National Commission to Address Racism in Nursing
For Public Comment only
Not for citation or quotation
Document not copyedited
January 2022

The History of Racism in Nursing: A Review of the Historical Scholarship

Dominique Tobbell, PhD, and Patricia D'Antonio, PhD, RN, FAAN

History matters. Beyond George Santayana's oft repeated cliché that "those who cannot remember the past are condemned to repeat it," history – or, more correctly – the stories we tell about our history – frames how we think about ourselves now and the possibilities we can imagine for our future.[1] These stories have their own power. They create a shared sense of identity. They can remain essential yet change over time in small but powerful ways to incorporate new questions and new issues. And they can construct meanings that sometimes bridge even if they cannot destroy divides based on what scholars have described as "positionality": where one stands vis-à-vis backgrounds, assigned roles, social constructs, political capital, and sheer ambition.

We acknowledge our own positionality. We are both white women. But we are also, respectively, the directors of the Eleanor Bjoring Center for Nursing Historical Inquiry at the University of Virginia and the Barbara Bates Center for the Study of the History of Nursing at the University of Pennsylvania. As such, we are experts in broad areas of the history of nursing and healthcare as well as in the narrower areas of our own expertise. We believe deeply in the power of history and historical analysis: we believe both give scholars and readers the distance of time to step back and reflect upon difficult and contentious issues. Historical concepts and methods reflect the complexity and interconnectedness of critical political, social, and cultural issues that cannot be reduced to single variables. They attend to the importance of context and causality. And, most importantly, they encourage for formulation of judgments and assessments of significance.[2]

G. Rumay Alexander, Katie Boston-Leary, and Cheryl Peterson, representing the *National Commission to Address Racism in Nursing,* commissioned this essay. The timeline they presented that would best use this essay to move the *Commission*'s work forward precluded original research. We have thus constructed what we call an historiographical essay. This established form of an essay reviews relevant published historical research that addresses issues central to examining the issue of racism in nursing. It moves forward in historical time to explain the evolution of relevant questions and issues. At times, it segues into earlier periods and other areas of significant historical research to explicate important themes. And it ends with suggestions for further areas for research that might help nurses understand the complex

[1] George Santayana, *The Life of Reason* (New York: Scribner's, 1905) p.284.
[2] Patricia D'Antonio, Conceptual and Methodological Issues in Historical Research, in Sandra Lewenson and Eleanor Herrmann (eds) *Capturing Nursing History: A Guide to Historical Methods* (New York: Springer Publishing, 2007) pp. 11-23. This chapter draws heavily on John Gaddis' *Landscape of History: How Historians Make Sense of the Past* (London and New York: Oxford University Press, 2002).

and complicated dimensions of racism in nursing. But we must begin with nursing's own origin story.

Nursing's Origin Story

Florence Nightingale lies at the heart of nursing's historical story. The educated daughter of Britain's elite struggles against the conventions of her mid-nineteenth century's time and place and achieves fame for her skilled care of her countrymen fighting in the Crimea. The epidemiological and sanitary science that underpins her ideas about proper nursing care strengthens her reputation. A grateful British public raises the funds that eventually leads to the establishment of the iconic St. Thomas's Training School for Nurses in London.[3] An attentive northern American public, looking for innovations as it begins planning for the care of the sick and wounded during its own Civil War, adopts the architectural and environmental prescriptions for healthy institutional healing set forth in her *Notes on Hospitals*.[4] And American women, most white and middle-class, stream to the war's battlefront waving serialized newspaper copies of *Notes on Nursing* as testament to their own ability to nurse.[5]

Notions of class ran though these origin stories. Lest anyone miss admonitions about the social hierarchies embedded in Nightingale's ideas about nursing, her *Notes on Nursing for the Labouring Classes* detailed the actual skills and techniques working class women needed to show their middle-class women employers who learned such supervisory skills from reading *Notes on Nursing.*[6] The emerging leaders of nursing in the United States eschewed such obvious class distinctions. They, for example, never imported the two-tiered training model at St. Thomas' that had one program for "ladies" and another for those who needed to earn their livings. Rather, their rhetoric stressed the need for the "right kind of woman" to enter nursing and enshrined the respectable middle-class virtues of honesty, faithfulness, truthfulness, obedience, and loyalty into the training of most other women who sought to become nurses.[7]

Whiteness, by contrast, was so embedded in these stories it needed no explication for generations. This began to slowly change in the 1960s and 1970s. The shortage of nurses in

[3] There is a vast literature on Florence Nightingale. We recommend the most recent and authoritative biography by Mark Bostridge which also grapples with both the extensive historiography and with Nightingale's social, political, and cultural impact. See *Florence Nightingale: The Woman and Her Legend* (New York: Farrar, Straus, and Giroux, 2008).

[4] Florence Nightingale, *Notes on Hospitals. Being Two Papers Read Before the National Association for the Promotion of Social Science, at Liverpool, in October 1858.*

[5] Florence Nightingale, *Notes on Nursing* (Harrison of Pall Mall, 1859). For an analysis of the impact of both *Notes on Hospitals* and *Notes on Nursing,* see Patricia D'Antonio, *American Nursing: A History of Knowledge, Authority and the Meaning of Work (*Baltimore: Johns Hopkins University Press, 2010) pp. 5-7.

[6] Florence Nightingale, *Notes on Nursing for the Laboring Classes* (London: Harrison, 1861).

[7] D'Antonio, *American Nursing,* chapter 2.

Britain led to the immigration of nurses of color from its former colonies, most notable South Africa and the Caribbean. These nurses found their own Crimean heroine in Mary Seacole, a British-Jamaican "doctress" who, when first the government and later Nightingale refused her offer of service, established her own "hotel" that provided health, healing, and social services for British soldiers. A statue to honor Seacole's contributions to the British army and empire stands today outside St. Thomas' in London.[8]

In the United States, Mary Elizabeth Carnegie's *The Path We Tread: Blacks in Nursing 1854-1984* sought to provide the first correction to a white nursing story in 1986. Carnegie, a pathbreaker herself as the first Black nurse to serve as a voting member of a state board of nursing, the first Black editor of the prestigious journal *Nursing Research,* and the first Black president of the American Academy of Nursing, wanted to correct two problems. First, she lamented a tradition in nursing of rendering the historical contributions of Black nurses invisible; beyond a rudimentary knowledge that Mary Mahoney held the title of America's first trained Black nurse, few white nurses and perhaps only a slightly larger number of black nurses had any knowledge about the role Black nurses played in the history of the discipline. Her book presents carefully constructed accounts of the heretofore invisible contributions of Black nurses to the educational institutions, practice initiatives, policy legacies, and professional associations that determined the history of the discipline.[9]

Carnegie's second critique – that historians of Black Americans, in general, and Black women, in particular ignored the experiences of nurses – was answered the several years later with Darlene Clark Hine's *Black Women in White: Racial Conflict and Cooperation in the Nursing Profession, 1890-1950.* If Carnegie, revered and respected among nurses when she wrote *The Path We Treat,* would venture a lack of knowledge as a reason for the invisibility of Black nurses, Hine, an historian of Black professionals, more forthrightly labeled this same phenomenon as racism. In her telling, enduring racism structured the American health care experience and the role of institutions and disciplines within it. It demanded separate hospitals, medical and nursing schools. It perpetuated separate organizations and health initiatives. And it demanded a "relentless" struggle among Black nurses and their leaders in the National Association of Colored Graduate Nurses (NACGN), to constantly push for recognition, and later, integration into the white body of American nurses.

[8] Seacole describes her service in the Crimea in her book, *Wonderful Adventures of Mrs. Seacole in Many Lands* (London: James Blackwood, 1987). See also https://en.wikipedia.org/wiki/Mary_Seacole, retrieved 13 October 2020.

[9] Mary Elizabeth Carnegie, *The Path We Tread: Blacks in Nursing 1854-1984* (Philadelphia: J.B. Lippencott, 1986)

Hine's story is one of "seemingly endless confrontation" as Black nurses sought access to the education, the resources, and the recognition they and their community of patients deserved.[10] They found power and some successes within their segregated orbits of Black hospitals and training schools and, Hine argues, experienced a stronger sense of responsibility to the Black communities that supported them than did their white colleagues. Black nurses found a little more freedom from the structures of segregation in the northern part of the United States than they did in the Jim Crow south. But even in parts of the more progressive north the prerogatives of whiteness took precedence over even stellar class, education, and work experiences. As D'Antonio notes, a 1931 survey of Black nurses' career opportunities in New York City, one of the more progressive of all northern cities vis-à-vis race were "confined to members of their own race because of race prejudices." A venerable institution such as the Henry Street Visiting Nurse Association might pay a Black nurse the same salary as a white one but it could only assign her to Black families: the idea of a Black woman giving orders to a white mother breeched entrenched racial norms. Not surprisingly, many talented Black nurses left nursing for other opportunities.[11]

Historians have traced how Black Americans resisted, challenged, and, at times, achieved within the broader social and political structures of racism. Racism, as the Swedish economist Gunner Myrdal wrote in 1944, was the central "American dilemma." His enormously influential book, *An American Dilemma: The Negro Problem and American Democracy,* prescribed initiatives that would improve the circumstances of Black American and/or decrease the prejudices of white Americans. Scholars have located Myrdal's analysis as central to the eventual success of the landmark *Brown vs. Board of Education,* that led to school desegregation, affirmative action programs, and the mixed legacies of urban renewal and "wars" on poverty that addressed what we now call the social determinants of health.[12]

An American Dilemma, however, was written for white audiences; Black activists would have found little new in these recommendations. Those more conservative, such as Frederick Douglas, had long promoted the value of education and economic self-sufficiency. Those more progressive, such as W.E.B. Dubois, looked to remedy underlying social and political structures. Those Black Americans involved in a then segregated healthcare enterprise hewed to a more pragmatic course. Perhaps nowhere can this be more clearly seen than the experiences of Black nurses during wartime.

Racism and War

[10] Darlene Clark Hine, *Black Women in White: Racial Conflict and Cooperation in the Nursing Profession, 1890-1950* (Bloomington: Indiana University Press, 1989), p. ix

[11] D'Antonio, *American Nursing,* pp. 74-76.

[12] Gunnar Myrdal, *An American Dilemma: The Negro Problem and Modern Democracy* (New York: Harper & Brothers, 1944).

In every war since America won her independence, many Black Americans held to the belief that if they demonstrated their patriotism and service – even if in a rigidly segregated military structure with their own regiments – a grateful nation would repay its debts with steps toward a more inclusive and participatory place for them within its democratic framework. Black Americans – from the Civil War, through the Spanish American War, through World War I and II – found themselves deeply disappointed in the post-war years. As did Black nurses. During the Civil War, before the establishment of training schools, Black women with hard won knowledge and nursing experiences, found themselves relegated to positions as cooks, cleaners, and laundresses as middle-class white women used their prerogatives of race and class to assume positions of direct patient care.[13] The short lived Spanish American War in 1898 coincided with the growth in the numbers of trained nurses in the United States; now, the segregated nursing corps could maintain their power by discounting the valid knowledge and experiential claims of Black women as "unscientific" despite the widely held belief (later disproven) that only Black women had the necessary immunity to yellow fever, endemic in the battlefields of Cuba.[14] The Army Nurse Corps inducted a very small number of trained Black nurses to nurse prisoners of war and the few Black soldiers injured or sickened in the line of duty; the Army, supported by nursing leadership, claimed it did not have the resources to maintain segregated accommodations believed necessary for the maintenance of discipline and harmonious relations.[15]

Yet Black nurses never assumed the position of passive observers. By World War II they had developed an organizational infrastructure through state chapters of the NACGN, key political allies in the Black press and among Black clergy, and some influential allies among leading white politicians and public health nurses. Under the inspired, but very carefully calculated, leadership of Mabel Staupers and Estelle Massey Riddle, the NACGN laid the groundwork to finally and fully desegregate the Army Nurse Corps. As dramatically told by Hine, they found their moment in 1944 when, in the face of an acute shortage of white military nurses, pending federal legislation proposed to draft white nurses. With what Hine describes as a "flawless sense of timing and political maneuvering" Staupers focused public opinion on the systematic exclusion of thousands of well-trained Black nurses who stood willing and ready to serve. The Army Nurse Corps formally desegregated within days; the Navy Nurse Corps quickly followed.[16]

[13] Jane Schultz, *Women at the Front: Hospital Workers in Civil War America* (Chapel Hill: University of North Carolina Press, 2004).
[14] Charles McGraw, "'Every Nurse Is Not a Sister': Sex, Work, and the Invention of the Spanish-American War Nurse," PhD dissertation, University of Connecticut, 2005, Chapter 2.
[15] There is a large literature on nursing in World War I and II. For a comprehensive overview, see Mary Sarnecky, *A History of the Army Nurse Corps* (Philadelphia: University of Pennsylvania Press, 1999).
[16] Hine, *Black Women in White,* pp. 171-186. Quote on page 181.

We know how this story ended. In 1946, the segregated boards of both the American Nurses Association (ANA) and the NACGN endorsed the principle of one integrated professional organization for all nurses. And on January 26, 1951 – with great fanfare – the NACGN formally dissolved. This was, Staupers acknowledged, a leap "of great faith."[17] Yet the rewards of faith can be complicated. As Charissa Threat argues in *Nursing Civil Rights,* Black women's gains in the military came at men nurses' expense. Men nurses had been simultaneously championing their own right to serve in the military nursing corps. But in the complicated matrix of gender and race within the military establishment, gender trumped race: it was easier to imagine Black women nurses touching male military bodies than it was men nurses doing the same.[18] Only in 1955 were men nurses authorized to serve in the Army Reserve Nurse Corps; only in 1966 were men authorized to serve in the regular Army Nurse Corps.

Language suffered. What did it mean to speak of "integration" as many Black nurses did? What did it mean to speak of "desegregation," the language of many white nurses? This remains an understudied area. One might posit that the elusiveness of definitional clarity allowed a space, of sorts, where different nurses of different backgrounds with different ambitions could coalesce around a meaningful way forward. One could also argue that it created some of the seeds of profound dissatisfaction that was one of a constellation of factors that lead Black nurses to re-create their own National Black Nurses Association in 1971.

And while the story of the ANA and the NACGN is important, the ANA was, in fact, a constituent association of states not individual members. The most significant battles for desegregation took place, then, in the individual states, in general, and in the southern states, in particular. To date, the only such historical study we have is that of Patricia D'Antonio's of North Carolina, in large part because of the extant mid-century records of both the white North Carolina State Nurses Association (NCSNA) and the State Association of Negro Registered Nurses (SANRN). In this telling, the early post-war leadership of the NCSNA took note of two important changes: that more and more of the ANA's leadership were actively entertaining the idea of desegregation, not just the "more liberal" member; and that Florida had just enacted a seemingly sensible plan where it simply dropped "white" from its by-laws and hoped no Black nurses would appear where they were not wanted.

