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Comment: Toward a History of Health Care: Repositioning the Histories of Nursing and Medicine

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In her compelling and provocative positioning paper, Patricia D’Antonio argues that “a new paradigm in the history of both nursing and medicine will involve studying these actors and their practices in relation to each other rather than, as we have done, in isolation” (p. XX).

Acknowledging that nursing and medicine have not always shared the same orientation or the same ambitions, where nursing “has had a more constant focus and impact on their particular communities; medicine, by contrast, more successfully articulated a commitment to depersonalized knowledge and expertise that seemed to transcend individual and community experiences,” nursing and medicine nevertheless “needed each other to make their particular claims to authority and expertise and, in the end, to achieve the success of their ‘scientific agenda’” (p. XX).

It is an honor to provide commentary on D’Antonio’s piece. My own thinking about and analyses of the history of nursing, including its relationship to the history of medicine, has long been deeply informed by D’Antonio’s scholarship, and this positioning piece will certainly influence my own scholarship moving forward. As I agree with D’Antonio’s call for historians to study nurses and physicians and their practices in relation to each other, I’m drawn, in particular,

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to the influence of “the structural apparatus governing the education and practices of all health care providers” (p. XX) and to the ways in which “dyads, interest groups, political factions of both groups of clinicians come together, break apart, dance around each other, and sometimes coalesce to create real change” (p. XX). To explore this further, I draw upon examples from the history of U.S. health care since World War II to highlight the intersections of governing structures, political economies, and the varied political interests of clinicians and health care leaders in the shaping of health care research and education and the health care workforce. I conclude by seconding D’Antonio’s call for historians of health care to be more expansive and inclusive with regard to the health care workers we study.

As D’Antonio notes, there are important questions to ask about “nursing’s historical relationship with their own disciplinary claims to science and to scientific medicine” (p. XX). Here, I acknowledge my own positionality with respect to this issue, having very recently completed a book that examines the development of nursing science in the decades after World War II.¹ This history demonstrates some of the ways in which nursing science is not only “as politicized as” but also shaped by “physicians’ claim to their own form of ‘medical science’” (p. XX). Indeed, during the 1950s, 1960s, and 1970s, academic nurses sought to establish nursing science as distinctive from yet complementary to the biomedical science that underpinned medical practice and research, particularly its focus on the identification, diagnosis, and

¹ Dominique A. Tobbell, *Dr. Nurse: Science, Politics, and the Transformation of American Nursing* (Chicago: University of Chicago Press, forthcoming).

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treatment of discrete diseases. Instead, nursing—and the science that underpinned it—would move beyond “merely . . . treating disease entities” and would treat “patients as ‘total persons.’”² Integral to this was the recognition “that many of the causal factors of illness, recovery and relapse are social, psychological, and cultural, as well as physiological” and that the social and behavioral sciences could make important contributions to patient care.³ While some medical leaders recognized the value of encompassing the behavioral and social sciences, their efforts to broaden the scope of medical education and practice to encompass them largely failed.⁴ Thus, incorporating the social and behavioral sciences into nursing education, and by establishing nursing science as an interdisciplinary science that integrated psychological, cultural, social, and physiological understanding of health, illness, and the patient, nurses could claim distinctive

² Frances Cooke Macgregor, *Social Science in Nursing: Applications for the Improvement of Patient Care* (New York: Russell Sage Foundation, 1960), 5; see also Esther Lucille Brown, “Nursing for the Future: A Report Prepared for the National Nursing Council” (New York: Russell Sage Foundation, 1948), 33–41.

³ Macgregor, *Social Science in Nursing* (n. 2), 9. See also Kylie Smith, *Talking Therapy: Knowledge and Power in American Psychiatric Nursing* (New Brunswick, N.J.: Rutgers University Press, 2020).

⁴ Macgregor, *Social Science in Nursing* (n. 2), 31. See also Julie Fairman, *Making Room in the Clinic: Nurse Practitioners and the Evolution of Modern Health Care* (New Brunswick, N.J.: Rutgers University Press, 2008), 36–37.

