

From Dispensary to Hospital:  
Public Service Medicine in the American Northwest, 1900-1926

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# Abstract

This thesis explores the use of public service rationales to define the means and ends of charitable care in the urban United States during the early 20<sup>th</sup> century. Using Portland, Oregon as a case study, I examine the development of several voluntary and charitable health associations. The public service rationales present in these associations included defining of deserving patients, centering industrial efficiency, and connecting clinical care treatment of individuals the wellbeing of the city as a whole. I separate charitable medicine from contemporary public health practices in order to evaluate charitable healthcare in the first decades of the 20<sup>th</sup> century as a distinctive social and professional formation. In this period, commercial health insurance was not widely available, and those who could not afford physician care had to rely on ad hoc systems of medical delivery. Meanwhile, many social reformers took up the cause of health reform and medical delivery, using medicine as an implement in their attempts to build a more efficient civic body. I argue that in forging alliances with such reformers, medical professionals, and especially nurses, derived novel ideologies of public service medicine by which they construed the city itself as the object of medical care. This reorientation of medicine towards the civic body influenced the development of hospital systems and public health initiatives in the 1920s. Still, early-20<sup>th</sup> century public service medicine cannot be conflated with these later developments. The first chapter describes the rise of the Portland Free Dispensary, a settlement house turned charitable clinic. Chapter two investigates the ways in which nurses deployed civic rationales to control gendered narratives of their labor and claim professional status. The final chapter describes the contributions of nurses and social reformers to the construction of a large research hospital complex on Marquam Hill in Southwest Portland during the 1920s.

*For Dorothy Fuller Silvers*

# Introduction

Soon after the 1926 opening of Doernbecher Memorial Children's Hospital, an institution in Portland, Oregon which is today a branch of the state's largest medical employer, one newspaper labeled the building as the "Castle on Marquam Hill" and a "fairylnd" for sick children.<sup>1</sup> In coining these descriptions, reporter Adelaide Lake portrayed the new hospital as a miracle that had, perhaps, appeared out of thin air on the wooded hill above Southwest Portland. She was correct inasmuch as the hospital boasted an impressive perch on the hill and the look of a medical fortress. The course of its emergence, however, was far more complex than any newspaper reporter let on. This hospital was one of the first on the campus of the University of Oregon Medical School, and to many, it represented the fulfillment of two decades of charitable medicine in the growing city of Portland. It inherited, by most accounts, the responsibilities of the Portland Free Dispensary, a charitable clinic that had operated in the city's downtown and waterfront neighborhoods for nearly twenty years.<sup>2</sup> Though the connection between the two institutions was obvious to those Portlanders involved in their operations, their geographies and programs differed dramatically prior to the integration of their services. The dispensary occupied a building in the midst of neighborhoods which its officials had identified as "needy," while the new hospital was elevated above the city's neighborhoods and waterfront. This difference resonated in the programs and services offered by each institution. The hospital was strictly for the care of children, who its promoters purported to lift out of sickly environments, while the dispensary claimed to treat anyone in need and was especially known for its accommodation of venereal patients, despite their perceived moral failings. Though originally divergent in their

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<sup>1</sup> Adelaide V. Lake, "Castle On Marquam Hill Is Fairylnd for Sick Children," *Sunday Oregonian*, December 25, 1927, 2.

<sup>2</sup> See *ibid* and "Special Report to Dr. Richard B. Dillehunt on Clinics and Charity Cases," (1928) Doernbecher Children's Hospital Records Box 1.7, OHSU Historical Collections and Archives.

healthcare missions, the dispensary was, over the following few years, slowly absorbed into the functions of the new hospital system on Marquam Hill.

The story of this transition reflected the changes writ large over the provision of health care in the early-20<sup>th</sup> century U.S. Before the birth of most modern hospital systems in the United States and after the largest legal landmarks in the professionalization of the physician's trade, many American social reformers sought to redefine affordable medical care as an indispensable public good. Intertwined efforts at the start of the 20<sup>th</sup> century to promote charitable health organizations, religious hospitals, and even prospective state-run healthcare schemes all contributed to the growing notion that medical care should not be only available to those who could afford doctors' fees. Among reformers and medical practitioners, however, there was not widespread agreement regarding the definition of deserving patients, or the proper means of healthcare delivery. In this period, commercial health insurance was not readily available and federal health programs were still decades in the future.<sup>3</sup> Across American cities, ad hoc healthcare schemes abounded as fraternal societies, trade unions, charities, and reform organizations attempted to address the need for publicly available medicine. The free dispensary, a common type of charitable health clinic in the urban United States beginning in the late-19<sup>th</sup> century, was a distinctive product of this environment. These clinics emerged out of a growing consensus that protecting American cities from epidemic and endemic diseases necessitated medical care for the urban poor. Eventually this clinical patchwork would be eclipsed by the predominance of modern hospitals in American healthcare networks.<sup>4</sup>

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<sup>3</sup> The American Medical Association initially opposed all third-party payment schemes. Commercial health insurance did not become widespread until the late 1930s, and the AMA did not endorse commercial health insurance until the 1940s. See Beatrix Hoffman, *The Wages of Sickness: The Politics of Health Insurance in Progressive America*, (Chapel Hill: University of North Carolina Press, 2001), 183-184.

<sup>4</sup> On the ad hoc nature of localized medicine and public health in the United States see Dorothy Porter, *Health, Civilization, and the State: A History of Public Health from Ancient to Modern Times* (London: Routledge, 1999), 147-162. For a case study on a particular network of early charitable hospitals see David Rosner, *A Once Charitable Enterprise: Hospitals and Health Care in Brooklyn and New York, 1885-1915* (Princeton: Princeton University Press, 1987). Finally, Hoffman, *The Wages of Sickness: The Politics of Health Insurance in Progressive America*, 1-23 gives an excellent account of

Free dispensaries served as outpatient clinics, centers of philanthropic public health efforts, and sponsors of social work among the urban poor. Some were affiliated with neighborhood houses, some with medical schools, and some with churches. Some were simply doctors' offices opened at certain predetermined times to those who could not pay the full price of care. This thesis begins with an account of the Portland Free Dispensary, which first operated in 1906. The history of this medical dispensary and related efforts to provide charitable care in early-20<sup>th</sup> century Oregon demonstrate the development of novel public service ideologies—specifically in the form of connections between the care of individual patients and the safeguarding of the city itself. Within this context, I examine further the application of such notions of public service in the nursing profession, and especially in the operation of Portland's Visiting Nurses Association. Nurses' civic and patriotic engagement demonstrated the ways in which emergent public service ideologies built upon, and departed from, existing justifications of feminine care. These existing rationales included maternalism, which cast nurses and reformers as guardians of the mother's sphere, and social reformer Jane Addams' notion of "civic housekeeping," which placed social work at the center of urban care. Finally, I describe the period of transition from dispensary and home care to centralized care in the inpatient wards of large teaching hospitals—in this case, institutions affiliated with the University of Oregon Medical School.<sup>5</sup>

Within the theaters of healthcare, medical professionalization, and social reform, the Portland medical charities were examples of intermediate social formations. As such, they are often overshadowed in historical accounts by the emergence of research hospitals and the stark authority of state health institutions. In approaching the particularities of dispensary care, this study instead embraces the mutable combinations of nursing, social work, and scientific medicine that preceded and influenced later institutional developments. Though such charities are often described as marginal forerunners of modern medical institutions, they displayed in the 1900s and 1910s

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patchwork medical protection in New York in the context of attempted health reform in the 1910s.

<sup>5</sup> The University of Oregon Medical School merged with the Willamette University Medical School in 1974 to form the Oregon Health and Science University, an independent public medical university.

distinctive practices, rationales, and goals. Through these organizations, reformers and medical practitioners converged on the practice of public service medicine, pursuing malleable care programs that increasingly embraced clinical medicine while also claiming the city itself as the main object of care. This public service rationale for medical practice also served at times to further reformers' moral prescriptions for urban life and to substantiate nursing leaders' claims to professional status.

## Medicine in the Early Twentieth Century

In the late-19<sup>th</sup> and early-20<sup>th</sup> centuries, medical practitioners in the United States responded to a succession of epidemic diseases with advances in medical technique and with efforts to claim professional status. After the American Civil War, cholera waned as a serious threat to U.S. cities.<sup>6</sup> Sporadic outbreaks of smallpox continued, and typhus remained a significant danger in the rural western states especially. The most rampant killer across the country was certainly tuberculosis, which consequently was the target of some of the largest public health initiatives beginning around 1900.<sup>7</sup> Endemic diseases like syphilis and gonorrhea came to the forefront of public discourse on health and morality, especially in urban areas. In 1910, one student nurse described the treatment of a syphilitic baby as “a case of the sins of the parents being spent on the children.”<sup>8</sup> Finally, the influenza pandemic of 1918 proved to be one of the deadliest in history. In this period, also, the germ theory of disease found acceptance among medical practitioners, who then introduced it to the public. This in turn led to increasing investment in bacteriology following the work of Louis Pasteur and Robert Koch, and to a refocusing of care onto the contagious body. The direct treatment of contagious patients stood in opposition to previous models by which individual sufferers from epidemic

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<sup>6</sup> Charles E. Rosenberg, *The Cholera Years: The United States in 1832, 1849, and 1866* (Chicago: University of Chicago Press, 1962), 1-7.

<sup>7</sup> See David Schuster, “The Rise of a Modern Concept of ‘Health,’” *A Companion to the Gilded Age and Progressive Era*, Christopher McKnight Nichols and Nancy C. Unger, eds., Wiley-Blackwell Companions to American History (Chichester, West Sussex: Wiley-Blackwell, 2017), 260.