Negotiations between the NCSNA and the SANRN lasted several years, until a mutually agreeable plan was reached. Like what little we know of other states' agreements, it presented no immediate threat to white supremacy and to the Jim Crow laws that supported it: Black nurses agreed to a higher fee structure than many could afford and to educational activities in desegregated venues but social ones in venues that prohibited Black patrons. Some SANRN,

[17] D'Antonio, *American Nursing,* pp. 131-133. Quote on page 103.
[18] Charissa Threat: *Nursing Civil Rights: Gender and Race in the Army Nurse Corps* (Chicago: University of Illinois Press, 2015)

D'Antonio suggests, might well have chafed at their subordination to the norms of their social, political, and disciplinary worlds. But these Black nurses had looked beyond their nursing worlds to their place in their broader communities. They did accept a compromise that their physician colleagues in North Carolina had refused. In exchange, they claimed the achievement of being "the first" among peer physicians, clergy, teachers, and social workers. The Black nurses who had claimed membership in the SANRN cheered the 1949 press release that proclaimed "Nurses Make Historic Decision." Their neighbors in the white Georgia State Nurses Association refused desegregation until they were threatened with expulsion from the ANA in 1961 if they refused to do so.[19]

To decenter whiteness in nursing's origin stories is also to acknowledge the systematic ways in which ways of knowing that fell outside of Western biomedical frameworks have been historically excluded from formal nursing education. For this, it is necessary to go back to the period of enslavement. It is in this period that historians have located the roots of the racialized and classed hierarchies that came to characterize first trained, and then professional nursing in the U.S., and it is in this period that Black women's knowledge, skills, and experiences were devalued and the parameters of racial exclusion in nursing first established.

Nursing and the Era of Enslavement

In the antebellum American South, enslaved women performed the majority of nursing work on plantations. They provided nursing care to sick and injured enslaved people housed in plantation hospitals ("sick houses"). They provided healing and nursing care within enslaved communities, integrating traditional healing knowledge and practices handed down from older community members, with Indigenous and European medical knowledge and practices. As Sharla Fett describes in *Working Cures*, "Enslaved women grew herbs, made medicines, cared for the sick, prepared the dead for burial, and attended births."[20] As healers and caregivers, enslaved nurses were highly valued by and provided essential care to their families and communities.

Enslaved women also cared for the children and family members of enslavers, attending births, and providing childcare, sick care, and elder care.[21] They "fed and washed patients,

[19] D'Antonio, *American Nursing,* Chapter 6.
[20] Sharla M. Fett, *Working Cures: Healing, Health, and Power on Southern Slave Plantations* (Chapel Hill: University of North Carolina Press, 2002), p. 5.
[21] Fett, *Working Cures*, Chapter 5; R. J. Knight, African Americans, Slavery, and Nursing in the US South. *Nursing Clio*, January 7, 2021 https://nursingclio.org/2021/01/07/african-americans-slavery-and-nursing-in-the-us-south/#post-27607-footnote-ref-9 Retrieved December 13, 2021; on enslaved wet nurses, see Stephanie E. Jones-Rogers, "'[S]he could… spare one ample breast for the profit of her owner': white mothers and enslaved wet nurses' invisible labor in American slave markets." *Slavery and Abolition* (2017) 38(2): 337-355, and Emily West

administered medicines, dressed wounds, changed beds," doing so in "in close confines with abusive slaveholders."[22] Enslaved women were also required to wet-nurse (breastfeed) their enslavers' infants. As Stephanie Jones-Rogers has documented, "white mothers' desires and demands for enslaved wet nurses transformed bondwomen's ability to suckle into a largely invisible, yet skilled form of labor, and created a niche sector of the slave market."[23] As Jones-Rogers argues, "white mothers were crucial to the commodification of enslaved women's reproductive bodies, their breast milk, and the nutritive and maternal care they provided to white children."[24] This was just one of the ways, Jones-Rogers argues in *They Were Her Property* that "white women actively participated in the slave market, profited from it, and used it for economic and social empowerment."[25]

The skilled health work that enslaved women performed "required experience and expertise as well as close observation and innovation," while also being "fatiguing, repetitive, and dirty."[26] "Daily sickcare," Fett argues, "thus represented both skilled labor and an area of 'superexploitation' for enslaved women."[27] Yet enslavers devalued the nursing and doctoring work of enslaved women, ignoring or obscuring the complexity of that work, even as they depended on it. Southern whites, R.J. Knight explains, "often characterized enslaved women as superstitious, uninformed, and injurious."[28] This echoed language that white physicians, public health officials, and nurses would again leverage in the early 20th century to denigrate the skilled and essential care of Black midwives, a point to which we will return.

In *Medical Bondage*, Deirdre Cooper Owens powerfully underscores the contradictions that characterized 19th century racial science and the violence it wrought.[29] As Cooper Owens details, enslaved women also served as surgical assistants and nurses for physicians such as J. Marion Sims who performed brutal experimental surgeries on enslaved women. But even as white physicians assumed that enslaved women were intellectually inferior, using their perceived intellectual and biological differences as justification for their enslavement and for the violence enacted upon them in the name of medical experimentation, they nevertheless

with R. J. Knight, Mothers' Milk: Slavery, Wet-Nursing, and Black and White Women in the Antebellum South. *Journal of Southern History* (2017) LXXXII (1): 37-68.

[22] Knight, "African Americans, Slavery, and Nursing."

[23] Jones-Rogers, "[S]he could… spare one ample breast for the profit of her owner."

[24] Jones-Rogers, "[S]he could… spare one ample breast for the profit of her owner."

[25] Stephanie E. Jones-Rogers, *They Were Her Property: White Women as Slave Owners in the American South* (New Haven: Yale University Press, 2019). Quotation from book's summary: https://yalebooks.yale.edu/book/9780300218664/they-were-her-property Retrieved December 13, 2021.

[26] Fett, *Working Cures*, p. 112.

[27] Fett, *Working Cures*, p. 112.

[28] Knight, "African Americans, Slavery, and Nursing."

[29] Deirdre Cooper Owens, *Medical Bondage: Race, Gender, and the Origins of American Gynecology* (Athens: University of Georgia Press, 2017).

relied on enslaved women to work as nurses and surgical assistants – work which required high levels of skill and in which intelligence and judgment were valued. Collectively, this scholarship on the nursing work of enslaved women highlights, as R.J. Knight recently summed up, that the work of enslaved nurses "encompassed exploitation and power as much as intimacy and care, forced labor as well as free, and has served both communities and regimes."[30]

The contradictions that characterized enslaved women's care work had implications for the development of trained nursing after emancipation and the Civil War. In the late 19th century, as Charles McGraw has argued, "wage-earning nurses, irrespective of race or training, contended with the occupation's deep roots in black women's domestic labor under slavery." And it was a strategy by white nurses "to erect a racial barrier between skilled nursing practice and general domestic labor, with Black women relegated to the latter."[31] So too, Black medical leaders worked to sever the link between nursing and domestic servitude, establishing their own barriers in which the experience and expertise of nurses who had worked for years were dismissed in favor of training young women with no prior experience. As both Darlene Clark Hine and McGraw have detailed, prominent Black physician, Daniel Hale Williams, who founded both the Provident Hospital and Nurse Training School in Chicago in 1891 and Freedman's Hospital Nurse Training School in Washington, D.C. in 1894, "sought to sever nursing… from the taint of slavery and working-class servitude."[32] He did so by "castigat[ing] the legacy of black women's health work,"[33] even as he used that legacy to simultaneously extoll "black women as natural nurturers."[34] When Williams arrived at Freedmen's Hospital in Washington, D.C., he disbanded the Howard University Medical Department Training School, which had admitted not only young student nurses but also "all working-class nurses employed at Freedmen's Hospital as well as other 'old women nurses' who sought technical certification." The new Freedmen's Hospital nursing school would only admit young student nurses, while "experienced practitioners who continued to draw on the rich traditions of enslaved healers found no place in his narrative or his training school."[35]

These moments signaled the transformation in what counted as legitimate knowledge and the basis for claims to expertise in nursing; a transformation that was infused with by meanings of race and class. No longer would experience and experiential knowledge serve as the basis for claims to legitimacy and expertise in nursing; instead, legitimate knowledge and claims to expertise were to be based on "proper character" and the acquisition and utilization of biomedical knowledge instilled through nursing education.

[30] Knight, "African Americans, Slavery, and Nursing."
[31] McGraw, "Every Nurse Is Not a Sister," p. 96.
[32] McGraw, "Every Nurse Is Not a Sister," p. 128.
[33] McGraw, "Every Nurse Is Not a Sister," p. 128.
[34] Hine, *Black Women in White*, p. 12.
[35] McGraw, "Every Nurse Is Not a Sister," p. 128.

Similar contradictions and racialized exclusions were operative in the early 20th century campaign, led by physicians, public health officials, and public health nurses, to eliminate traditional or lay midwives. As historians of midwifery have detailed, through the late 19th century, the majority of childbirths were attended by midwives, many of whom were Black, Indigenous, or immigrant women. Most midwives, including enslaved women, drew upon traditional healing knowledge and practices passed down through generations to provide birthing care within their communities. Other midwives learned their practice through apprenticeship either to local physicians or experienced midwives in their community. In the early 20th century, however, as childbirth became medicalized, physicians emerged as the primary birth attendants and childbirth moved from the home to the hospital. In the early 1900s, midwives delivered approximately fifty percent of all births in the U.S. By 1930, however, the number of midwife-attended births in the U.S. had decreased to fifteen percent.[36]

These early decades of the 20th century also witnessed high rates of maternal and infant mortality. Obstetricians and public health and social welfare reformers blamed the high mortality rates on midwives, despite convincing evidence from several research studies that midwife-attended births accounted for fewer maternal deaths than those attended by general practitioners, who were typically poorly trained in obstetrical techniques. Public health nurses joined obstetricians in a campaign to eliminate traditional midwives, calling Black, Indigenous, and immigrant midwives incompetent, unsanitary, and dangerous. As part of the broader reform effort to reduce infant and maternal mortality rates, Congress passed the Sheppard-Towner Act of 1921. One of the provisions of this Act provided federal funding to states to establish midwifery training and licensure. This regulatory initiative targeted Black midwives in the South, who represented the largest group of unregulated birth attendants. State health departments established midwifery classes taught by public health nurses, many of whom had far less experience attending births than the midwives they were training. To be licensed, midwives were required to attend this training and submit to supervision by public health nurses.[37]

And yet, even as states engaged in the "racialized marginalization" of midwives, they nevertheless remained dependent on their skilled labor given the dearth of physicians and public health nurses, particularly in rural and other underserved areas. In this way, state health departments sought at once to restrict and regulate and to appropriate the knowledge and

[36] See, for example, Charlotte G. Borst, *Catching Babies: The Professionalization of Childbirth, 1870-1920* (Cambridge: Harvard University Press, 1995); Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750 to 1950* (New York: Oxford University Press, 1986).

[37] Leavitt, *Brought to Bed*; Molly Ladd-Taylor, *Mother-Work: Women, Child Welfare, and the State, 1890-1930* (Urbana: University of Illinois Press, 1994); Jenny M. Luke, *Delivered by Midwives: African American Midwifery in the Twentieth-Century South* (Jackson: University Press of Mississippi, 2018).

practice of midwives.[38] Even as government-funded research in the 1930s continued to document the better birth outcomes achieved by midwives compared to physicians, reformers continued to blame Black, Indigenous, and immigrant midwives for the country's high maternal and infant mortality rates. Throughout the segregated South, however, Black midwives continued to provide essential care to Black families, especially in rural communities that lacked access to physicians or public health nurses.

Since the 1990s, a body of literature on the history of Black midwives, centered on the narratives and experiences of the midwives themselves, has been produced. This includes Gertrude Fraser's *African American Midwifery in the South*, Jenny Luke's *Delivered by Midwives*, and a handful of biographies by Black midwives including Margaret Charles Smith's *Listen To Me Good*, which was written in collaboration with Linda Janet Holmes; Onnie Lee Logan's *Motherwit;* and Claudine Curry Smith and Mildred H.B. Roberson's *My Bag Was Always Packed*.[39] Collectively, these works emphasize the skill, knowledge, and expertise that characterized the work of Black lay midwives, and the vital role they "played in the reproductive experiences of southern women, both black and white."[40] Fraser's work also reveals the contradictions and ambivalences that characterized the place of the Black lay midwife in rural Virginia, and more broadly, the South throughout the 20th century, reflecting both the praise and denigration ascribed to their work. Other scholars who have examined the emergence of nurse-midwifery in the mid-20th century, have made clear this history's imbrication with the decline of Black lay midwives.[41] At the same time that public health officials, physicians, and nurses sought to regulate and restrict the practice of midwives, public health nurses recognized that professional midwives in Britain and Europe contributed to low maternal and infant mortality rates in those countries. They thus worked to establish nurse-midwifery as a new nursing specialty in which nurses (the overwhelmingly majority of whom were white women) would be trained in both nursing and the practice of midwifery. The first nurse-midwifery training programs were established in the mid-1920s and early 1930s, and

[38] Lena McQuade-Salzfass, "'An Indispensable Service': Midwives and Medical Officials after New Mexico Statehood," in Laurie B. Green, John McKiernan-González, and Martin Summers (eds.), *Precarious Prescriptions: Contested Histories of Race and Health in North America* (Minneapolis: University of Minnesota Press, 2014), pp. 115-141, quotation from p. 128.

[39] Gertrude J. Fraser, *African American Midwifery in the South: Dialogues of Birth, Race, and Memory* (Cambridge: Harvard University Press, 1998); Luke, *Delivered by Midwives*; Margaret Charles Smith and Linda Janet Holmes, *Listen To Me Good: The Story of an Alabama Midwife* (Columbus: Ohio State University Press, 1996); Onnie Lee Logan as told to Katherine Clark, *Motherwit: An Alabama Midwife's Story* (New York: E.P. Dutton, 1989); Claudine Curry and Mildred H.B. Roberson, *My Bag Was Always Packed: The Life and Times of a Virginia Midwife* (Bloomington: 1st Books, 2003).

[40] Fraser, *African American Midwifery in the South*, p. 1.

[41] See, for example, P. Mimi Niles and Michelle Drew, "Constructing the Modern American Midwife: White Supremacy and White Feminism Collide." *Nursing Clio*, October 22, 2010 https://nursingclio.org/2020/10/22/constructing-the-modern-american-midwife-white-supremacy-and-white-feminism-collide/ . Retrieved December 13, 2021.

their growth continued over the ensuing decades. Some of these programs, such as the Frontier Nursing Service, explicitly excluded Black nurses, while other programs heavily restricted access to Black nurses and other nurses of color.[42] Ultimately, the increased regulation of traditional midwives by state health departments and the emergence and increasing role of nurse-midwives in the mid-20th century, contributed to the demise of traditional Black, Indigenous, and immigrant midwives.

