



# Historically-Informed Nursing: The Untapped Potential of History in Nursing Education

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## Historically-Informed Nursing: The Untapped Potential of History in Nursing Education

### Cover Page Footnote

This article is based on a short PowerPoint presentation the author created at the request of the American Association for the History of Nursing for members' use, available at <https://www.resourcenter.net/images/AAHN/Files/2013/AAHNWhyHistoryMatters08212013.pptx>  
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*Learning from nursing history is critical to advancing the profession in the interests of the Canadian public. Knowledge of nursing history socializes new nurses into the profession and encourages different forms of critical thinking among nurses.*

Canadian Nurses Association (2007)

Historical amnesia is dangerous (Nelson, 2009). In an essay describing the importance of history and how it can enrich nursing scholarship and student learning, Nelson argues that memory is necessary: “We need to know who we are if we have any hope of knowing where we are going” (p. 787). For much of the twentieth century, nursing history was a core component of nursing education. However, nursing history has all but disappeared from the curriculum (Toman & Thifault, 2012). Indeed, a 2004 Canadian survey revealed that there were no dedicated undergraduate courses on nursing history in Canada (Toman & Thibault, 2012). In an effort to prepare nurses for a rapidly evolving health care system, nursing educators emphasize the value of new, evidence-informed knowledge—specifically in the form of literature published within the previous five years. Our focus on the “cutting edge” has effectively, if inadvertently, severed nursing from its roots. As a result, we have become disconnected from the richness embedded in our nursing past—a history that spans four centuries in Canada. In this paper, I make a case for historically informed nursing as an area of untapped potential in nursing education. Framing the topic around the headings “History as Innovation,” “History as Education,” “History as Evidence,” and “History as Explanation”, I explain why history matters and why now is a perfect time for nurse educators to take advantage of what nursing history has to offer.

### **History As innovation: Not your mother’s history**

It was almost a generation ago that nursing history disappeared from nursing curricula. Previous to that, history was understood as a premier way to acculturate new nurses into the profession. The four-volume history by Adelaide Nutting and Lavinia Dock (1907–1912) had been a staple for decades after it was first published. Widely acknowledged as an enormous undertaking, the books aim to provide students with a comprehensive understanding of the profession. Like subsequent works published during the first wave of nursing history (pre-1970), the Nutting and Dock series trace the evolution of nursing systems from the earliest times through the development of training schools, emphasizing the rise of the professional nursing associations and the “grand dames” who provided significant leadership during key events or periods. Students graduated with a fairly clear sense of who the main players were in the development of nursing, and how nursing evolved over the years. They viewed themselves as the newest members of a long-standing profession. Today, whether they realize it or not, nurses enter a profession with long-standing traditions, values, and public expectations. Knowing their history equips students to endorse, embrace, critique, or change those traditions, values, and expectations.

While the reason for the decline of nursing history in Canadian curricula has not been carefully researched, it may have been influenced by the shift in nursing education from hospitals (where graduates acknowledged and celebrated historical milestones and leaders) to colleges and universities (where focus was less on tradition and more on nursing theory and the emerging field of nursing science). Another reason—albeit a less openly discussed one—for the decline of nursing history in curricula is that students and educators found it, simply, boring. As Cutler (2014) notes in the context of teaching high school history, for over 100 years “history has

been taught as little more than a callous exercise in regurgitation and rote memorization... This is no way to make learning about the past relevant and engaging. It never really was” (2014). For nursing educators reared on educational approaches to history that required memorization of key persons, dates, and events, nursing history may well have been viewed as both tedious and dispensable.