<sup>8</sup> Ollie Marquiss, *Diary of a Student Nurse*, Philip Mulkey Hunt, ed. (1910-1913), 21.

disease were generally left to resort to familial care.<sup>9</sup> Still, collective forms of quarantine in response to perceived health threats persisted in the form of the tuberculosis sanatorium and the insane asylum. Medical professionals also sought to bolster collective immunity through vaccines. The first experiments in mandatory vaccination were tried in this period, which led to strong associations between vaccines and bureaucratic control over the body.<sup>10</sup> Medical charities operated within this health milieu, attempting to deliver both treatment and preventative care. They relied on the voluntary work of physicians, who commonly deployed such work in efforts to bolster their professional standing.

At the turn of the century, the scientific and technical advances in medical practice that many upheld as sign of social progress developed concurrently with the solidification of national professional standards for physicians. In 1889, the Supreme Court Case *Dent v. West Virginia* prohibited the practice of medicine in the United States without a state-issued license.<sup>11</sup> This decision marked the first national regulation of the physician's profession. The heavy influence of the American Medical Association also contributed to the consolidation of the physician's trade into a clearly defined profession. In this case, claiming professional status meant asserting exclusionary norms in education, licensing, and regulation regarding the physician's trade. Andrew Beck writes that "because of the heterogeneity of educational experiences and the paucity of licensing examinations, physicians in America at the turn of the 20th century varied tremendously in their medical knowledge, therapeutic philosophies, and aptitudes for healing the sick."<sup>12</sup> With cases like *Dent v. West Virginia*, the American Medical Association enlisted the federal and state governments to uphold exclusive medical licensing practices. Generally, the association sought to force untrained or unorthodox practitioners

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<sup>9</sup> Andrew Wear, *Medicine in Society: Historical Essays* (Cambridge: Cambridge University Press, 1992), 8-9. See also Nancy Tomes, *The Gospel of Germs: Men, Women, and the Microbe in American Life* (Cambridge: Harvard University Press, 1998).

<sup>10</sup> Robert D. Johnston, "The Myth of the Harmonious City: Will Daly, Lora Little, and the Hidden Face of Progressive-Era Portland," *Oregon Historical Quarterly* 99, no. 3 (1998): 248-97.

<sup>11</sup> See James C. Mohr, *Licensed to Practice: The Supreme Court Defines the American Medical Profession*, (Baltimore: Johns Hopkins University Press, 2013), 9-24.

<sup>12</sup> Andrew H. Beck, "The Flexner Report and the Standardization of American Medical Education," *Journal of the American Medical Association* 291, no. 17 (2004): 2139.

of medicine out of business in favor of those who had received recognized medical school training.<sup>13</sup> Finally, the American Medical Association put pressure on medical schools themselves in order to establish consistent educational standards for physicians. In 1910, the publication of the Flexner Report in the *Journal of the American Medical Association* did exactly this. Abraham Flexner, an educational theorist, surveyed all U.S. medical schools and argued that only those with enough resources to provide laboratory and clinical training should be allowed to confer medical degrees. This prescription fit the American Medical Association's concerns about unregulated education. The organization then embarked on a campaign to force the closure of medical schools that did not fit their preferred standards. Among those closed were many small rural medical schools and almost all of those serving black medical students.<sup>14</sup> For many mid-sized medical schools, charitable clinics were the cheapest and most effective way to provide the requisite training. Often, this led to interdependencies between medical schools and free dispensaries by which charitable care relied on the participation of elite physicians and medical research depended on the delivery of medicine to the working poor.

The provision of medical care had its place within the often-noted environment of progressive reform in the early 20<sup>th</sup> century. Some social reformers threw their weight behind legislative campaigns to institute state health insurance schemes for those who could not afford doctor's fees. The American Medical Association fiercely opposed these efforts in state legislatures. Over the course of the 1910s, all such proposals failed due to the consolidation of political opposition not only from physicians' associations, but also from labor unions and large commercial interests, all of which cast compulsory health insurance as contrary to liberty and free enterprise.<sup>15</sup> Other reformers, including many doctors and nurses, saw sanitation, obstetrics, and pediatrics as the most important medical frontiers in the preservation of communal health. Their tactics also revolved

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<sup>13</sup> See Norman Gevitz, ed. *Other Healers: Unorthodox Medicine in America* (Baltimore: Johns Hopkins University Press, 1988).

<sup>14</sup> Schuster, "The Rise of a Modern Concept of 'Health,'" 257-258. See also Beck, "The Flexner Report and the Standardization of American Medical Education," 2140.

<sup>15</sup> On the state health insurance schemes, and particularly the New York bills see Hoffman, *The Wages of Sickness: The Politics of Health Insurance in Progressive America*.

around legislative lobbying at the local and state level, and especially advocacy for greater application of scientific methods on municipal health boards. Following accounts of successful and unsuccessful legal landmarks in national health policy, recent historiographical explorations of healthcare in this period tend to treat its broad range of charitable health practices and institutions as subsidiary to actual and proposed state superstructures.<sup>16</sup> Historian David Schuster, for example, consigns free dispensaries to a marginal role within the process by which “the government revamped its regulatory system so as to more effectively protect the health of Americans.”<sup>17</sup> While charitable health networks in Portland were connected to state public health initiatives, and increasingly so after 1920, their operations and methods diverged sharply. By treating developments outside of the realm of legal reform as minor facets in Progressive Era medical history, these accounts ignore the processes by which private actors staked claims on public responsibilities. Importantly, private charities’ public service rationales remained influential even as they eventually saw their operations incorporated under the purview of medical schools, government offices, and research hospitals.

The interplay between diffuse health practices and state authority has been more clearly articulated with regard to the field of early-20<sup>th</sup> century medicine that produced perhaps the most conflict and latter-day critique: eugenics. Recently, historians of the Progressive Era have interceded to place the eugenics movement firmly within the narrative of medical reform. Eugenicists perceived “individual bodies as the carriers of the pathological histories of their race or type, such ‘defects’ being passed from one generation or social group to another... [leading] to racial degeneration.”<sup>18</sup> They sought to stymie such “degeneration” by controlling the rates of reproduction among racial minorities, those with mental and physical disabilities. Their methods varied, encompassing birth control and “eugenic education,” as well as forced sterilization. The prevailing historiographical understanding of eugenics is that its advocates meant “to

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<sup>16</sup> See principally Mohr, *Licensed to Practice: The Supreme Court Defines the American Medical Profession*, and Hoffman, *The Wages of Sickness: The Politics of Health Insurance in Progressive America*.

<sup>17</sup> Schuster, “The Rise of a Modern Concept of ‘Health,’” 259.

<sup>18</sup> David Cantor, “The Diseased Body,” *Medicine in the Twentieth Century*, Roger Cooter and John V. Pickstone, eds. (Amsterdam: Harwood Academic Publishers, 2000), 356.

naturalize social prejudices through the adoption of scientific language and authority.”<sup>19</sup> Other historians have modified this view to cast eugenics as part of a “broader twentieth century modernist movement” through which reformers and bureaucrats sought to modify both individual and collective behaviors.<sup>20</sup> Like mandatory vaccination, eugenics represented the increasing pretension to control over individuals that states levied using the language and techniques of scientific medicine. This understanding of eugenics relies on the notion that the interests of reforming doctors and racist agitators who put stock in eugenic practices converged with those of state authorities in the 1910s and 1920s. Such a model can be productively applied to the broader formations of Progressive Era medical delivery and health reform.

This thesis seeks to revise the roles of free dispensaries, visiting nurses associations, and other localized medical charities within the broader social history of medicine. Narratives that focus exclusively on the rise of hospital systems and the establishment of modern public health are bound to elide local variations and intermediate formations in the history of early-20<sup>th</sup> century healthcare and reform. On the other hand, centering the rise of pliant and variable efforts to deliver public service medicine in this period reveals the extent to which the results of medical centralization relied on contingent civic alliances, unstable rationales of care, and responses to unpredictable moments of crisis.

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<sup>19</sup> Mark A. Largent, “‘The Greatest Curse of the Race’: Eugenic Sterilization in Oregon, 1909-1983,” *Oregon Historical Quarterly* 103, no. 2 (2002): 191.

<sup>20</sup> Ibid. Largent’s account of eugenics associations and forced sterilization is an excellent starting point for the study of eugenics in Oregon. For more recent case studies on eugenics in the United States see Bitsy Friauf and Michael Phillips, “A Serviceable Villain: Eugenics, The Fear of the ‘Underman,’ and Anti-Democratic Discourse in Texas Thought and Culture, 1900-1940,” *East Texas Historical Journal* 55, no. 2 (Fall 2017): 7–46 and Molly Ladd-Taylor, “‘Ravished by Some Moron’: The Eugenic Origins of the Minnesota Psychopathic Personality Act of 1939,” *Journal of Policy History* 31, no. 2 (April 2019): 192–216.

## Oregon and the American Northwest

Historians have commonly marked the end of the 19<sup>th</sup> century as a transitional period in the story of the Western United States. In the wake of the violent colonial conquests of the mid-century, far western states were recast in terms of their wealth in natural resources and their growing urban areas. In the 1890s, American writers asserted both the character of the Western United States as an immortal frontier and declared that frontier to be closed. Robert Hine and John Mack Faragher note that just before 1900, American demographers suddenly noticed that the western states were in the process of becoming more urban than rural as cities like San Francisco and Denver grew at rapid paces. They claim that “the modern regional West might be predominately urban, but westering had been predominately rural.”<sup>21</sup> In other words, the western cities of the early 20<sup>th</sup> century found cultural definition in terms of the vast rural areas which they abutted. By 1920, however, the Pacific coast states all had higher proportions of urban dwellers than the national average, indicating a continuing shift toward societies dominated by cities.<sup>22</sup> Progressive health reform in these states thus tended to focus on the unique problem of controlling disease in rapidly growing port cities with transient as well as settled populations.