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knowledge, skills, and expertise, rooted in an understanding of patient behavior and attitudes, that they—and not physicians—would contribute to the improvement of patient care.⁵ In this way, the parameters of nursing science were constructed in relation to the biomedical science of physicians.

But as academic nurses were constructing the new science of nursing, academic physicians were establishing the discipline of clinical epidemiology and asserting the superiority of the randomized controlled trial for generating the most objective and reliable knowledge.⁶ They did so in the context of the quality assessment movement in health care, which aimed to systematically measure the outcome of patient care so as to determine which clinical interventions worked and which didn't and to hold physicians accountable for those outcomes

⁵ Macgregor, *Social Science in Nursing* (n. 2).

⁶ Jeanne Daly, *Evidence-Based Medicine and the Search for a Science of Clinical Care* (Berkeley: University of California Press/Milbank Memorial Fund, 2005); Stefan Timmermans and Marc Berg, *The Gold Standard: The Challenge of Evidence-Based Medicine and Standardization in Health Care* (Philadelphia: Temple University Press, 2003); David S. Jones and Scott H. Podolsky, "The History and Fate of the Gold Standard," *Lancet* 385 (2015): 1502–3; Laura E. Bothwell and Scott H. Podolsky, "The Emergence of the Randomized, Controlled Trial," *New Engl. J. Med.* 375 (2016): 501–4.

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(referred to as outcomes research).⁷ The primacy of the biomedical sciences, the growing importance of outcomes research, and the broader quality assessment movement in health care shaped the ways in which research methods and the evidence they generated were evaluated and accorded status. By the 1970s, the randomized controlled trial had emerged as the gold standard research method in clinical medicine, but nurse scientists preferred instead descriptive quantitative studies, observational studies, and qualitative research methods that relied on the invocation of social theory rather than statistical analysis as a means of validation. This meant that the knowledge their research generated occupied a comparatively lower position in the so-called hierarchy of evidence.⁸ This led to nursing science—and nurse scientists—being undervalued within the research economy, even as nurse scientists contributed to clinical research that which was missing from physicians’ interventions-focused approach: evidence into the social and political context of patient care that could help explain why individuals made the choices they did about their own health and health care (including the prescribed interventions

⁷ Michael L. Millenson, *Demanding Medical Excellence: Doctors and Accountability in the Information Age* (Chicago: University of Chicago Press, 1997); Daniel M. Fox, *The Convergence of Science and Governance: Research, Health Policy, and American States* (Berkeley: University of California Press, 2010), 22–50; Nancy Tomes, *Remaking the American Patient: How Madison Avenue and Modern Medicine Turned Patients into Consumers* (Chapel Hill: University of North Carolina Press, 2016), 310–13.

⁸ Daly, *Evidence-Based Medicine* (n. 6), 231–32.

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they would choose to use and those they would not).⁹ To understand the development of nursing science and its relative value in the research economy, as well as the impact of nursing science on health care practice, requires then that we consider its history in relationship to the “medical science” of physicians.

I appreciate D’Antonio’s focus on the “structural apparatus governing the education and practices of all health care providers.” Not only are these structures critical to “understanding how norms of race, class, gender reproduce themselves in past and current environments” (p. XX), they are also sites in which we see the efforts of different groups of clinicians and stakeholders to either reinforce or work to transform or dismantle such structures. This is particularly so when we consider the different structure of nursing and medical education: since the 1950s, there have existed multiple educational pathways into nursing in contrast to the single, highly selective and thus restricted pathway into medicine. Indeed, when faced with shortages of nurses and the need to raise the educational preparation of nurses, nursing’s solution has been, invariably, to create new educational pathways into nursing—either by establishing advanced degrees commensurate with higher quality and preparation to provide specialized care, or by creating new subordinate categories of nursing worker, such as the LPN and delegating the more routine, putatively lower skilled nursing work to that new worker.¹⁰ In contrast, any changes to

⁹ Ibid., 16–17.

