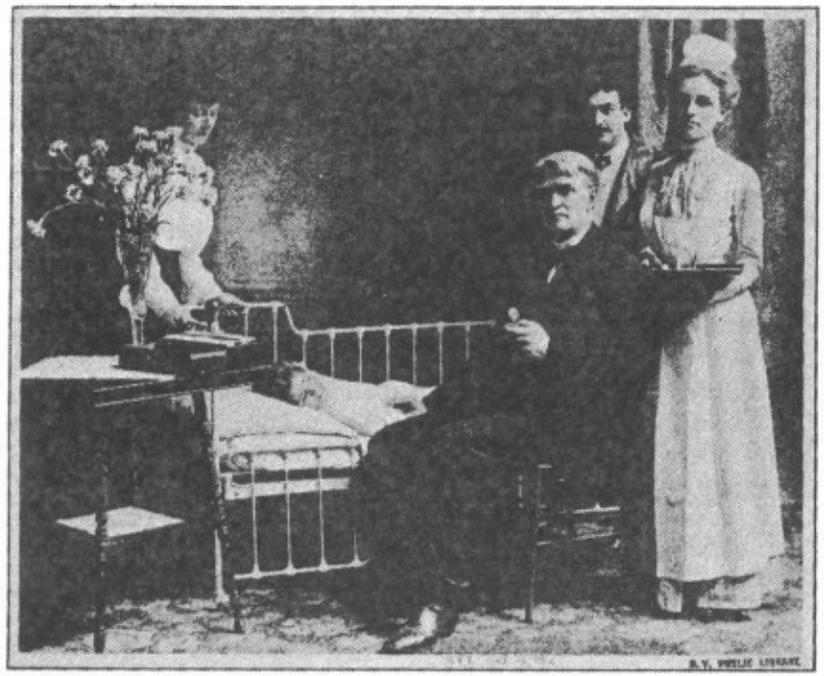


clear: Conform to the Johns Hopkins model or close. To get the message across, the Carnegie Corporation sent a staff man, Abraham Flexner, out on a national tour of medical schools—from Harvard right down to the last third-rate commercial schools.

Flexner almost singlehandedly decided which schools would get the money—and hence survive. For the bigger and better schools (i.e, those which already had enough money to begin to institute the prescribed reforms), there was the promise of fat foundation grants. Harvard was one of the lucky winners, and its president could say smugly in 1907, "Gentlemen, the way to get endowments for medicine is to improve medical education." As for the smaller, poorer schools, which included most of the sectarian schools and special schools for blacks and women—Flexner did not consider them worth saving. Their options were to close, or to remain open and face public denunciation in the report Flexner was preparing.

The Flexner Report, published in 1910, was the foundations' ultimatum to American medicine. In its wake, medical schools closed by the score, including six of America's eight black medical schools and the majority of the "irregular" schools which had been a haven for female students. Medicine was established once and for all as a branch of "higher" learning, accessible only through lengthy and expensive university training. It's certainly true that as medical knowledge grew, lengthier training did become

necessary. But Flexner and the foundations had no intention of making such training available to the great mass of lay healers and "irregular" doctors. Instead, doors were slammed shut to blacks, to the majority of women and to poor white men. (Flexner in his report bewailed the fact that any "crude boy or jaded clerk" had been able to seek medical training.) Medicine had become a white, male, middle class occupation

But it was more than an occupation. It had become, at last, a profession. To be more precise, one particular group of healers, the "regular" doctors, was now *the* medical profession. Their victory was not based on any skills of their own: The run-of-the-mill "regular" doctor did not suddenly acquire a knowledge of medical science with the publication of the Flexner report. But he did acquire the *mystique* of science. So what if his own alma mater had been condemned in the Flexner report; wasn't he a member of the AMA, and wasn't it in the forefront of scientific reform? The doctor had become—thanks to some foreign scientists and eastern foundations—the "man of science": beyond criticism, beyond regulation, very nearly beyond competition.

Outlawing the Midwives

In state after state, new, tough, licensing laws sealed the doctor's monopoly on medical practice. All that was left was to drive out the last holdouts of the old people's medicine—the midwives. In 1910, about 50 percent of all babies were delivered by midwives—most were blacks or working class immigrants. It was an intolerable situation to the newly emerging obstetrical specialty: For one thing, every poor woman who went to a midwife was one more case lost to academic teaching and research. America's vast lower class resources of obstetrical "teaching material" were being

wasted on ignorant midwives. Besides which, poor women were spending an estimated $5 million a year on midwives—$5 million which could have been going to "professionals."