The contradictions that characterized enslaved women's nursing work not only influenced the development of trained nursing and the campaign against lay midwives, but they also continue to influence 21st century characterizations of nursing and care work. As Fett argues, the ""Contradictions between skill and servitude in slave women's sickcare reveal similarities across time and space among societies that relegate hands-on care of the sick to subordinate groups of women… classifying hands-on care of the sick or elderly as 'menial' tends to obscure the complex nature of the work performed."[43] In short, the ongoing marginalization and devaluing of the dirty, hands-on, bodywork of nursing care in the 21st century is deeply rooted in the era of enslavement.[44]

The era of enslavement were also years in which physicians and scientists, many of them enslavers, constructed a racial science premised on the belief that women and men of African descent, as well as Indigenous people, were biologically and medically different from white people. As Dorothy Roberts has detailed, 18th century European "biologists were preoccupied with classifying all earthly creations, whether plants, insects, or animals, into a natural hierarchy. Their chief scientific method was taxonomy: observing, naming, and ordering the world by partitioning living things into biologically different types. Applying this method to human bodies naturalists made race an object of scientific study and made European conquest and enslavement of foreign peoples seem in line with nature."[45] Not solely a European exercise, however, as Rana Hogarth has documented in *Medicalizing Blackness*, "many physicians who worked and settled in the Greater Caribbean," beginning in the 18th century, "took to trying to make sense of the apparent differences they observed between black and white people's bodies during times of sickness. Their efforts helped to sanction the objectification, exclusion, and subjugation of black people for generations to come." This

[42] On the history of certified nurse-midwifery, see, Katy Dawley, "Origins of Nurse-Midwifery in the United States and its Expansion in the 1940s." *Journal of Midwifery and Women's Health* (2003) 48(2): 86-95; Arlene Keeling, *Nursing and the Privilege of Prescription, 1893-2000* (Columbus: Ohio State University Press, 2007), pp. 49-71.
[43] Fett, *Working Cures*, pp. 112-113. And on the history of nurse-midwifery and the resurgence of lay midwives after World War II, see Wendy Kline, *Coming Home: How Midwives Changed Birth* (New York: Oxford University Press, 2019).
[44] Janette Dill, Odichinma Akosionu, J'Mag Karbeah, Carrie Henning-Smith, "Addressing Systemic Racial Inequity in the Health Care Workforce." *Health Affairs Blog*, September 10, 2020.
[45] Dorothy Roberts, *Fatal Invention: How Science, Politics, and Big Business Re-Create Race in the Twenty-First Century* (New York: The New Press, 2011), p. 28.

objectification also, Hogarth argues, "became an essential component to the development of the medical profession in the Americas."[46] And in the 1840s and 1850s, leading American physicians, naturalists, and ethnologists were engaged in a project to "classify and rank groups on the basis of innate physiological and temperamental differences." They did so through the development of taxonomies based on the measurement of skulls, and the characterization of facial features (physiognomy), and through theorizing about human origins. These taxonomies "predictably reinforced the idea of "[b]lack inferiority and the immutability of racial types."[47] The creation and maintenance of racialized hierarchies were used to justify the institution of slavery. They also underwrote – and were fundamental features of – European and American colonialism and imperialism. To see the employment of racial hierarchies and their genocidal implications, we need to look no further than Nightingale's own writings about and involvement in the British imperial project.[48] So too, however, they are manifest in nursing's role in American imperialism, including the colonialism as it was exercised in Cuba, Puerto Rico, the Philippines, and Hawaii; American imperialist projects in post-World War I eastern and central Europe and Asia; as well as in the settler colonialism that has always and continues to characterize the United States' relationship to Native nations.

Nursing and Colonialism in the Indigenous United States

The United States is a settler colonial society. Settler colonialism is the process by which a nation "strives for the dissolution of native societies" and "erects a new colonial society on the expropriated land base."[49] As the anthropologist, Patrick Wolfe argues, settler colonialism employs a "logic of elimination" that "destroys to replace," the "primary motive" for which is "access to territory." As Wolfe puts it, "settler colonizers come to stay: invasion is a structure not an event."[50] The federal government's relationship with Native nations has and continues to be a settler colonial one.[51]

Historians have documented the deep entanglement of medicine in settler colonial projects. As Maureen Lux explains in *Separate Beds*, "According to non-Native observers, the susceptibility of Aboriginal bodies to diseases associated with contact showed that they were unable to

[46] Rana A. Hogarth, *Medicalizing Blackness: Making Racial Difference in the Atlantic World, 1780-1840* (Chapel Hill: University of North Carolina Press, 2017), pp. 1-2.
[47] Martin Summers, "Suitable care of the African American when afflicted with insanity." *Bulletin of the History of Medicine* (2010) 84(1): 58-91, quotation from p. 67.
[48] Natalie Stake-Doucet, "The racist lady with the lamp," *Nursing Clio,* November 5, 2020 https://nursingclio.org/2020/11/05/the-racist-lady-with-the-lamp/. Retrieved 8 November 2021.
[49] Patrick Wolfe, "Settler Colonialism and the Elimination of the Native." *Journal of Genocide Research* 8, no. 4 (2006): 387-409, quotation from p. 388.
[50] Wolfe, "Settler Colonialism and the Elimination of the Native," p. 388.
[51] For a comprehensive history of the Indigenous United States, Roxanne Dunbar-Ortiz, *An Indigenous Peoples' History of the United States* (Boston: Beacon Press, 2015).

survive independently in the changing conditions of European global expansion. In such a view, Aboriginal populations around the world consistently showed themselves, through their bodies themselves, to need and deserve colonization. That it was through colonization and the associated dual mechanisms of 'civilization' and medicine that these indigenous populations could ultimately be saved. Both the diseases and their cures justified colonization in a perfectly circular logic."[52] Following this logic, missionaries, physicians, and other settler agents used medical practices to surveil, categorize, and eradicate Indigenous bodies in pursuit of Indigenous territories.[53] Settler agents and the policies and practices they implemented also worked to eliminate Indigenous healing practices and to disparage and even criminalize Indigenous healers. In *Colonizing Bodies*, for example, Mary-Ellen Kelm documents the ways in which Indigenous bodies were materially affected by settler colonial policies in Canada during the 20th century. These included policies that "placed restrictions on fishing and hunting, allocated inadequate reserves, forced children into unhealthy residential schools, and criminalized Indigenous healing." In doing so, Kelm demonstrates the ways in which settler colonial processes sought to "pathologize" Indigenous bodies and "institute a regime of doctors, hospitals, and field matrons, all working to encourage assimilation." These settler colonial processes, as Kelm makes clear, created Indigenous ill-health.[54]

There is a particularly robust body of scholarship on the historiography of medicine, settler colonialism, and Indigenous health in First Nations. In a valuable survey of this literature, Mary Jane Logan McCallum highlighted four key arguments stemming from this body of scholarship: "first, that Indigenous people are not 'naturally unhealthy' or 'susceptible' to disease; second, that ill health is not just a matter of germs but also of colonial policies and practices of the Canadian government; third, that Canadian medicine served colonialist agendas that included at different times the elimination, coercion, and assimilation of Indigenous people; and, last, that Indigenous medicine was never fully replaced by an allopathic bio-medical model."[55] While McCallum, and the scholarship she engages, is focused on the settler colonial policies and practices of the Canadian government, these same arguments are equally important to the history of settler colonialism and Indigenous health in the U.S. There are relatively few studies,

[52] Maureen Lux, *Separate Beds: A History of Indian Hospitals in Canada, 1920-1980s* (University of Toronto Press, 2016), p. 197.
[53] Mary-Ellen Kelm, *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900-1950* (Vancouver: University of British Columbia Press, 1999); Warwick Anderson, *The Cultivation of Whiteness: Science, Health, and Racial Destiny in Australia* (Durham: Duke University Press, 2006); Seth Archer, *Sharks Upon the Land: Colonialism, Indigenous Health, and Culture in Hawai'i, 1778–1855* (New York: Cambridge University Press, 2018).
[54] Kelm, *Colonizing Bodies.* Quotation from book's summary https://www.ubcpress.ca/colonizing-bodies Retrieved December 13, 2021.
[55] Mary Jane Logan McCallum, "Starvation, Experimentation, Segregation, and Trauma: Words for Reading Indigenous Health History." *Canadian Historical Review* (2017) 98(1): 96-113, quotation from p. 100.

however, that examine the intersections of medicine and settler colonialism in the Indigenous United States, and fewer still that focus on the role of nursing in the settler colonial project.[56]

Before discussing this scholarship, we provide some very brief background on U.S. colonial policies and practices as they relate to Indigenous health. Throughout the 19th century, Indigenous health systems co-existed with western medicine within many Native American communities. Native American women and men played important roles as healers. Women, for example, often possessed healing expertise related to plant-based medicine, and also provided vital care within their communities as midwives. When the federal government established the Bureau of Indian Affairs (BIA) in 1824, it tasked Protestant missionaries with responsibility for American Indian health care.[57] While the federal government "could claim to be fulfilling its treaty promises of health care for American Indians," for missionaries, medicine was an important evangelizing tool, a means by which they hoped to convert American Indians to Christianity.[58] As part of this, missionaries and physicians sought to dissuade Native Americans from using Indigenous healing practices and to instead convince them to accept western medical practices. As several historians have demonstrated, however, many Native American communities pursued a pluralist approach to health care, making use of western medicine to treat some bodily ills, while continuing to rely on Indigenous healers and healing practices for many of their other health needs.[59]

In the late 19th century, the rapidly deteriorating health of Native Americans prompted the BIA to establish the field matron program. Established in 1890, the field matron program was intended to bring to Native American "women and their domestic world the benefits of

[56] See David S. Jones, *Rationalizing Epidemics: Meanings and Uses of American Indian Mortality since 1600* (Cambridge: Harvard University Press, 2004); David H. DeJong, *"If You Knew the Conditions": A Chronicle of the Indian Medical Service and American Indian Health Care, 1908-1955* (Lexington Books, 2008.) Brianna Theobald, *Reproduction on the reservation: Pregnancy, Childbirth, and Colonialism in the Long Twentieth Century* (Chapel Hill: University of North Carolina Press, 2019); Paul Kelton, *Cherokee Medicine, Colonial Germs: An Indigenous Nation's Fight Against Smallpox, 1518-1824* (Norman: University of Oklahoma Press, 2015)*;* Robert Trennert, *White Man's Medicine: Government Doctors and the Navajo, 1863-1955* (Albuquerque: University of New Mexico Press, 1998).

[57] Initially, the BIA was established within the War Department but in 1849 was transferred to the newly created U.S. Department of the Interior. From that time through the mid-20th century, the name of the BIA changed several times. For the sake of simplicity, we will use BIA throughout this document, recognizing that this was not always the name it was known by.

[58] Hancock, "Health Vocations," p. 115-116.

[59] Robert Trennert, *White Man's Medicine: Government Doctors and the Navajo, 1863-1955* (University of New Mexico Press, 1998); Wade Davies, *Healing Ways: Navajo Health Care in the Twentieth Century* (University of New Mexico Press, 2001); Paul Kelton, *Cherokee Medicine, Colonial Germs: An Indigenous Nation's Fight against Smallpox, 1518–1824* (University of Oklahoma Press, 2015); Margaret J. Flood, "Simple Medicines: Land, Power, and Health in the Nineteenth Century Ojibwe Western Great Lakes." PhD Dissertation, University of Minnesota, 2021.

modernity and Anglo-American culture."[60] Initially the field matron's primary role was to 'civilize' Indian women through white domesticity.[61] As Lisa Emmerich has described, field matrons offered to Native American women cooking classes, religious services, and child care seminars as a means of not only providing "practical help in adapting to… reservation life," but also "to emphasize the superiority of Angle-American models of femininity, wifehood, and motherhood."[62] As American Indian health continued to deteriorate in the early 20th century, the BIA expanded the responsibilities of field matrons to include rudimentary health care, supplying them with basic medical supplies, but not formal training.[63] The expansion of the field matron's responsibilities, however, did little to stem the ongoing deterioration of American Indian health. This was at a time when tuberculosis had replaced smallpox as the largest health threat to American Indians, and trachoma, a highly infectious eye disease that caused severe pain and eventual blindness, was also pervasive. Malnutrition facilitated the spread of disease. In the 1920s, amid growing criticisms of the Indian Service, the Secretary of the Interior launched an investigation of the administration of Indian Affairs. Lewis Meriam led the team that gathered data on almost one hundred Indian reservations. The resulting Meriam Report was especially critical of the Indian Medical Service, citing, in particular, the Indian Medical Service's failure to adequately combat tuberculosis and trachoma, and the abysmal and deteriorating state of Indian health on many reservations. In response, and heeding the recommendation of the Meriam Report, the BIA began the process of creating a more professional health program; the centerpiece of which was public health nursing. [64]

Much of the historical scholarship on nursing, colonialism, and Indigenous health in the U.S. has focused on the role of public health nurses who worked under the auspices of the BIA field nursing program in the 1930s. These field nurses, the overwhelming majority of whom were white, native-born, and middle class, sought to "inculcate Euro-American attitudes and values" as they provided much-needed health services on American Indian reservations.[65] The field nurses pursued an assimilationist strategy that sought to eliminate Indigenous beliefs and healing practices and replace them with allopathic medical care premised on the biomedical model.

In the late 1990s, historian Emily Abel and public health scholar, Nancy Reifel published a series of articles that examined the history of the BIA field nursing program from the perspective of

[60] Lisa E. Emmerich, "'Right in the Midst of My Own People': Native American Women and the Field Matron Program." *American Indian Quarterly* (1991) 15 (2): 201-216.
[61] Christin L. Hancock, "Healthy Vocations: Field Nursing and the Religious Overtones of Public Health." (2011) 23(3): 113-137, quotation from, p. 116.
[62] Emmerich, "Right in the Midst of my Own People."
[63] Hancock, "Healthy Vocations." pp. 115-116.
[64] Theobald, *Reproduction on the Reservation*, p. 71, and Hancock, "Healthy Vocations," p. 116.
[65] Emily K. Abel and Nancy Reifel, "Interactions between Public Health Nurses and Clients on American Indian Reservations during the 1930s." *Social History of Medicine* (1996) 9(1): 89-108, quotation from p. 93.

the field nurses and their Native American clients.[66] In their co-authored article, Abel and Reifel examined the interaction between BIA field nurses and their clients on two Sioux reservations in South Dakota during the 1930s. Their analysis drew upon "the accounts of the nurses, including letters, memoirs, and above all their monthly and annual reports" to the BIA, as well as twenty-three oral history interviews conducted by Abel and Reifel with elderly residents of the reservations in the early 1990s who were able to recall their experiences with the field nurses.[67] Abel and Reifel found that field nurses – like their colleagues in medicine and public health – frequently described their Indigenous clients as "'ignorant,' 'primitive,' 'prejudiced,' and 'superstitious.' Most nurses insisted that American Indians were capable of reason but had to be taught how to exercise it… the nurses denied the possibility that American Indians could be active participants in the construction of meaning and knowledge." Indeed, field nurses dismissed the value of Indigenous ways of knowing and healing. Further, the field nurses assumed that "American Indians would follow a linear progression from understanding the rules of health to the eradication of all traditional practices."[68] The field nurses provided a range of health services, that included "screening for such conditions as trachoma, tuberculosis, and sexually transmitted diseases, providing immunization, delivering home care, and placing clients in institutions for sickness [particularly, tuberculosis] and childbirth. Most nurses insisted, however, that education was their primary focus."[69] Health education was the vehicle by which the field nurses sought to conform Native Americans "to Euro-American standards of 'right living' to promote health."[70] This included concepts of cleanliness, personal habits and hygiene, diet, parenting, and sexual relationships. Nevertheless, Abel and Reifel argue, Native American clients asserted their own agency in their interactions with field nurses: "Sioux people viewed the nurses as resources to be used strategically and selectively. Those who accepted nurses' services did so because the services addressed specific needs the clients themselves defined as important. Most disregarded the health education program insofar as it assumed the superiority of Euro-American values."[71]