The city of Portland, Oregon, represented this rapid expansion of urban population in the American Northwest. At the turn of the century, Portland had recently been established as a major port city in the region, taking advantage of its position at the confluence of the Columbia and Willamette rivers to participate in the commerce of the Pacific Rim. Historian Thomas Jablonsky writes of the region that “West Coast cities dominated their hinterland’s economy and culture,” noting specifically that “The ports along Puget Sound and at Portland... allowed their cities to become regional entrepôts,

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<sup>21</sup> Robert V. Hine and John Mack Faragher, *The American West: A New Interpretive History* (New Haven: Yale University Press, 2000).

<sup>22</sup> Thomas J. Jablonsky, “The Midwest and the Far West During the Gilded Age and Progressive Era,” *A Companion to the Gilded Age and Progressive Era*, Christopher McKnight Nichols and Nancy C. Unger, eds., Wiley-Blackwell Companions to American History (Chichester, West Sussex: Wiley-Blackwell, 2017), 66.

nourishing hinterlands that blossomed through lumbering and agricultural exports.”<sup>23</sup> The city’s connection to the Pacific Ocean allowed not only for economic growth, but also for the movement of people. Portland became a destination for European and Asian immigrants alike, as well as for migrants from Atlantic Coast cities. Wealthy families relocated from New England helped shape the city’s elite society, and thus its culture of philanthropy and reform. Meanwhile, prominent sojourners such as birth control advocate Margaret Sanger, Reconstructionist Rabbi Stephen S. Wise, and his wife Louise Waterman Wise had deep, if brief, influences on the pursuit of social work and health reform.



Figure 1: View of Ships in the Willamette in the Portland Harbor (1904).

Image courtesy of City of Portland Archives and Records Management, Auditor’s Historical Records.

Progressive Era Portland saw significant conflict when it came to the convergence of medicine and social reform. In 1895, the state government of Oregon set up a board of “regular,” “eclectic,” and “homeopathic” physicians to administer standardized examinations to aspiring doctors.<sup>24</sup> Medical practices viewed as non-standard had been common in the state prior to the founding of its first medical school in 1887. These

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<sup>23</sup> Jablonsky, “The Midwest and the Far West During the Gilded Age and Progressive Era,” 66.

<sup>24</sup> “The Physician in Oregon,” *Journal of the American Medical Association* 25, no. 21 (1895): 914.

practices eschewed recent advances in bacteriology, pharmacology, and surgery, and their inclusion represented a partial compromise of mainstream physicians' claim to medical legitimacy. Physicians' associations and the state, however, refused to recognize the validity of the unique medical practices of American Indians and Asian immigrants. In the Northwestern states, the process of medical standardization thus included attacks on unlicensed Chinese physicians, Native medical practices, and even rural midwives.<sup>25</sup> Male doctors and their allies in government defined that which they considered feminine, non-white, or foreign as non-standard in the medical world, and therefore disallowed. At the same time, public conflicts over vaccination and eugenic sterilization raged in Oregon. Robert Johnston writes that popular opposition to mandatory vaccination "repudiated the authority of governmental and medical 'experts' to define personal and public health."<sup>26</sup> It is also telling that some of the same leaders who opposed mandatory vaccination also rallied against forced sterilization. These protestations, however, did not come to fruition. The first mandatory sterilizations in the state occurred in the early 1920s; in total 2,500 people became victims of forced sterilization, mainly between the 1930s and 1960s.<sup>27</sup> In Oregon, as in the rest of the United States, science and state regulation would increasingly define the administration of medicine in the early 20<sup>th</sup> century.

As a site of medical practice and reform, early-20<sup>th</sup> century Oregon displayed qualities that were both distinctive and representative with regard to broader trends in the Progressive Era United States. The seriousness of Portland's reform movements was rooted in both the idealized pioneer mentality of improvement through hardship as well as in the transplanted social scientific methods of progressives in New York, Chicago, and Boston. Conflicts over medical progressivism abounded in Oregon as well. Among the broader population, struggles over enforced sterilization and vaccination reached

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<sup>25</sup> Tamara Venit Shelton, "Curiosity or Cure?: Chinese Medicine and American Orientalism in Progressive Era," *Oregon Historical Quarterly* 114, no. 3 (2013): 267.

<sup>26</sup> Robert D. Johnston, *The Radical Middle Class: Populist Democracy and the Question of Capitalism in Progressive Era Portland, Oregon*, (Princeton: Princeton University Press, 2003), 178.

<sup>27</sup> Largent, "'The Greatest Curse of the Race': Eugenic Sterilization in Oregon, 1909-1983," 206.

fever pitch at various points between 1900 and 1930. Within the medical class, the same racialized and gendered professional norms that ensconced white male doctors' social power across the United States were fully present in the state. Still, certain non-standard practitioners had an unusually strong foothold in Oregon, even as legislative regulation solidified in the medical world. Critically, women nursing leaders, social workers, and a handful of women doctors also left clear marks on both public and clinical health practices in Portland during the 1910s. This final feature of healthcare delivery in Oregon was a central to public service medicine in the state. Women's construction of civic rationales for a broad range of techniques and strategies in medical care led charitable institutions to balance state authority with private interests, to contribute to the professionalization of nursing, and eventually to exert durable influence in the hospitals which would come to dominate clinical care.



Figure 2: Portland Waterfront and Downtown Looking West (1918).

Image courtesy of City of Portland Archives and Records Management, Auditor's Historical Records.

## Notions of Public Service

The landscape of public service in the United States during the 1900s and 1910s tended to prioritize masculine prerogatives to civic duty even as women carved out greater roles in certain professions and reform organizations. For example, Beatrix Hoffman writes that the influential American Association for Labor Legislation, which

threw its weight behind state health insurance proposals, relied on the work of women researchers. She writes, however, that at this reformist agency, “women were paid staff rather than voluntary AALL members... and as female employees their work was often devalued.”<sup>28</sup> Within this model, the wages of female researchers and reformers served as evidence against their magnanimity or public-mindedness, especially in comparison to men who built sterling civic reputations by volunteering their time and funds. This arrangement was present not only in national reform societies, but also in regional medical charities. In most free dispensaries, male, university-trained doctors gained prestige, as well as a theater for practice and experimentation, by offering their professional services at no monetary cost. Female nurses and administrators, on the other hand, saw their public service credentials marginalized by their status as paid employees. Revisionist historiography regarding the medical world has definitively mapped such gendered categorizations onto the divide between the physician’s and nurse’s profession. Some even claim that the primary distinction between nurses and doctors in this period was that the former were women and the latter were men.<sup>29</sup> Despite this tilt of the medical and civic spheres toward masculine participation, early 20<sup>th</sup>-century medical charities relied most of all on the labor of female social workers, reformers, administrators, and especially nurses. This thesis concerns primarily the civic missions espoused by such women. I investigate the function of Portland’s charitable health organizations principally from the perspectives of Valentine Prichard, a reform-minded social worker, and Grace Phelps, a leader in the city’s nursing associations.

In historical accounts, the efforts of women such as Phelps and Prichard have commonly appeared as minor threads in the history of public health.<sup>30</sup> Accordingly, the clear demarcations of public health influence historical accounts of more flexible charitable care. Elizabeth Fee and Dorothy Porter write that public health displayed from early in its history “a certain independence from medicine; as the medical profession remained wedded to fee-for-service practice and displayed little interest in salaried

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<sup>28</sup> Hoffman, *The Wages of Sickness: The Politics of Health Insurance in Progressive America*, 42.

<sup>29</sup> See Barbara Melosh, *‘The Physician’s Hand’: Work Culture and Conflict in American Nursing*, (Philadelphia: Temple University Press, 1982), 19-25.

<sup>30</sup> See Schuster, “The Rise of a Modern Concept of ‘Health,’” 259.

government positions, public health evolved as a somewhat separate professional specialty.”<sup>31</sup> As a professional specialty, it encompassed preventative work in sanitation, health education, nutrition, and city planning, among other extra-clinical pursuits. Fee and Porter thus construe public health as the territory of city health departments, government agencies, and large research institutions. The charitable medicine of the early-20<sup>th</sup> century does not easily fit this description. Free dispensaries’ amalgamation of home care, clinical medicine, and social work represented alliances of multiple professional fields and practices that were adjusted to match the ideals of reformers and the needs of the public. In creating these civic alliances, reformers and medical practitioners defined the city as the object of their care, thus applying public health rationales to the work of clinical medicine. These organizations did not fit in the historiographical binary of public health and medicine—they lay in between the two.

In the alliances between nurses, doctors, and social reformers that allowed for the administration of charitable care, the rationales and methods of such care produced the distinct practice of public service medicine. As a social and medical formation, this differs from public health for two related reasons. First, over the past two centuries, public health has developed into a well-defined science and professional field that incorporates clearly delineated subfields such as bacteriology and epidemiology with sanitation and urban planning.<sup>32</sup> These boundaries do not fit the breadth of practices embraced by early 20<sup>th</sup> century medical charities. The work of these associations ranged from the administration of regular culinary classes to the clinical treatment of venereal disease patients. Their prescriptions for the maintenance of civic health were always more flexible than that of state and municipal offices. Second, before the spread of health insurance and large inpatient wards, the distinction between public and private in medicine developed in reference to the fee-for-service home care provided by most physicians. This type of care, as well as the private-duty care performed by independent

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<sup>31</sup> Elizabeth Fee and Dorothy Porter, “Public Health, Preventative Medicine, and Professionalization: England and America in the 19<sup>th</sup> century,” in *Medicine in Society: Historical Essays*, Andrew Wear ed., (Cambridge: Cambridge University Press, 1992), 249.