Publicly, however, the obstetricians launched their attacks on midwives in the name of science and reform. Midwives were ridiculed as "hopelessly dirty, ignorant and incompetent." Specifically, they were held responsible for the prevalence of puerperal sepsis (uterine infections) and neonatal ophthalmia (blindness due to parental infection with gonorrhea). Both conditions were easily preventable by techniques well within the grasp of the least literate midwife (hand-washing for puerperal sepsis, and eye drops for the ophthalmia.) So the obvious solution for a truly public-spirited obstetrical profession would have been to make the appropriate preventive techniques known and available to the mass of midwives. This is in fact what happened in England, Germany and most other European nations: Midwifery was upgraded through training to become an established, independent occupation.

But the American obstetricians had no real commitment to improved obstetrical care. In fact, a study by Johns Hopkins professor in 1912 indicated that most American doctors were *less* competent than the midwives. Not only were the doctors themselves unreliable about preventing sepsis and ophthalmia but they also tended to be too ready to use surgical techniques which endangered mother or child. If anyone, then, deserved a legal monopoly on obstetrical care, it was the midwives, not the MD's. But the doctors had power, the midwives didn't. Under intense pressure from the medical profession, state after state passed laws outlawing midwifery and restricting the practice of obstetrics to doctors. For poor and working class women, this actually meant worse—or no—obstetrical care. (For instance, a study of infant mortality rates in Washington showed an increase in infant mortality in the years immediately following the passage of the law forbidding midwifery.) For the new, male medical profession, the ban on midwives meant one less source of competition. Women had been routed from their last foothold as independent practitioners.

The Lady with the Lamp

The only remaining occupation for women in health was nursing. Nursing had not always existed as a paid occupation—it had to be invented. In the early 19th century, a "nurse" was simply a woman who happened to be nursing someone—a sick child or an aging relative. There were hospitals, and they did employ nurses. But the hospitals of the time served largely as refuges for the dying poor, with only token care provided. Hospital nurses, history has it, were a disreputable lot, prone to drunkenness, prostitution and thievery. And conditions in the hospitals were often scandalous. In the late 1870's a committee investigating New York's Bellevue Hopital could not find a bar of soap on the premises.

If nursing was not exactly an attractive field to women workers, it was a wide open arena for women *reformers*. To reform hospital care, you had to reform nursing, and to make nursing acceptable to doctors and to women of "good character," it had to be given a completely new image. Florence Nightingale got her change in the battle-front hospitals of the Crimean War, where she replaced the old camp-follower "nurses" with a bevy of disciplined, sober, middle-aged ladies. Dorothea Dix, an American hospital reformer, introduced the new breed of nurses in the Union hospitals of the Civil War.

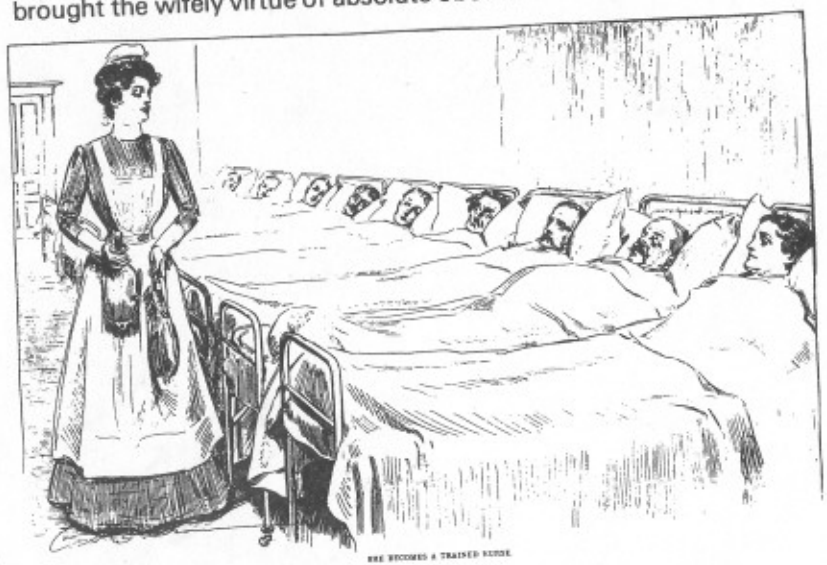
The new nurse—"the lady with the lamp," selflessly tending the wounded—caught the popular imagination. Real nursing schools began to appear in England right after the Crimean War, and in the US right after the Civil War. At the same time, the number of hospitals began to increase to keep pace with the needs of medical education. Medical students needed hospitals to train in; good hospitals, as the doctors were learning, needed good nurses.

