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Nursing in Brazil: a sociological perspective on a successful journey (1920-1950)

Enfermagem no Brasil: perspectiva sociológica de uma trajetória de sucesso (1920-1950)

Luiz Antonio de Castro-Santos* 

ABSTRACT

The article analyses the institutionalization of the nursing profession, by reviewing its historical backgrounds, highlighting the role of the engagement and association between those who propagated new principles and practices for caring, and the professional models that prevailed at different times. It reveals how the professional, cultural and political environment, and especially the degree of State intervention, were jointly responsible for shaping the standards for professional development and labor in each country or region. And then examines the development of the profession in Brazil.

Keywords: nursing, sociology of professions, hospital model, public health nursing, psychiatric nursing.

RESUMO

O artigo analisa a institucionalização da profissão de enfermagem, revisando seus antecedentes históricos, destacando o papel do engajamento e associação entre aqueles que propagaram novos princípios e práticas de cuidar e os modelos profissionais que prevaleceram em diferentes épocas. Revela como o ambiente profissional, cultural e político, e principalmente o grau de intervenção do Estado, foram corresponsáveis pela formação dos padrões de desenvolvimento profissional e laboral em cada país ou região. A partir disso, analisa o desenvolvimento da profissão no Brasil.

Palavras-chave: enfermagem, sociologia das profissões, modelo hospitalar, enfermagem em saúde pública, enfermagem psiquiátrica.

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I

Nursing has gradually taken shape as a professional area since the early twentieth century, or even earlier in the view of historians who highlight the legacy of Florence Nightingale (1820-1910) as a veritable rite of initiation for the profession on a world scale. Indeed, her personal influence and the strength of her charisma are not in question and have had a lasting impact in many regions of western Europe. However, the basic preconditions for professionalism received their greatest boost not only from the “lady with the lamp” – who is even today an icon of change in nursing worldwide – but more importantly from the engagement and association between those who propagated new principles and practices for caring, which changed and adapted to new scenarios in the passage from the old to the new world, defying but also integrating into long-held beliefs and routines in nursing. Countless nurses – leaders like Ethel Bedford-Fenwick in the UK, Anna-Emilie Hamilton in France, Mary Adelaide Nutting and Lavinia L. Dock in the USA, to mention a few of the most active – inspired their followers with a sense of mission and a quest for identity. It was they, amongst others, who led the strongest associations, making great inroads in the formation of a profession. By the late nineteenth century and the first decades of the twentieth century, national and international conferences and meetings provided a channel or catalyst for large scale movements and associations, which assured an exchange between nurses encouraged by professional and feminist ideals in many corners of the globe.

The literature contains some conflicting viewpoints. It is held, for instance, that long before Florence Nightingale, nursing had already become a profession. The UK provides the most revealing scenario, as it is suggested that there were many categories of male and female health workers as far back as the early 1800s, such as private duty carers for ill members of wealthy families, and physicians’ assistants in hospitals (almost always men), who helped them with dressings, bleeding, cupping, baths, the preparation and administration of potions, etc. One text that defends such an interpretation is by Dingwall, Rafferty and Webster (1988). However, these same authors also mention the possibility of a contrasting viewpoint when they indicate that private duty nurses were quite marginal in English households, while hospital assistants were only involved in routine tasks (ibid: 14-18). In both

hospitals and private spaces, “there was little technical content” (p. 18) in the activities carried out by the carers, who normally came from underprivileged classes and had no access to culture.

The point is that the hospital-based training centers in Europe were not yet emblems of professionalism, as they did not offer a systematic set of knowledge nor organized social networks (Collins, 2004) to assure the kind of interaction capable of establishing new roles or an autonomous institutional space, characteristics that would seal the *esprit de corps* of qualified nurses only later, in the late 1800s and early 1900s. In 1860, the Nightingale School of Nursing, the first prominent educational institution for nursing in Europe, adopted a hospital-inspired model, from which American institutions quickly deviated, giving greater emphasis to home visits. As Celia Davies, British historian and editor of the periodical *Rewriting Nursing History*, notes, “Nightingale’s image of the trained nurse was of the hospital matron; the American leaders were always prone to think of the private nurse in the community” (Davies, 1983, p. 53-54). These circumstances led to new kinds of support for qualified nurses, who worked alone, and community and public health services started to expand to other countries. Undoubtedly, there was some influence here of the concerted international effort to mitigate the suffering of the soldiers in the battle fields, which led to the organization of the International Committee of the Red Cross in 1863, formed by several national units, in Europe and Japan. Shortly afterwards, it became clear that the entity’s role would extend beyond troops and barracks. Historian John F. Hutchinson (1995) records the words of German public health leader, Rudolf Virchow, at the International Conference of the Red Cross in Berlin in 1869. He expressed the view that the organization should turn its efforts to the suffering of people in times of peace, not just during wartime (Hutchinson, 1995, p. 17, 21).

These specific concerns about the health of peoples fueled the first expressions of professional activism in hospital environments, led by former students of the “Nightingale schools”. One powerful sign of this resistance to the power exerted by physicians over ‘carers’, who already far outnumbered their male counterparts, was the creation of the Royal British Nurses’ Association in 1887 under the leadership of Ethel Bedford-Fenwick, who brooked the “strenuous opposition” of the Hospitals Association and Florence Nightingale (Davies, 1983, p. 55). Florence defended the need

for young candidates to have a “vocation” – a facet of professionalism that spread beyond the North and South Atlantic, reaching colonial Australia in the Pacific, and finally Korea and Japan in the early twentieth century (Godden & Helmstadter, 2004; Takahashi, 2002). Judith Godden and Carol Helmstadter raise the controversial point that “the concept of the woman’s mission undermined the equally important concept of nurses’ professional training,” (Godden & Helmstadter, 2004, p. 157). They go on to say that, ‘missionaries’ or not, these nurses had clinical knowledge that was highly effective “in the newly medicalized hospitals” (p. 164), and that the Nightingale-inspired supervisors in many parts of the world – such as Lucy Osburn, appointed Lady Superintendent at Sydney Hospital in 1868 – “were a major challenge to the patriarchal structure of the hospital,” (p. 166). As one can see, the unease caused by gender and professional domination was felt not just in public health but also in the hospital domain. As we see it, the professional ethos of “motherliness, religious commitment, repression, and moral influence” (p. 164) was never so predominant, and even if it was, its historical role must be reassessed. Rather than clashing with the professional dimension, it often provided a powerful emotional undercurrent for the attainment of a collective identity, an essential precondition for achieving greater autonomy.