<sup>32</sup> See Porter, *Health, Civilization, and the State: A History of Public Health from Ancient to Modern Times*, 231-278.

nurses, stood in contrast to all other health efforts, which were regarded as taking place within the public sphere. For this reason, outpatient care in the early-20<sup>th</sup> century, which eventually became a critical part in the development of centralized research hospitals in Portland and elsewhere, is often conflated with public health in historical scholarship. This conflation does not match the actual practice of medical delivery in the urban United States of the 1900s and 1910s. In short, this was a time at which the partition of mainstream health sciences into public health on the one hand, and hospital medicine on the other, had not yet fully crystallized.

I use the term public service medicine to demarcate the range of formations, strategies, and rationales that characterized Portland's charitable medical societies between 1900 and 1926. The reformers and medical professionals involved in these efforts claimed to further the health objectives of an idealized progressive state but, at first, had only situational connection to actual state offices. Still, these associations played a central role in defining the idea of deserving care on the public stage. They centered the care of the indigent and working poor while, at times, disqualifying some from aid on the basis of moral impropriety or even of racial categorization. For the most part, however, free dispensaries and nurses' associations broadened the effective reach of urban healthcare, applying both the tested techniques of the private-duty nurse and the newer developments of scientific medicine to the treatment of those who could not pay doctors' fees. In doing so, these organizations created a civic space through which nurses bolstered their claims to professional status and reformers attempted to reconcile the ideals of moral reform with the realities of urban care.

In separating public service medicine from state public health efforts, this thesis builds on the recent historiographical notion that reformers' pretensions toward social control only partially account for the civic rationales of their medical programs. This position mediates between historical narratives of health reform as a hallmark of scientific progress and of health reform as tool of bureaucratic authority. Dorothy Porter writes that the early historiography of public health charts "grand narratives of progress, arising from the technological advance of science and medicine and its capacities to

combat epidemic and endemic disease.”<sup>33</sup> Later critical examinations of this history, principally represented by Michel Foucault’s *The Birth of the Clinic* and *Madness and Civilization*, challenge “any heroization of public health as a great achievement of Enlightenment rationalism” and demonstrate “the ways in which public health regulation contributed to the rise of a ‘disciplinary culture.’”<sup>34</sup> Recently, historians have tempered the revisionary association of public health with power and discipline. Simon Finger, in his study of public health in early Philadelphia, writes that in these interpretations “political calculation almost seemed to crowd out health entirely, consigning philanthropic and medical reform to the status of mere pretext for more cynical designs for power and control.”<sup>35</sup> Pretensions toward moral and physical control certainly had significant effect on the provision of healthcare in the early 20<sup>th</sup> century, but, as Finger suggests, the methods and motivations of those who worked to provide public service medicine were far more fluid, shifting in response to popular and medical pressures. Within this debate it remains critical to separate the function of state public health entities from the more flexible charitable associations that provided clinical treatment, home care and other services. The professionals and reformers associated with the latter, while at times connected to the expansion of state authority, had greater interest in balancing progressive moralism with response to civic health needs.

The application of public service rationales to charity medicine ultimately served as a temporary link between the crystallizing professions of the physician and the public health official. The examples of dispensaries, nurses’ associations, and early teaching hospitals in Portland demonstrate the protean nature of this period in the delivery of charitable medicine that led to the dominance of hospital systems geared toward treating patients as individuals. The urgency ascribed to civic service through healthcare warranted tenuous alliances between nurses, doctors, and social reformers which deployed mixes of technique in healthcare delivery. Such delivery blurred the lines

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<sup>33</sup> Dorothy Porter, *Health, Civilization, and the State: A History of Public Health from Ancient to Modern Times* (London: Routledge, 1999), 1.

<sup>34</sup> *Ibid.*, 3.

<sup>35</sup> Simon Finger, *The Contagious City: The Politics of Public Health in Early Philadelphia* (Ithaca: Cornell University Press, 2012), x.

between public health and clinical medicine and relied on the claim that it treated the civic body as a whole, rather than individual patients or families.

The first chapter of this thesis uses the example of the Portland Free Dispensary to demonstrate how reformers and medical practitioners deployed civic service ideologies to justify the expansion of clinical medicine to a broadening patient population, especially to those suffering from venereal disease. The institution did so while attempting to maintain its credentials in social and moral reform. Chapter two approaches the ways in which members of the Visiting Nurses Association and volunteers in the Army Corps of Nurses constructed civic ideologies around their work. These nurses used their work in public service medicine as evidence to their claims of professional status. The final chapter assesses the influence of dispensary officials, visiting nurses, and military nurses in rapid foundation of new hospital programs on Marquam Hill in Southwest Portland during the 1920s. In their charity work, these new hospitals adapted the existing ideology of public service medicine to justify inpatient care which treated patients' individual bodies as separate from their neighborhood and family environments. These chapters chart the rise of ad hoc medical charities in Portland, and their eventual incorporation into a university-affiliated hospital program. In doing so, they present public service medicine as a combination of clinical methods and public health rationales which served as a platform for nursing professionalization and the redefinition of medical care as a civic responsibility.

This regional history sheds light on the processes by which conceptions of civic wellbeing emerged in a site of early-20<sup>th</sup> century urban population growth. It describes the organizations, alliances, and events which contributed to the transformation of exclusive healthcare rationales into universalizing programs in public service medicine. The free dispensary and the visiting nurses association, among many other charitable institutions, emerged as responses to specific perceived crises and eventually developed durable ideologies of care. They specified clinical medicine as a public good, the provision of which was incumbent on state and private actors in order to guard the city's wellbeing as a whole. Though individualist and commercial healthcare rationales later

superseded the influence of this civic justification, public service medicine endures as an elusive and alluring alternative.

# Chapter 1. The Portland Free Dispensary: Moral Reform and Clinical Care

Inspired by a 1902 report that detailed the “appalling conditions surrounding the women and children of this district,” four wealthy reform-minded women of Portland, Oregon founded in 1904 a social aid and reform organization which they named the People’s Institute.<sup>36</sup> These women, led by Helen Ladd Corbett, hired Boston-born social worker Valentine Prichard (1862-1951) as the paid superintendent of the organization. Most others who contributed work to the People’s Institute did so on a voluntary basis. Valentine Prichard was deeply influenced by the social settlement work of Jane Addams, and sought to model the work of the People’s Institute on that of Addams’ Hull House, which combined charitable aid and education with progressive social work.<sup>37</sup> Over the course of its operation, the People’s Institute also inaugurated the Portland Free Dispensary, which provided for the distribution of free medical care to those deemed to be in sufficient need. After it incorporated the medical dispensary into its social settlement program, the People’s Institute generally construed this program as one aimed at medical delivery in the public sphere. While the organization at first intended for the free dispensary’s clinical care to form only one part of its health doctrine, the dispensary soon came to dominate the operations of the People’s Institute.

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<sup>36</sup> “People’s Institute History,” (1907), Valentine Prichard Papers 1.1, Oregon Historical Society Research Library. All further citations of the Valentine Prichard papers are located at the Oregon Historical Society Research Library.

<sup>37</sup> Prichard also modeled the People’s Institute’s attempts to “Americanize” immigrants after St. Bartholomew’s Parish House, an Episcopalian aid society that focused on the assimilation of foreigners. On the influence of Hull House and St. Bartholomew’s on the Portland People’s Institute, see Valentine Prichard, “Fourth Annual Report of the People’s Institute,” (1909), Valentine Prichard Papers, 1.3. On Hull House and Jane Addams’ conception of social settlement work, see Jane Addams, *Twenty Years at Hull House* (New York: Open Road Integrated Media, 2016). On public health in settlement houses see Lillian D. Wald, *The House on Henry Street*, (New York: Holt and Company, 1915).

In the early 20<sup>th</sup> century, free medical dispensaries were common across United States cities. These clinics varied greatly in size. While some dispensaries were quite large and served hundreds of patients per day, others were not much more than a single doctor's office opened to those in need on certain days. In 1915, for example, two chiropractors in Salem, Oregon conducted a limited-time free dispensary asking especially for "incurable cases."<sup>38</sup> Many other dispensaries, large and small, were associated with nearby churches or medical schools.