¹⁰ Jean C. Whelan, *Nursing the Nation: Building the Nursing Labor Force* (New Brunswick, N.J.: Rutgers University Press, 2021), 123–44; Patricia Haase, *The Origins of Associate Degree*

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and improvements in medical education have been made within the *existing* structures of undergraduate and graduate medical education.¹¹ And when confronted with shortages of physicians, particularly those in primary care, medicine's solution has not been to introduce new pathways into medicine, but rather to collaborate with allied professions, including nurses, to create new categories of midlevel providers, such as nurse practitioners and physician assistants, but to make clear that these did not represent a new pathway into the exalted career of medicine.¹² Why, as D'Antonio asks, "when medicine was moving to consolidate its educational credentials, did nursing experience such variability?" (p. XX).

Nursing Education (Durham, N.C.: Duke University Press, 1990); Fairman, *Making Room in the Clinic* (n. 4); and AnneMarie McAllister, "R. Louise McManus and Mildred Montag Create the Associate Degree Model for the Education of Nurses: The Right Leaders, the Right Time, the Right Place, 1947–1959" (Ed.D. diss., Teachers College, Columbia University, 2012).

¹¹ Kenneth M. Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care* (Oxford: Oxford University Press, 1999); Ludmerer, *Let Me Heal: The Opportunity to Preserve Excellence in American Medicine* (New York: Oxford University Press, 2014).

¹² Fairman, *Making Room in the Clinic* (n. 4).

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Although these different structures could suggest the limits of nursing's professionalization, it is, as D'Antonio and others have noted, more complicated than that.¹³ Not least, the persistence of these pathways indicates their value in increasing access to nursing for underrepresented populations.¹⁴ (Although, it is important to acknowledge that these pathways have not resolved the problem of racial inequities in nursing.)¹⁵ The persistence of educational pathways in nursing, however, also speaks to the varied interests—and political power—of different nurses and other stakeholders in maintaining these pathways. For example, during the 1960s and 1970s, the ANA and other nursing leaders pushed for the closure of diploma programs

¹³ Barbara Melosh, *The Physician's Hand: Work Culture and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982); Susan Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850–1945* (New York: Cambridge University Press, 1987); Darlene Clark Hine, *Black Women in White* (Bloomington: Indiana University Press, 1989); Fairman, *Making Room in the Clinic* (n. 4); Patricia D'Antonio, *American Nursing: A History of Knowledge, Authority, and the Meaning of Work* (Baltimore: Johns Hopkins University Press, 2010); Susan Rimby Leighow, "Backrubs vs. Bach: Nursing and the Entry-into-Practice Debate, 1946–1986," *Nursing Hist. Rev.* 4 (1996): 3–17.

¹⁴ D'Antonio, *American Nursing* (n. 13), 178–79; Patricia D'Antonio, "Women, Nursing, and Baccalaureate Education in 20th Century America," *J. Nursing Scholarship* 4 (2004): 379–84.

¹⁵ Health Resources and Services Administration, "Review Health Workforce Research," <https://bhw.hrsa.gov/data-research/review-health-workforce-research>.

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and to establish the BSN as the minimum credential for professional practice. But this was at a time when state and federal policy makers prioritized expanding access to and diversity within higher education.¹⁶ In this context, state legislators were persuaded by the arguments of diploma- and AD-educated nurses to keep and even expand the educational pathways into and advancement within nursing because it fit their goals of expanding access to higher education as well as addressing the health care needs of the state. The intersecting interests of nurses and state legislators helped to shore up nursing's educational system as one characterized by differential pathways into nursing.¹⁷ Nurses have thus held power within their states. But the political interests of nurses have never, as D'Antonio notes, been monolithic. It is important then, for historians to acknowledge and interrogate the varied ways in which nurses have been policy actors, at times in alignment with and at others in opposition to other clinicians and stakeholders. How, for example, has the diffusion of power among a range of professional nursing organizations—not to mention the importance of the labor unions who represent nurses—impacted the institutional and political power of nurses at both the state and federal levels?