Without a doubt, the first model to spread out from England was the hospital model, inspired by Florence Nightingale. During the 1890s, the supremacy of this model underwent its first review on the other side of the Atlantic at Johns Hopkins University. It was there in Baltimore that the first university course for nursing was established (Williamson, 2000). From 1890 on, it provided a unique opportunity for young students to leave the hospital ‘cloisters’ and experience the more democratic campus environment. An influential figure behind many of these changes was Ethel Bedford Fenwick, who had discussed her ideas with Adelaide Nutting and Lavinia Dock, leading figures from Johns Hopkins, at a conference about social services and philanthropy in Chicago in 1893.¹ It was there that the seeds of two entities took root: the National League of Nursing Education and the American Nurses Association (Davies, 1983, p. 50). It was there, too, that bonds of friendship and professional solidarity were forged between the different leaders, providing the beginnings of a lasting sisterhood. At

¹ I owe this information to P-Yves Saunier.

another conference, this one held by the International Council of Women in 1899, Ethel Bedford Fenwick defended a different cause: the creation of the International Council of Nurses (ICN) that very year, adding its influence to the efforts of the first American associations, which were national only up to a point, for they became key elements in the circulation of agents and ideas amongst many countries. Such was the case of the repercussions in France, where nurse Anna Hamilton, who had trained in medicine at Montpellier in 1900, took up the banner of the underrated profession of nursing in her country. As she developed her career, she bore the brunt of severe criticism from other areas of the profession, especially of a religious leaning, and “throughout her career (...) maintained a regular correspondence with nursing leaders in the United States and England” (Schultheiss, 2001, p. 86).

But the real turnabout in the conception of professional nursing ultimately owed more to political factors than to any eloquent defense of health care or the efforts of the profession's first leaders. Woodrow Wilson, President of the USA between 1913 and 1921, defended a project for a League of Nations – “the quintessence of the progressive vision”² (Wiebe, 1965, p. 216, 273, 279) and supported a proposal put forward by sanitarians to group the Red Cross organizations under a single agency linked to the League of Nations (Hutchinson, 1995, p. 23). “Wilson and his advisors,” writes Hutchinson, “were looking for some immediate and practical demonstration that the ‘international spirit’ they were invoking in Paris was not simply a figment of their own imaginations” (Hutchinson, 1995, p. 23). Many critics pointed out the supposed fragility of the International Committee of the Red Cross and the need for a more active agency to promote cooperation between its member states. In Cannes in April 1919, a conference of the committee brought together physicians and representatives of philanthropic entities, and gave over a special session to nurses. At the end, their specific proposals for the field were added to the resolutions on public health (Hutchinson, 1995, p. 25). This provided the cornerstones for the League of Red Cross Societies and a specific programmatic line called the Public Health Division.

Historian Anne Marie Rafferty discusses the rivalries that permeated – and drove forward – international cooperation in the health sector, and

² In the United States, Progressivism was a movement inspired by professionals, small urban and rural businesspeople, and the middle classes, who called for government regulation of large corporations, legislation to protect society, the abolition of child labor, and other innovative political measures. W. Wilson supported many of the movement's claims.

shows how the new League got involved in political and administrative quarrels with philanthropic entities, such as the Rockefeller Foundation, when they sought to sow the fertile field of nursing, especially public health nursing, in the years following the Great War. The Rockefeller Foundation, a favorite target of the League's attacks, sponsored public health nursing and nursing schools in the USA, Europe and Latin America from the 1920s on, such as the schools at the University of Yale and at Rio de Janeiro (Anna Nery), and provided decisive support for the creation of national nursing associations, such as the Brazilian Nursing Association (*Associação Brasileira de Enfermagem*, or ABEn), in 1926 –, as well as opening and running primary health care units in different parts of the world (Rafferty, 1995; Castro-Santos & Faria, 2004; Faria, 2006). But the clashes and quarrels were actually music to the ears of the new leaders of international nursing, which started to take on its own identity and form thanks to the political stimulus provided by the conflicts and alliances.

Though the International Council of Nurses (ICN) was created at the turn of the twentieth century, it could only be described as a kind of 'private club' for British, American and German professionals for its first twenty years or so of existence (Takahashi, 2002, p. 103). However, in the period between the wars, the political clashes mentioned between the League of Red Cross Societies, the Rockefeller Foundation, and other voluntary agencies encouraged a greater interaction and discussion between the leaders of the profession and their proposals, and 'charged the batteries' of the associations in different countries and internationally. A revitalized ICN emerged from this process. If we had to name an 'ideal' forum for the transnational connection and interchange in the field of nursing in those early years of the twentieth century, it would be the ICN. The conferences held in different countries in Europe and the Americas during that period of upheaval provided a forum for an ever richer exchange of information and interaction and reflected in time the circulation of ideas and individuals, which was even stimulated by the preparation of the many events. The agenda and topics were extremely wide-ranging, often borrowing from other forums of a similar nature, such as the meetings of the League of Red Cross Societies, the International Council of Women (Ethel Bedford Fenwick, the figure behind the ICN, was also very active in the ICW) and the International Labor Organization (created in 1919 by the Peace Treaty agreed after WWI) (Takahashi, 2002; Rafferty,

