Reimagining Nursing’s Place in the History of Clinical Practice

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ABSTRACT. This work posits how medical history might be conceptualized if nurses and nursing history was used as the analytical lens. Nursing is seen not as a separate part or subsection of medical history, but rather one that is deeply embedded in the relationships and social order of clinical practice. Nursing is an analytical category in and of itself. By approaching nursing as such a category, we enlarge “new notions of historical significance” to encompass personal, political, public, and private activities that constitute medical experiences. KEYWORDS: nursing history, nurses, nurse practitioners, gender, medical history, clinical practice.

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CHARLES Rosenberg was one of the first historians of medicine to imagine nurses within the wonderfully complicated, sometimes idiosyncratic, but always critically important world of clinical practice. And Rosenberg was also one of the first to imagine nurses within the intellectual world of the “new” medical history, a history whose emphasis on the social as well as the intellectual dimensions of clinical practice has profoundly influenced how we think about patients, how we put this thinking into

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action, and how we decide if what we did worked.¹ He challenged nurses to consider the ways in which they and their care inevitably reflect, yet transcend the particular clinical and social world in which they practice. And he has always reminded us that, however much he might himself privilege physicians and their work, the development of roles and relationships in clinical practice is ultimately a matter of historical contingency, not of necessity nor fixed.²

Rosenberg has helped put nursing into medical history: nurses made hospital and medical practices possible. But has putting nursing into medical history done more than simply create a more nuanced historical world of clinical practice?³ We suggest that it has. In this article we address the question, what would a history of clinical practice look like from a nursing perspective? We would like to share the results of some of our thoughts, and speculate, as well, about how a history of clinical practice that draws as much from a nurse’s and a patient’s as well as a physician’s perspective might direct new research in the field. We see nursing not as a separate part or subsection of medical history, but rather one that is deeply embedded in the relationships and social order of clinical practice. We, in fact, argue that nursing is, to borrow from Joan Scott, an “analytical category” in and of itself.⁴ And we argue that by approaching nursing as such a category, we enlarge “new notions of historical significance” to encompass personal, political, public, and private activities that constitute medical experiences.

What, then, might a history of clinical practice, Rosenberg’s enduring interest, look like from a nursing and patient perspective? First, it might mean, in historian Joan Lynaugh’s frequent phrase, the “death of diagnosis” as the central event in an illness experience.⁵ As Rosenberg has argued, physicians have always been strategically

¹. Charles Rosenberg has always served as a trusted and generous advisor to our research studies; he encouraged the development of the Center for the Study of the History of Nursing at the University of Pennsylvania, and he served on the advisory board for several years.


⁴. Scott, “Gender: A Useful Category of Historical Analysis,” 1053.

situated to develop a language and to formalize particular methods to categorize disease. And, as Rosenberg also points out in *Framing Disease*, those who have the power to create the categories are well positioned to “rationalize, mediate and legitimate relationships between individuals and institutions in a bureaucratic society.”

As nurses and historians, we admit to an ideological bias in our argument about the death of diagnosis: as long as diagnosis is prioritized, and as long as physicians are analytically positioned as holding the keys to this particular process, nurses and, indeed, patients themselves can only be seen as subordinate players in the illness experience.

But our own research also suggests that however important diagnosis, the individual, social, and cultural processes of actually experiencing a particular set of signs and symptoms is often more important at a particular time and place than the process of naming that experience. Rosenberg himself notes that the patient’s experience and particular identity constructed by “pain, sickness and death” is unavoidable and “at some level inaccessible to medicine’s changing understanding of disease and the tools for managing it.”

Perspective from a nursing lens may make the patient’s “experienced identity” more accessible. There are, indeed, examples in nursing history scholarship that illustrate the power of this perspective. Karen Buhler-Wilkerson’s work on the history of home care, *No Place Like Home*, stands as a seminal example. Her work examines how the naming of a cluster of symptoms such as shortness of breath and fatigue as “congestive heart failure” fails to muster the resources needed by families and patients cared for at home. Such a diagnosis does help decide treatment and predict prognosis, and as our physician-colleagues have noted, unlocks financial resources; but it also tells us little about the individual’s and, even more importantly, the family’s interpretations, needs, and resources. In Buhler-Wilkerson’s study, in fact, the needs of families—for skilled

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care, for respite care, for long-term care, and, as importantly, for social and financial support—structure the historical work of home care agencies. In other words, the diagnosis fails to follow the patient home from hospitals or clinics. To care for individual members with congestive heart failure, to continue our example, families indeed needed medication and medical monitoring. But they also needed and asked home care agencies to help them negotiate equally pressing needs for income replacement, support for reordered relationships, transportation to clinics, assistance with hygiene and food preparation—all issues that shaped the lived experience of the disease as much as or more so than diagnosis. These needs, in fact, transcended almost everything else at particular times and places, and, more importantly, never fell neatly into medical categories.

