Handling the Sick

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Laying Claim to Caring

November 19th, 1928: First snowfall. The first time I gave a bed bath. Gave one to Mr. Van Camp—a young flirt. I told him to finish the bath and he said he didn’t need to. The sap. Complimented me to Miss Alson.

—St. Luke’s Trainee, 1928

Contemporary nursing leaders have rallied around the idea of caring, claiming this as the core of nursing practice and thus the field’s “special knowledge.” Consistent with professionalization theory, identifying, developing, and successfully laying claim to special knowledge is viewed as crucial to establishing nursing as a full-fledged profession. As elaborated in a frequently cited article in nursing, a profession is “distinguished by a domain of inquiry that represents a shared belief among its members regarding its reason for being.” Moreover, two prominent nurses assert, “It is the common link to caring that brings nurses together.” Another leader adds, “Caring is the central, dominant and unifying feature of nursing.” The titles of well-known, contemporary works in nursing highlight the claim to caring: Nursing as Caring; Care: The Essence of Nursing and Health; The Primacy of Caring; and Nursing: The Philosophy and Science of Caring.

The argument for caring is generally legitimized by asserting its historic basis. This argument typically proceeds as follows: “Care forms the basic core of nursing actions. Traditionally nurses have described the act of administering to patients as care behaviors.” Yet the nurses upon whom this view is based are frequently omitted from such descriptions. In other words, caring as the essence of nursing is assumed. When nurses from the past are cited, they tend to be from the professional elite. For example, the words of Isabel Stewart underpin a warning in the Journal of Professional Nursing that “caring is slowly disappearing” from nursing. Stewart is quoted as insisting: “The real essence of nursing . . . lies not in the mechan-
ical details of execution, not yet in the dexterity of the performer, but in the
creative imagination, the sensitive spirit, and the intelligent understanding
lying back of these techniques and skills. Without these, nursing may
become a highly skilled trade, but it cannot be a profession. 8

Even in those accounts that draw on information from rank-and-file
nurses, the assumption of caring is imposed on historical subjects rather
than discovered in their records. In one of the best-known works on nurs-
ing history, the conclusion that nurses were “ordered to care” is reached
without really questioning the underlying premise that equates nursing
and caring. 9 However, when we first suggested examining this premise, we
were chided by one nurse historian who remarked that we could not pos-
sibly be questioning the relationship between nursing and caring. She
added, “I infer that what (actually) intrigues you . . . (is) to spell out and
verify the conflicts and tensions (around) . . . being a caring nurse.” 10 For
her, the two terms were synonymous. Another nursing scholar acknowl-
enced our intent accurately but insisted that to understand nursing and
caring we would have to “go back to the original source—Nightingale,”
rather than relying on the statements of ordinary nurses. 11 In the field of
intellectual history such an argument might be normative but a social his-
tory such as this study relies precisely on just that—the experiences of ordi-
nary nurses, as best they can be recreated from extant records.

In current discussions, the claim to caring is frequently linked to femi-
nist ideas put forward in the theoretical debates of the 1980s that placed
women at center stage instead of in the periphery of society. As a well-
known nursing author explains in the American Journal of Nursing,
“women’s caring work,” nursing, must be esteemed by society if we are to
“move away from the masculine dream toward a new feminine future.” 12
The fact that society “systematically undervalues care,” according to
another account, is the primary reason for nursing’s difficulty in becoming
“a woman-valued work group.” 13

This construct ignores the negative consequences for women of being
seen as “natural” caregivers, such as their economic dependence on men
and their low status in the hierarchy of paid work. 14 Glazer, a sociologist,
clarifies the gender divide that tends to frame such discussions of caring:
the “view of the relative passivity of women finds a complement in femi-
nist views of women as more cooperative and relational, more caring and
less aggressive than men and . . . less mechanistic and hierarchical.” 15 In this
way caring, linked to specifically female historical actors, is correlated with
psychological attributes of passivity and even submissiveness. “The ‘femi-
nine’ principles,” emphasizes a feminist scholar, “correspond to the histor-
ical roots of nursing—caring, nurturance, receptivity.” 16
Yet, as one critic challenges, “if caring is really the ‘essence of nursing’ then it must be demonstrated and not simply proclaimed.” It must also be defined. This leads to the fundamental question: How solid is the historical relationship between caring and nursing, before more recent turns to a psychological definition of caring? Among the women engaged in the day-to-day work of nursing in the early twentieth century, was their work seen as caring, or closely related to caring? If not, how did these individuals conceive of their field?

