A Historical Review of Nurse–Physician Bedside Rounding

How the nurse's role in this hospital practice has evolved.

ABSTRACT: The purpose of this article is to describe and analyze nurse involvement in hospital bedside rounding from 1873 to 1973. Interdisciplinary rounding is touted as a collaborative activity between nurses and physicians. Understanding the historical trends in nurse involvement in this process can shed light on the opportunities and barriers that clinical rounding presents today. This research was gathered using historical sources, both primary and secondary, and a social history framework. Primary sources included manuals for head nurses, nursing journals, and nursing student diaries.

Keywords: bedside rounding, interdisciplinary health care, nurse–physician collaboration, nursing history

In 1913, Dorothea Gothson, RN, expressed her opinion about challenges nurses faced in making bedside rounds with physicians[1]:

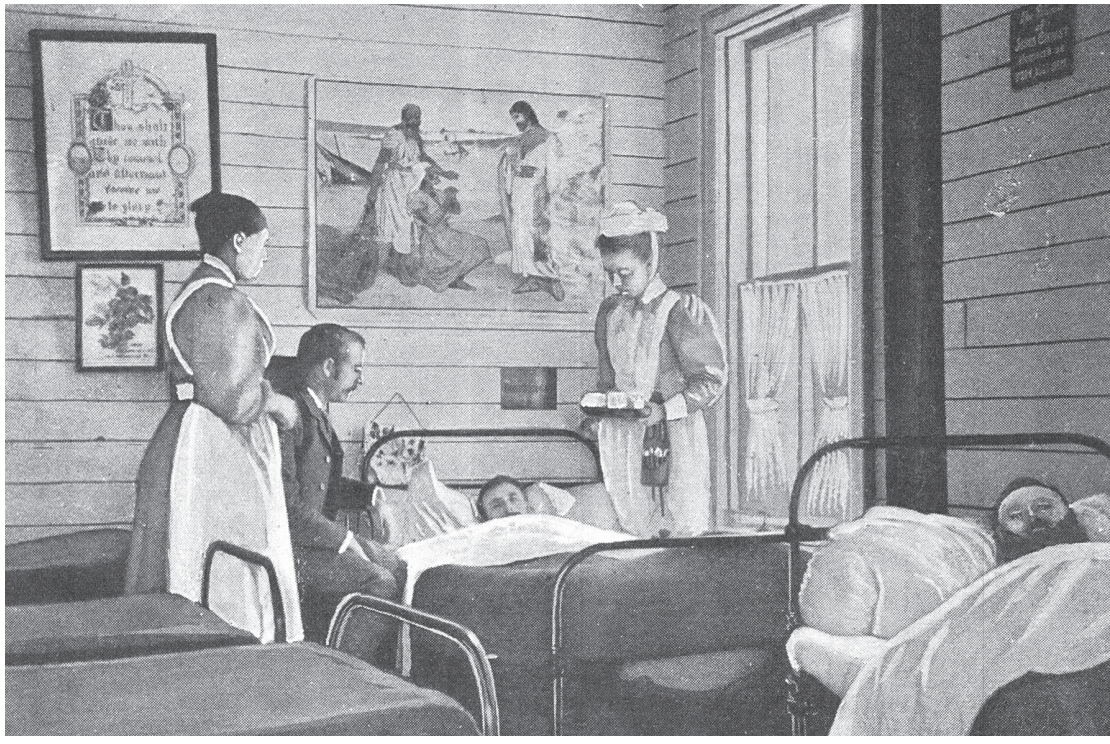
> The most important fact about the work at our hospital is that we are given a chance to be ready for the daily rounds and dressings. We know when the chief is coming, and we can adjust our work accordingly. There is nothing more distressing to either patient or the earnest hardworking nurse than to be surprised by the attending doctors. . . . Equally annoying is the experience of patients and nurses being ready, waiting for the doctors, and their not appearing for one or two hours after the appointed time—perhaps not at all—thus upsetting the order of the hospital.

