section, Specialization in Nursing Practice, the task force removed the term *NP*, opting instead to label all nurses with advanced skills and knowledge as *specialists*. It retained the ideas surrounding the need for specialists in nursing to have advanced education, either a master's or a doctorate, but conceded the point that nurses with less education also specialized. In addition, the section on certification was clarified, and the need for both types of specialists to seek out ANA certification was identified.

RELEASE AND DISSEMINATION OF THE SPS, 1981–1982

The Congress of Nursing Practice unanimously approved the SPS, and in January of 1981, the SPS was released to the ANA's constituents. Of all the changes, the item that would prove to be most troubling for the ANA was, once again, the definition of nursing and accompanying descriptions. The SPS provided a definition of nursing stating that "nursing is the diagnosis and treatment of human responses to actual or potential health problems."[33(p9)] This definition was credited to the New York State Nurses Association, and the language was part of the Nurse Practice Act of New York passed in 1972.[33] The document went on to say that

> nursing addresses itself to a wide range of health-related responses observed in sick and well persons. Those responses can be reactions to an actual problem, such as a disease, or they can anticipate a potential health problem. Nurses

diagnose and treat these responses—not the health problems themselves.[33(p10)]

It was the last sentence that garnered the most criticism of the ANA from individual NPs and organizations representing NPs.

Letters of protest poured in to the ANA from all over the country. Kay Ortman, writing in on behalf of the Oregon Nurse Practitioner Group, and Mickey Knutson, president, National Organization of Nurse Practitioner Faculties, both leaders in the nursing world, charged the ANA with being unsupportive of NPs.[34,35] Knutson went so far as to accuse the ANA of limiting the practice of nursing and harming the practice of NPs by failing to legitimize their scope. She was particularly upset about the lack of acknowledgment of nurses' ability to "diagnosis and [treat] . . . disease."[35] Knutson went on to say that the SPS's "omission of the curative practices within nursing is evident."[35] Virginia Henderson also added her comments at the ANA's Council on Nurse Practitioners meeting in San Diego: "Diagnose and treat. I don't know why we don't just come out and say it."[36]

Ruth Benson, an NP from Fairbanks, Alaska, wrote the following in a memo to task force chair Lang: "I love all of the gobble-le-gook [*sic*], but what in tarnations does it mean?"[37] She concluded with the following statement: "We counsel clients to buy iron pills and eat more vegetables, . . . , we advise 20 minutes of exercise, . . . , we instruct soaks and elastic bandage wraps, when we prescribe limited caloric diets, bulk formers, and stool softeners, nasal decongestants, and increased fluid intake, many times we are assisting clients in their treatment of health PROBLEMS—not 'human reactions' to those problems!"[37]

The gobbledygook Benson was referring to was the language used by the task force to describe what it is that nurses do or act upon on behalf of the patient. Here is where the group authoring the SPS chose not to take the advice given in responses to the draft. Instead of cleaning up the jargon-laden language, it added to it. For example, "human responses to actual or potential health problems" was further defined as "any observable manifestation, need, condition, concern, event, dilemma, difficulty, occurrence, or fact that can be described . . . and is within the target area of nursing practice"[33(p9)] The problem Benson had with the wording of the SPS was that it simply did not capture the work of nurses. The result was a final version of the SPS that managed to include even more confusing language than the draft. Many nurses, including Signe S. Cooper, once again urged Lang to condense the final document and remove the obtuse wording.[38] Cooper worried that the language would be a barrier to any nurse who might use the document as the basis for policy changes. Moreover, the length of the SPS, a total of 30 single-spaced pages, was too long to be useful for public consumption.

In light of the charge to the task force, Lang, the task force chair, felt it was necessary to strike a careful balance between overstating the role of some nurses and understating the role of others (N. Lang, oral communication, March 21, 2008). Moreover, Lang knew that this statement, no matter what it contained, could not satisfy everyone. It was a careful document, aimed at appeasing numerous groups of nurses experiencing changes in their practice.