1995). Anne Marie Rafferty describes the links between the ILO and the ICN that leaders of the stature of Ethel Fenwick forged. “Drawing upon the language of the international labour movement, Mrs. Fenwick argued that ‘if the poet’s dream of the brotherhood of man is ever to be fulfilled, then surely a sisterhood of nurses is an international idea’” (Rafferty, 1995, p. 276). If the feminist and socialist aspects of the movement, as highlighted in the literature, were aired at the ICN meetings (Takahashi, 2002), then the even wider issues of citizenship and universal rights tackled by the ILO could also be envisaged (Rafferty, 1995, p. 277). Rafferty raises a controversial topic: could we be seeing an incursion of the professional domination of the USA as a kind of “subtext of internationalization” of the world of nursing? (Rafferty, 1995, p. 277). We believe that an alternative reading of the growing internationalization could be that it was a time when the British ruling power, or indeed the supremacy of any other ‘model’, lost their force, when any supposedly ‘national’ models were overthrown. But ultimately what was at stake was the political agenda or the professionalization policy within the ICN, which pointed towards a growing autonomy, a more active stance, and a strengthening of anti-patriarchal values amongst nurses in western nations. From this perspective, it hardly matters whether the British or the Americans held the ‘hegemonic role’. Nonetheless, whatever the effective progress made in the profession under the auspices of the International Council of Nurses and the growing numbers at their periodic meetings, it is impossible to ignore the contrasting picture in Asia (Takahashi, 2002), where the prospects for a strengthening of the profession were still discouraging.

Let us now turn to the new principles and practices of professionalism and how they affected the state of epidemiology. Even though some diseases like malaria, trachoma and tuberculosis were a blight common to many western and eastern societies (Castro-Santos & Faria, 2004; Healey, 2006; Murard & Zylberman, 1987; Rafferty, 1995, p. 269; Takahashi, 2002), the institutional responses to the epidemics and the attempts to meet the human resource and professional needs varied greatly from country to country. The Rockefeller Foundation’s International Health Board financed and supervised widespread campaigns against tuberculosis and malaria and nurses training programs in western and eastern Europe.³ Against

³ For an outstanding analysis of the activities of the International Health Board against tuberculosis in France, see Murard and Zylberman (1987).

this backdrop of international cooperation, there inevitably emerged a wide range of situations in different nation states. The fact is that the professional, cultural and political environment, and especially the degree of State intervention, were jointly responsible for shaping the standards for professional development and labor in each country or region. In France, for instance, there were more schisms and disagreements amongst the leaders of the profession about their respective ideas for education for the field than one might expect, given the extent to which international reformist ideas were circulating there. Historian Katrin Schultheiss discusses this topic in detail, portraying the conflict between Anna Hamilton, reformer and founder of training programs in Bordeaux which aimed to produce “highly trained career nurses”, and the religious establishment in Lyons and Paris (Schultheiss, 2001, p. 5, 7). As already mentioned, the first conferences of the International Council of Nurses back in the first decade of the twentieth century provided the forums for interchange between European and American leaders. In France, Anna Hamilton was a key participant at these conferences. Rejecting the common belief that foreign proposals “would not take hold in Catholic France,” argues Schultheiss, the reformist thrust in Bordeaux “drew liberally on the experiences of foreign reform efforts.” In Bordeaux, matrons were hired that had been trained outside France and who kept in regular contact with the international community “in an effort to establish a clear professional identity for the ‘new nurse’” (Schultheiss, 2001, p. 87). In the words of historian Pierre-Yves Saunier, “each French sub-group had its *foreign* patrons and references which were used in the national competition to design the new French nurse,” (Saunier, personal communiqué, November 13, 2006; italics added).⁴

⁴ The conclusions of a recent study that the French ‘model’ “gave precedence to democratic education” and “revolutionized the practice of nursing” (Moreira & Oguisso, 2005, p. 17) seem to us unjustified or even unfounded. There existed different schools of thought in the country, as we have tried to show. Salpêtrière allowed for democratic recruitment (but not democratic ‘education’, which is something quite different), without attempting to create a professional elite, as defended by Anna Hamilton. However, if there was any ‘revolution’ – the reformist thinking to which Schultheiss refers – it happened most especially in Bordeaux, where a professional elite developed, quite open to international experiences and the formation of associations. Thus, it would be wrong to talk of a ‘French’ revolution in nursing, especially because there was no real single model, but a deeply divided national experience. Even the struggle against the diseases of the day, like tuberculosis, was led in France with the cooperation of an international agency, the Rockefeller Foundation (Murard & Zylberman, 1987). The Foundation’s prospect for nursing was that it be professional, organized in associations, lay, and founded on the scientific knowledge of the time, which had already ceased to be ‘national’ for a long time, be it German or French.

The experience of France should sound a warning note to any scholars who may wish to build up a picture of “national models” of nurse training for that period of intense ideological awakening and wide-scale discussion about doctrines and practices. In actual fact, pure models have never taken root in the history of the profession. The interchange of ideas, which snowballed from the 1890s on⁵, makes it unfeasible to label nursing services and teaching as “national systems” (e.g. “the French model” or “the English model”, etc.). If what gradually developed was systems of an extremely hybrid nature, such as the one that has more recently been called “Anglo-American”, then these dualities and cross-fertilizations would be better described by the terms “proposals” and “trends” than “systems” or “models”.