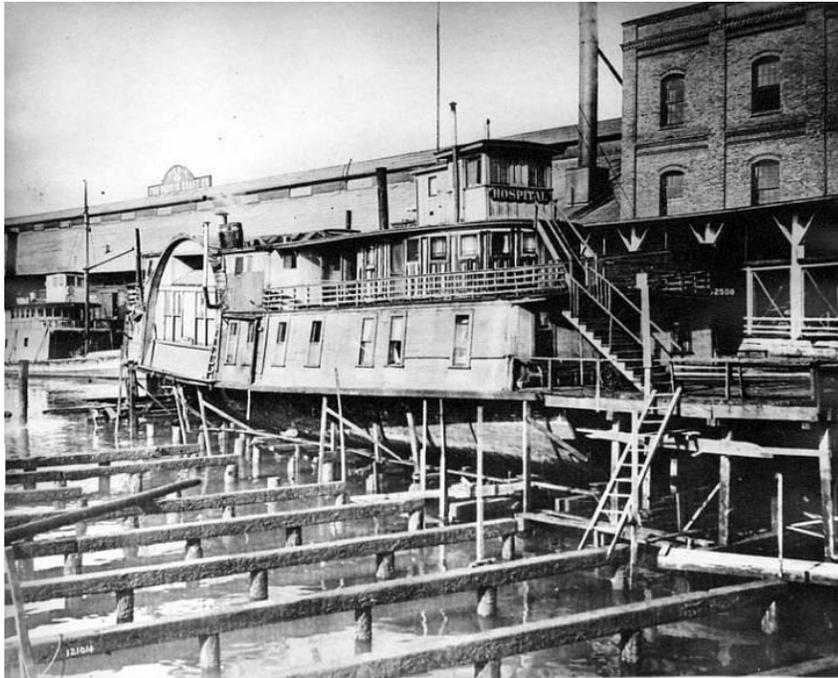


Figure 3: Wayside Mission Hospital at the foot of Jackson Street (c. 1907)

Image courtesy of Wayside Mission Hospital Photograph Collection, University of Washington Library Special Collections.

In some cases, the dispensaries of the American Northwest served as experiments in unorthodox methods of medical delivery in the most crowded and poorest neighborhoods of growing cities. One such dispensary, Seattle's Wayside Mission Hospital, was founded in 1899 with the support of the Seattle Benevolent Society and

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<sup>38</sup> "Free Dispensary for Worthy Poor," *Salem Capital Journal*, March 15, 1915, 5. This example points to both the value of free dispensary work to physicians looking augment their reputations as well as the commonality of free dispensary work among medical practitioners viewed as non-standard.

billed as the city's first emergency hospital. Its founder, Dr. Alexander de Soto, argued that poverty-related diseases and industrial accidents were most prevalent on the city's waterfront and thus established the charitable hospital on the decommissioned steamboat *Idaho*. On this repurposed ship, reported one periodical, "almost every day the frequent accidents of the industrial waterfront are treated and... emergency cases receive quick and expert care."<sup>39</sup> Though short-lived, the Wayside Mission Hospital demonstrated the urgency with which medical professionals and reformers approached the administration of charitable care, especially on the Northwest's working waterfronts. Institutions like these contributed to the growing sense that industrial cities required flexible purveyors of public service medicine.

Free dispensaries in the United States, however, have received relatively little attention in scholarship on the social history of medicine in the Progressive Era. Some historians have even denied the relevance of charitable clinics prior to the New Deal. Historian Michael Grey claims that "philanthropic involvement in healthcare delivery did not begin until the 1940s," and that such efforts engaged only in public health campaigns rather than in "medical delivery," meaning the clinical care of patients.<sup>40</sup> Grey seeks to separate these two ends when, in fact, associations like the Portland Free Dispensary aggregated medical delivery with public health rationales. The clinical care pursued by the Portland Free Dispensary, among countless other free dispensaries in U.S. cities at the turn of the 20<sup>th</sup> century, belies his assertion. Outpatient medicine defined the Portland clinic's civic program and became a critical part of its work well before the 1930s.

Other studies on United States medicine in the early 20<sup>th</sup> century place the free dispensaries within a constellation of institutions which provided emergency care to those who could not pay doctors' fees up front. Beatrix Hoffman labels this as a "patchwork of protection" for the urban poor and working class; she groups the free dispensaries with the varying insurance schemes of mutual aid societies, fraternal orders, trade unions, and

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<sup>39</sup> "Surgical Ward of the Wayside Mission Hospital," *The Commonwealth* 2, no. 11 (Seattle, 1903), 3.

<sup>40</sup> Michael Grey, *New Deal Medicine: The Rural Health Programs of the Farm Security Administration* (Baltimore: Johns Hopkins University Press, 1999), 12.

employers.<sup>41</sup> Such insurance plans, however, often differed greatly in their coverage. Most were meant to provide for either funeral expenses or wages for missed work due to illness. Only very few of the working poor could rely on plans such as these, and even fewer had access to a plan that included care from physicians. Additionally, commercial health insurance plans did not become common until the 1940s.<sup>42</sup> While professionalized medicine had been legally and scientifically defined decades earlier, the opportunities for wage-earners to access physician care were clearly quite limited. Free dispensaries differed greatly from these mutual aid programs in that they aimed to provide critical medical care without cost or for a nominal fee. Furthermore, they became an important part of medical education in many cities: many dispensaries were located at medical schools. Hoffman estimates that in 1919, more than one third of all New York and Boston doctors volunteered at free dispensaries.<sup>43</sup> Given their unique function in the Progressive Era medical environment, the free dispensaries bear examination on their own terms.

Even scholarship that purports to describe the connection between dispensaries and charitable hospitals tends to oversimplify the role of the former. David Sloane suggests that free dispensaries across the country were direct precursors to children's hospitals. He claims that through the collaboration of doctors and social reformers, both types of institution aimed "to create a fictional parent-less home managed by professionals for the purpose of saving children physically and spiritually."<sup>44</sup> He commits to a reading of this history that focuses on the binary between patrician female reformers and male doctors. In doing so, he cuts out the role of nurses who sought to transform their work into that of the civic professional rather than the domestic aide. Critical to the

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<sup>41</sup> Beatrix Hoffman, *The Wages of Sickness: The Politics of Health Insurance in Progressive America*, (Chapel Hill: University of North Carolina Press, 2001), 6-23.

<sup>42</sup> On the rise of commercial health insurance see Nancy Tomes, *Remaking the American Patient: How Madison Avenue and Modern Medicine Turned Patients into Consumers* (Chapel Hill: University of North Carolina Press, 2016), 141-149.

<sup>43</sup> Hoffman, *The Wages of Sickness: The Politics of Health Insurance in Progressive America*, 19.

<sup>44</sup> David Sloane, "Not Designed to Merely Heal: Women Reformers and the Emergence of Children's Hospitals," *The Journal of the Gilded Age and Progressive Era* 4, no. 4 (2005): 334.

function of charitable dispensaries and early children's hospitals, according to Sloane, was the "maintenance of a proper moral standard" and the undertaking of "moral education."<sup>45</sup> This claim holds true for organizations such as San Francisco's Pacific Dispensary for Women and Children, which pursued a fastidious moral education program while restricting its patient-base to mothers and children. Many other free dispensaries, however, did not maintain such straightforward connections to moral education or to children's healthcare. While many clinics claimed strictly moral and maternalist credentials by foregrounding their treatment of mothers and children, the aspiration to care for the civic body as a whole led to broadening definitions of deserving care. The development of the Portland Free Dispensary alongside its affiliated social settlement organization, the People's Institute, demonstrated the ways in which free clinics repositioned their relation to civic service over years of operation. Its history shows how reform ideologies, social interpretations of disease, and state interventions all adjusted the pursuit of public service medicine and the dispensation of charitable care.



Figure 5: Portland Free Dispensary Tuberculosis Clinic.

Image courtesy of People's Institute and Free Dispensary glass lantern slides, OHSU Historical Collections and Archives.

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<sup>45</sup> Sloane, "Not Designed to Merely Heal: Women Reformers and the Emergence of Children's Hospitals," 341, 349.

The People's Institute and Free Dispensary initially conceived its public service program mainly through efforts to mediate the home lives of poor families, and especially immigrants. Social workers furthered this goal through home visits, classes, and recreational clubs aimed at mothers and children. The organization inaugurated its free clinic initially as a supporting feature of this program. In the 1910s, growing demand for clinical care led the People's Institute to expand its dispensary work. Finally, the introduction of federal funding and controls on medical dispensaries beginning in 1917 shifted the focus of the Portland Free Dispensary, especially prioritizing the treatment of venereal disease. This shift de-emphasized moral hygiene and perceived innocence as requirements in determining who deserved free care and established clinical treatment of the working population as the People's Institute's primary mission.

## **The Origins of the Portland Free Dispensary**

Valentine Prichard, superintendent of the People's Institute, proudly traced the founding of its medical delivery efforts to the aftermath of the 1906 San Francisco Bay earthquake. While the tremors of the 1906 disaster affected large swaths of California, its social ripples had even broader effects. The disaster became a moment of civic reckoning for the rapidly urbanizing Pacific Coast of the United States. Historian Michael Helquist claims that, in the relevant scholarship, the relief work executed in Portland, Oregon, "has been overshadowed by larger events of the time, including a surge in the city's population, significant commercial expansion, and a push for political reform."<sup>46</sup> He does not recognize, however, that civic leaders in Portland and across the Western U.S. problematized the earthquake as a watershed in the region's continuing expansion of urban population, charity, and reform. In Portland, earthquake relief led the city's female reformers to incorporate systematized healthcare schemes into their social settlement work, forge alliances with the city's growing medical school, and to eventually expand their definition of "deserving" recipients of care.

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<sup>46</sup> Michael Helquist, "Portland to the Rescue: The Rose City's Response to the 1906 San Francisco Earthquake and Fire," *Oregon Historical Quarterly* 108, no. 3 (2007): 386-387.