In fact, the first American nursing schools did their best to recruit actual upper class women as students. Miss Euphemia Van Rensselear, of an old aristocratic New York family, graced Bellevue's first class. And at Johns Hopkins, where Isabel Hampton trained nurses in the University Hospital, a leading doctor could only complain that:

> Miss Hampton has been most successful in getting probationers [students] of the upper class; but unfortunately, she selects them altogether for their good looks and the House staff is by this time in a sad state.

Let us look a little more closely at the women who invented nursing, because, in a very real sense, nursing as we know it today is the product of their oppression as upper class Victorian women. Dorothea Dix was an heiress of substantial means. Florence Nightingale and Louisa Schuyler (the moving force behind the creation of America's first Nightingale-style nursing school) were genuine aristocrats. They were refugees from the enforced leisure of Victorian ladyhood. Dix and Nightingale did not begin to carve out their reform careers until they were in their thirties, and faced with the prospect of a long, useless spinsterhood. They focused their energies on the care of the sick because this was a "natural" and acceptable interest for ladies of their class.

Nightingale and her immediate disciples left nursing with the indelible stamp of their own class biases. Training emphasized character, not skills. The finished products, the Nightingale nurse, was simply the ideal Lady, transplanted from home to the hospital, and absolved of reproductive responsibilities. To the doctor, she brought the wifely virtue of absolute obedience. To the patient, she



SHE BECOMES A TRAINED NURSE

brought the selfless devotion of a mother. To the lower level hospital employees, she brought the firm but kindly discipline of a household manager accustomed to dealing with servants.

But, despite the glamorous "lady with the lamp" image, most of nursing work was just low-paid, heavy-duty housework. Before long, most nursing schools were attracting only women from working class and lower middle class homes, whose only other options were factory or clerical work. But the philosophy of nursing education did not change—after all, the educators were still middle and upper class women. If anything, they toughened their insistence on lady-like character development, and the socialization of nurses became what it has been for most of the 20th century: the imposition of upper class cultural values on working class women. (For example, until recently, most nursing students were taught such upper class graces as tea pouring, art appreciation, etc. Practical nurses are still taught to wear girdles, use make-up, and in general mimic the behavior of a "better" class of women.)

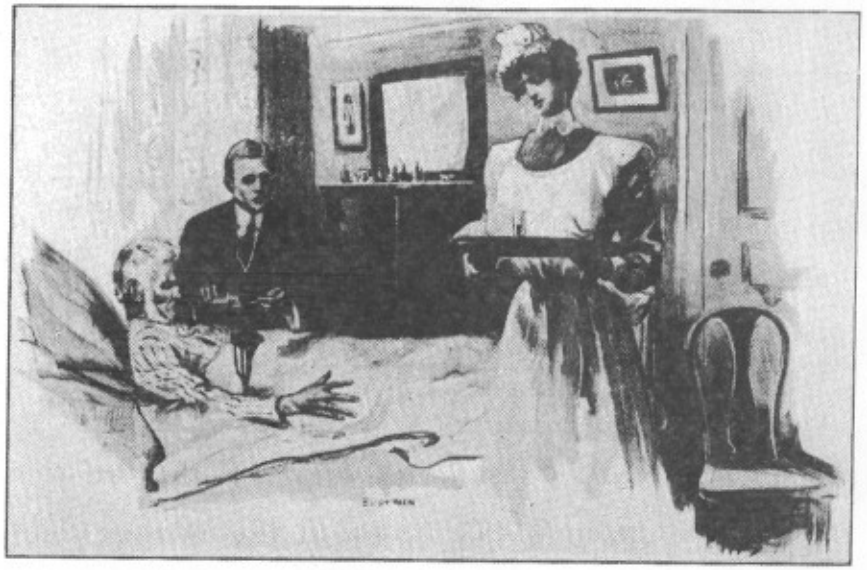
But the Nightingale nurse was not just the projection of upper class ladyhood onto the working world: She embodied the very spirit of femininity as defined by sexist Victorian society—she was Woman. The inventors of nursing saw it as a natural vocation for women, second only to motherhood. When a group of English nurses proposed that nursing model itself after the medical profession, with exams and licensing, Nightingale responded that "...nurses cannot be registered and examined *any more than mothers.*" [Emphasis added.] Or, as one historian of nursing put it, nearly a century later, "Woman is an instinctive nurse, taught by