However, the document seemed to create more dissension and division. The National Intravenous Therapy Association sent the SPS task force a letter describing its members' concerns with the document.[39] Eli Studebaker, writing on behalf of their board of directors, noted that they "did not accept the [final] draft of the document"[39] (many of the nurses writing in referred to the initial publication of the final documents; this was largely because many had not seen the draft). The ANA had maintained that the purpose of the SPS was to clarify for itself the issue of specialization and its effect on nursing practice. Studebaker questioned the ANA motive, asking, "If the intent was to address clinical specialties why were no specialty organizations included?"[39] Studebaker followed this fair, albeit rhetorical, question by citing his objection to the ANA "taking upon itself

to speak on behalf of the entire nursing profession."[39]

In fall of 1981, just 9 months after its release, the Congress was forced to reconsider its definition and descriptions of nursing practice, particularly the line "nurses diagnose and treat these responses—not the health problems themselves."[33(p10)] The Congress for Nursing Practice decided to delete the sentence from the SPS, but not without some hesitation.[40] Apprehension about the ANA's ability to both "achieve professional consensus" around the SPS and raise "awareness, understanding, and acceptance of the SPS on the part of NPs" was at issue.[40] Its thinking was that if the ANA was to "control nursing practice in the workplace, [they] needed to define what the ANA is organizing practicing nurses to practice."[40]

The position the ANA took on the purpose and goals of the SPS was too little, too late. Many of the NP organizations had established their own certifications, scope, and program accreditation standards. Essentially, these organizations had defined how nurses were practicing, largely because their membership was made up of practicing nurses. As shown earlier, the ANA and this statement, in a very real sense, simply reaffirmed what the ANA thought about the work of nurses rather than reflecting the actual work. It was an information practice designed by the ANA, for the ANA.

IMPLEMENTATION OF THE SPS, 1982–1984

Under the Congress for Nursing Practice, the Task Force on Implementation of the SPS was formed in early 1982 and charged with the continued dissemination and enforcement of the ANA's new policy. The implementation plan was multifaceted, directed at many of the ANA's constituency, and "centered around the need for the profession to establish territorial prerogatives."[41] Again, this reflected the ANA's need to play a part in these changes in practice, to have some relevance in light of the changes or face further financial and membership losses. The Congress for Nursing Practice believed that, in order to set up these territories, the Congress and other parts of the ANA needed to institute control over nursing practice. This management was redefined by the group as "control of quality assurance of practice, state licensure, certification, and standards."[41] The ANA viewed its 5-year master plan for implementing all the policies in the SPS as the key to this success.[41,42]

The area where the Congress for Nursing Practice and the SPS Implementation Task Force believed they had opportunity to exert greater influence over nurses was in the dissemination and acceptance of the SPS. One of the strategies employed by Lang, who was now the chair of the Implementation Task Force, was to solicit support from a number of fairly well-known educators in nursing. She began requesting letters from individuals such as Margretta Styles, dean of the School of Nursing University of California, San Francisco; Donna Diers, dean of the Yale School of Nursing; Luther Christman, dean of Rush University School of Nursing; and Vernice Furgeson, director of VA Nursing.[43–46]

For the most part, those Lang approached gave their support, but this was an odd strategy from the start. The discord caused by many of the statements in the SPS had to do with the fact that specialty organizations and nurses who were practicing NPs were not included in the creation of the SPS, nor did they feel that their interests were represented by it. Now, as the ANA attempted to disseminate the SPS to practicing nurses, the organization was soliciting support from nurses removed from practice to help sell the SPS to the very nurses who felt excluded by the elitist tone of the document. This misstep reinforced the growing disapproval of the ANA and its practices and did little to stem the tide of criticism of the SPS.

Lang's request for support was part of the 5-year master plan that included gaining support for the SPS in nursing education so that the next generation of nurses would come to accept the document. Under the category

of nursing education, one of the draft versions of the strategies directed educators to "determine where and how in undergraduate curriculum to teach [the SPS]."[47] Chairperson Lang reacted to this portion of the draft, noting to Hirsch that the bullet point was "too strong!" and that it seemed to "usurp faculty prerogatives."[47] This careful treatment of faculty by the task force, compared with the treatment of staff nurses and NPs, was astonishing. "Help practicing nurses understand nursing"[47] was one of the stated goals of the SPS implementation, a statement that met with little concern from the task force despite its condescending tone.