In searching for a deeper understanding of what nursing meant to the women of St. Luke's, it is important to keep in mind that once beyond probation, a trainee was thereafter referred to as “nurse.” Terms such as “student” or “pupil” were conspicuously absent from hospital dialogue and written records. So no longer a “probie,” Verdel Iverson, a young woman who came to St. Luke's in 1925, from Radcliffe, Iowa, was described during the remainder of her first year as “a good strong nurse.” This was according to Maple Baer, a charge nurse and a 1922 graduate of the hospital.

In her second year, the woman was characterized as “a reliable and conscientious nurse” by Elmyra Nelson, the assistant night supervisor and a 1925 graduate of St. Luke's. Soon after, another supervisor observed, “The patients all liked Miss Iverson very much. She is a very good nurse.” In her final year of training, a charge nurse explained that Miss Iverson was “a very capable nurse and pleasant to work with.” The superintendent of training offered her own terse summary, “Good Nurse in Practical Work.” In total, seven different graduate nurses provided written evaluations of this individual during her work and training. Each one referred to her as a nurse.

There was equal certainty during training about just which qualities a woman must possess to earn the title of nurse. Moreover, these were the same qualities that had been emphasized earlier during the application process. Above all, a nurse had to have physical strength and endurance, common sense, and a strong personality. A nurse was accordingly criticized in 1925 for having “neither a strong physique nor personality.” Gusta Erstad, the immediate supervisor, added “she lacks self-reliance.” The superintendent of nursing endorsed this opinion, stating there is “not much force to her.”

Others, such as Marie Weisbecker, merited praise from their supervisors for demonstrating the attributes of a nurse. For instance, the charge nurse in the operating room commended Miss Weisbecker for being “very neat and (having) confidence in her own ability.” Her obstetrical supervisor
said, “Miss Weisbecker showed good judgment with patients while on the floor.” In addition, the assistant superintendent of nursing pointed out, she has “splendid health and excellent common sense.”

These qualities, and the authority that came with being called a nurse, were integral to an overall definition that infused all aspects of nursing at St. Luke’s. A crucial part of this definition was repeated when Evelyn Ferrell, similar to many trainees before and after her, was praised in 1923 as “a good adaptable all around nurse” based on her “way of handling patients.” Indeed, “handling patients” was the most frequently used phrase to describe nursing at St. Luke’s. Among the last group of women to train at the hospital, one was portrayed as “a large girl—strong and capable in handling patients,” and another as “very capable in manual handling of patients.”

The way in which a nurse handled patients could be a source of criticism as well as praise. For instance, a superintendent of nurses wrote to an older sister of a trainee, decrying the younger woman’s “practical nursing.” The main problem, the superintendent explained, was that “your sister . . . finds it difficult to handle patients.” She added the following advice, “(your sister) tells me that she is very much interested in English with library training, and to be very candid with you, I feel she would be more successful in this line than in nursing.”

Only slightly less often than handling, nurses were judged in terms of how they “controlled” and “managed” patients. A “ward report” from 1929, for example, described Alice Dahl as a nurse whose “patients were always well under control.” Another woman was commended in 1933 because “she is interested in work (and) manages patients well.” Still other nurses received similar approval for having “managed children well” and for having “good control of babies.” At St. Luke’s, nurses could hardly ask for higher compliments than these.

Discussions with several women who trained and worked at St. Luke’s, most of whom were in their eighties when interviewed, helped to explain what was involved in handling, controlling, or managing patients. Sitting on the edge of her bed in a St. Paul–area nursing home, Edythe Newman, a 1936 graduate, remarked, “I don’t think I’d like the nursing nowadays—it’s the aides and the practical nurses who really deal with patients.” She continued, “in those days a patient was a patient and they stayed in bed and you did everything for (emphasis original) them. You gave them their bath and brought them the bed pan . . .” Nursing in this description, “deal(ing) with patients,” meant taking an active role in doing things for people, particularly carrying out procedures.