Meanwhile, a rejection of the notion of ‘national’ nursing models does not presuppose the illusion of borderless internationalism or suchlike. For instance, there was never an international proletarian movement with cohesive ideologies, nor was there any internationally organized feminism in the strictest sense. This is not what is at play in this discussion. What we maintain is that the huge wave of reforms experienced by the participants at the ICN meetings reflected fast-spreading “transnational” currents of ideas and practices. The topics addressed in nursing education and professionalization ultimately overlapped with the issue of women, who were “out of place” politically, socially and economically, no matter where they lived. But this broad, all-encompassing picture should not lead us to neglect the national events that gave the ICN its original driving force.

Historian Susan Armeny discusses whether the machinations behind the collective action which nurses organized in the more industrialized nations in the early 1900s reveal a set of attitudes deriving from the American “sanitary

⁵ This was the year that the Escola Profissional de Enfermeiros e Enfermeiras [Professional School of Nursing] was established in Brazil at the National Hospital for the Insane in the then capital, Rio de Janeiro. A praiseworthy effort of historical reconstruction has brought to light the long period of institutional maturity of the new school of nursing, as of the first years of the Republic (see in particular Moreira, 1990). Nevertheless, these historical research efforts have frequently stirred up an old, provincial discussion about the survival or predominance of this or that foreign ‘model’ in the organization of Brazilian schools or services. In our view, such a discussion would only make more sense if it was sustained by documental research about the education systems in question, whether they be French, English or American, etc. Almerinda Moreira and Taka Oguisso make a significant contribution in this sense (Moreira & Oguisso, 2005) when they investigate the international literature in such a way that a scholar can discuss the empirical sources consulted on these educational systems, but they also draw certain conclusions from them, as in the examination for nurse training in France, which are hard to sustain in the light of that same literature. I allude to this welcome example of a study by Brazilian authors about international experience, because thus far, this is a very scarce literature if compared with the wealth of international output on the topic.

ideal". This ideological or doctrinal cornerstone burgeoned in the work of the U.S. Sanitary Commission, especially in the activities of a group of nurses and women involved in philanthropic work in the country (Armeny, 1983, p. 15, 33). Lavinia Dock was a leading figure in the political development of these ideas of sanitary reform. However, it is not easy to associate the many aspects of the "sanitary issue" to a single historical context. The dire living conditions of the working classes in Victorian Britain led critics like Engels and writers like Dickens to express their horror and outrage at the perverse effects of industrialization, and gave rise to the perception of a social and sanitary problem, which many called "the sanitary idea" (Joshi, no date). The outspoken social criticism in the countries in the throes of industrialization undoubtedly influenced the emerging professions. The "action platform" set up by Dock and her companions would never have been successful in the US or any other country if her ideas had not been circulated, reproduced and discussed on the international stage. This was, in fact, the proscenium of the struggle. As a member of the National Women's Party in the USA and secretary of the ICN, Lavinia Dock wove a vast web of contacts and debate that stretched beyond the frontiers of the USA, joining forces with her British companion, Ethel Bedford Fenwick. For both, the political issues of Nursing and Women, both with capital letters, "were one and the same" (Williamson, 2000, p. V) and needed political action to cover them both simultaneously. On the domestic front, Dock was a staunch defender of women's rights, while her companion at Johns Hopkins, Adelaide Nutting, was tackling the issue of the inferior hierarchical positions held by nurses in military hospitals and campaigns. The drama of collective action depended on international activism if it was to gain strength.

The outbreak of the First World War brought the suffragettes⁶ from Europe and the USA closer to the leaders of nursing in their common demands for higher posts in the military hierarchy (Armeny, 2003, p. 17, 29). Nevertheless, what at the time seemed to be a gain for the new professionals actually had a

⁶ The suffragettes led the struggle for female suffrage, especially in the UK, in the last decades of the nineteenth century. With their excellent organization and willingness to engage in their struggle in the decade prior to the Great War, they achieved a significant victory in 1918. Following the example of the British, in 1919 all the states of the USA gave women the right to vote. However, in France, it was only in 1944 that women gained the vote (see the entry on suffrage, "Sufrágio" in Enciclopédia Barsa, Rio de Janeiro, 1964). In Brazil, the international movement found a voice in the person of Bertha Lutz, who took up the banner in the early 1920s, a time when there was much political turmoil about education and health in Brazil. In 1922, Bertha Lutz founded the Federação para o Progresso Feminino [Federation for the Progress of Women], which defended the vote for women. Ten years later, an edict signed by President Vargas assured Brazilian women the vote. (Source: Leonardo & Marmo, undated).

less clear-cut outcome in the long run, as noted by Aya Takahashi for Japan, where military careers were a key element – if not a controversial element – in the professional training of nurses (Takahashi, 2002). Susan Armeny suggests that the compatibility between military life and the qualities of discipline could promote Taylorist schemes of administration in hospitals. The ideology of efficiency propounded by Taylorism had a profound effect on the industrial activities in the Fordist capitalism of the USA, as well as on the bureaucratic industrial standards conceived by Lenin for the Soviet Union.⁷ Even though it spread fast, penetrating the models of Soviet communism and most ‘advanced’ capitalism, it is hard to imagine it making great inroads into the area of health – even in hospitals – where the uncertainties of health and illness make it a less clear-cut proposition to adopt. Even so, Armeny says that “in the 1920s and 1930s nurse leaders did develop an interest in the scientific-management approach to efficiency” (Armeny, 2003, p. 45) with a view to rationalizing hospital work. However, a barrier against the excessive focus on “efficiency” was raised within the realm of nursing by the professional associations for visiting nurses, such as the National Organization for Public Health Nursing in the USA, which in 1922 was already ten years of age. The Goldmark report, commissioned in 1919 by the Rockefeller Foundation and published in 1923, weighed up the state of nursing in the United States and exposed performance issues on the part of new professionals (quality standards, techniques, etc.), though it did not make any proposals for quantification or set ‘productivity’ targets. When the report discussed, for instance, the “time wasted” teaching students, this was not, as one might assume, a “Taylorist” proposal, but a criticism of the disrespect and disregard with which the novices were treated, who were often forced to undertake servile tasks that were entirely alien to a professional curriculum (Goldmark, 1923, p. 342-366, esp. p. 347; Silva Junior, 2003).⁸

⁷ The text by Reinhard Bendix (1974) is essential reading on the effects of Taylorism in the contemporary world.

