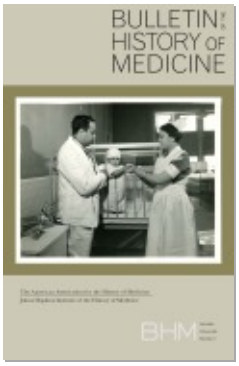
Comment: *Toward a History of Health Care: Repositioning the Histories of Nursing and Medicine*



Nicole Elizabeth Barnes

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

Nicole Elizabeth Barnes

In her essay, "Toward a History of Health Care: Repositioning the Histories of Nursing and Medicine," preeminent nursing historian Patricia D'Antonio makes a case for a paradigm shift. She argues that we should study nurses and physicians "in relation to each other rather than, as we have done, in isolation" in order to better understand modern medicine. She posits that the formulation of professional nursing may have fundamentally shaped not only nursing but "the very structure and practices of health care itself" (p. 287). D'Antonio argues convincingly that we have much to learn from uniting the histories of medicine and nursing.

I wholly agree with this proposition. In this essay, I make a case for amplifying what I call a "new history of healing" with three additional perspectives that decenter White North America and Western Europe to build a more capacious understanding of nursing and medicine as they have developed around the world. At this critical moment in the human experience, when we are still in the grip of a pandemic that first came to our attention in southern China and sparked a new wave of medicalized anti-Asian racism, it is imperative to consistently call into question assumptions of White centrality in the making and doing of modern medicine. Concomitant with this, the new history of healing should push us to question the centrality of "science" in modern medical practice. This pandemic has made the tenuous place of science abundantly clear, as myriad social and political problems consistently trouble the lifesaving power of vaccines, their unprecedentedly rapid development and revolutionary science be damned. A vaccine is powerful only once it is inside a human body, and getting it inside many a living body turns out to be extraordinarily difficult.

I argue that the new history of healing, in addition to jointly analyzing histories of nursing and medicine, must look for and incorporate analysis

of (1) interactive dynamics between these healing systems and indigenous medical systems, (2) multiple centers of innovation, and (3) exceptions to accepted paradigms. I write from my own perspective as a historian of nursing in twentieth-century China.

D'Antonio calls for "a new history that captures the complexity of the enterprise that is health care in the United States and around the globe" (p. 308) and that attends to multiple ways of knowing. Asia is a prime place for such examination. Home to many long-lived indigenous medical systems as well as countries that endured Western and Japanese colonial rule, Asia presents myriad examples of mutual adaptations between foreign and local medical systems.[1] And while historians have attended to the ways that anatomical knowledge, germ theory, colonial medicine, antibiotics, and mass-produced pharmaceuticals have changed medical practices around the world, we have yet to consider how the professionalization of nursing influenced the subsequent development of indigenous medical systems. In China, for example, classical medicine is patriarchal. Medical lineages rarely pass the family heritage onto daughters, few women have achieved national recognition as famous physicians, and all the celebrated authors of canonical medical texts are men. Modern nursing and midwifery therefore granted significant numbers of women their first opportunity to engage in medicine as a career. While women had long cared for parturient and ailing bodies, their work had generally been inside the home and was either unremunerated or a source of inconsistent income. The professionalization of nursing and midwifery