Her problems were not unique. Throughout much of nursing history, nurses were expected to adapt their schedules to accommodate physicians' needs when making bedside rounds. Today, as we strive toward interdisciplinary collaboration and away from a hierarchical health care structure, it's important to understand how nurses' perceptions of bedside rounding and their involvement in that process have evolved over the past century and a half to allow nurses to redefine the role they play in bedside rounding and achieve a more collaborative approach.

BACKGROUND AND SOURCES

The purpose of this analysis is to describe the nature and historical context of nurse involvement in bedside rounding from 1873 to 1973, thereby illuminating some of the challenges nurses and physicians face in implementing constructive, collaborative bedside rounding practices today. Using historical sources, both primary and secondary, and a social history framework, this article addresses the following questions as they relate to various periods within this 100-year span:

- In what capacity did nurses participate in bedside rounding?
- What were the perceived goals of rounding?



A photograph of bedside rounds in a "cheery, cosey-looking ward," as it appeared in the September 1903 issue of *AJN*.

- What was the perceived role of the nurse?
- What conditions or circumstances promoted or impeded nurse participation in bedside rounding?

Primary sources included manuals for head nurses and nursing journals of the various eras, with the *American Journal of Nursing* (*AJN*), the world's oldest nursing journal, serving as a major source of nurse commentary on bedside rounding. *AJN* has the most continuous and comprehensive archive in U.S. nursing literature, as most other U.S. nursing journals weren't launched until the second half of the 20th century. In accordance with norms of the time, the terms *she* and *her* were mainly used to reference nurses during this 100-year period, as nursing was—and largely remains—a predominantly female profession.

The history of bedside rounding. Medical education has long depended on bedside rounding. This tradition of teaching medical students on the units formed the basis of medical students' education and was a source of pride for distinguished physicians. Sir William Osler, a renowned physician at Johns Hopkins School of Medicine in the late 19th and early 20th century, remarked, "I taught medical students in the wards, as I regard this as by far the most useful and important work I have been called upon to do."[2] While it's easy to understand that the medical education of physicians is rooted in rounding practices, the connection between bedside rounding and nursing practice is best understood within the context of early hospital units and the makeup of the nursing staff during the late 19th and early 20th centuries.

THE ERA OF OBEDIENCE

With the development of nursing schools in the United States after 1873, many hospitals relied on nursing students as a primary labor force. In fact, it was widely accepted that nurse "training schools" provided cheap labor to meet patient care needs.[3] With the exception of head nurses and a few operating room nurses, most graduate nurses left hospitals for work as private duty nurses—a trend that continued until the early 1930s.[4] The head nurse helped define the training experience of nursing students.[3] That training was rooted in strict rules and a military-like discipline, which would be embraced by many in the nursing profession well into the 20th century.[5] As an early popular nursing textbook explained, "The organization and discipline of the hospital resembles that of the army. The so-called military discipline may be criticised or by some condemned, but it must continue to hold sway, for the reason that in a hospital as in war *human life is at stake*."[6] The text goes on to stress the

importance of "unquestioning obedience to superiors." Central to nursing education was a culture of deference toward physicians[6]:

> To the doctor should be accorded the respect due a superior officer. Absolute loyalty must be given him, whether the nurse has confidence in him or not. She must not, by word or look, reveal to the patient any animosity which she may feel toward him or his methods; she may have misjudged him, and have reason later to change her mind. Whatever her personal opinion, it is not within the province of a nurse to criticize a doctor's ability or lack of it.
>
> The nurse should stand while speaking with a doctor or taking an order from him. She should follow, not precede him. She should not state to him her opinions, nor should she make remarks unless requested.

The culture of obedience greatly influenced the way nurses viewed their role in physicians' bedside rounding practices. In some respects, however, the military analogy allowed nurses to feel as though they had a higher status in the hospital structure[7]:

> The physician was the commander, and the nurses were the lieutenants. But the analogy of the trained nurse as lieutenant also implied a significant amount of power. . . . She would . . . have the knowledge and the training . . . to take effective and immediate charge in the chaotic moments of the unexpected crises and emergencies that occurred in the absence of the physician commander.