⁸ The situation in Brazil clearly illustrates the distinction between performance and Taylorism. A few decades after the Goldmark Report, nurse Clarice Ferrarini states, in an invaluable interview, that nursing occupied a leading position at Hospital das Clínicas in São Paulo [Sao Paulo General Hospital] – questioning medical impositions, supplying working standards for nutrition and social work professionals – because there was a “structure of service with clearly defined attributes; the other services existed – medicine, nutrition and diet, social services – but they were not as well structured, so nursing naturally took a position of leadership” (see Sanna, 2003, p. 1063). Maria Cristina Sanna clearly sees a distinction between “industrial Taylorism” and “standards of professional performance” when she refers to the pioneering role of nursing in structuring the lines of authority and conferring responsibilities and tasks within the hospital environment after the Second World War (Sanna, 2003, p. 1069).

If the issue of ‘performance’ was forced into the spotlight in the twentieth century for nursing as it was for other professional activities – a classic topic of discussion for the Sociology of Professions –, some areas of applied medical knowledge followed along very specific tracks. In the 1920s, Preventive Medicine and Public Health Nursing expanded rapidly, spreading into underdeveloped nations, especially in Latin America, where governments were focusing on ‘rural health’ and community welfare services in programs such as the prevention and fight against hookworm and other rural endemics. This was the golden age of international partnerships between State health policymakers and the Rockefeller Foundation, especially in the 1920s and 30s (Castro-Santos, 1987, 2004; Birn, 1993; Vessuri, 2001; Palmer, 2004), when rural populations, still the vast majority in all the nations in the continent, were targeted by sanitation campaigns inspired by nation-building projects and efforts to strengthen the State apparatus. This was the backdrop for the remarkable growth in public health nursing, not only in Latin America but in other parts of the west and Asia. Before the Second World War, this progress resulted mainly from steps taken by the Rockefeller Foundation and attention given by some supranational agencies (especially the League of Nations) to the concepts of preventive medicine and collective health.

One of the most controversial issues has to do with psychiatric nursing, for which the state of affairs in Brazil at that time may well represent the reality throughout Latin America and to a lesser extent the situation in central nations. Some studies suggest that there was no interest in psychiatric nursing in the first years of the Anna Nery school, in the then capital of Rio de Janeiro.⁹ When any interest was shown, it took the form of a disciplinary posture on the part of nurses centered around the administration of medications for the containment of institutionalized patients (Barros & Lucchese, 2006, p. 341). In the 1920s, however, there were opposing efforts and initiatives based on community and preventive care which contained elements of what would today be called the “critical conception of mental health nursing”, defended by Latin American leaders (Malvárez & Heredia, 2005). “Mental hygiene”, especially in the period of the Ethel Parsons Mission at the Anna Nery school, was distinguished from psychiatry, which was hospital-based, and took root in the ‘community development’ programs

⁹ Barros and Lucchese (2006, p. 340-341) quote some studies that might have a similar vision, though in our view they make some rather precipitated generalizations.

put forward by the proponents of the sociology of the ghettos and minority groups in America's largest cities. (The radical sociology of Louis Wirth, in Chicago, set out such concerns and emerged from the academic sphere to have a direct influence on the community stance taken by the social services and nursing).¹⁰ In Brazil, it was at the Oswaldo Cruz Institute in Manguinhos that these notions were given special attention, as demonstrated by the courses in Public Health given from 1940 onwards to physicians who would later become "hygienists" at SESP, the Special Public Health Service, with close ties to nursing, and at other federal and state sanitation services. One of these courses, given by Adauto Botelho and Heitor Peres, was on Mental Hygiene. This more open or situational viewpoint was also defended by the Departamento Nacional de Saúde [National Health Department] which provided nursing courses in 16 states between 1939 and 1943, qualifying some seven hundred *visitadoras* or visiting nurses for the public services (Castro Santos & Faria, 2006, p. 305, 319). Despite the progress of hospital medical technologies and the diffusion of the biomedical model (which, we maintain, was not uncontested), nursing in the largest cities of Latin America, such as São Paulo, used "psychosocial caring" as an alternative to the "psychiatry of electric shocks". A statement by Clarice Ferrarini, who was a nurse Superintendent at the Hospital das Clínicas de São Paulo for many decades, is unequivocal:

When the psychiatric clinic [at Hospital das Clinicas] opened in 1954, we had just arrived from the United States. We had spent some of that year at the Teachers College at Columbia University and we were very up to date. We would ask the medical professor at the clinic a lot of questions, I cannot recall his name, because his idea of psychiatry was to have the patient tied up inside a room [...]. I questioned this because [...] I had acquired the latest knowledge of psychology about patient treatment [...] (*apud* Sanna, 2003, p. 1062).