Miss Newman was not alone in her thinking. Toward the end of September 1928, a young woman named Grace Bakke eagerly looked up at the stone
columns that framed the entrance to St. Luke’s and bravely climbed the steps to the hospital to begin her work as a nurse. She had just arrived from the small, close-knit, central-Minnesota farming community of Granite Falls, and the city surrounding St. Luke’s appeared menacing. St. Paul was in the midst of a prohibition-related crime wave, with prostitution, gambling, and dozens of speakeasies flourishing just blocks away from the hospital. Violence was common, with two men and a woman shot down near the state capitol in what local newspapers called “the third outbreak of gang warfare in the Twin Cities within two weeks.” Yet Miss Bakke’s determination to be a nurse never wavered as she resolutely took on the task of recording her daily observations of her new vocation in several tersely worded diaries. She emphasized her first experiences involving procedures and patients, such as the story quoted at the beginning of this chapter about Miss Bakke giving her first bed bath. Miss Bakke made similar comments about “the first time I gave a bed pan”; the first “evening toilet—made sure they (patients) brushed their teeth and (I) gave back rubs”; and the first enema she gave. On May 4, 1929, she proclaimed, “Shot my first hypo!” With equal excitement she also noted the day “I received my first paycheck—on fourth floor.”

Another nurse, originally from St. Paul’s Westside, kept a scrapbook that covered her years at St. Luke’s, 1929 to 1932. On one page was a poem that she read aloud, saying that it described her experience with a patient while on night duty:

The patient grows better night by night,
Because some nurse in her evening plight
Forces the fluids and forces them strong
Keeps on forcing them all night long
She makes drinks from oranges, from lemons, from grapes
And Oh, what a lot of fruits it takes,
She forces the fluid in great many ways
By temperature sponges, hot packs and on Trays. . . .

In this example, and the others presented above, the meaning of nursing is clear. Nursing meant taking the lead, assuming an assertive, vigorous role in carrying out common and not-so-common procedures, including bathing a patient and forcing fluids. Nursing also meant being paid for one’s work, even while in training. Consistent with Miss Bakke, this last individual set aside an entire page of her scrapbook to display “My last pay envelop.”

Recognizing a similar need for qualities of strength and forcefulness in nursing, the author of a turn-of-the-century guide to nursing highlighted the following lines from the poet Wordsworth:
A traveler betwixt life and death;
The reason firm, the temperate will,
Endurance, foresight, strength, and skill;
A perfect woman, nobly plann'd,
To warn, to comfort, and command. . .  

The ability to warn, comfort, and command, beyond its poetic sound, is not so distant from the St. Luke’s nurses’ own description of handling, managing, and controlling. Moreover, the strength that underlay all of these designations was central to everyday nursing practice.

The day-to-day routine of nursing was illustrated in the case records, or descriptions of work with specific patients, that were kept by the nurses. Two examples are included below, the first from the day shift and the second from the night shift. Both focus on patients on medical units, with undiagnosed illnesses. The nurse’s work with one particular patient during the day unfolded as follows:

7:15–7:30 A.M. Feeding patient.
7:30–8:00 A.M. Medications (given); patient toileted.
8:00–8:30 A.M. Patient bathed; alcohol rub; linen changed.
9:30–10:00 A.M. Application of splint.
12:20–12:45 P.M. Feeding patient.
12:55–1:00 P.M. Medications (given); patient toileted; patient prepared for rest. 

In addition to this patient, the nurse in this situation was responsible for two other patients during the same period.

With the exception of the application of a splint, the description from the day shift included regularly performed tasks. In contrast, the night nurse found herself in a situation in which she had to concentrate on changes in the patient’s condition. Her work proceeded as follows:

8:45 P.M. Vital signs taken. (Patient) complains of headache. Patient seems very excitable. Talks and laughs a great deal. Ice cap to head.
10:40 P.M. (Patient) taken to Physiotherapy Room II. Drank 2 cups

11:00 P.M. Patient quiet and appears to be sleeping. 36

As the night nurse’s experience shows, nursing was not just a matter of carrying out fixed procedures, but varied depending on a patient’s condition. Considered together, the different examples also underscore the forceful, physical, and pragmatic actions that were required of a nurse if she was to effectively handle patients. Her actions were all the more important during an era that preceded many of today’s commonly used medical treatments, such as the administration of antibiotics—an era in which the main offering of hospitals was, unquestionably, nursing skill.