Ironically, by the time nursing educators had closed the books on nursing history in favour of alternate forms of nursing knowledge, women’s historians were discovering its richness. The first wave of nursing history emphasized nursing leaders who established associations (Bates, Dodd, & Rousseau, 2005). The second wave includes the lives and experiences of ordinary nurses and the events and social structures that helped shape nursing into what it is today (Toman & Stuart, 2004). Among the earliest Canadian historians to take up nursing history, Strong Boag (1991) argues that the history of nursing was changing both women’s history and the history of Canada itself (p. 231). She notes that while traditional histories, written by nurses, testified to the significance of women’s contributions, new histories were illuminating the class and racial/ethnic character of nursing’s past and “pointed to the ways that patriarchy restricted nurses options.” (p. 231). Similarly, Kathryn McPherson (1996a) identified ways in which gender, race, and class shaped Canadian nursing. Historians brought different methodological tools to the study of nursing history, from women’s history, labour history, and sociology (D’Antonio, Fairman, & Whelan, 2013). They “sought out answers to innovative questions and mined new sources of evidence for insights,” bringing nursing history “out of narrow disciplinary perspectives of institutions and people and into a broader historical world that placed their actors within the context of social and political imperatives.” (p. 1).

The succeeding years have seen an impressive range of work, with nurses, historians, and archivists working closely together to better understand the context in which nurses work. Indeed, access to history has never been easier. The online availability of digital archive collections and scholarly publications gives learners unprecedented opportunities to pursue historical questions and identify historical echoes in contemporary practice. As Myrick and Pepin (2016) argue, nursing educators must harness the potential of ubiquitous digital technologies “by effectively expanding and intensifying our understanding of technology and pedagogical tools” (p. 1). Ironically, new technologies can be a great boon for the teaching and learning of nursing history, as illustrated further below.

In my experience, a good starting point for engaging students in nursing history is to arrange for a visit to a local archive—ideally a hospital archive—where their task is to identify photos or other artifacts of interest and write up a comprehensive description of their date and use. There is something about seeing and, preferably, touching old instruments, photos, and documents that triggers a sense of connection (“nurses 50 years ago touched this!”), curiosity (“what is *this*?!”), and surprise (“boy, they were racist back then, right?”). This was my introduction to nursing history; I still recall the thrill of “discovering” a cache of original documents signed by nurses from almost a century ago, running my fingers along the same pages these women had touched, imagining the place and reason for their writing.

Students can also be assigned treasure hunts with the aim of becoming more aware of public nursing history. In Lethbridge, Alberta, students could go, in the same day, to the gravesite of an early indigenous nurse, the statue of a nursing sister embedded in a city hall pillar, and an institution named after Edith Cavell—their task being to go to the address as provided, take selfies with their group and the site, and explain the historical angle of the site. In

Vancouver, British Columbia, students can be directed to nursing sisters portrayed as gargoyles and in stained glass windows. And in the Parliament Building Centre Block in Ottawa, after reviewing McPherson's excellent article on the subject (McPherson, 1996b), students can visit the Canadian Nurses Association War Memorial, a low-relief sculpture of nursing sisters unveiled in 1926. Carved in a single, 6-ton piece of white Italian marble, this impressive monument just outside of the Parliamentary Library is viewed by thousands of tourists, yet nurses (and, as I discovered, tour guides) know little about it.

Hospitals often have historical photos of earlier nursing classes hanging on the walls or nursing instruments under display cases. If you're lucky, there may be hospital or nursing archives nearby, as there are in Vancouver: the VGH nursing archives and UBC nursing archives. Even if it is not an archive specific to nursing, nursing does have a way of showing up in regular archives. The UBC Koerner archives and Wellwood library have the fascinating files of Ethel Johns. The College of Registered Nurses of BC has an oral history project comprised of dozens of interviews freely available to interested nurses. An intriguing letter or mysterious photo is all it takes for nursing students to become captivated.