With regard to NPs, the Implementation Task Force took a very different approach from the one used with nurse faculty. In a report to the Cabinet on Nursing Practice (formally known as the Congress for Nursing Practice), the task force illuminated ANA's stance on specialization:

> Up to a point, diversity is a constructive response to social change and increased professional capabilities. The diverse groups in nursing, however, must remind themselves or be reminded of their common mission, roots, and responsibilities. The sometimes contentious groups within nursing can be compared to tribes within a species. Tribes that deny the species do so at their own peril; the denial impairs the evolution of the species.[48(p7)]

The report went on to address the role of NP:

> Such adaptations in local practice are at best a collaboration between nursing and medicine toward possible increase in effectiveness and efficiency in the provision of health care. To incorporate local adaptations as a medical part of the larger whole of professional nursing through nurse practice acts is obviously illogical. It also connotes some substitution of nursing for medical practice and interprofessional competition, none of which are in the best interests of the public or in the interests of the evolution of either profession. For nursing in particular, it diverts energy that should be used in developing the potentials of nursing practice and of nursing as a national health resource.[48(p8)]

These statements, along with the accompanying document *Definition of Terms: Further Elaboration of Terms in the Social Policy Statement,* were not well received.[49] The Georgia Nurses Association commented in a memo to the ANA that the strategy, "promotion of unity," identified by the Implementation Task Force was unclear at best, and that the "comparison of infighting to tribes" was unhelpful.[50] Donna Nativio, a University of Pittsburg School of Nursing professor, wrote a letter to Jean Steel, one of the members of the Cabinet on Nursing Practice, in which Nativio voiced her frustration regarding the ANA's apparent stance. She was responding to the following line in the report: "The reimbursement objective should not be payment for nursing performance of medical acts."[48] Nativio felt that the SPS "chastised [the] work of some nurses for expanding their scope of practice."[51] She also felt that the "language [was] offensive."[51] Linnie Toney, a family NP and member of the Kentucky Nurses Association, also criticized the ANA, saying that she was "opposed to denying nurses reimbursement for medical acts" and found it to be a "grave injustice to deny [nurse practitioners] this reimbursement."[52]

Another letter, this one from Em Olivia Bevis and Charlene Hanson, directors of the Family Nurse Practitioner Program at Georgia Southern University, urged the Council to send the SPS back to committee for "massive revisions."[53] The two felt the SPS, in its current form, would "serve to further divide nursing."[53] They stressed the need for the ANA to have a "structure that supports those whose roles blur with others—for out of this role blurring develops new roles for nursing."[53] Both also thought that "equating specialty groups to species, species that need to be quiet"[53] was offensive.

Even within the ANA, there was a growing dissatisfaction with the SPS. Martha Garcia, chairperson of the Cabinet on Economic and General Welfare, in a memo to the Implementation Task Force, logged the cabinet's dissatisfaction with the implementation strategies, particularly the portion of the publication meant to "help practicing nurses understand nursing."[54] Maria Phaneuf, one of the authors

of the SPS, also called for dramatic changes in the document. She had long pushed for a more progressive, inclusive stance on the NP's role and better treatment of the staff nurse within the SPS.[55] The Kentucky Nurses Association reiterated their objections to the poor treatment of staff nurses or "technical nurses"[56] as they were referred to in the SPS. Donna Nativio also commented that the language "referring to nurses without a BSN [as] less than professional [was] elite, and frightening."[51]

CONCLUSION

First and foremost, the SPS is reflective of a particular view of nursing practice. The SPS provides a historical case study in which primarily academics developed an information practice. The members of the SPS task force included in the document skills and knowledge that they viewed as important according to their largely academic backgrounds. In a very real sense, these choices represented either a need to separate nursing from medicine (nurses assess patients rather than conduct physical examinations and nurses treat human responses to disease, not the disease itself) or a need to represent nurses' decisions as scholarly in nature (nurses make decisions that are based on theory rather than practical experience). We can understand why the group made such choices when we consider that it was composed of individuals who were invested in promoting the profession as one whose base was academic in nature and distinct from medicine.

In addition, the SPS delineated what the ANA and its leadership believed was its rightful role in American nursing—to define what nursing practice is and is not. The ANA SPS was in large part an attempt to exert control over the changes occurring in practice by offering a definition of nursing that organized the skills, tools, and knowledge of the current practice environment according to what was valued by the members of the task force. It did so by promoting the issues of importance to the organization at the time, like educational preparation and specialty certification. In projecting a definition of nursing that was contrary to the practice experience of many NPs, and overreaching to nurses still constrained by medical hegemony, the ANA ended up reinforcing the problems the organization faced and further alienating its membership. The SPS serves as an example of the ANA's continued resistance to acknowledging NPs and, at the same time, highlighted the role's influence on the practice environment. Moreover, it highlighted the flawed assumption on the part of the ANA that the organization alone owned the right to, and was therefore responsible for, defining nursing practice.