¹⁶ Christopher P. Loss, *Between Citizens and the State: The Politics of American Higher Education in the 20th Century* (Princeton, N.J.: Princeton University Press, 2012), 165–213; John D. Millett, *Conflict in Higher Education: State Government Coordination versus Institutional Independence* (San Francisco: Jossey-Bass, 1984).

¹⁷ Tobbell, *Dr. Nurse* (n. 1).

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The increasing importance of internationally educated clinicians during the Cold War decades is another area in which historians have begun to study the intersections of the governing structures of health care with broader political and economic structures. As Catherine Ceniza Choy and Sujani Reddy show for nurses educated in the Philippines and India, respectively, and as Eram Alam demonstrates for internationally educated physicians, the history of American imperialism, immigration, and foreign policy and the infrastructure of the U.S. health care system intersected in the making of an increasingly globalized clinical workforce.¹⁸ During the Cold War decades, as widespread concerns mounted about growing shortages of health care professionals, U.S. hospitals—with support of major nursing and medical organizations—increased the recruitment of internationally educated clinicians, especially from Asian countries. U.S. hospital administrators regarded internationally educated clinicians as cheaper solutions to recurrent crises of clinician shortages and used these clinicians to create and normalize a stratified—and racialized—health care workforce. While internationally educated clinicians had their own reasons for im/migrating to the United States, once here, internationally educated nurses were subject to discrimination and exploitation, often being assigned to “the

¹⁸ Catherine Ceniza Choy, *Empire of Care: Nursing and Migration in Filipino American History* (Durham, N.C.: Duke University Press, 2003); Sujani Reddy, *Nursing and Empire: Gendered Labor and Migration from India to the United States* (Chapel Hill: University of North Carolina Press, 2015); and Eram Alam, “Cold War Crises: Foreign Medical Graduates Respond to US Doctor Shortages, 1965–1975,” *Soc. Hist. Med.* 33 (2020): 132–51.

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shifts, units, and hospitals least able to retain their white colleagues,”¹⁹ while internationally educated physicians were mobilized to fill hospital staff vacancies in historically underserved and marginalized inner-city and rural communities, where physician shortages were most stark.²⁰ Viewing the histories of internationally educated nurses and physicians in relation to each raises questions about the ways in which the different regulatory structures of nursing and medicine have differentially shaped internationally educated clinicians’ access to nursing and physician careers in the United States. For example, have the higher licensing barriers faced by international educated physicians, dentists, and pharmacists in the United States led some professionals to retrain as nurses in order im/migrate to the United States and work in the U.S. health care system?²¹

Finally, I wholeheartedly endorse D’Antonio’s call to examine the history of health care from the perspective of nursing assistants, attendants, and licensed practical nurses “who have always had an enduring place at the bedsides of the sick and vulnerable” (p. XX). Much of the

¹⁹ Reddy, *Nursing and Empire* (n. 18), 12–13.

²⁰ Alam, “Cold War Crises” (n. 18), 150.

²¹ I thank Ren Capucao for alerting me to this difference and its potential impact on decisions of internationally educated clinicians hoping to immigrate to the United States. For a contemporary overview of U.S. licensure practices, see Linda Rabben, *Credential Recognition in the United States for Foreign Professionals* (Washington, D.C.: Migration Policy Institute, May 2013), <https://www.migrationpolicy.org/sites/default/files/publications/UScredentialrecognition.pdf>.

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intimate care work performed by nursing assistants and LPNs, as well as home health aides—in the past and today—takes place in nursing homes and other long-term care facilities, and in the homes of those living with chronic illness and debility. Thus, to consider a more inclusive history of health care work means that we expand the historical lens to sites of care beyond hospitals and clinics, to include nursing homes, hospices, rehabilitation centers, and patients’ homes.²² This more inclusive history of health care work is indelibly shaped by the long history of racial and gender discrimination in the American health care workforce, which has meant that women of color, in particular, have often been denied access to professional health care careers and been marginalized in low-paying, low-status direct care occupations, such as LPNs, nursing assistants, and home health aides.²³ The racialized and gendered marginalization of care work

²² Karen Buhler-Wilkerson, *No Place Like Home: A History of Nursing and Home Care in the United States* (Baltimore: Johns Hopkins University Press, 2001); Emily Abel, *The Inevitable Hour: A History of Caring for Dying Patients in America* (Baltimore: Johns Hopkins University Press, 2013).