Yet nursing entailed more than simply handling patients. In 1920, for instance, a senior nursing apprentice named Gertrude Rothschild was hailed as “a very capable charge nurse” for being able to “manage both patient and doctors.”37 This praise is noteworthy because it contradicts usual arguments that apprenticeship stressed passivity and subservience. It was through the apprenticeship system, according to such arguments, that “the rank and file in nursing were persuaded to believe in their inferiority.”38 If true, however, such a system would have left few if any individuals who were able to manage doctors, let alone patients.

Miss Rothschild’s praise is also one of the few references to physicians in the records of the St. Luke’s nurses. This was unexpected, given the deeply entrenched notion that “loyalty and deference to the physician . . . were stressed” in hospital programs.39 Certainly one outcome of this stress would have been that physicians were mentioned with some regularity, at the very least in regard to disciplinary issues which, as discussed in the next chapter, were described in meticulous detail. If there was a near absence of comments regarding doctors, however, the records were replete with descriptions of how nurses managed “the help,” primarily maids and male attendants, and “junior nurses,” those individuals who were relatively new to training.40 In one example, a senior apprentice was criticized by the superintendent of nursing because “she seemed to antagonize many of the junior nurses.” As a result, “Her associates . . . did not enjoy working under her.”41

The reality of work and practice at St. Luke’s was that the world of the nurse and the world of the physician were widely separated. Of necessity, the two worlds occasionally converged, but as swiftly as they came together they once again parted. According to Baer, a well-known nurse historian, the reason “this separateness of practice area . . . has never been, substantially recognized . . . (is) because medicine and nursing share a locus of
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work, a clientele group, and have certain overlapping functions.” Consequently, “this notion of relative amounts of authority is seen as the issue when it is not the issue.”42

The issue, as Nightingale and subsequent nurses argued, was that women had to be in charge of women because “in disciplinary matters a woman only can understand a woman.”43 Even the insistence on obedience to doctors, according to one historian, is best interpreted as “a shrewd understanding of the problems of women exercising control in a male dominated society.”44 What existed was an unwritten, but commonly understood trade-off, according to which “nurses would obey doctors’ medical orders but those doctors had no rights to direct nursing work or to discipline an individual nurse.”45

Aside from handling patients and managing attendants, maids, and junior nurses, the nurse was also expected to oversee the physical setting in which she worked. Consequently, a nurse was immediately applauded if she “manage(d) the sick room well,” “left the ward in good condition,” or “handled (the) floor nicely” (see figures 6A–6B).46 Yet just as quickly, she was criticized for the opposite actions, such as a 1928 nurse who was chided for leaving “the floor in a mess.”47 If a nurse excelled in the daunting task of handling patients, workers, and ward, she earned the ultimate praise, “an all around good nurse,” as Elmyra Nelson did in 1922.48 Before earning this accolade, however, her ability to handle such disparate responsibilities would have been judged against the overall goal of nursing.

At St. Luke’s the goal of nursing consistently focused on a tangible outcome. This was similar to artisans in other fields, such as seamstresses and shoemakers. Handling and managing were intended to produce, in the words of the nurses, “work that has a finished appearance.”49 This phrase, more than any other, was used to gauge an individual’s overall success in nursing.

Alice Thompson was judged to be a “conscientious nurse,” for example, because “her work presented a finished appearance and her patients were fond of her.”50 Several years later, a Wisconsin nurse was deemed to be “a splendid worker,” based on the fact that “her work always looks finished . . . her ward is in good condition at all times.”51 With the same goal in mind, supervisors praised one of the last women to graduate from St. Luke’s for doing “neat, finished bedside nursing.”52 Conversely, another nurse was admonished because “she is a slow worker and her work does not present a finished appearance.”53

Like the actions of handling, managing, and controlling, the goal of fin-
ished work encompassed more than a first glance might suggest. Beyond simply completing or finishing a task, it referred to the more general and observable end result of nursing work. Of course, specific results tended to vary depending on the situation. In the diet kitchen, for instance, finished work was equated with “serv(ing) lovely trays” and “taking an interest in having the trays look nice,” whereas finished work in the operating room meant “keeping equipment in order and ... good condition.” In the broadest range of nursing situations, finished work was demonstrated by maintaining “tidy rooms” and a “neat ward (or floor).” Indeed, one of the earliest and most repeated instructions that each nurse received was that the “appearance of (the) ward should have a finished look at 7 A.M. (and) ... at 7 P.M.”