Ultimately, what this case illustrates is that disagreements over content of the SPS were less about the information itself and more about a belief in the power of information to shape practice. Paradoxically, the ANA SPS did not change the work of clinicians; instead, it reinforced existing programs and perspectives of the ANA. Many of the nurses involved in the creation of the SPS were removed from practice, and the exclusion of practicing nurses meant that the information practice itself did not reflect the current priorities of nurses' work. Their attempt was largely unsuccessful because they ignored the needs of those who delivered nursing care and would ultimately decide the success of the SPS.

In considering how this historical case can inform present-day issues surrounding the development of information practices, think about the makeup of individuals who developed the tool. The composition of the group determined who would benefit most from the information practice and where it would likely be applied. Moreover, we can also see that the perspective taken on the skills, tools, and knowledge needed for patient care championed a particular view of nursing practice. Restated, who is involved in creating an information practice matters as much as what is created. Moreover, the perspective we hold about practice if not tempered by those who do, teach, research, and organize nursing can lead to privileging one view over another.

REFERENCES

1. ANA, Board of Directors. Minutes, December 1987. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
2. Hobbs JL. *Naming Power: A Historical Analysis of Clinical Information Systems, 1970–1990.* Philadelphia, PA: University of Pennsylvania; 2008.
3. McGaw J. Women and the history of American technology. *Signs.* 1982;7:798–828.
4. Fairman J. *Making Room in the Clinic*. New Jersey: Rutgers University Press; 2008.
5. Report from A. Young and Company to ANA Board of Directors, dated December 27, 1973. San Diego, CA: Private Collection, Author. L. Freitas Papers.
6. Report from the Congress for Nursing Practice to the ANA House of Delegates, dated 1978–1980. San Diego, CA: Private Collection, Author. Irma Lou Hirsch Papers.
7. Minutes, Congress for Nursing Practice, American Nurses Association, November 7–8, 1978. San Diego, CA: Private Collection, Author. Irma Lou Hirsch Papers.
8. Summary of Responses From Hospital Associations on Licensure and Mandatory Continuing Education, Fall 1977. San Diego, CA: Private Collection, Author. Irma Lou Hirsch Papers.
9. American Hospital Association, Special Committee on Continued Competence of Health Care Professionals. Minutes, January 13, 1978. San Diego, CA: Private Collection, Author. Irma Lou Hirsch Papers.
10. Definitions and Descriptions of Credentialing Mechanisms Affecting Nursing, July 26, 1978. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
11. ANA. Draft Report. *The Nature and Scope of Nursing Practice and Characteristics of Specialization: A Social Policy Statement*. Kansas City, MO: Author; April 1980.
12. Letter from Barbara Nichols, President ANA to Divisions of Practice, dated November 30, 1980. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
13. Letter from Executive Committee Division on Community Health Nursing Practice to Norma Lang, Chairperson, Congress for Nursing Practice, dated February 22, 1980. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
14. Letter from Catherine Dodd, Alternate Commissioner Region 12, California Nurses Association (CNA) to Norma Lang, Chairperson Congress for Nursing Practice, dated July 8, 1980. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
15. Letter from Francis Waddle, Coordinator, Ethical and Legal Aspects of Nursing Practice to Ruth Lewis, Director, Nursing Practice Department, dated May 12, 1980. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
16. Letter from Margaret Ann Quan, Secretary, ANA to Norma Lang, dated June 1980. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
17. Letter from Clinton DeWitt to Norma Lang, dated 1980. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
18. Notes, Norma Lang SPS Draft Communication, estimated date February 1980. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
19. Letter from Ida Orlando Pelletier to Norma Lang, dated May 23, 1980. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
20. Letter from Connie Holleran, Director, Government Relations Division to Ruth Lewis, Director, Nursing Practice Department, dated May 14, 1980. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
21. American Nurses Association, House of Delegates. Draft Proceedings, 1978–1980. San Diego: Private Collection, Author. Irma Lou Hirsch Papers.
22. Letter from Margaret Hicks, President, National Association of Pediatric Nurse Associates and Practitioners (NAPNAP) and Barbra Dunn, Executive Director, NAPNAP to Norma Lang, Chairperson, Task Force on the Nature and Scope of Nursing Practice data, dated July 9, 1980. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
23. Letter from Jane Ulsafer-Van Lanen, Associate Chairperson, Department of Psychiatric Nursing, Rush-Presbyterian Medical Center to Norma Lang, dated June 17, 1980. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
24. Letter from Professional Advisory Committee, Association of Operating Room Nurses, Inc., to Norma Lang, dated July 18, 1980. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
25. Letter from Shirley Bird, College of Nursing, University of Tennessee to Norma Lang, dated June 27, 1980. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.