Other scholars have gone on to provide further analysis of the BIA field nursing program. Christin Hancock has drawn connections between the field nursing program and "the same assimilation-style health practices begun generations earlier by missionaries and field matrons."[72] Hancock sees the persistence of a proselyting mission in the work of the field

[66] Emily K. Abel, "'We Are Left So Much Alone to Work Out Our Own Problems': Nurses on American Indian Reservations During the 1930s." *Nursing History Review* (1996) 4: 43-64; Abel and Reifel, "Interactions Between Public Health Nurses and Clients;" Nancy Reifel, "American Indian views of public health nursing, 1930-1950." *American Indian Culture and Research Journal* (1999) 23(3): 143-154.
[67] Abel and Reifel, "Interactions Between Public Health Nurses and Clients," p. 89.
[68] Abel and Reifel, "Interactions Between Public Health Nurses and Clients," p. 94.
[69] Abel and Reifel, "Interactions Between Public Health Nurses and Clients," p. 96.
[70] Abel and Reifel, "Interactions Between Public Health Nurses and Clients," p. 96.
[71] Abel and Reifel, "Interactions Between Public Health Nurses and Clients," p. 90.
[72] Hancock, "Health Vocations," p. 113.

nurses, who's program of health education centered on "the gospel of health" and the "counsel of 'right living.'"[73] Hancock also makes clear the harm and ill-health perpetuated by the "racial, cultural, and religious prejudices" of the field nurses, as well as the biomedical framework that shaped their approach to illness, health, and health education, all of which "contributed to the prioritization of individual causes of sickness and disease over socioeconomic ones."[74] During home visits, in particular, field nurses "underscored the importance of individual health and hygiene, largely holding women accountable for tribal health."[75] Field nurses "viewed Indian homes as health hazards that were in perpetual need of public health education." In these visits – and at the core of their health education work – field nurses emphasized the importance of "personal hygiene, sanitation, diet, and pre-natal and infant care." But in "targeting Indian women, field nurses emphasized individual hygiene rather than social or environmental causes of illness." In this way, field nurses held Indian women – rather than the structural impacts of colonialism and racism – "personally responsible for the health and wellness of their families."[76]

Hancock's analysis, like that of Abel and Reifel, builds upon primary sources that center both non-native and Native voices. Hancock uses the writings of the white field nurses, together with oral histories with Native women that are part of the Doris Duke American Indian oral history project conducted in the 1960s and 1970s. It is in the responses of Native American women to field nurses that Hancock elaborates on the agency and power of Native American women in these encounters. As Hancock notes, though "their responses to field nurses varied, American women regularly negotiated the presence of Western health care." Echoing the earlier work of Abel and Reifel, Hancock highlights the agency that Native American women maintained in their encounters with field nurses, accepting services that were useful to them, and rejecting that which "they deemed unnecessary or even offensive."[77] For example, even when Native American women used some of the medical care provided by field nurses, "they typically maintained their own health regiments as well, in the process of preserving cultural power unavailable to Western medical providers." This included their reliance on handmade herbal remedies, for which American Indian "women historically maintained responsibility for gathering, preparing, and administering herbs."[78] And while Native American women selectively accepted the services of field nurses, Hancock asserts, field nurses also, "frequently became students of native women," learning about Indigenous beliefs and practices.[79] As Hancock explains, the home visits "allowed field nurses into the intimate spaces of Indian women's

[73] Hancock, "Health Vocations," p. 114.
[74] Hancock, "Health Vocations," p. 115.
[75] Hancock, "Health Vocations," p. 119.
[76] Hancock, "Health Vocations," pp. 120-121.
[77] Hancock, "Health Vocations," p. 122.
[78] Hancock, "Health Vocations," p. 124.
[79] Hancock, "Health Vocations," p. 122.

lives," while also providing "the backdrop for education in native customs. Some field nurses found themselves and their rigid ideas on Western medicine transformed by the experience." [80]

As Hancock's work and other scholarship on the BIA field nursing program makes clear, "While field nurses brought some important medical services to American Indians on reservations…. They were also white women expected to instill in American Indian women a hunger for middle-class Anglo-American expectations of personal hygiene and domestic cleanliness." And in doing so, "field nurses defined health and healthful living in ways that often conflicted with tribal customs, emphasizing individual responsibility over socioeconomic causes of illness. Although providing some relief to impoverished reservation communities, field nurses performed their work within a long established colonial context." So too, the "heavy emphasis on personal hygiene targeted Indian women, making them largely responsibility for the poor health and disease that affected entire reservations." Doing so "obscured the reality of the socioeconomic conditions on reservations" and diverting attention – and accountability – from the impact of colonial practices and policies on Indigenous ill-health. [81] Ultimately, Hancock concludes, "field nurses, and their public health agenda, relying as it did on an ideology that presumed western medical authority, contributed, even unwittingly, to the ongoing hegemonic colonization of native North Americans." [82]

Nevertheless, as Native studies scholars and historians have demonstrated, Native American communities continued to assert agency over their individual, community, and tribal health, and in many communities, Indigenous health practices and healers persisted. For example, in *My Grandfather's Knocking Sticks*, Brenda Child highlights the centrality of Ojibwe women's labor and healing practices to life on Ojibwe reservations in Minnesota during the early 20th century. Child writes that even as government physicians trivialized the medical expertise of Ojibwe women, women persisted in their healing work. While physicians blamed American Indian families – women, in particular – "for the dismal state of health in Indian communities," disparaging the Ojibwe method of health and wellness, and asserting Western ideas and approaches to health and disease, Ojibwe people were "Relentlessly pragmatic." As Child explains, on the Red Lake reservation in northern Minnesota, Ojibwe people "accepted western medicine, adding it to their long-standing repertoire of Indigenous healing." The government physician for the reservation "misinterpreted the willingness of Ojibwe people to visit the doctor as a sign of cultural submission," when it was anything but.[83] As Child describes, "In Ojibwe Country," there remained "a dynamic network of women who specialized in plants and

[80] Hancock, "Health Vocations," p. 125.
[81] Hancock, "Health Vocations," p. 128.
[82] Hancock, "Health Vocations," p. 128.
[83] Brenda J. Child, *My Grandfather's Knocking Sticks: Ojibwe Family Life and Labor on the Reservation* (St. Paul: Minnesota Historical Society Press, 2014), p. 138.

their healing properties." [84] Ojibwe women participated in considerable labor and utilized healing expertise, working with plants and medicines, to provide care to their families and other community members. Brianna Theobald has similarly described Crow men and women in the early 20th century selectively using the medical services provided by the government, while also utilizing Crow healing systems. As Theobald explains, while many Crow men and women "had grown accustomed to using the Crow reservation hospital for at least some purposes," much to the chagrin of government employees, "an individual's use of the hospital did not signify repudiation of Crow healers. Crows accepted Western medicine selectively and generally did not view the two healing systems as mutually exclusive."[85]

A handful of scholars have centered on the experiences of Native American nurses, detailing the motivations of Native women to pursue nursing careers, the barriers and discrimination they experienced as they did so, and the vital contributions of Native American nurses to Indigenous health and healing. In *African American and Cherokee Nurses in Appalachia*, Phoebe Pollitt documents the experiences of several Eastern Band of Cherokee Indian women who trained as registered nurses and practiced in the Qualla Boundary in Appalachia during the early and mid-20th century.[86] In 2016, Barbara Charbonneau-Dahlen and Karine Crow provided "A Brief Overview of the History of American Indian Nurses."[87] Their article summarizes both the discrimination experienced by Native American nurses and the important contributions made by individual American Indian nurses during the 20th century. For example, Charbonneau-Dahlen and Crow summarize the barriers – as well as opportunities – encountered by Native American women seeking to pursue careers in nursing. Congress's passage of the Indian Child Removal Act in 1880 mandated that all Native American children attend boarding schools in an assimilationist strategy to eliminate Indigenous beliefs, customs, and practices and inculcate in students Euro-American beliefs and values. The BIA instituted a standardized – and gendered – curriculum across all American Indian boarding schools, which combined academics with vocational training.[88] For girls, this meant various forms of domestic labor and, potentially, some rudimentary nurse training.[89] Among the many harms the boarding schools caused to children, one was that they exposed children to infectious diseases. The schools were often

[84] Child, *My Grandfather's Knocking Sticks*, p. 144.
[85] Brianna Theobald, "Nurse, Mother, Midwife: Susie Walking Bear Yellowtail and the Struggle for Crow Women's Reproductive Autonomy." *Montana Historical Society* (2016) 66(3): 17-35, quotation from p. 20.
[86] Phoebe Pollitt, *African American and Cherokee Nurses in Appalachia: A History, 1900-1965* (Jefferson, North Carolina: McFarland & Company, 2016), pp. 92-110.
[87] Barbara Charbonneau-Dahlen and Karine Crow, "A Brief Overview of the History of American Indian Nurses." *Journal of Cultural Diversity* (2016) 23(3): 79-90.
[88] Charbonneau-Dahlen and Karine Crow, 2016, p. 80. On the history of boarding schools, see for example, Brenda J. Child, *Boarding School Seasons: American Indian Families, 1900-1940* (Lincoln: University of Nebraska Press, 1998); and Margaret Jacobs, *White Mother to a Darker Race: Settler Colonialism Maternalism, and the Removal of Indigenous Children in the American West and Australia, 1880-1940* (Lincoln: University of Nebraska Press, 2009).
[89] Theobald, "Nurse, Mother, Midwife," p. 21.

overcrowded, poorly maintained, and with inadequate sanitation, and children were malnourished, all of which contributed to the spread of infectious diseases, particularly tuberculosis and trachoma. Given the high rates of illness in these schools, Charbonneau-Dahlen and Crow explain, boarding school infirmaries and hospitals "functioned as a pre-nursing training facility for American Indian female students while in high school." In addition to providing basic care to their fellow sick students, the training experience also prepared Native American women to enter nursing schools after graduating high school.[90] In *My Grandfather's Knocking Sticks*, Child writes about the experiences of Lutiana LaVoye, an Ojibwe woman from the Great Lakes area. At nineteen years old and a recent graduate of the Haskell Indian Boarding School in Lawrence, Kansas, LaVoye worked as a "volunteer nurse" in military hospitals in the Washington, D.C. area during the influenza epidemic of 1918. LaVoye likely received rudimentary nurse training at the boarding school.[91]

Native American women who sought to enter nursing schools in the late 19th and early 20th centuries, encountered discrimination. Barred from many of the first nursing schools, Charbonneau-Dahlen and Crow note that the first Native American students graduated from nursing schools in the late 1880s. When the Hampton Training School for Nurses was established at the Hampton Institute in 1891, as a Black nurse training program, the school also admitted Native American students. [92] Their article includes a list of the American Indian women who attended the Hampton Institute between 1879 and 1924; drawing upon data originally compiled by Jon Brudvig.[93] In 1930, Dr. Clarence Salsbury, a Presbyterian missionary, established the first accredited American Indian school of nursing, on the Navajo reservation in Ganado, Arizona in 1930.[94] And in 1935, the Commissioner of Indian Affairs, John Collier, secured funds to establish a nurse training course at the Kiowa Indian Hospital in Oklahoma. The course was not accredited, "however, and effectively prepared students to work as aides in government hospitals, where they remained near the bottom of hospital hierarchies."[95] By 1941, "only eight-night of the more than eight hundred nurses in the Indian Health Service were of Native descent."[96]

As Hancock notes in her essay on the BIA field nursing program, although the majority of BIA field nurses were white women, in the context of the early 1930s' Indian New Deal, "official OIA

[90] Charbonneau-Dahlen and Crow, "Overview," p. 80.
[91] Child, *My Grandfather's Knocking Sticks,* pp. 150-159.
[92] Charbonneau-Dahlen and Crow, "Overview," p. 81.
[93] Charbonneau-Dahlen and Crow, "Overview," pp. 82-87.
[94] Jim Kristofic, *Medicine Women: The Story of the First Native American Nursing School* (Albuquerque: University of New Mexico Press, 2019).
[95] Theobald, "The History-Making Work of Native Nurses." *UNC Press Blog*, October 14, 2019. https://uncpressblog.com/2019/10/14/brianna-theobald-the-history-making-work-of-native-nurses/ Retrieved December 13, 2021.
[96] Theobald, "Nurse, Mother, Midwife," p. 23.

[Office of Indian Affairs] policy encouraged the recruitment of American Indians to fill positions in Indian Health Services programs." However, throughout the 1930s, the number of American Indian women hired as field nurses remained very low. Moreover, "American Indian women were heavily concentrated in 'aide' and 'assistant' roles, meaning that their work was typically directed and supervised by non-native health workers."[97] This created similar dynamics to those established in other colonial contexts (see below), in which Black and Indigenous nurses, and other nurses of color, were marginalized in low status, low paying subordinate positions within the nursing hierarchy, subject to supervision by white middle class nurses.