The historical issues involving psychiatric nursing require much more archival research and a thorough analysis of life histories and professional careers, but even so it would not be wrong to draw some links between the

¹⁰ Wirth's works on Clinical Sociology and Sociology of Nursing, published between 1928 and 1931, focus on the term "clinic" from a "situational" rather than individualist approach (Wirth, 1928, 1931). It can be seen how much the phenomenological sociology of the time was concerned with the 'mental hygiene' tradition, putting emphasis on situational factors to explain the behavior of children and the development of their personality (Burgess, 1930).

nurses' criticism of the old "madhouse" treatments in São Paulo and the psychosocial and situational approach that some leaders of the profession came into contact with when they were trained abroad at institutions such as the University of Columbia in New York and the School of Nursing in Toronto. One way or another, a fortuitous dialectic allowed their biomedical training to be "contaminated" by knowledge rooted in the humanities. The preventive medicine and community health care practices that were spreading out across the globe were ultimately engaged in a Sisyphean struggle, which the progress of the medical and hospital conglomerates would ultimately make ignoble and bound to collapse. After the Second World War, the attempts of intergovernmental agencies like the World Health Organization to promote professional nursing in Africa and Asia came up against not only organizational and cultural hurdles, which will be discussed later, but more particularly an expansion of private interests in the medical, pharmaceutical and hospital field on a world scale. In the 1960s there was already a steady expansion of the "health industry"¹¹ – an unfortunate pairing of morally contradictory words and concepts – which represented and still surely represents one of the greatest challenges to the role of a nursing profession committed to the ideals of the pioneering generations and their leaders.

II

So far we have discussed the leading figures who, against the odds and at great pains, built the groundwork for the new profession on the national and international levels, in the first decades of the twentieth century. Huge cultural, political and economic obstacles stood in the way of the protagonists of the ritual processes of professional growth and autonomy (Collins, 2004). It was not just a matter of establishing a new identity, which would mean prevailing over the previous image, which could hardly be called "professional". It was also a matter of facing up to the racial and sexual discrimination at the heart of the profession, a battle fought bravely by activists during the meetings and discussions of the International Council

¹¹ The term "health industry" (see, for instance, Fuchs, 1973) is what is known as an oxymoron: a figure of speech that denotes contradictory, apparently mutually exclusive words.

of Nurses. Despite the efforts made by their main leaders, government programs, and voluntary organizations, the social atmosphere in which the profession was emerging was stained by prejudice, albeit not necessarily by discrimination. Race was a sensitive issue the world over, and no historian could reasonably hope or suggest that the arguments of eugenics – which were stronger and more pernicious in Europe than anywhere else – would have no influence on the socialist thinkers and activists of the early twentieth century. Not even a ‘warrior’ of the stature of Lavinia Dock was unblemished: in her writings, she makes evident her prejudice against young black nurses when she recommends that they be trained and monitored by colleagues born to a “more experienced race” (*apud* Williamson, 2000, p. VI).

This charged atmosphere also affected the programs sponsored by the Rockefeller Foundation. In 1923, plans by the International Health Board to send a colored person to join the teaching staff at the brand new Anna Nery school were cancelled because of fears that a ‘half cast’ would not be well received by the ruling classes in the Brazilian capital.¹² In India, the caste system aggravated the weight of discrimination amongst social groupings with a marked disregard for women’s roles. The international consultants who prepared the training for new nurses in India, shortly after its independence, did not turn a blind eye to the ‘fragile’ constitution of Indian women, ultimately reinforcing the male domination in the hospital domain (Healey, 2006). In Japan, the traditionally submissive role of women made it little different from India in this respect. In this case, patriotic activism and the conservative ideology of the National Committee of the Red Cross, which controlled nurses’ training in the country, spread like a protective cordon against feminism and the quest for professional autonomy on the part of the leaders of the ICN. They were often called “dangerous socialists” by the authorities of the Japanese Red Cross (Takahashi, 2002, p. 94).

The fact of the matter is that there were obstacles of every kind – cultural, political, economic – standing in the way of the new educational training programs in many parts of the world and hampering the spread of professionalism globally, as defended and envisaged by the consultants from the Rockefeller Foundation for the area of nursing and by the specialists from the World Health Organization. The question facing contemporary historians could be summarized in this way: to what point could the

¹² Letter from Florence Read, of the Rockefeller Foundation’s International Health Board, New York office, to Lewis W. Hackett, Regional Director of the International Health Board in Brazil, Rio de Janeiro office. (02/02/1922; Rockefeller Archive Center, USA - 305 – R.G.1.1).

harshly segmented social structures at that time – especially in agrarian Eastern Europe, Africa, Asia and Latin America – make room for a genuinely democratic recruitment policy for nurses in both race and gender terms? In many countries, leading nurses and educators proposed the creation of small “ruling elites” at the heart of the profession as a valid strategy for winning over a field of “legitimate” knowledge in the eyes of the upper classes, thereby attracting promising young students. In other words, the idea was to produce professionals with a sense of self-esteem, a good cognitive background, and exemplary technical training, rather than submissive figures subjugated to the administration of “MDs”. There were countless preconditions for opening up new opportunities within the limited market in the public and private sectors, in hospitals or public health, which were also a source of self esteem for the new professional. In the long run, meeting these conditions would mean barring competition from unqualified girls, establishing a reasonable degree of autonomy, and overcoming their subservience within the medical hierarchy, especially in hospitals.¹³

Whether the professional training in hospital or community service was deep-rooted or not, the “bureaucratic ethos” which prized discipline, efficiency, order and hierarchy dated back to the “Sanitary Ideal” already mentioned in this essay. There was a latent tension between two clusters of values: one of a bureaucratic order, in the Weberian sense, and another set that had been closely related to the “sanitary issue” since the late nineteenth century. Meanwhile, throughout this period of intense bureaucratic organization of the profession in the sociological sense, these attributes and behaviors cohabited uncomfortably with an ethic of professionalism that emphasized the sense of “calling”, or the internalized concept of duty – also in the Weberian sense of the word (Eisenstadt, 1968, p. 28-42).¹⁴ This ultimately means that the nursing profession, maybe better than any other, foretells of the tensions between

¹³ Interestingly, even the undisputed leaders in Brazil, imbued with an almost missionary spirit of dedication to the profession, were not clear about the risks of perpetuating the elitist strategy. We can see this in the comments of Clarice Ferrarini: “We had formidable leaders at the National Nursing Association from different parts of Brazil (...) – it was a smaller, cohesive, dedicated, elite group with interests in common. Later, nursing became less exclusive (...), with universities that we are not familiar with and people from other social levels.” (Quoted in Sanna, 2003, p. 1064). Meanwhile, educational programs these days, especially at private universities, combine more democratic (onerous for some) recruitment with a less strict curriculum and a notable fall in teaching standards and academic requirements.