Second, considering the history of clinical practice from a nursing perspective values both making things and making things work. It relishes technological challenges, and it sees the patient beneath the machines. As Julie Fairman and Joan Lynaugh have argued in their study of critical care nurses, *Critical Care Nursing: A History*, the concentration of vigilant and experienced nurses at the bedside, rather than new technology or medical therapeutics, put “intensive” into intensive care.\(^9\) Likewise, as Kathleen Burke argued in her study of the Swan–Ganz catheter, inserting a catheter into a central vein and floating it into the right atrium, the right ventricle, and into the pulmonary artery outflow tract to measure filling pressures of the heart, among other things, almost as a sailboat skimmed the ocean into port (in Dr. Swan’s words)—was indeed a wonderful technological breakthrough in cardiac care.\(^10\) But, she argues, it did not work with patients until the nurses, who were responsible for the functioning of the catheters at the bedside or catheterization lab, brought out their adhesive tape and pliers and literally made the Swan–Ganz catheter do in practice what it was meant to do in theory.

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Third, in important ways, integrating a nursing perspective into medical history also allows one to more fully understand what Jack Pressman, in *Last Resort*, describes as the “human element” in the history of clinical practice.\(^{11}\) In Pressman’s work, the reality of the undeniable suffering of hopelessly insane men and women doomed to miserable lives on the back wards of under-funded state asylums collides with the physicians’ training and genuine wish to “do something” in the face of perceived helplessness.\(^{12}\) The results, that is, the program of psychosurgery, were a disaster. In fact, the alternative to the pervasive technical, functional, and cure-driven concept of “doing something” was not, as physicians believed, doing nothing and thus abandoning their troubled patients. As contemporary nursing theorists have long argued, “being with” is often as powerful a therapeutic practice as “doing to.”\(^{13}\) Admittedly, given the state of the current acute care health system with its nursing shortage and high patient complexity, the notion of “being with” may exist largely in the breech (except, of course, for the vigilance that families, friends, and private duty nurses provide). Still, the idea that there may be other noncurative therapeutic options allows one to move beyond a starkly dichotomized discourse of something versus nothing and explores alternate possibilities.

Those involved with the contemporary hospice movement, perhaps more than any other group of clinicians, patients, and families, recognize alternate possibilities. To them, dying is a context, a process, and a place.\(^{14}\) It is not a diagnosis. Although physicians and insurers may control access to hospice services, hospice is a place where doing nothing—no further heroic or curative treatments—becomes transformed into doing something—relief of pain and support for patients and families. Diagnosis is, in fact, irrelevant. Indeed, it may be that at the end of an illness experience—when someone is dying—that the idea of the “death


\(^{12}\) Ibid.


of diagnosis” as the central event in the illness experience is metaphorically writ large.

What such alternate possibilities, then, might direct new research in the history of clinical practice? Our more recent work suggests that, first, we might move toward examining the historical perspectives and experiences of patients and practitioners in the context of their complete lives, not just the parts of or the times in their lives when they may be involved in the illness experience or process of naming illness through a formal diagnosis. Granted, we are doing fairly well in recognizing and understanding patients’ illness experiences in the context of their whole lives. We need only look to Chris Feudtner’s work in *Bittersweet* and Keith Wailoo’s in *Drawing Blood*, for example. Feudtner and Wailoo build their arguments about the construction of the diseases diabetes and sickle cell anemia, respectively, from the foundation of the patient’s daily life experiences within particular social structures such as their families or communities—experiences structured as much by disease as by their gender, race, and class.

But what about practitioners? Rosenberg, as we well know, was quite interested in the men and women who nursed in the historical hospital. His nineteenth-century hospital trustees, superintendents, and physicians may have written the ostensible rules staff and patients were to follow. But, in Rosenberg’s mind, it was the nurses and the student nurses who actually defined their and their patients’ day-to-day experiences. During the early nineteenth century, the class-based alliances formed between nurses and their patients mitigated harsh and oppressive moral oversight that their social betters often brought to bear. Later, as nursing itself changed into a respected and respectable career option for women, alliances crossed class lines. Rosenberg saw, quite correctly, that the now newly “trained” late nineteenth-century nurses identified less with their patients and more with physicians’ and with physicians’ increasing authority. Trained nurses did so to legitimate their own claims to professional practice, and as a way of countering the power of lay

overseers. But, Rosenberg argued, it resulted in a particularly awkward piece of business and problematic relationship: the nature of the physician–nurse relationship in clinical practice assumed the historical subordination of nursing to physicians.16