Brianna Theobald has detailed the career of Susie Walking Bear Yellowtail.[98] Yellowtail was born in 1903 in Pryor, Montana, on the Crow reservation. As a child, Yellowtail first attended the Catholic boarding school at Pryor, and then transferred to the government boarding school at Crow Agency [99] At the age of sixteen, she left Montana to attend the Bacone Indian School in Oklahoma. In the early 1920s, she traveled to the East Coast. With the assistance of a Baptist sponsor, Yellowtail "enrolled in the nursing program at Franklin County Memorial Hospital in Greenfield, Massachusetts, before going on to Boston City Hospital School of Nursing." In 1927, when Yellowtail graduated from the school, along with five other classmates (all of whom were white), "she became the first Crow registered nurse and one of the first Native American registered nurses."[100] A year later, Yellowtail joined the Indian Service, returning to the Crow Agency, where she worked a supervisory nurse at the hospital. [101] Yellowtail stayed at the hospital for only a few months, resigning after she married. But as Theobald explains, Yellowtail's decision to resign "stemmed in part from her deep frustration with the hospital's white employees." Her experience "convinced her that Crows commonly endured mistreatment at the reservation hospital. Yellowtail later recalled that she 'went to bat' for mistreated patients."[102] Several years later, Yellowtail returned to the Crow hospital to give birth to her second child, where she experienced first-hand mistreatment at the hands of the government physician. But even before her experiences as a patient, Yellowtail's experiences working at the reservation hospital transformed her into a "political activist."[103]

Theobald builds on the work of historian Cathleen Cahill, who in *Federal Fathers and Mothers* demonstrated the ways in which 20th century Native Americans turned positions within the federal Indian Service into "politicized sites of resistance," countering the federal governments

[97] Hancock, "Healthy Vocations," p. 126.
[98] See both Theobald, "Nurse, Mother, Midwife," and Theobald, *Reproduction on the Reservation*.
[99] Theobald, *Reproduction on the Reservation*, p. 73.
[100] Theobald, *Reproduction on the Reservation*, p. 74.
[101] Theobald, "Nurse, Mother, Midwife," p. 23.
[102] Theobald, "Nurse, Mother, Midwife," p. 25.
[103] Theobald, "Nurse, Mother, Midwife," p. 25.

intentions and expectations.[104] Theobald shows this to be no less true for Native American women like Susie Yellowtail who worked as nurses within the Indian Health Service. Some of Yellowtail's superiors deemed her a 'troublemaker' and she was unable to secure health-related employment on the reservation throughout the 1930s.[105] In part to mitigate their potential for disruption, Theobald explains, the BIA preferred not to assign Native American nurses within their home communities, sending them instead to hospitals on other reservations. However, for tribal leaders, the employment of tribal members at local hospitals was viewed as a matter of self-determination.[106]

After resigning from the Crow Indian Hospital, Yellowtail continued both her health work and her political activism – both of which were, Theobald makes clear, integrally connected. In particular, Yellowtail began serving as a midwife for women in Wyola and throughout the Little Big Horn valley. As Theobald explains, Yellowtail "had delivered a number of babies during her employment at Indian Service hospitals, and after 1930, she had also given birth herself, which many Crows still viewed as a prerequisite for midwifery. She combined her Western medical training with birthing knowledge she had learned from women in the Yellowtail family, in order to provide women with safe childbirth experiences outside the government hospital. According to Yellowtail, by mid-decade, many women avoided the hospital out of fear of the doctors" who were known to perform involuntary or forced sterilizations. [107] In 1934, Yellowtail was herself sterilized without consent during a gynecological procedure performed by a government physician at the Crow Indian Hospital. As Theobald explains, "Considered in context, Yellowtail's midwifery constituted an act of resistance" to the sterilization abuses in the Crown Indian Hospital.[108]

Yellowtail continued to work as a midwife throughout the 1940s and into the 1950s. She also served on the tribe's committees on health and education. In her role on the health committee, she acted as "patient advocate and government watchdog." In the late 1950s, as Theobald describes, the health committee "distributed a circular encouraging Crows to report all hospital-related complaints to the committee and to bring a committee member to serve as a witness to doctor visits." Then in 1961, Yellowtail was appointed by President John F. Kennedy to the Surgeon General's Advisory Committee on Health; a position she held through the Johnson and Nixon administrations. In this capacity, Yellowtail traveled "throughout Indian Country, investigating reservation health conditions, and making recommendations for

[104] Cathleen Cahill, *Federal Fathers and Mothers: A Social History of the United States Indian Service, 1869-1933* (Chapel Hill: University of North Carolina Press, 2011), p. 113, as quoted in Theobald, *Reproduction on the Reservation* p. 80.
[105] Theobald, *Reproduction on the Reservation* p. 80.
[106] Theobald, *Reproduction on the Reservation* p. 80.
[107] Theobald, *Reproduction on the Reservation*, p. 97.
[108] Theobald, "Nurse, Mother, Midwife," p. 34.

improvement." As she traveled throughout the West, Yellowtail "came to realize the patterns of abuse and neglect at the Crow Indian Hospital were not unique." In the early 1960s, she helped found the Native American Nurses Association (later renamed the American Indian Nurses Association), an organization of Indigenous nurses whose professional experiences had alerted them to the coercive sterilization practices that occurred in government hospitals and the poor treatment Native patients received from government and contract health workers." [109]

Theobald's examination of Yellowtail's life and career is part of a broader analysis in which she traces the reproductive histories of generations of Native American women from the 19th through the early 21st centuries, "focusing attention on what women said and did."[110] Yellowtail is just one of the Native women on whose words, actions, and experiences that Theobald centers in *Reproduction on the Reservation*. Theobald does so by drawing upon the writings, speeches, and stories held in tribal archives, oral histories with Crow individuals, as well as bureaucratic records, sociological and anthropological studies, and activist literature. [111] In doing so, Theobald shows that Native women "navigated pregnancy and birthing… in myriad ways."[112] For some Native women, this meant incorporating "field matrons, nurses, physicians, and even hospitals into their reproductive lives on Native terms." For example, "women who chose or felt pressured to give birth in a hospital continued to consult midwives before and during pregnancies and after their deliveries," while women "who might have acted as midwives in other circumstances also accompanied women to the hospital, where their efforts to serve as patient advocates and authorities on birthing were met with varying degrees of success in different contexts."[113] In other words, "Native women have displayed fortitude and creativity in navigating the federal government's often contradictory demands on their bodies and behaviors and in meeting their perceived parturition and childbirth needs in evolving historical contexts." [114] Theobald also shows that since at least the 1930s, Native women "worked to secure the best possible care for Native women;" "advocated for women's health and the health and well-being of their communities by pressuring federal agencies to uphold Native 'treaty rights;'" demanded that Native women receive services comparable to those of white women with private insurance; and "demanded that government health workers provide culturally appropriate care." [115] Theobald's work also highlights the "network of Native nurses and other health professionals who assumed roles as watchdogs and patient advocates in colonial medical institutions," and who, in the 1970s and 1980s, struggled alongside Women of All Red Nations for Native women's reproductive autonomy.[116]

[109] Theobald, "Nurse, Mother, Midwife," p. 34.
[110] Theobald, *Reproduction on the Reservation,* p. 10.
[111] Theobald, *Reproduction on the Reservation,* pp. 14-15.
[112] Theobald, *Reproduction on the Reservation,* p. 10.
[113] Theobald, *Reproduction on the Reservation,* p. 11.
[114] Theobald, *Reproduction on the Reservation,* p. 12.
[115] Theobald, *Reproduction on the Reservation,* p. 13.
[116] Theobald, *Reproduction on the Reservation,* p. 13.

Collectively, the scholarship on nursing and colonialism in the Indigenous U.S. makes clear the ways in which nursing has been integral to settler colonialism. It also highlights the colonial context in which Native American people have in the past and still today experience health, illness, and health care. This literature also emphasizes the agency and power that Native American people maintained as they negotiated health and health care. And it emphasizes the vital work that Native American nurses have done to resist, contest, and navigate colonial health care institutions, and to advocate for the health and health care of Native American people.

Nursing and American Imperialism Beyond the Continental U.S.

Over the last decade, a small but growing number of scholars have begun to explore and problematize nursing's role in American imperialism. The first scholar to critically address the intersections of nursing and imperialism was Catherine Ceniza Choy. In *Empire of Care*, Choy uses oral histories of Filipino nurses in New York City as well official government documents, to demonstrate that the history of U.S. colonialism in the Philippines indelibly shaped the development of professional nursing in the Philippines, while also explaining the expansive transnational network of Filipino nurse migration in the decades after World War II. Choy argues that the migration of these nurses from the Philippines transcended economic self-interests: that it was, instead, deeply rooted in an exploitative form of American imperialism that began with in that country's self-conscious adoption of a distinctly American hospital, healthcare and nurses training system.[117] As Choy explains, the Americanized nursing programs were important sources of educational and social mobility for Filipino women. With support from philanthropic foundations like the Rockefeller Foundation and Daughters of the American Revolution, the American colonial government established the pensionado program, which "sponsored members of the Filipino elite at universities and colleges in the US to prepare them to assume top positions in American-established institutions in the Philippines." For the Filipinas who participated in the program, argues Choy, "study in the U.S. became a prerequisite for social and occupational mobility in the nursing profession in the Philippines," it also "created the professional and social foundations that enabled the Filipino nursing labor force to work and study in the U.S."[118]

As Choy makes clear, the history of colonialism in the Philippines is key to understanding why, by the late 1960s, Filipino nurses constituted the overwhelming majority of foreign-trained

[117] Catherine Ceniza Choy, *Empire of Care: Nursing and Migration in Filipino American History* (Durham: Duke University Press, 2003).
[118] Catherine Ceniza Choy, "'Exported to Care': A transnational history of Filipino nurse migration to the United States," in Nancy Foner, Rubén G. Rumbaut, and Steven J. Gold (eds.), *Immigration Research for a New Century: Multidisciplinary Perspectives* (New York: Russell Sage Foundation, 2000), pp. 113-133.

nurses who entered the U.S. through the government's Exchange Visitor Program (EVP). Congress established the EVP in 1948 and between 1956 and 1969, over eleven thousand Filipino nurses participated in the program."[119] Participants of the EVP came to the U.S. for up to two years to work and study in sponsoring institutions, which provided them with a monthly stipend. The ANA and individual hospitals were among the several thousand sponsoring U.S. agencies and institutions. While Filipino nurses had their own reasons for participating in the program, U.S. hospitals "used exchange nurses as an inexpensive labor supply to alleviate growing nursing shortages in the post-World War II period."[120] As Choy details, Filipino nurses were routinely exploited by the hospitals that sponsored them: "Some hospital administrators took advantage of the exchange status of Filipino nurses by assigning them the work of registered nurses and compensating them with minimal stipend. Other American hospital administrators abused the educational and professional component of the EVP by assigning Filipino exchange nurses the work of nurse's aides."[121] Congress's passage of the Immigration and Nationality Act in 1965 further encouraged the recruitment of foreign-trained nurses by American hospitals. With ongoing shortages of health care professionals, and concerns that those shortages would be exacerbated following the implementation of Medicare and Medicaid, foreign-trained nurses were in particularly high demand and large numbers of Filipino nurses immigrated to the U.S. in response. Indeed, as Choy notes, by 1967, "the Philippines became the world's top sending country of nurses to the United States."[122]

In the 15 years since the publication of Choy's seminal work, a handful of scholars have begun to interrogate the logics of imperialism, professionalization, and racialization that were at work as nurses participated in the U.S.'s other colonial projects; each of which was a product of the 1898 Spanish-American War.[123] As Choy demonstrated for the Philippines, nursing imperialism was premised on the superiority of American nursing and with it, Euro-American values. In this rendering, white American nurses saw themselves as a civilizing force that would – along with

[119] Choy, *Empire of Care*, p. 65.
[120] Choy, *Empire of Care*, p. 78.
[121] Choy, "Exported to Care," pp. 122-123.
[122] Choy, "Exported to Care," p. 127.
[123] See, for example, Winifred C. Connerton, "American Nurses in Colonial Settings: Imperial Power at the Bedside," in D'Antonio, Fairman, and Whelan, (eds.), *Routledge Handbook on the Global History of Nursing* (New York: Routledge, 2013); Winifred Connerton, "Working Toward Health, Christianity and Democracy: American Colonial and Missionary Nurses in Puerto Rico, 1900-30," in Helen Sweet and Sue Hawkins (eds.), *Colonial Caring: A History of Colonial and Post-Colonial Nursing* (Manchester: Manchester University Press, 2015), pp. 126-144; Ellen Walsh, "'Called to Nurse': Nursing, Race, and Americanization in Early 20th-Century Puerto Rico," *Nursing History Review* (2018) 26: 138-171; Laura R. Prieto, "Dazzling Visions: American Women, Race, and the Imperialist Origins of Modern Nursing in Cuba, 1898-1916." *Nursing History Review* (2018) 26: 116-137; Jean J. Kim, "Professionalizing 'Local Girls': Nursing and U.S. Colonial Rule in Hawai'i, 1920-1948," in Laurie B. Green, John McKiernan-González, and Martin Summers (eds.), *Precarious Prescriptions: Contested Histories of Race and Health in North America* (Minneapolis: University of Minnesota Press, 2014), pp. 143-165.

the larger colonial missions – "civilize" colonial subjects and prepare them for "self-rule."[124] As Winifred Connerton argues, by embodying "'benevolent' approach of American colonialism," American nurses "were the personal face of America in their contact with patients at the bedside and in the clinic."[125] Connerton's work shows that American nurses who went to Puerto Rico as members of the Army Nurse Corps, as colonial service workers, and as Protestant missionaries after the Spanish-American War, participated in the U.S. government's colonial project to Americanize and "modernize' Puerto Rico. The U.S. colonial government and missionary administrators "needed trained nurses to effectively run their public health and hospital facilities," and they – along with the American nurses they hired – "believed in the power of nursing training to 'improve' Puerto Rican society."[126]

Latinx Nursing

But to be sure, the development of professional nursing in Puerto Rico was not simply the product of colonial imposition. Rather, as Ellen Walsh's research on the Protestant missionary project in Puerto Rico shows, some Puerto Ricans supported the U.S. colonial project of modernization – though they didn't adopt it wholesale, adapting it, instead, to their own ends.[127] As they did so, Puerto Rican nurse leaders contributed to the racialization of nursing education in Puerto Rico. Although the racial classifications, and the social hierarchies that resulted from them, were different in Puerto Rico than on the mainland, "features identified as African consigned Puerto Ricans to a lower position on the spectrum." As Walsh explains, "imperialist and local ideologies of white racial superiority" converged in the development of nursing education in Puerto Rico "to Afro-Puerto Ricans' disadvantage."[128] Segregation was commonly practiced in Puerto Rico under the U.S. colonial government. For example, the Presbyterian Hospital training school excluded Afro-Puerto Rican candidates, and many of the "best" institutions around the island would not hire Afro-Puerto Rican nurses. However, "racist policies were not universally adopted throughout the island."[129] The fact that de jure segregation was not operative in Puerto Rico had implications for the professional standing of Puerto Rican nurses in the U.S. Despite, as Walsh argues, "imperial ideologies that discursively darkened all Puerto Ricans," the Association of Registered Nurses of Porto Rico, which was founded in 1916, was accepted into the ANA just four years later (at a time, of course, when African American nurses were excluded – by law in the South and custom in other parts of the country – from the ANA and other majority white nursing organizations and nursing schools).

[124] Choy, "Exported to Care," p. 118.
[125] Connerton, "American Nurses in Colonial Setting," p. 11.
[126] Connerton, "Working Toward Health, Christianity and Democracy," pp. 126-127.
[127] Walsh, "Called to Nurse," p. 139.
[128] Walsh, "Called to Nurse," p. 156.
[129] Walsh, "Called to Nurse," p. 161.