On April 21, 1906, Dr. Charles E. Morris and his wife returned to Portland from a brief sojourn in California. They had been in San Francisco when the earthquake of April 18 struck. The couple managed to board the second train going north from Oakland after the disaster. After arriving in Portland, they recollected the horrors they had seen in San Francisco before escaping to Oakland by ferry in order to reach the outgoing train. The two characterized the stricken city as a place of futility and of violence. From within a collapsed lodging house, they “could hear the poor wretches screaming for assistance but there was no possible way they could have been saved.”<sup>47</sup> Mrs. Morris also claimed to have seen police officers shoot and kill two “looters” who had reached into a broken store window to take hats, having each lost their own. Many reports noted that people were killed not only in the buildings that collapsed from seismic shocks, but also in buildings that were demolished by the Army Corps of Engineers in an attempt to halt the fires resulting from the earthquake.<sup>48</sup>

Reports of the disaster that had engulfed the San Francisco Bay dominated the news in cities across the U.S. in those last weeks of April. Early accounts described damage to buildings as far north as Eureka and as far south as San Luis Obispo; in addition, refugees from the San Francisco area began to pour into the other urban centers of the West Coast within a few days.<sup>49</sup> In the first week after the disaster over 5,000 refugees arrived by train to Portland where members of the local Chamber of Commerce and Commercial Club prided themselves on their efforts to welcome the displaced. The most visible welcome effort, however, was organized by the Ladies’ Relief Committee. The members of the committee met trains at Portland’s Union Station in order to provide food and arrange temporary accommodations. The *Oregonian* assured its readers of the that “care is being taken to single out only those who are deserving. They will be provided for until they can secure employment,” though neither the newspaper nor the

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<sup>47</sup> “Second Train of Refugees,” *Morning Oregonian*, April 21, 1906. All articles from the *Morning Oregonian* and *Sunday Oregonian* accessed via America’s Historical Newspapers, Newsbank.

<sup>48</sup> See “Thrilling Tales by Refugees,” *Morning Oregonian* April 22, 1906.

<sup>49</sup> Andrea Henderson, “The Human Geography of Catastrophe: Family Bonds, Community Ties, and Disaster Relief After the 1906 San Francisco Earthquake and Fire,” *Southern California Quarterly* 88, no. 1 (2006): 59-61.

relief committee indicated how the deserving would be differentiated from others.<sup>50</sup> By May 2, the various relief organizations of Portland claimed to have served hot meals to 8,500 refugees in total.<sup>51</sup>

Over these few weeks of crisis response the People's Institute, a recently founded settlement house, placed itself at the center of relief efforts. The Ladies' Relief Committee was largely comprised of People's Institute members and acted to funnel refugees into the care of the charitable organization. In particular, the funders of the People's Institute acted quickly to acquire and deploy emergency medical supplies. The organization converted the gymnasium of its building into a makeshift medical dispensary complete with rows of hospital beds. While there were few injured people in the first trainloads of refugees, medical care became increasingly important as displaced Californians continued to arrive in the city. Oregon newspapers characterized the dispatch of supplies and monetary support to San Francisco as the prerogative of the Portland's business-owning men, as represented by the city's Chamber of Commerce. But the actual work of accommodating refugees fell to the city's women-led associations.<sup>52</sup> In this manner, charitable aid reflected gendered divisions of labor: the large body relief work that placed the city of Portland as a host was the business of the city's charitable women whereas the shipping of goods south was that of the businessmen's organizations.

For the reformers of the People's Institute, the need to provide earthquake relief was an opportunity to publicly demonstrate the efficacy of charitable action in the civic sphere. Later, they would single out these humanitarian efforts as the origin point for their charitable public health program in Portland. Valentine Prichard, the superintendent of the People's Institute, wrote that expanding their relief work to include the provision of medical care and supplies served to establish a "firm bond of friendship between the Institute and the general public," noting that as the trains arrived more and more space had been consigned for refugee accommodation. "Surely," she wrote, "the appalling

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<sup>50</sup> "Food and Rooms for Refugees," *Morning Oregonian*, April 23, 1906.

<sup>51</sup> "Refugees are Few," *Morning Oregonian*, May 2, 1906.

<sup>52</sup> See "Portland Comes to the Rescue," *Morning Oregonian*, April 19, 1906. See also Helquist, "Portland to the Rescue: The Rose City's Response to the 1906 San Francisco Earthquake and Fire," 396.

calamity of that April morning formed a new link in the chain of Universal Brotherhood, which shall stand for all time.”<sup>53</sup> For Prichard, disaster relief was a chance to bolster the reputation of the newly founded People’s Institute. Out of adversity, she suggested, the linked cities of the American West would show their cohesion and durability.

The social optimism of the receiving relief committees tended to stand in contrast with eyewitness accounts of the earthquake. Noted novelist and socialist Jack London, who memorialized his observations of the 1906 earthquake with a set of landscape photographs of the ruined San Francisco skyline, understood the disaster as a catastrophic failure of the modern city. “All the shrewd contrivances and safeguards of man,” he wrote, “had been thrown out of gear by thirty seconds’ twitching of the earth-crust.”<sup>54</sup> Another eyewitness wrote from San Jose that “The once fair Queen City of California is a mass of smoking ruins... We are yet without telephone, telegraph or mail service, railroad communication, or, in fact, any means of learning the truth of this, the most awful calamity that ever befell California.”<sup>55</sup> While the physical signs of modern life on the West Coast had been damaged and destroyed by the earthquake, relief workers outside the disaster’s area of physical effect saw it as only strengthening the social bonds of progressive civic life.

### *Expanding to Regular Clinical Care*

After the relief work was done in May of 1906, the People’s Institute had a significant stockpile of medical supplies left over; in 1908 they used these materials to formally inaugurate a permanent medical dispensary. The original aim of the Portland Free Dispensary was to provide aid solely to the city’s women and children in need. This fit with the stated aim of the People’s Institute as a whole, which was to “establish and support Social Settlement Work among the women and children within its reach, offering

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<sup>53</sup> Valentine Prichard, “Second Annual Report of the Social Settlement Work of the Institute Club of the People’s Institute,” (1908), Valentine Prichard Papers 1.3, Oregon Historical Society Research Library, 12-13.

<sup>54</sup> Susanne Leikam, “The 1906 San Francisco Earthquake and Fire,” *Journal of Transnational American Studies* 7, no. 1 (2016): 205, 207, 214.

<sup>55</sup> Carrie Stevens Walter, “Writes of the Horror of It,” *Morning Oregonian*, April 22, 1906.

to them educational, industrial, medical, social, religious, and friendly aid.”<sup>56</sup> For the first few years of the dispensary’s existence it operated under the principle that serving deserving patients necessarily meant limiting the intake to only women and children. The administrators of the People’s Institute saw ill men, and especially working-class men, as risky charges. Their perceived proclivities toward drinking, violence, and sex out of wedlock were often understood to be the causes of their ill health, thus disqualifying them as deserving patients. The continued operation and expansion of the clinic, however, required increasing participation from Portland doctors and nurses given the legislation of professional standards in medicine that had crystallized across the U.S. a few decades prior.<sup>57</sup> For the Portland Free Dispensary, cooperation with the nearby University of Oregon Medical School on Marquam Hill in Southwest Portland became a necessity. The formalization of this alliance between reformers and medical practitioners in turn led to an expansion of the boundaries of deserving care, which reformers then rationalized by recasting the organization’s mission as that of treating the city as a whole.

In 1909, the medical school proposed to affiliate with the dispensary run by the People’s Institute and offered the requisite funding and staffing to expand their operation. This included a large pool of physicians who were willing to provide free services at the dispensary under the condition that the dispensary serve as a teaching location for medical students and resident doctors. Additionally, the medical school required that the Portland Free Dispensary open its doors to male patients and offered to provide the extra equipment necessary to segregate the care of men and women to different floors of the People’s Institute building.<sup>58</sup> Portland’s Visiting Nurses Association also began to cooperate with the dispensary around the same time, dedicating a number of paid staff to full-time work at the clinic. Later expansions of the Portland Free Dispensary were often contingent on the availability of qualified nurses. For example, when the People’s

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<sup>56</sup> The term “medical” was only added to this mission statement after the founding of the Portland Free Dispensary. See “People’s Institute and Portland Free Dispensary, 1920” (1920). *Public Health in Oregon: Discovering Historical Data*. 282.

<sup>57</sup> On professionalization in the physician’s trade during the late 19<sup>th</sup> century, see James C. Mohr, *Licensed to Practice: The Supreme Court Defines the American Medical Profession*, (Baltimore: Johns Hopkins University Press, 2013), 2-15.

<sup>58</sup> Valentine Prichard, “People’s Institute Yearbook, 1909,” (1910) Valentine Prichard Papers 1.3, Oregon Historical Society Research Library, 29.

Institute became interested in opening a separate clinic for patients with tuberculosis, the first concern was the necessity of hiring a “tubercular nurse.”<sup>59</sup> The creation of an effective charitable clinic relied on this alliance between nurses, doctors, and reformers, and the subsequent adjustments in rationales of care constituted the beginnings of public service medicine in Portland.

In opening the clinic to male patients, the reform-minded directors of the Portland Free Dispensary had to justify expansion of their services and collaboration with larger medical institutions as necessary given their previous goals. Valentine Prichard had, since the beginning of her career at the People’s Institute, characterized the ills of the city as lying somewhere along a causal chain that began with inefficiency. “The direct result of inefficiency,” she wrote, “is poverty, and the progeny of poverty includes intemperance, immorality, crime, and a host of lesser evils.”<sup>60</sup> Members of the People’s Institute commonly referred to its social settlement work as a remedy for the inefficiency which, according to their own assessments, plagued the urban lower classes. Thus, just as the proponents of state-funded health insurance in New York had cast their program as an augmentation to industrial capacity, Portland’s social reformers understood public service medicine as a subordinate piece in the sweeping improvements of settlement work.<sup>61</sup> The People’s Institute retrospectively justified the expansion of the dispensary by likening the aims of the social worker to those of the medical professional. Prichard wrote:

It is perhaps only the physician or the social worker who realizes to what an extent inefficiency and even crime are due to poor health. The records of any charitable organization show that a large proportion of poverty is due to sickness. If people are healthy they are apt to be efficient in some line or to wish to be so, for health is the foundation upon which efficiency is built.<sup>62</sup>

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<sup>59</sup> Valentine Prichard, “People’s Institute Yearbook, 1909,” (1910) Valentine Prichard Papers 1.3, 29.