The military analogy with its strict hierarchy and protocols inevitably affected both nurse-to-nurse and nurse-to-physician communication. Head nurses expected nurses in lower positions to demonstrate a deference in communicating with them. Similarly, nurses were not expected to question physician orders.

BEDSIDE ROUNDS AND NURSING EDUCATION

In the early 1900s, hospitals functioned as training sites, with bedside rounds serving as educational activities for nursing students and new nurses. Head nurses took responsibility for students' overall nursing education, as well as the delivery of patient care, and making rounds with physicians provided nursing students an additional learning opportunity. In 1923, Mary Power discussed this method of clinical instruction in *AJN*[8]:

> [L]et the pupils individually make rounds throughout the whole visit with the chief and his staff accompanied by the [nursing] supervisor. Make [the nursing student] responsible for all questions by the chief. He may object to this at first but, as a rule, when he comes to know [the] object [of the head nurse] he will not only agree to it but will include [the nursing student] in his instruction. The pupil in this way not only gets the actual knowledge transferred but catches the spirit of a great physician.

THE HEAD NURSE'S ROLE IN BEDSIDE ROUNDS

From its inception, the head nurse's role was to accompany physicians during rounds, documenting new orders and notes about patient care. Bedside rounds were seen as part of the routinized system. Patients themselves recognized the different roles physicians and nurses played. As one patient noted[9]:

> The doctor, his assistant, and the head nurse go the rounds together just after breakfast. There is a certain order of procedure which is, I believe, invariable. The doctor raps, enters, shakes hands with the patient, sits down; the nurse stands at the foot of the bed, instruction book and pencil in hand.

While the head nurse's role on rounds was primarily supportive in nature, it was an important part of her job and was not to be interrupted. The following account describing a student's hesitancy at interrupting rounds, even for what could have been a critical change in a patient's vital signs, demonstrates the importance head nurses placed on their involvement in bedside rounds[10]:

> One morning a patient had just come down from the operating room. I thought her pulse was bad. The head nurse was having rounds with the doctors. I knew she'd be through in 10 minutes. . . . The last time I called her from rounds for what I thought was important, she scared me most to death, telling me never to do it again. I just couldn't decide. So I waited. The patient didn't die, but I got sent to the front office.

During the early decades of the 20th century, head nurses were determined to receive the professional respect and recognition they deserved, which meant dedicating themselves solely to the physicians during rounds. From her position of power within the hospital, the head nurse focused with military discipline on obedience and streamlined efficiency.

As late as 1962, head nurses saw medical rounds as an opportunity for the nurse "to gain insight into the thinking of the medical group relative to the patient's care and prognosis."[11] But while the role of the head nurse in the mid-20th century had developed

well beyond its humble origins, many head nurses still considered medical rounds a forum in which they could observe and learn, but not necessarily engage in the discussion of care planning.

NURSE PARTICIPATION IN BEDSIDE ROUNDS

A major part of nurse participation in bedside rounds involved preparing for the physicians' arrival under the direction of the head nurse. As one *AJN* author noted in 1923[12]:

> If the students have a time limit within which all beds must be made, in order that the ward may be swept before the time for rounds for physicians, the result will be clean, orderly wards and dignified medical and surgical rounds when all attention is focused on patients.

The nursing students' role was thus largely ceremonial. They were meant to set the stage for rounds, take notes, provide assistance, and answer any questions posed by the physician, not offer opinions or question his judgments. However, despite the outwardly subservient position nurses held in the hospital hierarchy, by some accounts, nurses and the nursing profession were gaining respect in the eyes of physicians. In one of his classic *Aequanimitas* addresses, William Osler described the nursing profession as having once been "unsettled and ill-defined," noting that it "took, under Florence Nightingale—ever blessed be her name—its modern position."[2] He later described nurses as "one of the greatest blessings of humanity, taking a place beside the physician and the priest, and not inferior to either in her mission."[2]

> With the increasing demands made on the head nurse, one woman can no longer be held responsible for the proper maintenance and upkeep of supplies and equipment and for nursing service on her ward. . . . [T]he time has arrived for assistant head nurses . . . one to administer and lend her cooperation to the frequent demands and "rounds" of the medical staff, the other should supervise nursing care and instruction of the patients.