¹⁴ In the work edited by S. N. Eisenstadt, Chapter 4 reproduces a text by Max Weber on the meaning of discipline. We highlight here Weber’s suggestion that under certain historical circumstances, discipline has been intertwined with motivations of an ethical nature or a “sense of duty” (Eisenstadt, 1968, esp. p. 29).

existential and professional dimensions pointed out in the very thinking of Max Weber (Lazarte, 2005, p. 30). Sociologist Rolando Lazarte encapsulates this tense duality when he speaks of Weber and the twin poles of passion or vocation on the one hand, and professional or scientific know-how on the other. In fact, the author notes that the origins of science are profoundly alien to any conception of personal coldness or aloofness. Here, we see the duality that defines the very praxis of nursing.

In these days, these issues often surface in Latin America, and certainly in Brazil, with values tinged by excessive corporativism and credentialism, and by the material interests of the professional group. A struggle for better wages, the occurrence of power conflicts and litigation in professional associations and councils, the adoption of compulsory membership of unions and associations, all these factors often put in second place the ideas of solidarity and altruism which, inspired by Florence Nightingale and so many activists mentioned here, formed the moral backbone and the political legitimacy of modern nursing. Anna-Emilie Hamilton knew this professional dilemma all too well when she wrote, “in order to become a career, nursing must remain nonetheless a vocation,” (quoted in Schultheiss, 2001, p. 92; also see Paicheler, 1995). Another challenge exists for today’s leaders of the profession, who have to deal with the friction caused by the internal divisions between qualified and non-registered or attendant nurses, without being seduced by the rites of status domination which have historically marked relations between the power of physicians and ‘subordinate nursing’. Any shying away from this challenge would certainly erode identities and damage the solidarity amongst the different layers of the profession (especially the lower hierarchical levels), calling to mind the invaluable, or cautionary, writings of sociologist Erving Goffman (Goffman, 1969). There have been concerted efforts to overcome the hierarchy issues, including an examination of the psychological and educational issues involved in the professionalization of attendant nurses and nursing assistants, which has received support from international organizations such as the Kellogg Foundation, and the Human Resources Development Units of the Pan American Health Organization, which cover the whole of Latin America (Malvárez & Heredia, 2005). A third challenge particularly pertains to nursing in Latin America, which has to overcome the linguistic barriers of English and French which have hampered the flow of transnational interaction. Though the Pan American Federation

of Nursing (FEPPEn), officially founded in 1970, has strengthened the bonds between professional Portuguese- and Spanish-speaking organizations, it seems to have had the unexpected side-effect of weakening their political and intellectual relationship with the other member states of the ICN. On the intellectual plane, it is surprising and regrettable how little overlap there is between Latin American literature on nursing and the excellent output of American, British, Canadian and French historiographers.¹⁵ Comparative historical analysis, one of the strengths of American, French and British academics (such as Davies, 1983; Feroni & Kober, 1995; Rafferty, 1995; Godden & Helmstadter, 2004) is precisely one of the weaknesses of their Latin American counterparts. The powerful political and intellectual activism of nursing in Latin America currently seems not to appreciate that the 'radical' policy of international leaders started at the large-scale meetings of the International Council of Nurses, such as the one held in Copenhagen in 1922, whose organization has been based on feminist and socialist proposals ever since (Rafferty, 1995, p. 277, 281). The weakened intercontinental interchange caused by linguistic and institutional barriers may even put in jeopardy the bold, universalistic ideals conceived by Ethel Bedford Fenwick in the UK, Anna-Emilie Hamilton in France, and Mary Adelaide Nutting and Lavinia L. Dock in the USA around a century ago. Ultimately, what is at stake is a proposal for universal solidarity capable of truly assuring that nursing will force open all frontiers and accept the challenges of trespassing.

¹⁵ Naturally I am referring to an overall trend. One welcome exception in Brazil is a recent essay by Maria Itayra C. de S. Padilha about the teaching of nursing history, in which the author discusses national and international trends (Padilha, 2006). Likewise, Moreira and Oguisso (2005) also add to the discussion with references to other foreign literature and experience.

III

A successful journey abroad: Fellows in action¹⁶ (A most crude and tentative outline)