<sup>60</sup> Prichard, “History,” (1914) Valentine Prichard Papers 1.1, Oregon Historical Society Research Library.

<sup>61</sup> On the efforts to enact state-run healthcare in New York, see Hoffman, *The Wages of Sickness: The Politics of Health Insurance in Progressive America*, 24-68.

<sup>62</sup> Prichard, “People’s Institute Yearbook, 1909,” (1910) Valentine Prichard Papers 1.3, 29.

In expanding their medical operations, the directors of the People's Institute had found another cause for inefficiency: sickness. By pivoting their mission towards the provision of systematized medical care, the People's Institute bolstered the claim to guardianship over the civic body. Prichard used this claim to justify their alliance with the University of Oregon Medical School and the decision to admit male patients. In doing so, she and other People's Institute officials redefined the 1906 San Francisco disaster as the impetus for a renewed campaign against the ills which they saw writ large over the urban environment. These ills, they believed, could be reduced down to the effects of inefficiency and would find their cure through efforts aimed at treating the entire civic body.

## **Defining Public Service Medicine**

For the People's Institute, the promotion of health encompassed a broad range of charitable work. It included the medical care taking place at the Portland Free Dispensary, but also the preventative work of education, municipal lobbying, and home hygiene visits, especially in working-class or immigrant neighborhoods. The officials of the People's Institute understood all of its programs, and especially the dispensary's outpatient care, as moving beyond the limits of public health. In its early years, the dispensary's resources were limited, leading its administrators to limit its client base as much as was possible. On the other hand, the administrators of the institute's clubs and classes were in a constant search for new attendees in order to spread the social reach of the organization as far as possible. In some cases, the clubs served as fundraising opportunities for the organization's health services.<sup>63</sup> For this reason, the governing board of the People's Institute and Free Dispensary initially did not limit their understanding of public service medicine to the distribution of drugs. Its leaders thought that the well-being of the civic body would be determined by inculcating familial norms, constructing urban park spaces, and lobbying local government bodies to institute health-oriented

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<sup>63</sup> See Prichard, "Second Annual Report of the Social Settlement Work of the Institute Club of the People's Institute," (1908) and "Third Annual Report of the Institute Club of the People's Institute," (1909), Valentine Prichard Papers 1.3.

reforms. This incorporation of public health techniques prioritized the establishment and enforcement of norms; such a focus meant that the organization deemed particular practices and affinities in the growing city as unhealthy and targeted them for exclusion or suppression. To take one example, the People's Institute and Free Dispensary fiercely opposed commercial dance halls and vaudeville theaters, claiming that these establishments encouraged drinking and the spread of venereal disease, and therefore caused general ill-health. Accordingly, the organization associated itself with a number of campaigns to shut such establishments down. Later, as the reach of the People's Institute grew, clinical care waxed whereas its direct attempts to engineer social mores waned. Valentine Prichard and the other officials of the People's Institute found that outpatient care had to take a central part in the provision of civic healthcare.

### *The Deserving Patient*

The question of how to determine who would be served by the Portland Free Dispensary proved a central point of debate during its two decades of operation. After the decision to admit men alongside women and children was made, no clear answer to this question, nor any general policy regarding patient intake requirements was ever produced. While many medical dispensaries across the United States established clearly-stated restrictions on who they would serve, enforcing these rules was often another matter. In San Francisco, the founders of the Pacific Dispensary for Women and Children announced their patient intake requirements explicitly in the institution's name. This dispensary, however, was recast as the Children's Hospital of San Francisco in 1880, just five years after its founding.<sup>64</sup> Because of the high demand for medical care, free dispensaries either quickly expanded their operations or sought to limit the body of patients they served by enforcing exclusive requirements. Some clinics in the Northeast asserted that they would only serve the "indigent." They assumed that wage-earners, by their own means or through their employers, would pay their own way in maintaining healthy, working bodies. In practice, the working poor relied on dispensaries to provide

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<sup>64</sup> "Report of the Pacific Dispensary for Women and Children," (San Francisco: 1876) San Francisco Public Library Collections.

real medical care since most workingmen's health schemes provided little more than sick pay prior to the rise of commercial health insurance. The resultant high demand for clinical care led the funders of free dispensaries to guard the limits of their relief mission. These constraints on intake sometimes overtook the original mission of charitable care. Beatrix Hoffman writes that "dispensaries in Northeastern cities became so crowded during the 1910s that by the end of the decade the public health committees of both the New York Academy of Medicine and the Rockefeller Foundation advocated charging fees for clinic admission."<sup>65</sup>

As in the Northeast, the problem of defining deserving and undeserving patients at the Portland Free Dispensary was contentious from the beginning. A common thread in the outcries against the supposed abuse of medical dispensaries was the pressure immigration was seen to exert on the charitable resources in urban areas.<sup>66</sup> The unprecedented growth of immigrant communities across the United States in the late 19<sup>th</sup> century commonly led to reactionary assertions of immigrants' intractability which characterized these groups as drains on public resources. In these circumstances, the free dispensaries of the West Coast were often closed off to Asian immigrants, who were prohibited from attaining citizenship by naturalization. In the aftermath of the 1906 earthquake, the *Oregonian* mentioned that "among the refugees were a few negroes and Chinese, but none of the latter applied to the relief committee as they were met and taken in charge by their countrymen in Portland."<sup>67</sup> Both relief workers and Portland press attempted to disqualify Chinese immigrants from the polity of the American West, thus admitting their status as refugees while at the same time denying their right to emergency care. Singling out black refugees, the *Oregonian* further reassured readers that relief

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<sup>65</sup> Hoffman, *The Wages of Sickness: The Politics of Health Insurance in Progressive America*, 19.

<sup>66</sup> See Nayan Shah, *Contagious Divides: Epidemics and Race in San Francisco's Chinatown*, (Berkeley: University of California Press, 2001).

<sup>67</sup> "Food and Rooms for Refugees," *Morning Oregonian*, April 23, 1906. Similar claims were made about the ineligibility of Japanese immigrants for medical care from civic organizations in the wake of the disaster. One newspaper account suggested that Japanese San Franciscans they should not receive domestic aid because the government of Japan had already appropriated relief funds for them. See "Japanese Care for Their Own," *Morning Oregonian*, May 4, 1906.

would be racially differentiated. In Oregon such limitations on the definition of deserving patients would likely not have been out of the ordinary given the long history of attempted black exclusion in the state.<sup>68</sup> These refugees of Asian and African descent, while not turned away from the city, were directed to segregated spaces for treatment. The earthquake relief work, as well as later public service medicine efforts, tended to reflect the divides that white elites overlaid on the civic body.

The People's Institute relief work also revealed suspicion towards women whose familial situations could not be fully accounted for. While the dispensary narrowed its aims to only meeting the needs of women and children in the following years, the arrival of unaccompanied refugee women during the earthquake relief effort was met with distrust from Portland's social reformers. In one instance, billed as a "Woman's Strange Story" by the *Oregonian*, the People's Institute and associated groups demonstrated their interest in refereeing refugees familial relations:

Among the refugees who arrived in Portland yesterday was a woman with two babies, one 2 months old and the other over 14 months of age. The woman told Ms. Lola G. Baldwin, of the Travelers' Association, that the youngest of the two babies was not her own and that she had picked it up on the streets of San Francisco during the panic which followed the earthquake. She wanted to keep the baby, but it was taken away from her and placed in the People's Institute. The woman in the afternoon demanded the baby, saying that it was her child. The baby bears marked resemblance to the woman, and the ladies of the Travelers' Aid Association believed that it was really her child and returned it to her. It is thought that the woman was looking for notoriety.<sup>69</sup>

Given the odd claim that the episode stemmed from the woman's desire for "notoriety," it is likely that the published account lacked some information regarding this woman and her children. The newspaper did, however, transmit a clear feeling on the part of the People's Institute that single women refugees with children were not trustworthy. The

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<sup>68</sup> See Ethan Johnson and Felicia Williams, "Desegregation and Multiculturalism in the Portland Public Schools," *Oregon Historical Quarterly* 111, no. 1 (2010): 6-11. On the composition of Oregon's constitution see David Alan Johnson, *Founding the Far West: California, Oregon, and Nevada, 1840-1890* (Berkeley: University of California Press, 1992), 139-188.

<sup>69</sup> "Refugees Are Few," *Oregonian*, May 2, 1906.

sources of this distrust were likely varied. Fears that such women were “immoral,” or that that she or her children might become public charges are two distinct possibilities. The People’s Institute fed on this indeterminate distrust and used the earthquake to assert its civic authority in mediating relations of social and physical care. In this situation, social workers could easily justify the seizure of a child with the reasonable belief that it had been orphaned. To elevate this claim to authority over the definition of redeemable family ties, the story was couched in the failings of the mother: lying and attention seeking. The absence of a father or husband in the account likely led readers to further doubt the moral standing of the woman in question.