Nursing was coming into its own as a profession, but an increasingly complex health care system made new demands on nurses.

BEDSIDE ROUNDS AND STAFFING ISSUES

During the early 20th century, nurses often made their own bedside rounds to ensure that all patients were receiving excellent care. Not only did head nurses make rounds when coming onto their shifts, but they also made rounds throughout the day for the purpose of clinical instruction. As nurses spent more time meeting the needs of physicians and medical students, often serving as chaperones during patient examinations, it became increasingly difficult for them to complete their own work in addition to the work the physicians expected of them. In her 1933 *AJN* article, "Nursing and Medical Education: A Study on the Disposition of Nursing Time with Reference to Medical Education," an RN named Blanche Pfefferkorn spoke out about the unrealistic demands imposed on nurses, given physician expectations, insufficiently sized nursing staffs, and erratic scheduling of teaching clinics[14]:

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THE BUREAUCRATIZATION OF NURSING

An increasing professionalism in nursing created a need for more bureaucracy. As the role of head nurse became more clearly defined over the first two decades of the 20th century, head nurses and hospital administrators called for support from assistant head nurses. In 1931, Marian Rottman expressed her concerns[13]:

> To adjust nursing service needs to meet medical education needs, and at the same time to maintain good nursing standards, becomes practically impossible unless an *adequate staff* of nurses is provided, and clinics are scheduled in advance and carried out *according to schedule*.

Medical students and staff often visited the units during the morning, the busiest time of day for nursing services. As increasing numbers of medical students joined the hospital ranks, nurses had to be constantly vigilant of their activities in order to ensure patient safety.[14]

THE SHIFT FROM PRIVATE DUTY TO HOSPITAL NURSING

Hospital nursing underwent significant turbulence in the years following the onset of the Great Depression in late 1929. As work opportunities in private duty nursing dwindled in the early 1930s, graduate nurses increasingly sought employment in hospitals.[4] Hospital administrators found they could employ experienced graduate nurses who "could manage the care of several patients, serve as head nurses on the wards, or care for the most seriously ill patients" for lower wages.[4]

The introduction of nursing aides also changed the hierarchy and power dynamics on the units.[3] With the majority of nursing work performed or supervised by graduate nurses, rather than by students, the role of the nurse on the hospital unit was primed for a change.

EFFECTS OF WARTIME STAFF REDUCTIONS

World War II brought many challenges to the nursing profession, both in the military and on the home front. Hospitals, newly accustomed to employing graduate nurses, had to adjust to staff reductions as large numbers of nurses left the hospitals for military service. Some hospitals were forced to close units, even though the beds were needed. A 1944 article in *AJN* highlighted steps taken by one American hospital to adjust to wartime pressures: "We are living from day to day doing what we can to facilitate and improve the nursing service."[15] Some of the steps taken included adjusting salaries, reducing lengths of shifts, changing clinical teaching procedures, and adjusting policies for clinical procedures. As hospitals significantly reduced the number of general staff nurses and increased their reliance on nursing students, large numbers of RNs moved away from the patient's bedside and turned instead to taking on supervisory roles with aides and LPNs (see Figure 1[15]).

Cooperation from the medical staff eased the adjustment to wartime pressures for nurses. With the reduction in the numbers of graduate nurses and increased demands on nurses' time, physicians often conducted rounds without nurses.[15] In an attempt to improve efficiency, nursing participation in rounds gradually diminished during the 1940s. Later in the century, nurses would find it difficult to resume their involvement in that process.