This, in turn, helped the ARNPR and its leaders, "build critical professional networks" with nurses on the mainland.[130]

American nursing was also integral to the U.S. imperialist project in Cuba, which in turn was shaped by the intersections of both Cuban and U.S. racial hierarchies. As Laura Prieto has documented, "The exclusion of Afro-Cuban women followed that of African American women nurses in the early phase of U.S. occupation." Although Americanized nursing in Cuba offered expanding opportunities for some Cuban women, "modern nursing was an American export bounded by racial exclusion and suffused with an imperialist ideology."[131] As in Puerto Rico, "Race had its own complicated history in Cuba."[132] Racial classifications in Cuba "attempted to affix an identity based on degree of African ancestry and skin color," doing so along "'multiple color lines.'" [133] The U.S. occupation exacerbated the racism that was already operative in Cuba whereby "The island's elites were already predisposed to regard people of African descent as inferior and perhaps even a danger to the republic. Thus they eagerly worked to 'white' and even Anglo-Americanize Cuba." In Cuba, as it was in Puerto Rico, race was classed. As Prieto continues, "over time even black Cuban elites separated themselves from the poorer, less educated Afro-Cuban masses. Thus, across races, Cuban elites found American imperialist views of race ideologically persuasive as well as strategically useful, since they needed to persuade the United States of Cuba's fitness for political autonomy in order to end U.S. occupation." [134] As Prieto argues, "From the U.S. perspective, Cuba's readiness for independence was contingent upon establishing 'racial exclusion' and segregation… By this thinking, black nurses were unsuitable exponents of the 'modern' nursing the United States hoped to inculcate in its possessions." [135] The ideology of racial hierarchy and white racial superiority marked American nursing's imperialist project in Cuba in other ways. White American nurse leaders, Prieto argues, saw Cuban nursing as a "*tabula rasa*," whereby Cuba's "native women [were] in need of tutelage, like the Cuban people as a whole." In this rendering, "The white corps of American nurses thus saw Cuban women as a decidedly inferior," and yet also, "malleable-redeemable."[136] But as in Puerto Rico, "not all Cuban women seemed equally eligible" for 'modern' nursing; "Afro-Cuban women were unwelcome as potential nurses… The very insistence on making nursing a *respectable* profession, one that would 'entice and charm' more elite women, meant excluding black women."[137] In this way, "the U.S. occupation of Cuba brought about the racial cleansing of the American nurse corps *and* the racialized foundation of

[130] Walsh, "Called to Nurse," p. 161.
[131] Prieto, "Dazzling Visions," pp. 117-118.
[132] Prieto, "Dazzling Visions," p. 121.
[133] Prieto, "Dazzling Visions," p. 122.
[134] Prieto, "Dazzling Visions," pp. 122-123.
[135] Prieto, "Dazzling Visions," p. 125.
[136] Prieto, "Dazzling Visions," p. 127.
[137] Prieto, "Dazzling Visions," p. 128.

nursing training for Cuban women. White American women alone would uplift their Cuban sisters to the standards of professionalism." [138]

But the Latinx experience in the United States is not, of course, limited to Puerto Rico and Cuba. What historians have called the "Spanish Borderlands" – the intersections of a strong Latino presence and culture with the expanding frontiers of an Anglo-dominated United States in what is now New Mexico, Arizona, and California – have been described as places of violent political and social conflict but also hard-won interdependence and mutuality.[139] They lament, however, that little has been done as yet of the day-to-day experiences of women; gender studies have largely focused on Hispanic women in the Americas and in Europe.[140] Barbara Brush and Antonia Villarreul have started to address this discrepancy with their brief biography of Ildaura Murillo-Rohde, who struggled to include Hispanic nurses within the ANA's administrative structure before finally founding, with like-minded colleagues, the National Association of Hispanic Nurses in 1976.[141] D'Antonio has described some of the health experiences of Puerto Ricans migrating to New York City in the 1920s and 1930s – individuals and families whose valid citizenship claims were seen even by rather progressive public health nurses as tenuous, complicated and preferably ignored. And whose health needs – complicated by the discrimination they experienced in where they might live, work, and educate their children – were not well suited to the increasing dominance of an acute health care system.[142] And Lena McQuade-Salzfass has documented the experiences of parteras – or Spanish-speaking midwives – and the symbolic role they played in New Mexico after it became a state in 1912. In the post-statehood period, McQuade-Salzfass argues, "midwifery came to symbolize all that was different about New Mexico in the United States."[143] Like other states in the early 20th century, New Mexico passed a series of midwifery laws that required lay midwives, including parteras, to register with the public health department, attend birth education classes led by public health nurses and physicians, and restrict the scope of their practice. The midwifery licensing laws placed reproductive health care practices under the purview of the state public health department and "rendered certain birth practices and practitioners illegal."[144] Parteras who violated the laws – who practiced without certification or engaged in practices that were prohibited, such as performing any internal exams – could be and were prosecuted. The implementation and enforcement of the state's midwifery laws depended on the state health

[138] Prieto, "Dazzling Visions," p. 127.
[139] Vicki Ruiz, Why Latino History Matters to US History, *Japanese Journal of American Studies,* 20, 2009: 7-26.
[140] Sueann Caulfield, The History of Gender in Historiography of Latin America, *Hispanic American Historical Review,* 813, 2001: 449-499.
[141] Barbara Brush and Antonia Villarreul, "Heading the Past, Leading the Future," *Hispanic Health Care International,* 12 (4), 2014: 159-160.
[142] Patricia D'Antonio, *Nursing with a Message: Public Health Demonstration Projects in New York City* (New Brunswick: Rutgers University Press, 2017).
[143] McQuade-Salzfass, "An Indispensable Service," p. 118.
[144] McQuade-Salzfass, "An Indispensable Service," p. 129.

department recruiting qualified public health nurses to work in the state. As McQuade-Salzfass shows, however, their recruitment efforts centered on perpetuating "the notion that New Mexico was an exotic, foreign space greatly in need of Americanization." And that according to the director of child hygiene and public health nursing, moreover, New Mexico was "a region where white, female nurses endowed with the 'pioneer spirit' performed 'greatly needed' work educating 'the most ignorant' New Mexicans who clung to 'age-old superstitions' and 'believe[d] in their medicine women rather than in modern methods.'" In the context of the U.S. government's recent colonization of the region and subsequent incorporation of New Mexico as a state, McQuade-Salzfass explains, "descriptors such as 'superstitions' evoked the indigenous and Catholic health practices of Nuevomexicanos and racialized people of Spanish Mexican descent." In this way, the regulation of midwifery was cast as a means by which New Mexico would "be brought within national norms," including the norms of Euro-American reproductive health.[145] Nevertheless, throughout the first half of the 20th century, the public health department relied on the indispensable labor of parteras, who provided vital reproductive health care, "primarily to rural, economically impoverished Nuevomexicanas and their families, who often had no other access to physicians or hospitals well into 20th century."[146] Ultimately, McQuade-Salzfass argues, the midwifery laws and policies "reveal much about the consolidation of racialized and gendered health hierarchies in early twentieth-century New Mexico and the centrality of reproduction to demarcating national belonging."[147]

Imperialist Legacy

The role of nursing in American imperialism was not restricted to its immediate colonial/territorial interests. As Julia Irwin has demonstrated in *Making the World Safe*, the thousands of U.S. nurses who volunteered to work as instructors in nursing schools and staff public health agencies in Europe, Asia, and the Caribbean in the wake of World War I, were not only motivated "to tackle world health issues," but also by the conviction "that the spread of U.S. professional nursing ideas stood to modernize the world."[148] The American nurses who volunteered with the American Red Cross, as Irwin shows, "carried their experiences and assumptions about health, race, and civilization with them." As they sought to implement these ideals via the establishment of nursing schools and public health campaigns in eastern and central Europe, Asia, and the Caribbean, these white nurses (the American Red Cross barred African American from serving overseas)[149] "shared a modernizing impulse that ordered the

[145] McQuade-Salzfass, "An Indispensable Service," p. 132.
[146] McQuade-Salzfass, "An Indispensable Service," p. 123.
[147] McQuade-Salzfass, "An Indispensable Service," p. 136.
[148] Julia F. Irwin, "Nurses Without Borders: The History of Nursing as U.S. International History." *Nursing History Review* (2011) 19: 78-102.
[149] Julia F. Irwin, *Making the World Safe: The American Red Cross and a Nation's Humanitarian Awakening* (New York: Oxford University Press, 2013), pp. 101-102.

world's people according to hierarchy of levels of development and progress – they defined certain populations as easy and willing to reform and others as more difficult. And they believed all populations could be improved if the US took the lead in educational and environmental interventions."[150]

But it wasn't just that the logics of racial and cultural hierarchies informed and underpinned nursing's role in American imperialism overseas, American imperialism also contributed to the racialization of nursing in the U.S. As Choy did for the history of Filipino nurse migration to the U.S., Sujani Reddy has demonstrated the intersections of American imperialism, professionalization, and racialization in the history of Indian nurse im/migration to the U.S. In *Nursing and Empire*, Reddy shows that the emergence of transnational immigration of Indian nurses during the Cold War decades was rooted in the U.S. imperialism of the pre-World War II decades, led by the Rockefeller Foundation, and Christian medical missionaries prior to that. She also explains the ways in which foreign nursing labor was racialized in the U.S. during the Cold War decades.[151] Foreign-trained nurse graduates – the overwhelming majority of whom were nurses from the Philippines, India, and other parts of the so-called Third World – "faced stigmatization as a 'cheap(er)' solution to recurrent crises in what was cast as a chronic nursing shortage."[152] This stigmatization was rooted in the long history of racial exclusion in U.S. immigration policy whereby migrants from a legislatively defined "Asiatic Barred Zone" had been ineligible for both immigration and naturalization since the early 20th century. "'Foreign' was thus a racially loaded category that would mark Indian nurses in a way that did not apply to their white American or European immigrant counterparts."[153] As foreign-trained nurses they were subject to increased testing and regulation, which caused "some to experience forms of downward mobility, including employment in nursing's nonprofessional ranks where Third World and especially African American labor was disproportionately concentrated." Even when hired into the professional nursing ranks, Reddy found that most Indian nurses "found their labor relegated to the shifts, units, and hospitals least table to retain their white colleagues."[154]

What sets the work of Choy and Reddy apart is that through their use of oral histories, their analysis centers on the experiences and perspectives of Filipino and Indian nurses within the matrix of American imperialism and the professionalization and racialization of American nursing. As the scholarship of Choy and Reddy make clear, nursing's role in American imperialism is integral to understanding the increasingly important role – and racialized experiences – of foreign-trained nurses in the Cold War decades. As both scholars demonstrate,

[150] Irwin, "Nurses without Borders."
[151] Sujani Reddy, Book, *Nursing and Empire: Gendered Labor and Migration from India to the United States* (Chapel Hill: University of North Carolina Press, 2015), pp. 9-10.
[152] Reddy, *Nursing and Empire*, p. 12.
[153] Reddy, *Nursing and Empire*, p. 154.
[154] Reddy, *Nursing and Empire*, pp. 12-13.

in the decades after World War II, as U.S. hospitals confronted ongoing – and growing – nursing shortages, foreign-trained nurses assumed increasing importance in the U.S. nursing labor market. But as they did so, their entrance served to reinforce racialized hierarchies in U.S. nursing *and* contributed to racialization of nurse im/migrants from the Philippines, India, and other parts of Asia, as "foreign" and thus always "other." For Reddy, the racialization of foreign-trained nurses cannot be understood apart from the racial dynamics of the white-Black binary that had constituted American nursing since the introduction of trained nursing in the late 19th century. As Reddy argues, for example, "the relative immobility" of African American nurses in the post-World War II U.S. "must be understood as part of the conditions of possibility for Indian nurses' advancement." While many Indian nurses who had been relegated, initially, to the roles of nurses' aide or LPN could, eventually, "move further up the occupational ladder," oftentimes their Black colleagues continued to face barriers to occupational mobility. But at the same time, white nurses denied Indian nurses "full access to the privileges of whiteness." In this way, discrimination was "a multifaceted phenomenon, flowing both up and down the nursing hierarchy," positioning "Indian nurses on both the perpetuating and receiving ends of racism." While Indian im/migrant nurses troubled the Black/white binary in American nursing, Reddy argues, the question of "who/what are they within this racialized field" was answered by their racialization as "foreign."[155]

As this scholarship on the role of nursing in American imperialism makes clear, then, the racialization of professional nursing that was central to America's colonialist projects was also integrally connected to the racialization of professional nursing in the U.S. In particular, the intersections of imperialism and racialization in nursing's professional project were inextricably contextualized within the dynamics of the Black-white binary that was operative in American nursing not only during the years of Jim Crow segregation, but also in the decades thereafter. And as the work of Choy and Reddy make clear, this history has implications for understanding the experiences of Filipino, Indian, and other foreign-trained nurse migrants and immigrants in the U.S. in the 21st century, as well as the intersectional imprint of racism and colonialism on the attitudes, practices, and policies of professional nursing organizations, including the ANA, towards foreign-trained migrant and immigrant nurses of color.

While the work of Choy and Reddy are the first book-length analyses of not only America's nursing imperialism but also the transnational place of nursing in a global world, they should not be the last. More concretely, how does this history help us make sense of the activism of California's Filipino nurses, particularly in this time of COVID and how do we reconcile a subtext of exploitation with the fact that one of the first presidents of National Nurses United is a Filipino nurse? And what of other under-represented groups? What kinds of colonialist,

[155] Reddy, *Nursing and Empire*, p. 178.

imperialistic, and / or transnational concepts might help us understand the experiences of Hispanic, Asian, and men nurses?

The Limits of Integration and the Need for Activism

By the 1970s, it was clear that the gains of the Civil Rights movement, including the integration of the ANA, had its limits. Even after civil rights legislation in the 1960s dismantled the legal system of segregation and made racial discrimination in education and employment illegal, practices of racial exclusion in nursing and higher education continued.[156] As Darlene Clark Hine wrote in 1989, "The end of overt discrimination and segregation… did not mean the eradication of more subtle and sophisticated forms of institutional racism."[157] As Hine explained, "In the twenty years following the dissolution of the NACGN and the ostensible integration of black nurses into the ANA, only imperceptible improvements had been registered in the actual status of black women within the profession."[158] For example, the ANA had effectively denied Black nurses leadership positions. As of 1970, there had never been a Black president or vice president of the ANA and "few black nurses won appointment to committees or commissions or were invited to present papers at the annual conventions."[159] The 1970s was also characterized by ongoing inequities in nursing and higher education. The majority of Black nurses graduated from practical nursing and associate degree programs, which subsequently limited their opportunities for career advancement, leadership, and faculty positions, all of which required, at minimum, a BSN. This reflected broader trends in higher education in which students of color were overrepresented in community colleges and heavily underrepresented in four-year colleges and universities. These trends were a product not only of discrimination but also of socioeconomic factors. After all, community colleges were far more affordable and thus accessible to students from low-income backgrounds. But this meant that in 1965, when the ANA attempted to establish the BSN as minimum credential necessary for entry into professional nursing practice, it effectively discriminated against nurses of color who already faced substantial barriers to higher education in nursing

Majority white organizations were also failing to address the health needs of people of color. For example, in 1969, nurse leader, Rhetaugh Dumas wrote in the *American Journal of Nursing* that the "social destructive force of poverty" is "one of the most serious hazards to the survival and health of man." For people of color, she continued, "the problems of poverty are precipitated and compounded by racism and other forms of prejudice and discrimination."[160]

[156] Hine, *Black Women in White*.
[157] Hine, *Black Women in White*, p. 191.
[158] Hine, *Black Women in White*, p. 192.
[159] Hine, *Black Women in White*, p. 192.
[160] Rhetaugh G. Dumas, "This I believe… about Nursing and the Poor." *Nursing Outlook* (September 1969): 47-49, quotation from p. 47.