But, perhaps assumptions about nurses’ historical subordination are just one particular historical perspective normalized by their invisibility in and exclusion from medically centered narratives. The historical hospital had its own bureaucratic imperatives and its own particular workforces with particular hierarchies and explanations. But as Patricia D’Antonio suggests, however important the historical hospital was for shaping nurses’ clinical identity and skill, the hospital was never quite the historical workshop for nurses that it was for physicians. Her work on late nineteenth- and early twentieth-century hospital nurses—nurses who were students whose structural position always makes them innately subordinate—knew of, and, in fact, eagerly anticipated, the “disconnect” between their training and their subsequent lives outside the hospital walls. Most graduated to positions in patients’ homes as private duty or public health nurses, and many of them eventually returned to their own homes as trusted and respected members of their social (rather than their medical) communities.

Indeed, D’Antonio, in the nineteenth century, and Fairman, in the twentieth, suggest that some physicians actively “courted” nurses because they sensed the economic and professional promise of “trained assistants” or “educated allies” during times of declining patient loyalty and trust.17 Those physicians, writing nineteenth-century home care manuals or supporting the later twentieth-century nurse practitioner movements, believed that if they could find competent collaborators who could provide some of the personal, hands on care that took so much time, they might, by proxy, gain back some of the public’s trust, support their own

professionalizing agendas, and improve patient care. And they did find such collaborators in nurses. The character of these new kinds of collaborative relationships depended on person, time, and place. Relationships in the hospital, for example, were more constrained by bureaucratic and professional hierarchies, while those in public health and other outpatient settings were less structured, more flexible, and highly individualized.\(^{18}\) But the essential point is that nurses and physicians agreed to work together to develop and participate in new clinical practice relationships. And in these kinds of agreements, we can see the alternative possibilities that open when we consider nurses and physicians in relation to each other rather than in isolation, and if we move away from the discrete categories of doctors and nurses and concentrate instead on the more fluid and mutually constitutive processes of doctoring and nursing.\(^{19}\)

A second alternate possibility that might direct new historical research in clinical practice is that what we now term “alternative” practitioners may not be quite so “alternative,” thus questioning traditional disciplinary paradigms and assumptions of historical significance that position medicine as the normative provider and paradigm in American health care. American nurses, in fact, represent the largest health professional group and influence all aspects of the health care system and health policy. By numbers alone, nurses’ history brings important perspectives to the surface. The profession itself is also highly heterogeneous and idiosyncratic, providing an appropriate case for reflecting upon an equally heterogeneous and idiosyncratic American health system in general. Furthermore, nurses are highly specialized in terms of education level, practice skills, and clinical knowledge. As such, they are emblematic of the specialization of American health care. This historical standpoint provides a new perspective for exploring the historically contingent relationships among the social, political, and economic forces that shaped contemporary health care. Categories of “alternative” or “the norm” are no longer fixed or devoid of contextual interpretation.


Taking this point further, nurses (both individually and as a heterogeneous group) are emblematic of the entrepreneurial, quite contingent, and ultimately enduring process of deciding who actually owns medical skills and knowledge. Lynaugh, when describing the emergence of the nurse practitioner movement in the later half of the twentieth century, describes the process quite nicely. “We were,” she claims, “looking for an exam room of our own.”

She and supportive medical colleagues, including the late Barbara Bates (herself a student too of Rosenberg’s), were negotiating authoritative access to patients who needed nursing care both inside and outside institutional walls. The process was not dyadic (that of nurse and physician), although as practitioners or historians, we may often think so. It was, at the very least, “triadic,” involving nurses, physicians, and patients and their families with their own social and cultural beliefs. These actors substantively influenced the debates, the negotiations, and, ultimately, the resolutions or, at least, the temporary truces surrounding sources of power in clinical practice.

Our third alternative possibility emphasizes the “clinical moment” when a practitioner and a patient communicate to develop an objective and subjective “picture” of the clinical encounter. These moments drive substantive change. We, too, love the process of diagnosis (perhaps the most politically powerful example of both a subjective and objective story)—and the historical nurses we study do it all the time. But the fact that they do (did) has led us to think about diagnosis as part of a larger system of time and place (and certainly Rosenberg would agree) and as both a highly public and private process owned as much by patients and institutions (and, we need to add: the state, the pharmaceutical industry, and the insurers and the insured) as by practitioners. We think about diagnosis, then, as a process of arriving at a particular

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20. Joan Lynaugh, personal communication with Julie Fairman, 13 January 2006. Lynaugh’s conceptualization of NPs is both structural and metaphorical, and it borrows from Virginia Woolf’s essays on the historical place of women as writers and as subjects in fictional literature. See Woolf, *A Room of One’s Own* (1929; New York: Harcourt Brace Modern Classics, 1991).

name, not just the name itself. And, we think about diagnosis as less the exclusive provenance of medicine and more as an organizing strategy of engagement used by many, including patients and nurses.