POSTWAR MOVES TOWARD INTERPROFESSIONAL COLLABORATION

After the war, a thinly stretched and overburdened nursing workforce began to show signs of stress. With many nurses returning to their roles as homemakers and a growing discontent among nurses over nursing duties, those who remained advocates for the profession rallied for stronger nurse–administrative and nurse–physician relationships. Nursing leader Marguerite Manfreda wrote[16]:

PROFESSIONAL NURSING AND AUXILIARY NURSING PERSONNEL

	1941 DECEMBER	1942 DECEMBER	1944 APRIL
General staff nurses	176	92*	74
Student nurses assigned to hospital wards, exclusive of preclinicals	79	92	169
Postgraduate students	0	10	8
Licenced practical nurses	45	53	42
Ward secretaries	10	14	16
Paid aides	53	35	32
Orderlies and male attendants	36	15	13
Red Cross nurse's aides	0	73	104
Men volunteers	0	10	78
Women volunteers	83†	251	320†

* 137 per cent turnover in 1942.
† Estimated.

Figure 1. Staffing changes in a U.S. hospital, December 1941–April 1944. Reprinted from the June 1944 issue of *AJN*.[15]

We must recognize the staff nurse as a truly professional person and we must strengthen the interrelationship between the physician and nurse. . . . I honestly believe that, because staff nurses have been thwarted in their attempts to achieve satisfaction of their innermost needs, they have become frustrated in their work and desire to escape from it.

In an attempt to improve efficiency, nursing participation in rounds gradually diminished during the 1940s. Later in the century, nurses would find it difficult to resume their involvement in that process.

Historically, head nurses had accompanied physicians during bedside rounds. In the late 1940s, however, staff nurses were clamoring for a higher status on hospital units and a return to greater interaction with their physician colleagues. Some nurse leaders advocated for a reorganization, in which RNs would assume direct responsibility for patients rather than reporting to a head nurse. In a 1947 *AJN* article, Constance White outlined the "group nursing" model, which had been introduced at a New Orleans infirmary[17]:

> Each nurse is directly responsible for the care of her three patients. This means that she has direct contact with the patient's physician, can discuss the patient's care with him, accompany him on his rounds, and receive his orders directly. . . . [T]here is time for the nurse to give quality nursing to each patient, with the resulting satisfaction and pride that come with the knowledge of work well done.

Nurse–physician collaborative efforts were described by Marguerite Manfreda as mutually beneficial. To "have the responsibility of discussing these patients with the physician, making rounds with him, and in general working *with* him to provide the best care for the patient" was seen as a way to increase the nurses' status.[16] According to Manfreda, "[T]he physician would come to know the real value and contribution of staff nurses, and the patient, in turn, would have higher regard for them."[16] While much nursing discontent at the time surrounded salary and hours, advocates like Manfreda argued that recognition as a professional nurse was the only way to produce a generation of satisfied nurses.

EFFECTS OF SEX-BASED STEREOTYPES

While roles for women were changing rapidly in the postwar United States, most of the nursing workforce was still primarily female, while physicians were typically male. In fact, nearly 98% of the nursing workforce was female in 1950.[18] Meanwhile nurses were beginning to question their role in relation to the physician. Writing in *AJN* in 1947, one nursing student made her position clear[19]:

> The respect given doctors has been overdone. In the first place, it's unnatural to treat a fellow worker like a god. Courtesy is desirable at all times, but . . .[w]hy should busy nurses have to attend doctors routinely on the floor? During the war in one hospital, the doctors were told to request a nurse if they needed one to help with an examination. If they were just making rounds . . . the nurse was not expected to accompany them. Someplace along the way a compromise must be made.

By the middle of the 20th century, it was apparent that working conditions needed to improve for the nursing profession to attract the type of workers it needed. This idea laid the groundwork for recognizing the contribution of nurses as valuable members of the health care team.

THE HEAD NURSE: A LINK BETWEEN NURSE AND PHYSICIAN

By the mid-1950s, the head nurse had resumed her early 20th-century role as the link between hospital physicians and nursing staff. In 1954, Helen Graves explained the importance of the head nurse's role[20]:

> When she makes rounds with the doctors, she has an opportunity to learn about the medical plan of care and how it is to be carried out. She is often called upon to interpret the plan

> to the patient or reinforce the plan. In turn she is expected to interpret to the doctor the patient's problems, as the nursing staff have noted them, and thus help the doctor to develop better medical care plans.