1. The full bibliography of works addressing these encounters is substantial. Prominent works include Bridie Andrews, *The Making of Modern Chinese Medicine, 1850–1960* (Vancouver: University of British Columbia Press, 2014); Sokhieng Au, *Mixed Medicines: Health and Culture in French Colonial Cambodia* (Chicago: University of Chicago Press, 2011); Pratik Chakrabarti, *Bacteriology in British India: Laboratory Medicine and the Tropics* (Rochester, N.Y.: University of Rochester Press, 2012); Tina Phillips Johnson, *Childbirth in Republican China: Delivering Modernity* (Lanham, Md.: Rowman & Littlefield, 2011); Sean Hsiang-lin Lei, *Neither Donkey nor Horse: Medicine in the Struggle over China's Modernity* (Chicago: University of Chicago Press, 2014); Laurence Monnais, *The Colonial Life of Pharmaceuticals: Medicines and Modernity in Vietnam* (Cambridge: Cambridge University Press, 2019); Projit Bihari Mukharji, *Doctoring Traditions: Ayurveda, Small Technologies, and Braided Sciences* (Chicago: University of Chicago Press, 2016); Hans Pols, *Nurturing Indonesia: Medicine and Decolonisation in the Dutch East Indies* (Cambridge: Cambridge University Press, 2018); Ruth Rogaski, *Hygienic Modernity: Meanings of Health and Disease in Treaty-Port China* (Berkeley: University of California Press, 2004); Soyoung Suh, *Naming the Local: Medicine, Language, and Identity in Korea since the Fifteenth Century* (Cambridge, Mass.: Harvard University Asia Center, 2017); Timothy M. Yang, *A Medicated Empire: The Pharmaceutical Industry and Modern Japan* (Ithaca, N.Y.: Cornell University Press, 2021); and Mei Zhan, *Other-Worldly: Making Chinese Medicine through Transnational Frames* (Durham, N.C.: Duke University Press, 2009).

granted women some measure of social standing, a recognized role and title in public institutions, a degree of authority over the bodies of others—including men!—and a consistent paycheck. It seems self-evident to consider how this changed gender roles and women's lives, but we can also ask how women's entry into professional medicine instigated change in indigenous medical practice. Did women learn from each other about new medical sciences and use this knowledge to demand more as patients?[2] Did the presence of women working in medical wards—many of which in contemporary China incorporate Chinese medicine and biomedicine into the same space—instigate changes in therapeutic practices of indigenous medicine practitioners? Did official recognition and codification of previously home-based therapies encourage shifts in nomenclature and categories of indigenous medical systems?

If the history of medicine is weakened by the paradigm of scientific medicine moving "from the West to the rest," the new history of healing should from the outset pay attention to and account for multiple centers of innovation. The history of public health nursing in China offers an illustrative example. It began in the late 1920s under the direction of local Chinese and the American John B. Grant, director of the Department of Public Health at the Peking Union Medical College in Beijing; further developed in the early 1930s with the expert guidance of Andrija Štampar from the School of Public Health in Zagreb, Croatia (the former Yugoslavia); continually incorporated practices and theories from around the world during decades of warfare and political revolution; and ultimately grew into the barefoot doctor system that inspired member nations of the World Health Organization to enshrine the goal of "Health for All" through primary health care services at the Alma Ata conference in 1978.[3] This peripatetic trail of influence resulted in part from a single entity whose outsized influence on international medicine and public health is already well known: the Rockefeller Foundation (RF). The RF underwrote Štampar's School of Public Health in Zagreb, sponsored his 1931–33 trip to the United States, and introduced him to the public health colleagues he met in China during his time there from 1933 to 1936 on behalf of his then employer the League of Nations Health Organization (LONHO).

2. This question seems worthy of examination since Volker Scheid locates a core facet of the plurality of modern Chinese medicine in patients' agency. Scheid, *Chinese Medicine in Contemporary China: Plurality and Synthesis* (Durham, N.C.: Duke University Press, 2002), 107–33.

3. One prominent autobiography that elucidates the long and multicentered life of rural health care in China is C. C. Chen, in collaboration with Federica M. Bunge, *Medicine in Rural China: A Personal Account* (Berkeley: University of California Press, 1989).

But the story does not stop there. Rockefeller initiatives gained traction and staying power in China only through Chinese people's initiative and drive. Štampar visited the county in northern China where Chen Zhiqian (陳志潛C.C. Chen, 1903–2000), now celebrated as "the father of public health," and Major General Zhou Meiyu (周美玉, 1910–2006), founder of both military nursing and public health nursing, were busily creating the rural public health program that would later inspire the famed barefoot doctors. Chen and Zhou devoted their entire lives to public health and nursing—after 1949 in mainland China and Taiwan, respectively—and it is thanks to individuals like them that the Rockefeller imprint made a lasting impression. Zhou's international acclaim as a nursing leader fostered a new network in 1952 when Taiwan hosted the inaugural nursing conference for the Western Pacific Regional Office of the WHO. Nurses from Australia, Singapore, the Philippines, and Japan convened in Taiwan for this meeting.[4] Soon after the Philippines gained independence from the United States, well before Singapore gained independence from Britain, and while the two colonial powers continued to hold inordinate sway over Japan and Australia, Taiwan offered inspiration and guidance for nurses across the Pacific. If we pay close attention to nurses' professional and personal networks, we may see patterns that call into question old interpretive frameworks. In my book I noted that missionary women in China, subject to sexism and therefore unaccustomed to exercising unilateral authority, more readily mentored Chinese women into leadership roles than did male medical missionaries.[5] How might we see things differently if we foreground a female-led profession rather than a male-dominant one in our analysis of medicine? It is possible that we will begin to see thick networks of South-South medical exchange that have long escaped our notice.