Our suggestion of this as an alternate possibility is informed by our own clinical practices. We see it in the disruptiveness of an insane patient, the instability of a critically ill patient, the struggles of laboring woman, or the frustration of a family attempting to care for a sick member at home. This possibility, from our perspective, assumes the validity of the experiences of patients, families, and practitioners, and the reality of their participation in the process of thinking, discussing, and rethinking what is happening, and then doing something. We sense how it provides a sense of structure, containment, and control for them. In our minds, then, diagnosis can still be seen, as Rosenberg has explained, as mediating social and political actions. But we believe it is no longer medically privileged: it is a tool used by all for many different purposes.

In offering these new perspectives, we are responding to Rosenberg’s challenge to us (all of us, not just those of us who are nurses) to articulate why nursing was important to the structure of clinical practice. Other historians with both clinical and liberal arts backgrounds have responded, and their particular historical analyses of nursing draw from many different ideological, theoretical, and methodological perspectives. Some attend to nursing actors; others to nursing organizations; and still others to the place of the discipline in more expansive social and cultural contexts. Some borrow the language of paternalism and victimization; others analyze the relationship between nursing and the gendered discourses of science and professionalism. For all their admitted differences, however, these studies share one common theme: they are all studies that emphasize constraints faced in historical nursing practice. They all portray the various aspects of the seemingly insurmountable ideological, structural, and political obstacles nurses faced as they tried to access the privileged world of men, machines, and medicine.  

But nurses had little use for such perceived constraints and actively pursued and expanded their clinical practice. In Lynaugh’s words, they found their own exam room. They believed they

succeeded because, in spite of constraints, they found their ways to patients who needed nursing care; they carved out the physical, intellectual, and social space they needed for their practice; and they dreamed about the possibilities of their work both alone and in collaboration with sympathetic (or, at least, quite pragmatic) physicians. Rosenberg, standing outside their particular world, acknowledged nurses’ importance to clinical practice. But in Rosenberg’s work, the positioning of nurses was framed by the power he assigned to professional medicine and medical practice.

We challenge this placement because we assume the normative power of nursing in clinical practice. This challenge does not require a disempowering of medicine. Rather, it changes the gaze and makes us focus in a different way on the persons, activities, and the systems that operate quietly but critically outside the margins of traditional power sources. Nursing as normative is, as Joan Scott might note, “a useful category of analysis.” This subjectivity assumes the existence of a powerful combined intellectual force for understanding the place of health and illness in American society, and in the end, clinical care.²³ It goes beyond analyzing nursing as a separate entity and as a valid subject and instead insists nursing is relational and instructive to understanding the larger complexities of the politics of health and illness. This is not just a subject for nurses or women historians who have traditionally shown the most interest in the history of nursing as a subject. Nor should this be a partisan or ideological approach. Scholarship framed by various historical paradigms needs to attend to the mechanism Rosenberg first offered in Care of Strangers.²⁴

But historians must go beyond Care of Strangers to mine the rich perspectives nurses offer. Nurses’ (our) eyes see different things; our experiences shape different points of view; and our interests construct different questions. We have welcomed the resurgence of interest in nursing history that accompanied the historiographical shift of interest to the experiences of those on the margins of the practices of the “great doctors” and structures of the grand institutions. The persistence of the language of marginalization, however illustrative, still presents intellectual difficulties. We do not

²³. Scott, “Gender: A Useful Category of Historical Analysis.”
²⁴. Rosenberg, Care of Strangers.
place our nurses on the margins: for us, they are the core of clinical practice, a place that can be obscured by the hegemony of medicine and the power of economics. Nurses may seem marginal to historians of medicine because their class and gendered, structural place and authority has always made it necessary for nurses to negotiate and forms alliances to achieve ends, necessitating a positionality that is always shifting in response to the needs of patients and the nurses themselves.

This is a different model of thinking about the possibilities of change, complexity, and power in clinical practice—it requires a certain analytical nimbleness and comfort with accommodation and uncertainty, and thus a broader historical understanding of contemporary health needs. Our argument about nursing builds on the tradition Rosenberg helped set for our discipline: nursing is as central to the history of clinical practice as it is already to our health care system and to our American society.

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