Having seen artifacts up close, students can also be assigned an online treasure hunt, where they search out anything they can find on nursing from a list of digital archive sites. Some excellent examples are the Glenbow Museum (nursing photographs), Museum of Health Care at Kingston (nursing artifacts), BC History of Nursing Society's Archives, Canadian Museum of History's Canadian Nursing History College Online, and the Nursing History Digitization Project. In addition, photos of letters handwritten by Nightingale, for example, are freely accessible through archives as varied as the Florence Nightingale Museum, the University of British Columbia, the University of Chicago, and the University of Kansas. Access to digital copies of nursing documents, photos, films, and equipment is essential to a nursing history revolution.

### **History as education: Shaking up our thinking**

The Canadian Association for Schools of Nursing's (CASN) *National Nursing Education Framework* (2015) identifies history as an essential component of baccalaureate education: "The program prepares the students to demonstrate foundational knowledge of nursing, including nursing history" (p. 10). One way to help students engage with history is to emphasize the "story" part of history. The compelling nature of historical stories can be seen by the success of the British television series *Call the Midwife*. Telling nursing stories, and telling them well, gives students insight into and an appreciation for the work of ordinary women and men. In a similar way, histories focusing on mental health nurses (Boschma, 2012), African nurses (Mann Wall, 2015), Filipino nurses (Choy, 2003), and missionary nurses (Grypma, 2008, 2012a) emphasize the experience and voice of ordinary nurses. For instructors and learners alike who are new to nursing history, stories are an effective and interesting entry point.

CASN, by including nursing history as an essential component of undergraduate nursing education, builds on the recognition that a good education in nursing does more than impart knowledge and hone skills. It helps to shape identity and thinking. Done well, nursing education also provides a safe space for students to explore sensitive topics, and history is uniquely positioned to help us to do this well.

Knowledge of our history shapes our identity. Corfield (2008) notes that all people are living histories. They speak languages inherited from the past, live in cultures created over time,

and use technologies they have not invented. History, she argues, is essential for “rooting” people in time. I suggest that for nurses, just as with families, knowing the character, values, priorities, and reputation of our forebears helps us to understand ourselves better. Knowing how nurses in the past responded to hardship or success, for example, helps us to understand expectations put on members of the profession, and provides a clear starting point for discussions about how (or whether) nurses should live up to expectations. As Sioban Nelson (2009) notes, history has a role in the ongoing development of individuals, groups, nations, and generations.

Whether we are aware of the details or not, Nelson writes, the gestalt of nursing practice in a particular place has been shaped by its history (2009). By identifying and remembering the struggles and achievements of the past, we honour those who struggled to create the possibilities for those who followed. How nurses are remembered forms part of a narrative for a community, which links in with the broader national, political, or gender narrative in critical ways that shape how nursing is viewed. This, in turn, argues Nelson, “shapes everything from the way the professions are able to recruit people to the field, to the way they are funded and valued” (p. 784). By remembering the events that shape a community, we become better participants in it.

History also shapes our thinking. Contemporary nursing education values critical thinking—that is, disciplined thinking that is clear, rational, open-minded, and informed by evidence. Critical thinking involves the ability to critique and a commitment to continually honing one’s thinking abilities. Noting that nurses seem to be reluctant to use history as a valid source of data or as a reliable foundation upon which to build knowledge, D’Antonio and Fairman (2010) suggest that history balances nursing’s current prioritization of science and statistics over the humanities. History, they contend, creates an imaginative space that “refracts and reflects practice” (p. 113). While researchers using scientific methods work to control variables such as contingency, ambiguity, and uncertainty, historians embrace them. “Rather than wonder which variable is likely to produce the largest magnitude of change,” they continue, “we wonder how variables interact within time and place to effect change. We thrive in the uncertainties and subjectivities of politics, power struggles, and practice.” (p. 114). In this way, they suggest, historical thinking prepares nursing for the broad complexities of nursing practice.