For Dumas, nursing shared responsibility for effecting change in the health care system "to make health services more responsive to the needs of the poor."[161] In the early 1970s, members of the Committee on Nursing in a Society in Crisis also called on nurses to reorient their priorities and focus their attention on the "interrelationship of sociopolitical issues and nursing" – particularly racism and poverty – so as "to plan and take part in changing the health care system."[162]

As both Hine and Gloria Smith have each detailed, following the ANA's 1970 annual convention, more than 150 Black nurses began meeting to "discuss ways in which to better articulate the health needs of the black community and to share frustrations with their lack of mobility in the health-care system." [163] Under the leadership of Lauranne Sams, a group of Black nurses organized a new independent professional association, the National Black Nurses Association (NBNA). Established at the end of 1971, the NBNA published a set of ten objectives to improve the health and health care of Black Americans and to promote the professional development of Black nurses. The NBNA was to be an advocate for Black patients, acting as "change agent in restricting existing institutions and/or helping to establish institutions to suit the needs of black people." The NBNA would serve as "the national body to influence legislation and policies that affect black people and work cooperatively and collaboratively with other health workers to this end." The NBNA also sought to "Conduct, analyze, and publish research to increase the body of knowledge about health care and health needs of blacks," and would establish "standards and quality education of black nurses on all levels by providing consultation to nursing faculty and by monitoring the proper utilization and placement of Black nurses." NBNA would also work to increase the recruitment of Black people into nursing and would be "the vehicle for unification of black nurses of varied age groups, educational levels, and geographic location to insure continuity of our common heritage." The NBNA recognized that such research and advocacy – led by Black nurses – was integral to improving the health and health care of Black Americans.[164]

Black nurses were not the only nurses to organize at this time. Nurses from diverse populations began taking on larger roles in meeting the health needs of their communities and promoting greater leadership and influence in nursing education and the nursing profession itself. The reasons that led different communities of nurses to organize were varied and represented the complex developments and intersections that shaped the experiences of different populations of nurses. In 1974, for example, a group of Hispanic nurses who felt the ANA was not being

[161] Dumas, "This I believe," p. 47.
[162] Carolyn Sullivan, Janice Robinson, and Janice Ruffin, "Nursing in a Society in Crisis." *American Journal of Nursing* (1972) 72(2): 302-304.
[163] Hine, *Black Women in White*, p. 192; Gloria R. Smith, "From Invisibility to Blackness: The Story of the National Black Nurses' Association." *Nursing Outlook* (1975) 23: 225-229.
[164] Smith, "From Invisibility to Blackness," p. 227.

responsive to the needs of Hispanic nurses met at the ANA Convention with the intent of establishing a Hispanic Nurses Caucus of the ANA. As noted earlier, the group, which included Ildaura Murillo-Rohde, struggled to include Hispanic nurses within the ANA's administrative structure. After two years, in 1976, the group instead established the National Association of Spanish-Speaking/Spanish-Surnamed Nurses, which was renamed the National Association of Hispanic Nurses in 1979.[165]

In 1973, Native American nurses organized the American Indian Nurses Association (AINA). Native nurses formed the professional organization to raise awareness of and work to address health disparities; to increase the number of Native American nurses; to sensitize "non-Native medical providers to tribal histories and cultures;" and to advocate for "greater opening to Native healing practices."[166] AINA also sought to increase the number of Native American nurses. Susie Yellowtail, who was one of AINA's founding members, asserted, "It is time, for our own people to work with Indian people, because few non-Indian people know what makes us tick."[167]

Brianna Theobald has written that sterilization abuse was also among the AINA's earliest priorities. In *Reproduction on the Reservation*, Theobald recounts the important role that Community Health Representatives, a program launched by the Indian Health Service (IHS) in the late 1960s, played in alerting the IHS to concerns of sterilization abuse in its facilities. Community Health Representatives were "Native women and men who acted as health aides and served as liaisons among patients, local health committees, and providers."[168] In their conversations with women about their reproductive health care, Community Health Representatives in Wisconsin identified differential rates of sterilization procedures in different institutions and that some institutions lacked transparency in their sterilization protocols and reported their concerns to the IHS.[169] Also, in 1974, a study by Connie Pinkerton-Uri, a Choctaw and Cherokee physician, found that one in four American Indian women had been sterilized without consent at an IHS hospital in Claremore, Oklahoma. Pinkerton-Uri initiated the research after an unnamed 26 year-old Native American woman entered her physician's office in Los Angeles in 1972 requesting a "womb transplant." The woman had received a hysterectomy six years earlier when she was struggling with alcoholism; now sober and married, the woman wanted to begin a family. Pinkerton-Uri realized the woman had not understand the nature or implications of her earlier hysterectomy. The following year, Theobald writes, "Pinkerton-Uri had visited the IHS hospital in Claremore, Oklahoma, at the invitation of more than a dozen nurses who were protesting discriminatory labor practices and poor patient care." At

[165] https://www.nahnnet.org/about/history Retrieved December 14, 2021.
[166] Theobald, "The History-Making Work of Native Nurses."
[167] Yellowtail quoted in P. Arnold, "Indian nurses hold national conference." *The American Nurse* (1975) 7(6): 8.
[168] Theobald, *Reproduction on the Reservation*, p. 155.
[169] Theobald, *Reproduction on the Reservation*, p. 155.

Claremore, Pinkerton-Uri "encountered what she characterized as a 'sterilization factory.'"[170] Pinkerton-Uri reported her findings to the IHS and to congressional legislators. Theobald explains that it was pressure from Uri-Pinkerton, *and* Native nurses, and others that led congressional members to call on the Government Accounting Office (GAO) to investigate sterilization practices at IHS facilities in New Mexico, South Dakota, Oklahoma, and Arizona. The 1976 GAO report confirmed that IHS had performed 3,406 sterilizations between 1973 and 1976. Although the GAO found no evidence of forced or coerced sterilizations, the report identified inconsistencies in the informed consent process. It is telling, however, that investigators did not interview any of the women who had been sterilized. Theobald explains that Indigenous nurses came together to establish the AINA because their "professional experiences had alerted them to the coercive sterilization practices that occurred in government hospitals and the poor treatment Native patients received from government and contract health workers." [171] Native nurses and other health professionals fought alongside other Native women activists to protest the sterilization abuses experienced by Native women in IHS facilities and to demand Native women's reproductive autonomy.

Also in the 1970s, as Catherine Ceniza Choy has detailed, the "exploitive recruitment practices" of Philippine and U.S. recruitment agencies, "controversial licensing examinations, and a growing awareness of their complex and unique situation in the United States motivated Filipino nurses to organize."[172] But Filipino nurses differed in their criticisms of recruitment practices and licensing examinations, which led to the development of three different national organizations representing in the U.S.: the National Federation of Philippine Nurses Association in the United States (later renamed the National Organization of Philippine Nurses Associations in the United States and then the Philippine Nurses Association of America), the National Alliance for Fair Licensure of Foreign Nurse Graduates, and the Foreign Nurse Defense Fund. [173] The existence of "multiple Filipino nurses' organizations in the United States," Choy argues, "reflected their diverse and competing interests within the United States." [174] (Reddy has likewise described the impact of the controversial licensing requirements and recruitment practices on Indian nurses who im/migrated to the U.S. in the late 1960s and 1970s.[175])

As both Choy and Reddy have detailed, changes in immigration practices in the late 1960s and 1970s intersected with changing approaches to the licensing requirements of foreign-trained nurses. Use of the Exchange Visitor Program decreased and was replaced by the increasing use of the H-1 visa, a temporary visa for professional workers. The activism of Filipino nurses had

[170] Theobald, *Reproduction on the Reservation*, p. 157.
[171] Theobald, "Nurse, Mother, Midwife," p. 34.
[172] Choy, *Empire of Care*, p. 166
[173] Choy, *Empire of Care*, pp. 166-185.
[174] Choy, *Empire of Care*, p. 167.
[175] Reddy, *Nursing and Empire*, pp. 160-164.

led to nursing being designated as a preferred profession for the H-1 visa. Through the late 1960s, the overwhelming majority of foreign-trained nurses who im/migrated to the U.S. were able to practice as registered nurses without having to take the state licensing exams required of U.S. nurses. Instead, they were able to practice through the endorsement of their employees or through reciprocity, which was often granted to Filipino nurses who had a license to practice as a registered nurse in the Philippines. "As the permanence of immigrants within the US market became more apparent," Reddy argues, "U.S. nursing leaders pushed states to require that foreign nurse graduates take the State Board Test Pool Examination (SBTPE) in order to practice as an RN."[176] American nurse leaders argued that requiring foreign trained nurses to pass the SBTPE would ensure the competency of foreign-trained nurses, thereby safeguarding U.S. nursing practice and, ultimately, patient care. The SBTPE was developed by the National Council of State Boards of Nursing, which until 1978 was part of the ANA. The exam was composed of five test areas – medical, surgical, psychiatric, obstetric, and pediatric nursing. To take the exam, foreign-trained nurses needed to possess both an occupation visa and proof of their licensed status as registered nurses in their countries of origin. The majority of foreign-trained nurses who took the SBTPE, however, failed. A 1976 national report cited a failure rate of 77 percent.[177] As Choy discusses, there were several factors that contributed to nurses failing the SBTPE at such high rates. In addition to the fact that the examination could induce anxiety and fear in test-takers, many of whom hadn't been in school for many years, "Filipino nurses' comparatively limited training in psychiatric nursing in the Philippines resulted in difficulty passing that area of the SBTPE," and "Some Filipino nurses also claimed that the multiple-choice format of the examination was confusing."[178] Furthermore, recruiters and hospitals who hired foreign-trained nurses did not always inform nurses of the testing requirements. The consequences of failing the SBTPE could be devastating. For H-1 visa holders, whose visa status was tied to their ability to work as registered nurses, failing the SBTPE could lead to their visa being revoked and being subject to deportation. Reddy also recounts the exploitative work conditions that some nurses who failed the SBTPE faced as hospitals reliant on their labor continued to hire them but did so 'under the table' and assigned them work as nurses' aides. [179]

The high SBTPE failure rates led the ANA Commission on Nursing Services to issue a 12-point platform at the ANA's 1974 convention that, as Choy describes, had two objectives: "to remove the preferential status of foreign nurses in U.S. immigration policies, and to support the authority of state nurses associations to evaluate foreign-trained nurses" via the SBTPE.[180] As Choy continues, "The ANA Commission claimed that 'many foreign graduates are *not prepared*

[176] Reddy, *Nursing and Empire*, p. 160.
[177] Tomoji Ishi, "Class Conflict, the State, and Linkage: The International Migration of Nurses from the Philippines," *Berkeley Journal of Sociology* (1987) 32: 290, cited in Choy, *Empire of Care*, p. 169.
[178] Choy, *Empire of Care*, p. 170.
[179] Reddy, *Nursing and Empire*, p. 161.
[180] Choy, *Empire of Care*, p. 172.

to work in roles expected of them," "some employers place foreign nurse graduates in roles for which they are *unprepared*," and "United States professional schools of nursing cannot provide sufficient education programs to foreign nurse with *academic deficiencies*.'" The ANA Commission also "characterized the presence of foreign-trained nurses in the United States as detrimental because they accepted 'salaries lower than the acceptable rates for U.S. nurses' and they were 'attracted to areas where US nurses cannot find employment.'" [181] This platform, however, was defeated by another group of ANA members, which included Clarita Miraflor, president of the Philippine Nurses Association of Chicago, who "characterized the resolution as nativist and racist." [182] Miraflor was joined by other ANA members in proposing an alternative resolution. This resolution "highlighted the role that U.S. hospital recruiters played in the problems of foreign-trained nurses in the United States," and "called for the ANA to collaborate with the International Labor Organization and World Health Organization in the elimination of misleading US recruitment practices." This resolution also called for the creation of prescreening examination for foreign-trained nurses that they would need to pass before arriving in the U.S. This alternative resolution passed, and in 1977, the ANA and the National League for Nursing cosponsored the establishment of the Commission on Graduates of Foreign Nursing Schools (CGFNS), which would be responsible for overseeing "the implementation and administration of the prescreening examination, known as the CGFNS examination." This examination was composed of a nursing competency section, which including the five areas covered by the SBPTE examination, as well as an English-language competency section. The CGFNS administered the first CGFNS examination in thirty-two cities around the world on October 4, 1978.[183]

Although the CGFNS did lead to dramatically increased rates of testing success for foreign-trained nurses, the CGFNS examination was also controversial. As Choy describes, "While individual American nurses interpreted the CGFNS as beneficial to foreign-trained nurses and detrimental to U.S. nurses, some Filipino nurses took the opposite view, characterizing the Commission and its use of the CGFNS examination as 'anti-Filipino.'"[184] Filipino nurses' dissatisfaction led to the formation of three U.S. national organizations, each with "distinct agendas and interpretations of the 1970s controversy regarding licensure of foreign-trained nurses." [185] In 1979, local Philippine Nurses Association chapters throughout the U.S. formed a new national U.S. nursing organization, the National Federation of Philippine Nurses Associations in the United States (later, the National Organization of Philippine Nurses

[181] American Nurses Association, "Proposed Resolutions," 10, cited in Purita Falgui Asperilla, "Problems of Foreign Educated Nurses and Job Satisfaction of Filipino Nurses," as cited in Choy, *Empire of Care*, p. 172; emphasis added by Choy.
[182] Choy, *Empire of Care*, p. 172,
[183] Choy, *Empire of Care*, pp. 173-174.
[184] Choy, *Empire of Care*, p. 175.
[185] Choy, *Empire of Care*, p. 176.

Associations in the United States, NOPNAUS). As Choy explains, "While H-1 visa nurses' problems and the CGFNS controversy were the immediate concerns that motivated formation" of the National Federation, "its formation was also linked to the transnational origins of these local chapters and the changing relationship between them and the PNA in the Philippines."[186] In 1977, "over one hundred Filipino nurses and community activists formed the National Alliance for Fair Licensure of Foreign Nurse Graduates."[187] The NAFL-FNG "demanded an end to what they considered to be a culturally biased nursing licensure examination." [188] And finally, also in the late 1970s, Filipino nurses organized the Foreign Nurse Defense Fund, "which defended the rights of foreign nurses in the United States through the use of civil rights legislation." This included accusing the National League for Nursing "of violating state and federal civil rights through its development of a 'racist and discriminatory' licensing examination." The Foreign Nurse Defense Fund also accused government officials from the Department of Health Education and Welfare and the Immigration and Naturalization Services "of 'criminal conspiracy' through their use of SBTPE as a basis for deportation of foreign nurses in the United States."[189] In 1982, the National Council of State Boards replaced the SBTPE with the National Council Licensure Exam (NCLEX). But the CGFNS remained in place, and passage of both the CGFNS and NCLEX examinations are required for foreign-trained nurses to practice as registered nurses in the U.S. Although the NAFL-FNG and Foreign Nurses Defense Fund had dissolved by the mid-1980s, the NOPNAUS continued and was renamed the Philippine Nurses Association of America in 1987.

Conclusion

As is readily apparent, our historiographic review of relevant literature is only as robust as the interests and questions of scholars who champion particular topics and forms of analyses. We also note that the vast majority of these scholars do not share nurses' disciplinary backgrounds. That is not, we emphatically state, necessarily problematic: all scholars must share similar methodological training, epistemological stances, and commitments to standards of reasoned arguments. But we do believe it suggests a dearth of disciplinary scholars who may ask different kinds of questions, and who can seek to repair the vast holes that exist in the historical literature when we seek to address the roots of racism in nursing. History has simply not been valued as a way of knowing in the discipline, and we now experience the results of an over reliance on bio-medical paradigms when we seek to explore one of the most important issues facing the discipline. There are simply too many questions still left unanswered.

