

THE IMAGE OF NURSES – THE HISTORICAL ORIGINS OF INVISIBILITY IN NURSING

In the nineteenth century thousands of European women felt called by God to care for the sick. In the nursing orders of sisterhoods that proliferated at this time women accomplished remarkable things in the name of God: they travelled the world establishing communities of immigrant and local women, they built and ran large hospitals, and even networks of hospitals, and they built schools, orphanages and other important social institutions for the poor. At times these women functioned with a great deal of autonomy, far away from bishops or other authority figures in the Church. At other times they were in direct conflict with the men of the Church as the sisters attempted to follow what they believed to be their mission on earth. These women were not just meek and humble nurses devoted to God, but dynamic builders, creating social institutions and health care in alliances with municipal, state or federal governments. Often they made partnerships that the Catholic Church was not happy about, allying with Jewish or Protestant community leaders to get hospitals built and to provide care for the poor. At the same time they typically ran very good private hospitals in order to make money to support their work among the poor. In other words they were formidable capable women who transformed their communities – yet despite their accomplishments they remained invisible to everyone around them and their achievements are little appreciated today.

One of the central themes of my book, *'Say Little Do Much': Nurses, nuns and hospitals in the nineteenth century* (University of Pennsylvania Press, 2001), was that because they were women, and because the Church was concerned to contain their independence and autonomy, it was critical to their survival that the sisterhoods downplayed their accomplishments and successes (the title 'say little do much' comes from St Vincent De Paul). In the first place, these were religious women and modesty was the fundamental virtue they all needed to acquire. Furthermore, all they did was for God and nothing else was important. Second, if they were too visible the Church would get worried about women having too much independence and their freedom would be cut short and they would be placed under the close supervision and direction of men (which indeed happened to many communities of women). In my book I described this phenomenon as building nursing and health care institutions 'under the radar' (or beneath the notice) of the church and the men who ran the Church.

Over the late nineteenth and early twentieth centuries, as non religious women moved into nursing, and the profession began its secular professional evolution, nursing still constituted itself as a feminine domain of moral authority and womanly skill. To create nursing into a profession that would be respectable enough to attract middle class women, who would not be a threat to medical authority, what took place was the continued downplaying of nursing knowledge and skill and an emphasis on virtue and ethics. This meant that the very success of nurse reformers in creating the first mass profession for women, put nurses in the paradoxical position of playing an important role in health care while sentimentalizing and trivializing the very critical role they played. The only legitimacy nurses could claim was to couch their description of their work in charitable, devotional or altruistic terms.

In our edited book *Complexities of Care: Nursing reconsidered* (Cornell University Press, 2006), Suzanne Gordon and I pulled together a series of essays that looked at the challenges facing nursing and the problem we as a profession have created for ourselves by talking only of caring and emotional and relational work and never about the technical and scientific basis of nursing expertise.

We argued that even where the primary intervention is emotional support – this is not because the nurse is a good person, or a natural carer due to her femininity or religious vocation, but because she or he has understood that this is the intervention that the patient requires at this time, and because the nurse has the expertise and education to effectively provide support to the patient. This is not holding someone's hand – this is a psychosocial intervention and takes education and training.

We also argued that the image of nurses as caring and kind support workers, as opposed to being highly skilled professionals, is actually produced by nurses. In fact we described a phenomenon we called the 'Virtue Script', where nurses portray themselves as angels, or as sweet kind people, the public then warmly to nurses, which makes nurses feel good. It is due to this positive reinforcement that nursing continues to portray itself in these child-like and unprofessional ways.

Women negotiating the path to professional pursuits and public respect arguably had few other scripts or templates to follow in the late nineteenth and early twentieth centuries. What is remarkable is that this reliance on the 'virtue script' has changed so little in the late twentieth and early twenty-first centuries as women have gained greater social, economic, legal and political power. A sampling of campaigns - from advertisements, to videos, brochures, articles, newsletters, tee-shirts all of which not only describe but define nursing to the public - suggests that nurses are still grounding their claims for social legitimacy and respect on their virtues rather than their knowledge.

As nurses in twenty-first century come under increasing pressure to concretely connect nursing practice and patient outcomes, it is difficult to understand why nursing and nurses appear to have such a limited vocabulary when talking about and promoting the importance of their work. When women in other professions have moved from virtue to knowledge, why has this framing of nursing as a virtuous profession been so consistent? Even more difficult to understand is why, when there is now a great deal of data to document the critical importance of nursing to patient care, nursing groups make so little use of it. The most logical answer to this question is that nurses feel they gain something from this focus on virtue. One reason nurses may rely so heavily on this virtue script is that many believe this is their only legitimate source of status, respect and self-esteem.

The persistent recourse to what we term the 'virtue script' has serious consequences for contemporary nursing. In fact it may even discourage the right kind of candidate to nursing. Someone interested in combining caring with intellectual and scientific challenges would be likely to reject the traditional constellation of moral and ethical framings of the nurse. Finally, the virtue script undermines nurses' ability to help the public understand why researchers find that patient recovery - indeed their very lives - depends on adequate numbers of well educated registered nurses. This inability to articulate the importance of nursing in the current climate of economic rationalism threatens the viability of nursing practice.

I would urge all nurses to look for the virtue script in your organization, in your schools or associations or health care provider. We need to all be aware of the image of nursing that we all portray in our professional lives and take responsibility to communicate a professional and knowledgeable role model. Only in this way will we move beyond 'say little do much' and become visible in the health care system.

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