Other historians argue that the act of learning how to think historically is even more valuable to students than learning historical content. Olwell, for example, argues that the most important goal of history classes is the development of thinking skills (as cited in Toman & Thifault, 2012, p. 187). These include how to read primary sources critically, how to examine the evidence, and how to question various interpretations of the evidence. Similarly, to Wineberg, the discipline of history “teaches us to resist first draft thinking and the flimsy conclusions that are its roots” (as cited in Toman & Thifault, 2012, p. 185). In other words, history challenges its students to develop a critical eye, to resist taking things at face value, and to recognize when someone’s interpretation of the evidence doesn’t add up—thinking skills, nurse historians would argue, as essential to the practice of nurses as they are to the practice of historians.

Finally, history provides a safe space to explore sensitive topics. To Nelson (2009), good history challenges our assumptions about our contemporary selves by helping us to see ourselves and our practice as a more complex story than we previously thought. Some of the stories are noble and inspiring; others are skeletons in the closet.

In my experience in teaching nursing history, this is one of the most critical—and unexpected—advantages to historical teaching, one that I’ve found difficult to replicate in other

classes. For example, history allows us to explore the role of social constructs like gender, race, religion, and class in nursing and how these helped to shape the profession in ways that have been both embarrassing and inspiring. Students are often surprised, for example, to learn how the profession barred certain groups from nursing schools: until as late as the 1970s in some cases, there were restrictions placed on men, married or pregnant women, and those of African, Asian, or Indigenous descent. Such historical knowledge helps students to reflect on what inequities exist today, and how nurses may be complicit—however unintentionally—in marginalizing certain groups.

I've also found students to be fascinated by the role nurses played in wartime—empathetic toward nurse prisoners of war (Grypma, 2012a), curious about army nurses (Toman, 2007, 2016), and appalled by nurses who were complicit with the Nazis (Benedict, 2006). Being at arm's length from such narratives allows students to ask ethical questions not only of the nurses involved but also of themselves and of each other. It nudges the question: To what will historians of the future hold our generation to account?

### **History as evidence: Finding “proof”**

The value nurses place on evidence has never been clearer. We teach our students to ensure that their practice is guided by the best research and information—that is, as evidence-informed practice. What, then, counts as evidence? While most students and faculty are comfortable with the notion of qualitative or quantitative evidence, historical evidence is not always on the radar. D'Antonio and Lewenson (2011) note that with the increasing emphasis on evidence-informed practice comes a belief within nursing that the standards of evidence might be found only in controlled double-blind clinical trials. Now we know, they argue, that many other sources of evidence exist that can serve as evidence for current practice—including historical practices, policies, and procedures. Historical evidence is also valuable when considering broad, systems-related questions, including those related to health promotion. Social determinants of health (SDOH), for example, recognize the importance of availability or resources and access to educational and health services. Including historical evidence in discussions of SDOH helps our students to develop upstream thinking. In addition to teaching students to look for social, political, economic, *and* historical influences on current health care crises, educators can use historical evidence as a way to understand what influenced the successful resolution of health crises in the past. Knowing about the devastating effects and resolution of the polio outbreak in 1952, for example, helps to contextualize contemporary controversies over mandated public immunizations. History bears witness, gives voice, and dispels myths—all of which can lead to better health care decisions today.

In her essay on historical amnesia, Nelson (2009) recalls her conversations with her doctoral student Ryoko O'Hara who was undertaking an oral history of nurses who were survivors of Hiroshima (O'Hara, 2009). Disagreeing with those who maintain that the reason such horrific events should not be forgotten is to prevent their reoccurrence, Nelson contends that we must remember because, simply, we owe it to the dead. We must honour nurses whose work put their lives at risk. To illustrate, Nelson notes the difference in the treatment of religious nurses who worked in the cholera and yellow fever epidemics in the 18th and 19th centuries compared to nurses who worked in the SARS epidemic in 2003. Whereas the death notices and eulogies of the religious nurses always included the epidemics they served in, we do not even know the names of the nurses and physicians who died in the SARS outbreak, nor do we honour those who volunteered to work on those units.