²³ Hine, *Black Women in White* (n. 13); Victoria Tucker, “Race and Place in Virginia: The Case of Nursing,” *Nursing Hist. Rev.* 28 (2020): 143–57; Janette Dill, Odichinma Akosionu, J’Mag Karbeah, and Carrie Henning-Smith, “Addressing Systemic Racial Inequity in the Health Care Workforce,” *Health Affairs Blog*, September 10, 2020.

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dates back at least to the era of enslavement,²⁴ and is also deeply imbricated within histories and contemporary experiences of social welfare, disability, labor, and health policy, and the shifting meanings, values, and ethics of care work. For example, as Eileen Boris and Jennifer Klein argued, despite the essential nature of intimate care work, beginning with the New Deal, state policy makers, experts, and institutions made home health care a “low-wage job that was stigmatized as welfare and relegated to the bottom of the medical hierarchy.”²⁵ In doing so, they remind us that intimate care work is not only devalued and stigmatized by the nature of the work itself “as if the mere touching of dirt or bodily fluids degrades the handler,” or “because of its ascribed racial and gendered meanings but because of the way the state chooses to structure it.”²⁶ The structural and cultural devaluation of intimate care work is also, as Catherine Kudlick reminds us, shaped by the meanings that clinicians and policy makers have ascribed to disability. From the late nineteenth century through the rise of the disability rights movement in the 1970s, a medical model of disability dominated the health care system’s response to people with

²⁴ Sharla M. Fett, *Working Cures: Healing, Health, and Power on Southern Slave Plantations* (Chapel Hill: University of North Carolina Press, 2002); Deirdre Cooper Owens, *Medical Bondage: Race, Gender, and the Origins of American Gynecology* (Athens: University of Georgia Press, 2017).

²⁵ Eileen Boris and Jennifer Klein, *Caring for America: Home Health Workers in the Shadow of the Welfare State* (New York: Oxford University Press, 2012), back page blurb.

²⁶ *Ibid.*, 8

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disabilities, whereby disability was seen as a problem to be “fixed, rehabilitated, or cured.”²⁷ The focus on cure, Kudlick explains, “reflected and shaped a set of hierarchical responses to disabled bodies; the promise of a cure, however remote, would increasingly trump other forms of intervention, culminating in today’s privileging of dramatic technological fixes over low-key palliative treatments.”²⁸ This in turn has been reflected in disparities in federal research funding, reimbursement by third-party payers, and the wages of those “who enable people with disabilities to live and even thrive,” such as nurses and personal care assistants, compared to the physicians and scientists who seek to ‘cure’ disability.”²⁹ Broadening our histories of health care to encompass all those who have provided care not only provides a more inclusive, diverse, and representative history of health care but also, as D’Antonio argues, is essential if we are to “confront an artificial divide between the primacy of diagnosis and the reality of the lived experience of illness, and between the rhetoric of care . . . and that of cure” (pp. XX).

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²⁷ Catherine Kudlick, “Social History of Medicine and Disability History,” in *The Oxford Handbook of Disability History*, ed. M. Rembis, C. Kudlick, and K. Nielsen (Oxford: Oxford University Press, 2017), 106–25, quotation on 106.

²⁸ *Ibid.*, 114.

²⁹ *Ibid.*, 114.

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Informatics at Minnesota: The First Fifty Years (Tasora Books, 2015); and *Pills, Power, and Policy: The Struggle for Drug Reform in Cold War America and its Consequences* (University of California Press/Milbank Series on Health and the Public, 2012).