26. Letter from Kathryn Hall, Chairperson, Clinical Specialist Group, University of Maryland Hospital to Norma Lang, Chairperson, Congress for Nursing Practice, dated July 10, 1980. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
27. Letter from Rosemary Dale, Administrator Nursing Services, Medical Center Hospital of Vermont to Hildegard Peplau, dated June 27, 1980. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
28. Letter from Mary Crane, Family Nurse Practitioner to Norma Lang, dated June 25, 1980. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
29. Letter from Jo Ann Powell to Marilyn Chow, dated June 24, 1980. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
30. Letter from Ernestine Kotthoff, Chairperson, Council of Primary Health Care Practitioners, Denver Colorado to Norma Lang, dated July 1, 1980. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
31. Letter from Jean Steel, Primary Care Graduate Training Program, Boston City Hospital to Norma Lang, dated July 8, 1980. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
32. Stevens, R. *American Medicine and the Public Interest.* San Francisco, CA: University of California Press; 1998.
33. ANA. *Nursing: A Social Policy Statement.* Kansas City, MO: Author; 1980.
34. Letter from Kay Ortman, Oregon Nurse Practitioner Group to Norma Lang, dated March 1981. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
35. Letter from Mickey Knutson, President National Organization of Nurse Practitioner Faculties to Norma Lang, dated April 5, 1981. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
36. Note from Jean Steel to Norma Lang, dated January 29, 1981. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
37. Letter from Ruth Benson to Norma Lang, dated September 4, 1981. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
38. Letter from Signe S. Cooper to Norma Lang, dated November 28, 1981. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
39. Letter from Eli Studebaker, National Intravenous Therapy Association, Inc., to Norma Lang, dated September 13, 1981. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
40. ANA, Congress for Nursing Practice. Minutes, February 13–16, 1982. San Diego, CA: Private Collection, Author. Irma Lou Hirsch Papers.
41. Worksheet for Defining and Implementing Policies on Professional Practice, 1980. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
42. ANA, Taxonomy Task Force. Minutes, January 5th & 6th, 1982. San Diego, CA: Private Collection, Author. Irma Lou Hirsch Papers.
43. Letter from Norma Lang to Margretta Styles, Dean, University of California San Francisco, dated December 13, 1982. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
44. Letter from Norma Lang to Donna Diers, Dean Yale School of Nursing, dated January 3, 1983. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
45. Letter from Norma Lang to Luther Christman, Dean, Rush University, dated January 15, 1983. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
46. Letter from Norma Lang to Vernice Furgeson, Director of VA Nursing Service, dated January 10, 1983. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
47. Draft, Implementation of Nursing: A Social Policy Statement, September 2, 1982. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
48. Report from the Task Force on Implementation of Nursing: A Social Policy Statement to Cabinet on Nursing Practice, dated January 1984. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
49. Letter from Hildegard Peplau to Jean Steel, Marjory Gordon, Marlene Ventura, and Irma Lou Hirsch, dated December 6, 1983. Enclosure, Draft, Definition of Terms: Further Elaboration of Terms in The Social Policy Statement. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
50. Letter from Georgia Nurses' Association to ANA, dated June 14, 1984. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
51. Letter from Donna Nativio, University of Pittsburg to Jean Steel, dated June 23, 1984. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
52. Letter from Linnie Toney Family Nurse Practitioner, Kentucky Nurses Association Member to Jean Steel,

dated June 19, 1984. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
53. Letter from Em Olivia Bevis and Charlene Hanson, Directors, Family Nurse Practitioner Program, Georgia Southern University to Implementation Task Force, dated June 11, 1984. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
54. Letter from Martha Garcia, Chairperson, Cabinet on Economic and General Welfare to Norma Lang, dated June 24, 1984. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
55. Letter from Maria Phaneuf to Irma Lou Hirsch, dated April 13, 1984. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.
56. Letter from Board of Directors, Kentucky Nurses' Association, dated June 17, 1984. Milwaukee, WI: Manuscript Collection, University of Wisconsin–Milwaukee. Norma Lang Papers, unprocessed.