Historical evidence of how nurses were honoured (or not) can lead to class discussions of how public perception influences practice decisions. For example, during the Ebola crisis of 2014, so-called “Ebola Nurses” were ostracized for their work while “Ebola Fighters”, including nurses, were honoured as TIME magazine’s Person of the Year. Knowing how public portrayals of nursing influenced their decisions in the past is a key part of discussions about the mobilization of nurses into risky fields of practice today.

History also gives voice. Nursing owes much to scholars of women’s and gender studies for energizing the study of nursing history over the past three decades. In 1991, historian Strong-Boag wrote that nurses were among the prime candidates for historical attention because of the relative abundance of available records, nurses’ role in establishing women’s claim to public employments, and their influence on their community (Strong-Boag, 1991). The aim is to bring history to Nursing, and nursing to History. Nursing stories “are the way in which women have become written into a national narrative” (Nelson, 2009, p. 784). In other words, in a field dominated by the stories of men, history gives voice to women and their experiences.

History also provides the opportunity to include nursing voices to contemporary health care policy discussions. Recently, the director of nursing at Duke University noted that while nurses’ education provides information about how the health care system works, it does not teach them how to “get their voices heard by those to make the policies” (Short, 2014). To D’Antonio and Fairman (2010), history is key to ensuring that policy makers recognize the centrality of nursing to the profession: “Our success will depend on our ability to give voice to an historical perspective that places nursing and nurses at the centre of long standing debates about health services delivery, knowledge formation, patient safety, technology, and education for practice.” (p. 114). It is easier to see the potential of nursing’s role in leading change when recognizing how change has been achieved in the past.

Finally, history dispels myths. It is unwise to label any history as “definitive”. Instead, our understanding of the past evolves as new sources become available and scholars revisit earlier interpretations. Perhaps the best example in nursing history is the life and work of Florence Nightingale. Nightingale has been variously described as a saint, fiend, feminist, statistician, and modern mystic (Grypma, 2005a, 2005b). Volumes have been written about Nightingale over the past 150 years, and yet new studies continue to surface—often disputing earlier studies. Some have brought into question inconsistencies between the romanticized public image of Nightingale and private documents that portray her in a less flattering light. However, given the prominence that Nightingale continues to hold in the collective nursing imagination, it seems that students should, at least, be able to distinguish between myths and reality. For example, Nightingale made an immense impact on the soldier mortality rate at Scutari, reducing it from 42% to 2.2% in six months in 1855. However, it is unlikely that she trailed through the wards at night with a lamp, wiping fevered brows; this image came from a poem about the Lady with a Lamp written by the American poet Longfellow in 1857 (as cited in Grypma, 2005, p. 25).

Similarly, although it is true that Nightingale developed a three-year hospital apprenticeship program at St. Thomas in 1860 that became the blueprint for nursing education for the next 100 years, she did not actually set foot in St. Thomas until 1882; she was bedridden for 22 years after returning from the Crimea. The rest of her life was characterized by seclusion. Yet her reclusiveness allowed her to focus her considerable intellect on reformation efforts, analyzing data, writing reports, advising officials, and lobbying for sanitary reform in England and India (Grypma, 2005a). Although the myths have endured, the “real” Nightingale is

infinitely more fascinating, and her intellect and perseverance arguably more instructive for nursing students than her legend. As Tosh (2008a) suggests, it is better to acquaint students with the real past, than with the “right” one, especially if the “right” one is simply meant to shape a particular type of citizen—in the case of Nightingale’s myth, nurses who are compassionate and self-sacrificial, but little else.