[186] Choy, *Empire of Care*, p. 176.
[187] Choy, *Empire of Care*, p. 181.
[188] Choy, *Empire of Care*, p. 176.
[189] Choy, *Empire of Care*, p. 183.

We always look to doctoral students who chose to study history when we think about the future. As D'Antonio writes in a forthcoming essay in *Nursing Inquiry,* Natalie Stake-Doucet's indictment of Florence Nightingale as the "racist lady with the lamp" in *Nursing Clio* has created profound sense of dislocation among champions of both the discipline and its iconic heroine.[190] Historians have long recognized that Nightingale represented a global, colonizing healthcare project that created a powerful place for middle class white women at the apex of a racialized hierarchy. But we are now being asked to consider the long term, certainly structural but too often hidden implications of her successful crusade. We know how, to paraphrase Joan Lynaugh and Claire Fagin, a group of clinicians of the wrong gender, the wrong class, with the wrong educational background transformed the historical experience of health and illness.[191] We now ask: what cost came from the implicit dominance of whiteness? And we wonder: how might such answers to these new questions help at least crack the historically persistent structural barriers that invite some into the nursing enterprise, leave others out, and create nearly insurmountable hurdles for those that construct different meanings about the discipline's work and place in the world.

Recovering and highlighting the stories of these and other nurses are important. But however important, the stories themselves will not be sufficient. Stories need context; the data they provide, like all data, need interpretation; and the process of interpretation demands frameworks that engage with new questions and new issues. To choose one example: recent colonial and post-colonial scholarship now suggests we look for more nuanced meanings of power. It positions historical nurses and midwives as "intermediaries," simultaneously translating official colonial directives into specific lessons and practices more easily understood by those with whom they directly worked, and by providing data up the proverbial chain of command about changes needed, and, in the end, shaping public health policy.[192] Their role in the colonial and imperialist enterprise conferred real status and authority. Can we think about underrepresented nurses as such "intermediaries" navigating and changing both from below and above the complex, subtle, and intersecting social and structural dynamics that simultaneously reinforce and sometimes change established hierarchies and systems of power? Can we think about such "intermediaries" as more actively choosing which messages to incorporate into their own practices and which to transmit? Do such "intermediaries of different race, gender, and class backgrounds interpret this role differently? Stories need meanings and meanings are what historians create.

[190] Stake-Doucet, "The racist lady with the lamp."
[191] Joan Lynaugh and Claire Fagin, "Nursing Comes of Age." *Image: The Journal of Nursing Scholarship* (1998) 20 (4): 184.
[192] Ryan Johnson and Amna Khalid (eds.), *Public Health in the British Empire: Intermediaries, Subordinates, and the Practice of Public Health* (New York: Routledge, 2011).

Perhaps this might be the place to break with the historiography of this essay and to tell one particular story that may pull these themes together. This story comes from D'Antonio's *American Nursing* and it bears repeating. It goes as follows:

> In 1923, Elizabeth Jones sought to describe nurses and nursing to the readers of *The Messenger,* a then popular and influential lay magazine. As was typical, Jones began by invoking the spirit of Florence Nightingale, in her mind "the world's greatest nurse." She continued by telling how this spirit inspired the next generation of American nursing leaders to establish training schools, create professional associations, and bring advances in medical science into the lives of families across the nation. The nurse, Jones wrote, was more than a teacher. She both brought advice and embodied it. She was, Jones continued, "looked upon by most of those with whom she comes in contact, as an example of a higher life."[193]
>
> However important the work of nurses, Jones noted, how they did that work was even more significant. She believed a particular combination of content and character defined professional nursing. Content opened the nurse's gaze to the life of an individual "as it really is, and not as it seems to be" and character placed the nurse in a position of trust when dealing with "other problems besides helping to heal the diseased." Certainly, education was important. She told her readers of the "educational unrest" of nurses felt who sought more scientific knowledge about dietetics, pathology, bacteriology, and languages to care for individual patients.
>
> But ultimately, she wrote, "it is not the duties we have to perform that count." Nurses and nursing were "impressions," or, as we might say today, representations. It was as much about how one presented oneself as what one did. As an African American nurse, Jones believed she epitomized the "New Negro Woman." And it would be the New Negro Nurse's professional combination of education and disciplined integrity that would force white America, however reluctantly, to acknowledge the African American nurse and through her all black America's "aptness and talent." Nurses would be among the vanguard and, she concluded, "eventually [the white man] will be compelled to take us on our merits rather than on our skins."[194]

[193] Elizabeth Jones, "The Negro Woman in the Nursing Profession," *The Messenger*, (July 1923) 5, p. 764.

[194] Jones, "The Negro Woman in the Nursing Profession," p.765. Darlene Clark Hine's "Black Professionals and Race Consciousness: Origins of the Civil Rights Movement, 1890-1950." *Journal of American History* (2003), 89(4) pp. 1279-1294 addresses the role professional physicians, lawyers, and nurses played in setting the stage for the later Civil Rights movement.

Nursing has long simultaneously existed within complicated, conflicting, supporting, and delegitimizing communities both within and outside the discipline. We believe in the compelling need for more historical studies that elucidate the dimensions of this simultaneity and explore the strengths it brings not only to the discipline but also the individuals, families, and communities it serves.

Still, this essay and Jones' own story suggests ways to move forward. And we offer the following suggestions that we believe the historiography and the stories support.

- We need more contextualized historical studies about the experiences of underrepresented groups in nursing
    a. See appendix A for feedback we have given NINR on its strategic plan
    b. But historical studies need time as much as they do grants of monies. The members of this commission should encourage their constituent associations to support historical research

- These studies should grapple with both complexity and also the complicity of nurses and nursing in perpetuating systems of structural racism
    a. For example, although nursing has gained clear power and authority in its embrace of biomedical science, how does its embrace of a form of knowledge formed by hierarchies of racialized power and practices affect its work with individuals, families, and communities?
    b. Nurses and nursing must acknowledge and explore the ways in which particular commitments to different kinds of knowledge, education, and practices are themselves rooted in clear but unexamined racist traditions.
        i. We point, in particular, to examining a commitment to reified forms of "standards" (IE: examination requirements, educational credentials and licensing and certification requirements) that have often been imbricated with systems of exclusion
        ii. While we acknowledge there is a body of scientific knowledge that is needed for safe, quality nursing practice, we encourage examination of how tests and standards for such concepts as "critical thinking" and "clinical reasoning" reflect and refract unspoken and unexamined knowledge hierarchies that may not best serve the discipline.

- They should also locate nurses within simultaneous communities – not only of professional identity but also of community connections
    a. Sims' use of Black women both as nurses and as research subjects, for example, suggests that there are also more complicated forces at play

1365 b. W.E.B. DuBois' concept of a "double-consciousness" or a sense of "two-ness"
1366 among Black Americans may prove a useful framework when exploring all nurses
1367 sense of connection to one particular discipline and also to very different
1368 communities of identity.
1369 i. These concepts also suggest that goals of representation as a method to
1370 diminish the legacy and practices of racism in nursing will be necessary
1371 but not sufficient. We will also need to increase the official and unofficial
1372 power of the many voices and experiences of individuals and groups that
1373 comprise the discipline of nursing
1374 c. Our histories, though, do caution that the move into the community and primary
1375 care will not, in and off itself, solve the problems of knowledge validity and
1376 unconscious biases that nurses will inevitably carry into their patients' homes
1377 and communities. We must be more assertive in providing the incentives and
1378 tools for nurses to acknowledge both the valuable and biased knowledge and
1379 practices they bring with them
1380
1381 • But we need to also acknowledge the limitations of knowledge (data) alone as a force for
1382 change. While Carnegie's *The Path We Tread* was an essential contribution to the historical
1383 literature on Black nurses, it was the activism of the later 20th century that produced
1384 substantive change. Nursing needs to confront the historical tension between its belief in
1385 education as a force for good, and the need to actively engage in political and social
1386 struggles for a more just and equitable discipline and society.
1387 a. History suggests that we should not be timid, and that we should forthrightly
1388 name the issue of structural racism. Language is important – and we might no
1389 longer hide behind an admittedly successful strategy that allowed many
1390 individuals their own unspoken definitions of what was to be achieved.
1391
1392 We do not and should not diminish nursing's successes. As this historiographical essay argues,
1393 we need to think about nursing not only as a particular form of work, but also about a form of
1394 work that carries particular meanings – both ascribed to it by those who do the work and by its
1395 larger social, political, and structural context. It also provided opportunities to many from a
1396 variety of different backgrounds seeking ways to both do good and do well. We suggest that we
1397 can claim the good – and acknowledge the problems, especially those that coalesce around
1398 race and racism. History does not suggest this will be easy. But we will be stronger doing the
1399 work required to make this a reality.
1400
1401
1402
1403
1404

APPENDIX A
FEEDBACK TO NINR RE DRAFT STRATEGIC PLAN

The current draft of the National Institute for Nursing Research's strategic framework provides an important template to guide inquiry into critical issues within the discipline's domain. We strongly support its attention to innovation; advancing equity, diversity, and inclusion; contextualized approaches that address systemic and structural racism; and studies that examine the social determinants of health. We also support its concept of "research lenses" to capture the multiplicity of rich and varied methods that will help the discipline achieve its scholarly, practice and policy goals. As the respective directors of the Barbara Bates Center for the Study of the History of Nursing at the University of Pennsylvania, the Eleanor Crowder Bjoring Center for Nursing Historical Inquiry at the University of Virginia, and the Midwest Nursing History Research Center at the University of Illinois Chicago we firmly believe that if NINR is to meet its ambitious goals it must include historical studies or "lenses" among those it will support.

History and historical analysis have long been recognized for their power to give scholars and readers the distance of time to step back and reflect upon the difficult and contentious issues that the draft NINR Strategic Framework identifies as critical to meet the current and future social and healthcare needs of individuals, communities, and populations. Historical concepts and methods reflect the complexity and interconnectedness of critical political, social, and cultural issues that cannot be reduced to single variables. They attend to the importance of context and causality. And, most importantly, they encourage formulation of judgments and assessments of significance.

Some most recent studies that capture the range and impact of historical studies directly relevant to understanding the policy and practice implications of the Draft NINR's Strategic Framework include:

- Technological interventions that intend to decrease disparities have had unanticipated consequences of actually increasing disparities of access and utilization when analyzed over time. The most recent example is the history of telehealth, a technology designed for under-resourced communities that became most heavily used by those with access not only to technology but also the resources that would best take advantage of it.[195]

[195] Jeremy Greene, et al, Innovation on the Reservation, *Isis,* 2020, 20(3): 443-470

- In a similar vein, technology has also had an impact on dissemination strategies. Our experience has been that social media has gained increasing importance in reaching lay audiences with the impact of scholarship. For example, In Whose Best Interest, a video produced by Bates Center faculty in support of compact state registration received more publicity than our more traditional policy brief.

- Despite clear and convincing evidence of the superiority of midwifery attended births at home in the early 20th century, disadvantaged women fought for access to the same childbirth experiences as their middle-class sisters: medically supervised births in hospitals. Public health nurses were outspoken champions of this medically oriented experience, and directly contributed to the decline of alternative forms of childbirth in the United States (unlike what happened in western Europe). These studies suggest that data-based interventions need political as well as scientific support among relevant, middle-class constituents.[196]
- The turn toward a narrow definition of "science" in public health and nursing practice and education has significantly diminished these disciplines' historical commitment to the social determinants of health. In nursing, this "turn" toward "science" has affected its historical strengths of activism and engagement.[197]
- Yet, some nurses have maintained such a commitment. Some white nurses joined black nurses in the Civil Rights movement, moving to the southern United States in support of the movement's goals. Scholarship to date captures not only the commitment of these nurses but also the difficulties of sustaining such commitments in the absence of social and material support.[198]

These studies also represent the interdisciplinary backgrounds of those interested in relevant issues of the history of health care. This also aligns with the NINR's own historic mission: to the scholarship of all scholars interested in advancing its core mission of "illuminating the whole picture of health for individuals, communities, and populations." [199] But this "whole picture"

[196] Patricia D'Antonio, *Nursing with a Message: Public Health in New York City, 1920-1940* (New Brunswick: Rutgers University Press, 2017)

[197] Dominique Tobbell, *Dr. Nurse: Science, Politics, and the Transformation of American Nursing,* Chicago: University of Chicago Press, in press.

[198] Julie Fairman, "Service is the Rent We Pay": The Complexity of Nurses' Claims to Their Place in Social Justice Movements, *Nursing History Review 28* (2020): 16–30.

[199] Until the mid-2000s, NINR had provided individual pre and post-doctoral fellowships for students and trainees interested in exploring the historical roots of clinical and policy questions that would inform its own then stated mission. After about 2005 it explicitly limited the range of methods it would support to explicitly exclude historical methods. While this has not precluded our success with other funding sources from other agencies (including the National Endowment for the Humanities and the National Library of Medicine) and foundations (including the Robert Wood Johnson Foundation and the Rockefeller Foundation), this policy has had the (unintended) effect of inhibiting new scholars' interest in pursuing their stated interests in historical analysis. Despite accreditation standards that speak clearly to the importance of history and the humanities as a critical way of knowing in

approach must also encompass the same diversity of methods as the interventions need for the diversity of constituents affected. That is, we believe the Draft NINR Strategic Framework must explicitly recognize its support of a diversity of approaches, by a diversity of scholars, committed to solving the health and illness experiences of the diversity of its constituents. It must, in other words, expand its "research lens" to be inclusive of diverse research methodologies including historical methodologies.

To operationalize this commitment, we also believe that NINR must support:

- Individual pre and post-doctoral Ruth L. Kirschstein *National Research Service Awards* (*NRSA*) for historical research studies that propose to address NINR's guiding principles and priority areas.
    - These awards have been and continue to be important building blocks for new scholars' trajectories of research.
- Providing support through various R-level mechanisms for more established scholars
    - We acknowledge the support of the National Library of Medicine's program of funding for "scholarly works in bio-medicine and health" https://www.nlm.nih.gov/ep/GrantPubs.html . However, the NLM's program is specifically designed for book monographs. Although important, such book-length projects rarely find their ways into the hands of clinicians more used to journal articles.
- When appropriate, RFPs that ask that phenomena and / or variables and outcomes of interest be historically contextualized
    - The most obvious, but not the only example, lies with those studies whose lenses involve Community Based Participatory research and methods. As historians who have worked within this perspective have long argued, such historicizing of grassroots health and social welfare initiatives had been successful in reframing community members' perspective and power from that of passive subjects to that of empowered activists.[200]

We would welcome the opportunity to engage further in discussions about opportunities that would enhance and enable the fulfillment of NINR's ambitious and important strategic plan. History is the one method that captures the complicated dynamics of change – and we strongly believe that NINR's mission and outcomes cannot move forward without this particular lens.

practice, they receive discouraging advice that only NINR funded programs of research will mark successful careers in knowledge generation.

[200] See, for example, Alondra Nelson, "The *Longue Duree* of Black Lives Matter." *AJPH* (2016) 106(10): 1734- 1737; or
Merlin Chowkwanyun, "Cleveland versus the Clinic: The 1960s Riots and Community Health Reform." *AJPH* (2018) 108(11): 1494-1502.