Nurses were evaluated in regard to their direct involvement with patients in similarly concrete terms. “Keeping babies clean and dry,” for example, constituted “neat, finished appearing work” for an individual assigned to the nursery. In general, a nurse’s bedside work was measured on the basis of whether or not patients were properly positioned, in orderly surroundings, and that “routine work ... was thoroughly completed.” The latter included such tasks as feeding, bathing, and “toileting” patients. Finished work with patients also required that additional “procedures were properly done,” including techniques and treatments that went well beyond the routine. If a nurse’s work with patients presented a finished appearance in all of these aspects, then patients would “speak well of the nurse,” or so it was assumed (see figures 7 and 8).

Whether the work was routine or not, it generally required a nurse to follow specific and detailed steps. To make a finished-appearing bed at St. Luke’s, for example, a nurse had to first assemble eleven pieces of “equipment” before proceeding through the twelve steps of bed making. This was a simple matter, however, compared to the eighteen steps for administering a hot pack or the twenty-one steps necessary for giving a bath. Yet all of these were routine tasks, overshadowed by the even greater detail and skill demanded in more complex procedures, such as urinary catheterization, dressing burns, gastrogavage (feeding the patient through a tube to the stomach), and hypodermoclysis (injection of fluids into subcutaneous tissue).

Meticulous attention to detail was the norm not only at St. Luke’s, but elsewhere as well. In one study of nurses’ work from 1920 to 1939, the author described the elaborate procedure involved in administering a hypodermic injection. To prepare for this procedure, the nurse began by setting up “a small tray with the medication, a sterile jar with alcohol and sterile sponges, one jar containing the needles, another with the alcohol and hypodermic syringe, a small bottle of alcohol and one of sterile water, an alcohol lamp and spoon, and matches.” In its entirety, the process of...
doing finished-appearing work in giving an injection demanded that a nurse carefully implement no less than seventeen steps:

1. Have medication ready.
2. Test your needle.
3. Place needle with stilette in spoon and cover with water.
4. Boil over lamp two minutes.
5. Place cover over wick.
6. Rinse out barrel of syringe.
7. Draw amount of water required into syringe.
8. Discard water remaining in spoon.
9. Attach needle to syringe and remove stilette.
10. Place tablets on spoon and dissolve with water in syringe.
11. Draw prepared fluid into syringe, taking up last drop.
12. Expel air from syringe.
13. Pick up sponge on point of needle and replace tray in cupboard.
14. Cleanse the area, make a cushion of flesh and insert quickly.
15. Withdraw slightly and insert fluid slowly.
16. Withdraw needle quickly, massage area gently with a circular motion.
17. Chart time, medication and initials immediately after giving drug, and mark off in order book.62

The ability to produce neat, finished-appearing work, by mastering hypodermic injections and the many other complex tasks of nursing, must have seemed a daunting undertaking for new entrants to the hospital program. Of course, the need to flawlessly execute the intricacies of nursing work also provided the justification for the months and years of practice to which each woman committed herself. Yet practice alone was of little value unless the nurse could also command the physical strength and skill that underlay nearly all of the procedures that she was called upon to do. If successful in mustering these qualities and completing a particular procedure, the nurse’s expertise was duly noted on the “Record of Nursing Procedures” (see figures 9A–9B). This record was second in importance only to the monthly record, which documented time in training. For all of the women, it was consistently used to track their progress, with the title of graduate nurse limited to apprentices who demonstrated finished-appearing procedures in class and actual clinical situations.