### **History as explanation: Discerning historical echoes**

History helps us to better understand the societies we live and work in. It provides insight into the past and explanation of the present. In writing about the aftermath of the 2010 Haiti earthquake, authors noted that nurses have important roles to play in helping survivors through the grieving process to accept the “new normal” in an uncertain world (Snyder, Terzioglu, & Keeling, 2011, p. 253). Elsewhere I have argued that in the 21st century, where globalization, digital technologies, and catastrophic events are the new normal, nurses have had unprecedented opportunity to respond quickly to the global humanitarian disasters of our day (Grypma, 2012b). Stories of nurses who responded to the Ebola outbreak in West Africa in 2014, for example, or the Syrian refugee crisis in 2015–2016 were spread through social media. Those wishing to assist may access up-to-the-minute data on social media, and those on the ground may provide instant updates via Facebook, Twitter, Instagram, and Snapchat. Nursing students are keen to participate in global health efforts, too. Yet it will take years to fully understand its impact and influence (both helpful and harmful) on nursing and global health. Historians of the future will be able to evaluate disaster response in a way we cannot today; they will have an arms-length perspective that comes with time and distance.

In a similar way, future nurses will have opportunity to understand how the global community prepared and responded (or failed to prepare or respond) to disasters like the 2016 Fort McMurray, Alberta, fire, earthquakes in Nepal, and flooding in Chennai, India. They may have new insights about the role that nurses played in the wake of wars, coup attempts, and acts of terrorism, from the attacks of 9/11 to recent ISIS attacks in Turkey, Brussels and Belgium. Future nurses may grapple with lessons embedded in the 2016 passing of the medical assistance in dying legislation in Canada. They may (or may not) heed warnings that emerged following the outbreak of SARS and H1N1 and recognize how this crisis affected subsequent pandemic policies. And they may (or may not) raise questions about the deaths of nurses and others during various tragedies, and name and honour those who died. After all, it would be a shame for future nurses to ignore lessons learned through such a rich period in history as ours, would it not? And yet this is exactly what we do when we treat contemporary nursing as if it has no past.

According to Tosh (2008b), history provides a basis for an informed and critical understanding of our society. Similarly, Davey (2012) suggests that historical perspectives facilitate sharper reflection on the current system and clearer understanding of key stakeholders within and beyond it. To understand the role of Canadian nurses in global health or disaster relief, for example, it is helpful to understand that Canadian nursing came of age at the precise time that it began to embrace (and export) the notion of nursing as an international ideal: at the turn of the 20th century. Those who led the professional nursing movement were as relentless in their pursuit of new opportunities to advance the profession as missionaries overseas as they were in their pursuits on Canadian soil (Grypma, 2011). The profession that leaders in the early 20th century envisioned was rooted in Christian perspectives on suffering as a symptom of a broken world, with nursing as an enactment of Christ’s care for the poor, sick, and weak. Missionary nursing in those days was not an outlier—it was simply the furthest extreme of a

profession already suffused with internationalizing and religious ideals. Whereas contemporary nursing is no longer framed by religious ideals, the historical emphasis on nursing as a globally responsive profession remains.

Lynaugh has noted that what happens in the present is not an accident; it has a past (as cited in D'Antonio & Fairman, 2010). While this may seem self-evident, studying nursing's past can help us to recognize historical echoes in the present. Learning, for example, that the "new" field of global health actually evolved from the public health and missionary movements of the early 20th century may sensitize nurses to enduring religious motivations, public health teaching methods, and the centrality of volunteerism in contemporary work that seeks to achieve equity in health for all people.

Canadian mission groups sent their first missionary nurses overseas in the late 1880s (Grypma, 2008). Public health nursing started in Canada with the establishment of the first provincial health nursing service in Manitoba in 1916 (Rutty & Sullivan, 2010). Missionary nursing slowly gave way to international nursing during the Second World War, culminating in the establishment of the World Health Organization in 1948. By the time missionaries and their religious ideals fell out of favour both at home and abroad after the Second World War, global work had already been shifted over to the United Nations. During the Second World War, Canadian nurses worked with the United Nations Relief and Rehabilitation Administration (UNRRA), an international relief agency that operated between 1943 and 1947. Its mandate was to administer relief for victims of war through provision of, among other things, medical services. Its functions were later transferred to the World Health Organization, with whom Canadian nurses were also employed. Indeed, Canadian nurse Lyle Creelman became the chief nursing officer of WHO from 1954 to 1968 (Armstrong-Reid, 2014).