Nurses were aware that communication with physicians was critical to good patient care and that information obtained on rounds allowed the head nurse to make administrative adjustments for the staff she supervised.[21]

TEAMWORK FOR BETTER QUALITY CARE

The growing focus on improving patient education provided new opportunities for nurses to participate in rounds. In 1953, Virginia Streeter interviewed nurses to determine which factors they felt inhibited effective patient teaching. According to Streeter, "[A]lmost all nurses interviewed expressed difficulty in teaching because they did not know what the doctor wanted taught."[22] Patient rounds were seen as an opportunity to increase nurse–physician communication, even if it was a one-way process, with the physician speaking and the nurse listening. At the very least, such teamwork helped nurses gain clarity on the most appropriate educational content to impart to patients.

In the 1950s, it was becoming increasingly clear that interdisciplinary rounds promoted interdisciplinary teamwork.

With rapid medical advancements and a growing ancillary workforce, nurses began to understand and accept that "team nursing" might be the best means of providing quality patient care.[23] Using this approach, the unit staff at some nursing schools began to assemble themselves into teams of nurses, ancillary staff members, and nursing students. Senior nursing students served as "team leaders."[24] One "nursing intern" remarked on her participation in the clinical rounds[24]:

> Making rounds with the doctors helped me to understand the plan of care for the patients, and I learned what to teach the patients, and consequently I was better prepared to do an effective job. I found the patients more receptive to my teaching, too, since they were aware that I knew exactly what the doctor wanted them to do.

While her account reveals the hierarchical hospital structure in which nurses were viewed as nonautonomous caregivers, it also demonstrates that nurses and physicians participating in the rounding process together could improve patient care.

In the 1950s, nurses invited social workers to join the team. It was becoming increasingly clear that interdisciplinary rounds promoted interdisciplinary teamwork. Writing in *AJN* in 1955, Minna Field, a social worker, noted[25]:

> Where the group making medical-social rounds includes the nurse as well as the physician and social worker, these members of the three professional groups are seen by the patient as a team, all of whom are equally concerned with his progress. Problems which are upsetting to the patient can be aired, a joint evaluation of these problems achieved, and the necessary steps taken to mitigate them.

As Field explained, integration of all disciplinary perspectives was necessary to achieve comprehensive patient care[25]:

> If the team approach is to accomplish what it is designed to do, it must be based on a give-and-take relationship among the members of these groups who have an understanding of each other's function and specialized skills as well as respect for each other's competence. As our skills in the use of such relationships increase and as we gain better understanding of each other's roles we will be able to work together with ever-increasing effectiveness, utilizing to the fullest the contribution each profession can make toward the ultimate goal of teamwork—the patient's welfare.

A NEWFOUND RESPECT FOR NURSING

By the 1960s, nursing had carved out its place in the world of modern health care alongside other health care disciplines. In 1970, the American Medical Association (AMA) released a position statement acknowledging the significance of nursing as a primary component in the delivery of health care, recognizing that nurses had taken on additional responsibilities and technical procedures formerly carried out by physicians and noting that increased administrative demands on nurses were disruptive to the nurse–physician relationship[26]:

> The AMA supports the additional concept that the professional nurse should share authority with the physician. The nurse contributes to

> management decisions in patient care, carries out those decisions in the nurse's sphere of competence, takes responsibility and authority for nursing care of the patient, and makes decisions in the nursing aspects of the patient's care within the overall patient-care context agreed upon. The nurse, therefore, can take a logical place at the physician's side when associated with him in patient-care responsibilities.