Mother Nature." (Victor Robinson, MD. *White Caps, The Story of Nursing*) If women were instinctive nurses, they were not, in the Nightingale view, instinctive doctors. She wrote of the few female physicians of her time: "They have only tried to be men, and they have succeeded only in being third-rate men." Indeed, as the number of nursing students rose in the late 19th century, the number of female medical students began to decline. Woman had found her place in the health system.

Just as the feminist movement had not opposed the rise of medical professionalism, it did not challenge nursing as an oppressive female role. In fact, feminists of the late 19th century were themselves beginning to celebrate the nurse/mother image of femininity. The American women's movement had given up the struggle for full sexual equality to focus exclusively on the vote, and to get it, they were ready to adopt the most sexist tenets of Victorian ideology: Women need the vote, they argued, not because they are human, but because they are Mothers. "Woman is the mother of the race," gushed Boston feminist Julia Ward Howe, "the guardian of its helpless infancy, its earliest teacher, its most zealous champion. Woman is also the homemaker, upon her devolve the details which bless and beautify family life." And so on in paeans too painful to quote.

The women's movement dropped its earlier emphasis on opening up the professions to women: Why foresake Motherhood for the petty pursuits of males? And of course the impetus to attack professionalism itself as inherently sexist and elitist was long since dead. Instead, they turned to professionalizing women's natural functions. Housework was glamorized in the new discipline of "domestic science." Motherhood was held out as a vocation requiring much the same preparation and skill as nursing or teaching.

So while some women were professionalizing women's domestic roles, others were "domesticizing" professional roles, like nursing, teaching and, later, social work. For the woman who chose to express her feminine drives outside of the home, these occupations were presented as simple extensions of women's "natural" domestic role. Conversely the woman who remained at home was encouraged to see herself as a kind of nurse, teacher and counsellor practicing within the limits of the family. And so the middle class feminists of the late 1800's dissolved away some of the harsher contradictions of sexism.



The Doctor Needs a Nurse

Of course, the women's movement was not in a position to decide on the future of nursing anyway. Only the medical profession was. At first, male doctors were a little skeptical about the new Nightingale nurses—perhaps suspecting that this was just one more feminine attempt to infiltrate medicine. But they were soon won over by the nurses' unflagging obedience. (Nightingale was a little obsessive on this point. When she arrived in the Crimea with her newly trained nurses, the doctors at first ignored them all. Nightingale refused to let her women lift a finger to help the thousands of sick and wounded soldiers until the doctors gave an order. Impressed, the doctors finally relented and set the nurses to cleaning up the hospital.) To the beleaguered doctors of the 19th century, nursing was a godsend: Here at last was a kind of health worker who did not want to compete with the "regulars," did not have a medical doctrine to push, and who seemed to have no other mission in life but to serve.

While the average regular doctor was making nurses welcome, the new scientific practitioners of the early 20th century were making them *necessary*. The new, post-Flexner physician, was even less likely than his predecessors to stand around and watch the progress of his "cures." He diagnosed, he prescribed, he moved on. He could not waste his talents, or his expensive academic training in the tedious details of bedside care. For this he

needed a patient, obedient helper, someone who was not above the most menial tasks, in short, a nurse.

Healing, in its fullest sense, consists of both curing and caring, doctoring *and* nursing. The old lay healers of an earlier time had combined both functions, and were valued for both. (For example, midwives not only presided at the delivery, but lived in until the new mother was ready to resume care of her children.) But with the development of scientific medicine, and the modern medical profession, the two functions were split irrevocably. Curing became the exclusive province of the doctor; caring was relegated to the nurse. All credit for the patient's recovery went to the doctor and his "quick fix," for only the doctor participated in the mystique of Science. The nurse's activities, on the other hand, were barely distinguishable from those of a servant. She had no power, no magic, and no claim to the credit.