The central importance of carrying out procedures epitomized nursing’s
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traditional emphasis on practical learning and experience, a tradition that even today casts doubt on knowledge gained mainly from books. The reality of this situation, and the ongoing struggle to define the nature of nursing, is often brought to awareness in small, easily overlooked ways. For us, one reminder came during a recent visit to a prestigious university school of nursing in the eastern United States. On the way from the airport, Olson shared a taxi with an energetic, self-described “factory nurse” (occupational health nurse) who lived in the same area as the university. The nurse was more than willing to provide her impression of the school of nursing, though she added that she was not a baccalaureate nurse. She explained that, while the university nursing students take an impressive list of courses, the problem is that even after graduation “they can’t control the (hospital) unit.”

Yet the finely honed skills that transformed a probie into an experienced nurse, with a confidence equal to any skilled artisan, were veiled by the assumption that “skill” was something masculine, both in how it was defined and in who was allowed to attain it. This gave nurses’ work a kind of invisibility, and with it a corresponding remarkable freedom to shape their own domain, since what they did was not seen as overlapping or in the way of the masculine jurisdiction of medicine. Invisibility, then, was a mixed blessing for nurses. It was far from unique, being common in other predominately female occupations. For example, a study of clerical workers during the last part of this century revealed “a whole array of positions,” from office management to healthcare coordination, in which male supervisors were “full of personal praise” for the women occupying these positions, “but the work itself was never considered.” In each instance, it was found, a woman’s job responsibilities and accomplishments were hidden under the heading: “low level (female) clerical support.”

Although the exact nature of nursing may have been hidden to many outside this field, among the women of St. Luke’s it was well understood. For them, nursing meant handling, managing, and controlling individuals, as well as situations, with the aim of producing neat, finished-appearing work. What is glaringly absent from their idea of nursing is the term “caring” and the various words associated with caring that were in common use during this period: “nurturing,” “soothing,” and “comforting.” Instead, “handling,” “managing,” and “controlling” were the constant terms used to report and assess nurses’ work. Ironically in today’s perspective, when “care” was mentioned, it was in reference to inanimate things, such as “care of room or ward” or “care of bed and bedding.”
Equally unlikely as finding expressions of caring in the conversations and reports of the St. Luke's nurses is trying to find room for their definition of nursing within the current rhetoric of caring. Typical of other accounts in the nursing literature, an article in the *Journal of Nursing Education* claims a historic basis for the following interpretation of caring and, by implication, nursing: “assisting another to grow in a cognitive and emotional sense so that the receiver of the care may become self-actualized.”

In another recent example, nursing, “the philosophy and science of caring,” is depicted as “mental-spiritual growth for self and others; finding meaning in one’s own existence and experiences; discovering inner power and control; and potentiating instances of transcendence and self-healing.” A frequently cited expert on caring and nursing adds that receptivity is the key to accomplishing these aims, explaining that caring occurs when the nurse “receives the other” (the patient) completely.

In sharp contrast, the definition of nursing that was reinforced year after year among the women of St. Luke’s emphasized an approach to nursing that was based in action, force, and pragmatism, not receptivity. To maintain that their view of nursing can be subsumed within contemporary notions of caring, as nursing leaders essentially have tried to do, threatens to enlarge this concept beyond usefulness. Consider, for a moment, the following description of caring and nursing offered by a noted historian of nursing: “an unbounded act, difficult to define, even harder to control.” Although an attitude of caring may be implicit in nursing, the St. Luke’s nurses would have had difficulty understanding, let alone accepting, such a nebulous expression of nursing action. For them, nursing was neither vague nor uncertain, but a clearly delineated endeavor that embraced physical strength, physical closeness, and physical skill.

No doubt these early nurses would have echoed the sentiment of one contemporary nurse who, frustrated with the present discourse on caring, declares “caring alone is not enough.” This same nurse argues that a more suitable view of nursing is one that recognizes that “nurses today . . . must reason well, make deliberative judgments, and speak forcefully.” She credits her insight on nursing to the legacy of early-twentieth-century nursing activist Lillian Wald, whom she states took an action-oriented, assertive approach to nursing. As fitting as it may be for present-day nurses, this “new” approach would also seem very familiar to the women of St. Luke’s.

Still unexplained, however, is the wide gap between the perception of nursing by early rank-and-file nurses, and the more visible interpretations espoused by nursing leaders and historians. Part of the explanation is that modern claims to caring seem to make intuitive sense, as they build on traditional ideas of femininity. The receptive and nurturing qualities associ-
ated with caring emerge from a highly gendered and psychologized interpretation of women's different socialization and social experiences relative to men. Consequently, information to the contrary can be rejected, or at least reframed, if it does not fit preconceived notions. As sociologist Steinberg observes, “The central defining characteristics of jobs are often perceived in terms that are consistent with sex-role stereotypes.”