Ironically, there are suggestions that the newfound respect for the nursing profession may have reduced the participation of nurses in rounds. A 1971 editorial by Thelma Schorr in *AJN* offers insight into the status of nurse–physician bedside rounds at the time.[27] Schorr advocated for collaborative nurse–physician rounds and expressed concern that the workforce had moved too far away from the tradition[27]:

> Making rounds with the attendings. It's been a long time since we've heard that eminently useful activity mentioned unself-consciously. We suspect that there is a whole generation of young nurses and physicians who never had the opportunity to go on rounds with the head nurse and the attending physician, to stop with them at every patient's bedside, to hear them discuss, evaluate, and revise his care and treatment *together*, without worrying too much about professional boundaries. If ever there was an opportunity for collaborative thinking for the patient's good, making rounds together provided it.

Schorr went on to discuss the challenges of making interdisciplinary rounds, noting that there were physicians who ignored nurses, interns, and even patients for that matter. She also pointed out that there were nurses who exercise "the power of their negative martyrdom" and called for moving on from this stance[27]:

> It's time we stop pandering to their weaknesses and start serving our own strengths. If the intellectual energy that has been spent deploring the handmaiden attitude and pleading for collaborative *status* were put into collaborative *effort*, the health care system might not be in the sorry state it is today.

After discussing the risks of confining nurses to an inflexible system of standing orders and dependent functioning, Schorr went on to advocate for rounds: "Collaborative rounds, we submit, inside or outside the hospital, is a way of safeguarding against that risk. A doctor knows best about some things, but the nurse knows better about others. The patient deserves the kind of collaboration that assures him the best of both disciplines."[27]

Schorr's statements indicate that, with the increased emphasis after World War II on nursing as a profession, nurses may have avoided participating in traditions, such as rounding, that harked back to the notion that nurses were assistants to physicians. Schorr indicated that nurses needed to redefine their role in the bedside rounding process if they were to provide excellent care to their patients and work to the full potential of their professional role. Her insights on rounding, and those of others representing nursing leadership in years past, may help us shape a more collaborative, interdisciplinary rounding process going forward.

BEDSIDE ROUNDING: 21ST-CENTURY CHALLENGES

Nurse–physician collaboration in patient care and delivery underwent several transformations over the course of the 19th and 20th centuries, the examination of which may offer insight into the challenges still encountered during bedside rounding. While the American health care system has evolved into one that incorporates an interdisciplinary team approach, remnants of its patriarchal, rigidly hierarchical roots may still be seen in the relationship between physicians and nurses and in the increasingly outdated images of physicians as predominantly male and nurses as inevitably female. With nurses historically put in a subordinate position to physicians, efforts to promote collaboration often present challenges.

Today, however, there is a pervasive call for increased interdisciplinary collaboration at the bedside as a means of improving quality and safety in patient care.[28,29] Analyses of the Joint Commission's Sentinel Event database have consistently shown that "[i]nadequate communication between care providers or between care providers and patients/families is consistently the main root cause of sentinel events."[30] Health care leadership and practitioners are thus challenged to improve communication among providers, which requires them to identify the impediments to quality communication.

Nonhierarchical, collaborative rounding, in contrast to the physician-centric rounding of the past, may be a way to promote clear communication, increased collaboration, and improved quality of care. It has been shown to reduce mortality, medication errors, hospital length of stay, and hospital costs; improve staff and patient satisfaction; expand the health care team's understanding of the patient's plan of care; and increase both efficiency and perceptions of patient safety.[28,31,32]

With a tradition so steeped in physician education and lingering sex-based stereotypes, it's easy to see why nurse participation in bedside rounding may have been perceived by some as reinforcing regressive role identities. Understanding the historical and

existing barriers to effective collaboration and communication in the rounding process is a critical first step to implementing progressive reform. ▼

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Genevieve Beaird is a clinical assistant professor and a PhD student at Virginia Commonwealth University School of Nursing, Richmond. *The author gratefully acknowledges Arlene Keeling, PhD, RN, FAAN, for her editorial assistance.* *Contact author: gbeaird@vcu.edu.* *The author and planners have disclosed no potential conflicts of interest, financial or otherwise.*

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