The first sections of this paper briefly highlighted the role the Rockefeller Foundation played in the promotion of public health nursing and in the opening of nursing schools in several regions of the world as early as in the 1920s. The first nursing institution headed and staffed by nurses in Brazil was located in Rio de Janeiro, Brazil's federal capital at that time. Funded by the Rockefeller Foundation, the school became known as Anna Nery Nursing School, its name given in honor of a brave woman, a practicing nurse who volunteered to treat wounded soldiers during the Paraguay War (1864-1870). The Rockefeller nurses, who held the first teaching positions at the Rio de Janeiro Nursing School, were also responsible for the creation of the Brazilian Nursing Association (*Associação Brasileira de Enfermagem*, or ABEn). The ABEn is until the present a major integrative force behind the innumerable academic and professional groups that spread from its creation in 1926. In fact, these instances of professional philanthropy could not be seen as just "a little help from a neighboring friend." From the Rockefeller Roster of Fellows and Scholars, one can glimpse the amplitude of the donor program for nursing in Brazil: among all the recipient nations, Brazil may have received the largest number of Rockefeller fellowships for the training of nurses. They totaled 47 fellows until the year of 1950, allocated to a diversity of fields: General, Nursing Administration, Education, and Public Health. These figures do not include all recipients, since a most unfortunate – and absurd – editorial decision wiped out from the roster all "deceased fellows and scholars, and those for whom addresses are unknown" (sic, p. 356). Two of the outstanding Brazilian fellows, Rachel Haddock Lobo and Edith Fraenkel, are not listed. Lobo died prematurely in 1933, and Fraenkel possibly had an "unknown address". In general, all fellows were recent

¹⁶ For this part, yet to be expanded, I would like to acknowledge the research work on Brazilian archives by Camilla Castelo Branco, Djynnana Avena, Priscilla Oliveira da Silva, Sueli Batista de Almeida and Rita Moura, who were my students at the Seminar on Population, Health, and Society, taught at the Institute of Social Medicine/UERJ, during the Fall of 2007. On the international front, I did research on the Brazilian fellows at the collections of the Rockefeller Archive Center, during four months, as a Scholar in Residence (1999/2000). The Roster of Fellows and Scholars (*The Rockefeller Directorship of Fellowships Abroad, 1917-1950*, NY: The Rockefeller Foundation, 1950), as well as the short biography files about the scholarship recipients, were extremely helpful sources.

graduates from different areas in the country, but the program directors gave priority to promising students from the first cohorts graduated at the Ana Nery School, in Rio de Janeiro.

Let us briefly, and crudely, outline some personal, professional, and academic elements in this first cohort of students. As a general trend, prospective fellows went to the University of Columbia's Teachers College or to the University of Toronto, and originated from two of the economic prosperous states in Brazil, the states of Rio de Janeiro and São Paulo. Those that came from Rio de Janeiro were Ana Nery graduates, or had had their training at the São Francisco de Assis Hospital. All young fellows had difficult language problems, a handicap that was overcome in intensive short courses in small colleges or Catholic convents. Often, an intensive, introductory, course was taken in hospital nursing, a requirement suggested by the program supervisor in Brazil: this was generally done at the Philadelphia General Hospital. Ethel Parsons, R.N., the first Ana Nery director and head of the Rockefeller mission in Rio, suggested the specific training program designed especially for each fellow. Brazil did not have a Ministry of Health – not until 1931, when a federal department mingled together Education and Health –, but an all-powerful National Department of Public Health (DNSP, the initials in Portuguese) took its share in the decision process. Doctor Carlos Chagas (the discover of the trypanosomiasis that bears his name) and Plácido Barbosa (also an specialist on rural diseases) picked up the most promising names and passed them over to Nurse Parsons, who generally took their demands open-heartedly. After two or more terms abroad (fellowships could be renewed in many cases), the fellows travelled back to Brazil, to take positions that were known to them beforehand, either as a visiting or public health nurse at the national programs held by the DNSP, or yet became new instructors at the Ana Nery School.

The scenario changed considerable for those students coming from São Paulo. São Paulo only had its first Nursing School in 1942 – basically funded by US federal money, the Institute of Inter-American Affairs, under an agreement between the administration of Franklin D. Roosevelt and President Vargas. However, since 1925, the foundation's International Health Board had accepted a bold proposal by a former fellow at Johns Hopkins – the “paulista” (from São Paulo) sanitarian Dr. Paula Souza – who stressed the need for public health action and advised the creation of a Health Education

course. The prospective candidates would be chosen among middle-class graduates¹⁷ called “normalistas” (for “Normal School” graduates in charge of public elementary schools), to attend a shortened version of a Nursing school curriculum. The Rockefeller-funded course for the “educadoras sanitárias” was a success, in part because it was housed in a Rockefeller-supported public health institution, the Institute of Hygiene – initially linked to the Medical School – and also because an Institute of Hygiene health center was the training grounds for the students (Castro-Santos & Faria, 2004). The Institute of Hygiene later became a School of Hygiene and Public Health – an institution erroneously portrayed by John Farley as having “collapsed” (sic – Farley, 1993, p. 96). This acclaimed institution of applied health sciences is now the University of São Paulo School of Public Health. Anyway, the number of “girls” coming from São Paulo was much lower than the outflow from Rio de Janeiro.

As a general unwritten rule, the students should remain single, so that they could supposedly dedicate their lives unconditionally to their vocation and professional needs. They were predominantly from a middle-class origin and almost all “white” (whatever this color might reveal or hide in a profoundly multiracial, or transracial, society). In a previous section, I already alluded to the fact that race was a sensitive matter not only for foreign agencies such as the Rockefeller, but also for public health officers and educators in Brazil. In fact, most historians of nursing in Brazil tend to take the Rockefeller officers to task over their racial prejudices, but the evidence points more sharply in the direction of the Brazilian elites: elite mothers would hate to see their girls taking up a “new” profession in the middle of lower class “colored” students. However, the mentors and pioneers of these first cohorts, as they became undoubtedly a role model for the latter, were by no means “racially” oriented against the young black nursing fellows. Their names should be honored, in this closing paragraph. Three outstanding Brazilian nurses, who had been Rockefeller fellows, were Rachel Haddock Lobo (1927-29), Edith Fraenkel (1940-41), and Glete de Alcântara (1941-1945). They were able to consolidate the professional tracks for upcoming new nursing cohorts in the country, establishing institutional options and choices for educational training.

¹⁷ Same class bias as happened at Ana Nery School.

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