Doctoring and nursing arose as complementary functions, and the society which defined nursing as feminine could readily see doctoring as intrinsically "masculine." If the nurse was idealized Woman, the doctor was idealized Man—combining intellect and action, abstract theory and hard-headed pragmatism. The very qualities which fitted Woman for nursing barred her from doctoring, and vice versa. Her tenderness and innate spirituality were out of place in the harsh, linear world of science. His decisiveness and curiosity made him unfit for long hours of patient nurturing.

These sterotypes have proved to be almost unbreakable. Today's leaders of the American Nursing Association may insist that nursing is no longer a feminine vocation but a neuter

"profession." They may call for more male nurses to change the "image," insist that nursing requires almost as much academic preparation as medicine, and so on. But the drive to "professionalize" nursing is, at best, a flight from the reality of sexism in the health system. At worst, it is sexist itself, deepening the division among women health workers and bolstering a heirarchy controlled by men.

Conclusion

We have our own moment of history to work out, our own struggles. What can we learn from the past that will help us—in a Women's Health Movement—today?
These are some of our conclusions:

☐ We have not been passive bystanders in the history of medicine. The present system was born in and shaped by the competition between male and female healers. The medical profession in particular is not just another institution which happens to discriminate against us: It is a fortress designed and erected to exclude us. This means to us that the sexism of the health system is not incidental, not just the reflection of the sexism of society in general or the sexism of individual doctors. It is historically older than medical science itself; it is deep-rooted, institutional sexism.

☐ Our enemy is not just "men" or their individual male

chauvinism: It is the whole class system which enabled male, upper class healers to win out and which forced us into subservience. Institutional sexism is sustained by a class system which supports male power.

☐ There is no historically consistent justification for the exclusion of women from healing roles. Witches were attacked for being pragmatic, empirical and immoral. But in the 19th century the rhetoric reversed: Women became too unscientific, delicate and sentimental. The *stereotypes* change to suit male convenience—*we* don't, and there is nothing in our "innate feminine nature" to justify our present subservience.

☐ Men maintain their power in the health system through their monopoly of scientific knowledge. We are mystified by science, taught to believe that it is hopelessly beyond our grasp. In our frustration, we are sometimes tempted to reject *science*, rather than to challenge the men who hoard it. But medical science could be a liberating force, giving us real control over our own bodies and power in our lives as health workers. At this point in our history, every effort to take hold of and share medical knowledge is a critical part of the struggle—know-your-body courses and literature, self-help projects, counselling, women's free clinics.

☐ Professionalism in medicine is nothing more than the institutionalization of a male upper class monopoly. We must never confuse professionalism with expertise. Expertise is something to work for and to share; professionalism is—by definition—elitist and exclusive, sexist, racist and classist. In the American past, women who sought formal medical training were too ready to accept the professionalism that went with it. They made *their* gains in status—but only on the backs of their less privileged sisters—midwives, nurses and lay healers. Our goal today should never be to open up the exclusive medical profession to women, but to open up medicine—to all women.

☐ This means that we must begin to break down the distinctions and barriers between women health workers and women consumers. We should build shared concerns: Consumers aware of

women's needs as workers, workers in touch with women's needs as consumers. Women workers can play a leadership role in collective self-help and self-teaching projects, and in attacks on health institutions. But they need support and solidarity from a strong women's consumer movement.

☐ Our oppression as women health workers today is inextricably linked to our oppression as women. Nursing, our predominate role in the health system, is simply a workplace extension of our roles as wife and mother. The nurse is socialized to believe that rebellion violates not only her "professionalism," but her very femininity. This means that the male medical elite has a very special stake in the maintenance of sexism in the society at large: Doctors are the bosses in an industry where the workers are primarily women. Sexism in the society at large insures that the female majority of the health workforce are "good" workers—docile and passive. Take away sexism and you take away one of the mainstays of the health hierarchy.

What this means to us in practice is that in the health system there is no way to separate worker organizing from feminist organizing. To reach out to women health workers *as workers* is to reach out to them as *women*.

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