This brings me to my third and final point. The new history of healing should prompt us to look for exceptions to accepted paradigms. I return to the RF to make my case. As eluded to above, the RF played a major role in the development of public health in China, primarily through its flagship institution, the Peking Union Medical College, the "Johns Hopkins of China" where everyone who became a leader in China's national health system either received training or worked, or both. In this way China fits the paradigm. But it also challenges it. D'Antonio writes that "the prerequisites for a foundation investment abroad were a sponsoring institution's

4. "Nursing Education Seminar Sponsored by World Health Organization Western Pacific Region, Taipei, Taiwan, November 1952," in *Seminars/Conferences Reports, WHO Regional Offices for the Western Pacific, 1952–1957* (Geneva: WHO Library).

5. Nicole Elizabeth Barnes, *Intimate Communities: Wartime Healthcare and the Birth of Modern China, 1937–1945* (Oakland: University of California Press, 2018), 138.

strong commitment to physician education, influential medical and political champions, and a history of a region's investment in public health" (p. 290). In China, the RF took major risks and displayed formidable commitment well before the country possessed such prerequisites. The numbers also show a singular dedication to China: whereas Rockefeller donations to over seventy countries channeled through the International Health Board (est. 1913) totaled ninety-four million dollars from 1913 to 1951 (a per-country average of $1.34 million), donations to China alone through the China Medical Board (est. 1914) totaled forty-four million over a similar period (1914–51).[6] China was exceptional in two other important regards. Hospital nursing there began as a male profession, and only the pressures of war with Japan (1937–45) led to its feminization.[7] Unlike in many other countries, in China women retained their authority over midwifery as it professionalized and moved into hospitals.[8] What does China as an outlier case mean for the new history of healing? To properly "captur[e] the complexity of the enterprise that is health care" we must consistently look for precisely that: complexity. Moments that prove our assumptions wrong and lead current models to failure. And this is where my three propositions nest together in affirmation of Dr. D'Antonio, for it is precisely by tending to new questions—how nursing has influenced indigenous medical systems, how it took shape in and around multiple centers of innovation, and how it harbors the exceptional—that we nurture an intellectual openness to new paradigms and enable ourselves to see the patterns of a new history of healing.

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Nicole Elizabeth Barnes is Assistant Professor of History and Gender, Sexuality and Feminist Studies at Duke University. She is author of the award-winning book on female nurses and midwives in mid-twentieth-century China, *Intimate Communities: Wartime Healthcare and the Birth of Modern China, 1937–1945* (2018). She is currently writing a book on night soil and toilets in modern China and is a wholehearted champion of dry composting toilets.

6. Mary Brown Bullock, *The Oil Prince's Legacy: Rockefeller Philanthropy in China* (Stanford, Calif.: Stanford University Press, 2011), 19. Elsewhere the precise sum for medical projects in China is given as $32,810,322.33. "The Rockefeller Foundation Payments for Work in China, 1914–1951," p. 9, folder 133, box 13, series 601, RG 1, RF, RAC.

7. Barnes, *Intimate Communities* (n. 5); and Chou Chun-yen, "Funü yu kangzhan shiqi de zhandi jiuhu" [Women and battlefield first aid during the Second Sino-Japanese War], *Research on Women in Modern Chinese History* 24 (December 2014): 133–220.

8. Johnson, *Childbirth in Republican China* (n. 1).