Exploring job perception further, Steinberg takes special note of authority, an aspect of work that is implicit in the St. Luke’s terms of handling, managing, and controlling. She asserts, “Authority is part of the male sex role, and everyone sees the authority associated with male work, while the authority associated with female work is invisible.” For nurses, most of whom are women, work such as handling, controlling, and managing thus remains hidden, obscured by explanations that seem to have a better fit with accepted beliefs about work and gender.

Arguments that a receptive and nurturing caring is the historic essence of nursing also stem from nursing leaders today identifying this concept as the focal point of their field’s special knowledge. “One of the most consistent strategies to achieve professionalization for nursing,” explains a nurse sociologist, “has been the attempt to acquire a unique knowledge base, the possession of such knowledge being seen as one of the essential traits of a ‘true’ profession.” And yet, while prominent nurses, particularly those in academia, continue to promote the centrality of caring, they have consistently acted to distance nurses earning baccalaureate and graduate degrees from direct participation in providing such care.

A dean emeritus of one of the nation’s foremost schools of nursing acknowledges that “the vast majority of nurses with university education have either no or limited contact in the health services with patients.” Nonetheless, this fact does not deter him from asserting, along with numerous other nursing leaders, that entry into nursing practice should be at the doctoral level, rather than the current system in which individuals may enter with a two-year degree, a three-year hospital diploma, or a baccalaureate degree. While this assertion might be effective as a professionalizing strategy, it runs the risk of condoning the idea that nurses are a small and elite group that, by definition, does not deliver nursing care but coordinates it and provides backup through advanced knowledge and skills.

An associate dean at another leading school of nursing confirms that “the functions for nursing as a member of the health care team have moved away from being primarily the provider of total patient care to manager of the delivery of care.” The resultant deskilling of nursing means that university-educated nurses are frequently in the position of just arranging for nursing to be done by others, most of whom are minimally qualified nursing assistants,
rather than doing the work themselves. The irony of this situation was recently depicted in a Better Homes and Gardens cartoon in which a nurse tells a patient, “The doctor’s nurse’s aides’ assistant can see you now.”

Not only does the notion of a singular tradition of caring clash with the experience of the St. Luke’s nurses, but the dedication to a psychological caring ideal by nursing leaders is doubtful, given their repeated calls for reforms that would only widen the gap between nurses and patients. Caring, as understood in both the past and the present, could simply be one of several unspoken traditions that have been handed down to succeeding generations of nurses, a part of nursing that, as some contend, is “unrecordable and hence not entirely legitimate.” To rely on this part to define the whole, though, particularly in regard to understanding nursing history, tends to cloud other meanings of nursing, especially those in evidence among ordinary nurses. In fact, the persistence of disparate meanings and traditions helps to explain the deep divisions that continue to plague nursing in the United States, divisions that preclude agreement on even the basic issue of what preparation one must have to be called a nurse.

For the women of St. Luke’s, caring was a subtext to a definition of themselves and their work that challenges traditional ways of viewing women in general, and nurses in particular, in the past. Handling the sick, managing other workers, and controlling the ward, all to produce neat, finished-appearing work, were responsibilities that held consistent to the nurses’ frequently stated ideals of physical and mental stamina and skill. In addition, the fact that practical learning was not sacrificed to service at St. Luke’s, as historians have previously argued was normative, fit with the apprentices’ expectations about mastering nursing techniques through an extended period of hard work and training. At the same time, the emphasis on hands-on experience versus book learning and theory matched the women’s belief that common sense and practical ability were more important than intellect and scholastic talent.

To this point, however, we’ve considered the women as one group, regardless of whether or not they completed the nursing program. In general, all the nurses seem to have shared common expectations and heard similar messages about their chosen field, as well as having faced the same arduous schedule of work and training. Of course, this begs the question of why some left training early while others remained until graduation. Most importantly, what do the experiences of those who left early suggest about the image of nursing that has begun to emerge from St. Luke’s? These questions are the focus of the next chapter.