Canada had a noteworthy presence in the history of international health, with Canadians holding key positions in missions, the UNRRA, and the WHO. Studies in China missions have laid a firm foundation for understanding the breadth of Canadian involvement in China (Grypma, 2008, 2012a), and new research is revealing the extent of Canadian involvement with the UNRRA and the WHO (Armstrong-Reid, 2010, 2014). These are promising lines of inquiry for informing global health today. For example, Minden's examination of Canadian medical missions in China (1989), Compton Brouwer's study of the "NGOization" in mainstream churches (2010) and Liang's study of Canadian missionary women in Henan (2007) are imbued with implications for contemporary global health, each noting that dilemmas facing decision makers about strategies for foreign aid are perennial. Furthermore, Webster's (2011) study of the UN's development program identifies how colonial legacies continued in the postwar period, where the UN employed the language of unselfish generosity that characterizes Canadian foreign policy today. Finally, Tyrrell's (2010) study of transnational American moral reform found that, in the face of humanitarian disasters, evangelical groups united to find new sources of charitable giving and create relief organizations. Studies like these reveal important historical continuities with contemporary issues such as uncoordinated relief efforts and lack of local resources and infrastructure. Integrating these histories into contemporary discourse can help to understand how we got to be here, help to avoid repeating mistakes of the past, and gain clarity regarding what is changeable and what is not.

History may also provide a way to look forward. One of the challenges of nursing education is to try to prepare nurses for an unknown future. In a rapidly changing profession, it is difficult to imagine what nursing practice will be like by the time our first-year students

graduate—never mind in 10 years from now. One way to anticipate the future of nursing is to track changing social and political trends and related health care policies. Another way is to stay abreast of emerging nursing knowledge and new research. A third, less-traveled way is to study nursing's past. Tracing current issues back to their roots provides context and helps to understand the present. Tracking the trends of issues across decades can help us to map out a trajectory towards a likely future. More importantly, knowing how nurses have successfully responded to professional and practice concerns in the past can provide nurses with strategies and confidence to try new (old) clinical interventions or to interrupt concerning social or political trajectories. For example, in her study of community mental health nursing in Alberta, Boschma (2012) explores how nurses understood and created their new role and identity in the context of deinstitutionalization in the 1960s and 1970s. She concluded that new rehabilitative, community-based mental health services are best understood “as a transformation of former institutional practices rather than as a definite break with them” (p. 135). Similarly, D'Antonio & Lewenson (2011) note that knowing what nurses actually did to care for their patients in the past can help us to identify effective responses and mine them for their ability to reconstruct current practices. It can also help nurses to identify and, if necessary, counter premises upon which current policies are based.

### **Conclusion**

According to the CNA *Position Statement: The Value of Nursing History Today*, nurse educators are, among other things, responsible for imparting a sense of the value of nursing history to students (2007). CASN requires students to demonstrate a foundational knowledge of nursing history. The removal of nursing history from the curriculum a generation ago means that few nurse educators have themselves studied nursing history. And yet, as this paper argues, never has there been a better time to access and incorporate history as part of the nursing curriculum.

Historically informed nursing shapes who we are and informs our identity. In their experience of teaching two new online courses in nursing history, Toman and Thifault (2012) found that students shifted from a superficial acceptance of historical “facts” to the interrogation of original material for themselves. In the process, they emerged with a stronger professional identity. They also learned to critique both health care practices and practitioners, ultimately expressing “a new or renewed confidence about their place in the profession and their agency as health care practitioners.” (p. 202). Surely this is precisely what CNA and CASN had in mind.

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