In response to publicized moments of dubious moral character, the People’s Institute and Free Dispensary embarked on medical and social settlement projects that, its officials predicted, would be future sites of state control. In laying claims to far-reaching civic service, the administrators, reformers, and social workers of the People’s Institute and Free Dispensary cast themselves as a vanguard to future government efforts. They sought efficient public works through regulating physical health, family relations, and public morality. By strict definition, the Portland Free Dispensary was a private charitable enterprise. The board of the People’s Institute, however, advertised its various charitable efforts as instruments by which the health of the city would be guarded, and thus the will of the public enacted. To do so, they recounted a progressive historical understanding of healthcare and social work. “The record of history,” the board declared, “is such that upon the initiative of private philanthropy depends the recognition of public duty... philanthropy has rendered its most patriotic service by accepting as its mission the awakening and the stimulating of the state and nation.”<sup>70</sup> At some future time, the board contended, the government would provide every vital social service to “assist people into a physical condition where they can help themselves.”<sup>71</sup> In the meantime, the interests of the growing civic body would be overseen by private charitable funders. This justification for charitable involvement in the civic sphere led the volunteers of the People’s Institute and of the Free Dispensary to lobby Portland’s school board in order to

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<sup>70</sup> “A Resume of the Work of the People’s Institute for Fourteen Years,” (1917), Valentine Prichard Papers 1.1, Oregon Historical Society Research Library, 2.

<sup>71</sup> *Ibid*, 3.

ensure clean milk supplies, regular health inspections, and the hiring of an adequate number of public school nurses. They also claimed to be the originators of the move to build children's playgrounds in downtown Portland, arguing that such spaces would allow for the proper exercise and socialization which would improve young people's health in the city.<sup>72</sup>

### *A Step Beyond Public Health*

While the board governing the Portland Free Dispensary felt that their efforts were necessary to pick up the slack left by government agencies, Portland's municipal government also had a growing department of public health. Dr. Esther Pohl, one of the first women graduates of the University of Oregon Medical School, was the leading figure of the city's health board and health office between 1905 and 1909. Though founded in 1873, the Portland Health Board did not reserve a seat for a practicing physician until thirty years later in 1903. Dr. Pohl's tenure as a paid public health official in the city marked the first time that Portland's Health Board and Health Office were both headed by physicians. In 1907, Dr. Pohl was appointed as the city health officer. She immediately became well-known in the city for her swift response to a bubonic plague scare that had arisen on the Pacific Coast after the infection of twenty people in San Francisco. Dr. Pohl improved waste management on the city's waterfront, inaugurated a rat extermination campaign, and pushed for the city to fund a bacteriological laboratory. Despite Pohl's focus on residential sanitation, the city's offices tended to understand public health as a matter of protecting commercial interests. Dr. Pohl privately condemned this approach, insisting that public health must also address threats to household life and the "woman's sphere," but she found it necessary to adopt the city government's focus on commerce. Kimberly Jensen, Dr. Pohl's most recent biographer, writes that it was only after Pohl demonstrated the bubonic plague's threat to the city's shipping industry that "male commercial interests and the business-oriented city council came together rapidly to provide the funds and the political will to assist the health

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<sup>72</sup> See Brenin T. Wertz-Roth, "From Stumptown to Forest Park: 100 Years of Parks in Portland, Oregon" (Reed College, 2008), 67-69. See also "A Resume of the Work of the People's Institute for Fourteen Years," (1917).

department.”<sup>73</sup> Dr. Pohl’s tenure in the city’s health office was extraordinarily successful: no plague cases were recorded in Portland and the office recorded the lowest rates of death from disease of any major city. But she failed to focus the commerce-oriented city government on health issues that threatened women and private households in general. The People’s Institute and Free Dispensary attempted to fill this gap and to reconstitute the delivery of care to private families as a civic concern.

In conceptualizing a health mission that lay beyond the work pursued by the city’s public health office under Dr. Pohl, the People’s Institute fell back on the notion that their medical and social work would do far more for the city’s health than the beleaguered municipal health office could. The professionals in the city government understood public health as a matter limited to infrastructure and institutional reform. The People’s Institute and Free Dispensary, on the other hand, construed its public service medicine as a more flexible response to urban ills. Its nurses and social workers sought neighborhood involvement in private family practices, especially in the neighborhoods they identified as “most needy.”<sup>74</sup> Valentine Prichard wrote in 1907 that even when government agencies recognized their full role in combatting social ills, the efforts of civic-minded philanthropists would still be necessary:

For all agencies combined cannot keep pace with the evils consequent upon this lack of industrial and moral training, nor combat the influence of disorderly, ill-kept homes, counteract the physical effects of unsanitary living conditions, and overcome the demoralizing example of degraded ideals.<sup>75</sup>

Neither government agencies nor narrowly-focused medical clinics alone could effectively remedy the “degraded ideals” of “ill-kept homes.” While the operation of the Portland Free Dispensary strengthened the provisions for illness and injury treatment, Prichard clearly doubted that lobbying government health offices was the ultimate solution. She and her colleagues at the People’s Institute and Free Dispensary thus

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<sup>73</sup> Kimberley Jensen, *Oregon’s Doctor to the World: Esther Pohl Lovejoy and a Life in Activism*, (Seattle: University of Washington Press, 2012), 80.

<sup>74</sup> “A Resume of the Work of the People’s Institute for Fourteen Years,” (1917) Valentine Prichard Papers 1.1.

<sup>75</sup> Prichard, “Third Annual Report of the Institute Club of the People’s Institute,” (1907), Valentine Prichard Papers 1.3.

fostered a deep concern with the operations of individual homes and families which, they suspected, the city government could not fully control. Attempts at such control, she wrote, would always be the responsibility of private philanthropists working in the public sphere.

To this end, the various classes and clubs run by the People's Institute aspired to educate working-class Portlanders on proper social relations within the family. People's Institute social workers accordingly conceived maternalism as one pillar of the organization's work. The People's Institute Mother's Club heard lectures on "The Care of Babies," "The Glory of Motherhood," and "Methods of Punishment," which were delivered by male doctors from the University of Oregon Medical School.<sup>76</sup> Meetings of the Mother's Club were also used as fundraising opportunities; the attending women were expected to regularly contribute to a fund for the purchase of flowers for the sick. Additionally, the club voted in 1909 to appropriate its funds for the support of the Free Dispensary and agreed to hold a "bazaar" in order to raise additional funds for the clinic.<sup>77</sup> Such monetary demands on top of the attempts made by the People's Institute to define correct behaviors for women in families meant that the Mother's Club was not nearly as popular as the Free Dispensary or the People's Institute baby clinics and kindergarten, which provided urgently needed services. In some instances, volunteers from the dispensary and kindergarten paid home visits to the families who had used their services in order to compel women to participate in the Mother's Club.<sup>78</sup> In these cases, the People's Institute's use of maternalist ideals buoyed both its early clinical program and its social work. Free medical care and childcare were understood as stepping stones in a bid to gain influence within individual homes and to characterize these private intercessions of People's Institute social workers as a public service.

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<sup>76</sup> J.E. McOmber, "Fourth Annual Report of the People's Institute: Report of the Mother's Club," (1910), Valentine Prichard Papers 1.3, Oregon Historical Society Research Library.

<sup>77</sup> *Ibid.*

<sup>78</sup> See "Visiting Committee" in "Third Annual Report of the Institute Club of the People's Institute," (1909), Valentine Prichard Papers 1.3. On low attendance at the Mother's Club, see "Second Annual Report of the Social Settlement Work of the Institute Club of the People's Institute," (1908), Valentine Prichard Papers 1.3.

## *Immigration and the Health of the City*

The People's Institute's use of public service to push a standardized conception of proper household relations was most prominent in its engagement with immigrant populations in Portland. Beatrix Hoffman claims that patriotic rhetoric regarding the sanctity of free enterprise was at the center of efforts to rebuff socialized medicine legislation in New York.<sup>79</sup> The state of Oregon lacked such legislative efforts, and in their absence, medical charities claimed public service medicine to be a patriotic end in itself. People's Institute reformers cast free medical care and other social services as tools in the propagation of American civic nationalism by deploying their services to aid in the assimilation of recent immigrants.<sup>80</sup> They saw the Port of Portland as a liability not only in its capacity to spread disease, but also in that it allowed for the arrival of immigrants from both Europe and East Asia. The Free Dispensary had initially been set up on the north side of downtown Portland where "old rookeries and tenement houses [*sic*]" stood near the city's port on the Columbia River.<sup>81</sup> Even after the Free Dispensary and other People's Institute operations moved toward the center of the city, its administrators understood waterfront immigrant neighborhoods as being the source of civic ills.<sup>82</sup>

Some accounts from People's Institute officials played on the destitute surroundings that they perceived in immigrant neighborhoods in order to glorify their own work. Vida Nichols, one of the organization's social workers, recorded an account of administering a Christmas gift distribution in 1908. Her Dickensian description of Portland's waterfront, especially the squalid conditions of families living on scows,<sup>83</sup> was

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<sup>79</sup> See Hoffman *The Wages of Sickness: The Politics of Health Insurance in Progressive America*, 1-7.

<sup>80</sup> Civic nationalism refers to the understanding that immigrant assimilation into U.S. social and political practices would strengthen the American polity. See Gary Gerstle, *American Crucible: Race and Nation in the Twentieth Century* (Princeton: Princeton University Press, 2001), 7-10.

<sup>81</sup> "A Resume of the Work of the People's Institute for Fourteen Years," (1917).

<sup>82</sup> *Ibid.* The People's Institute relocated the Free Dispensary toward the center of downtown Portland in the early 1910s. The organization also moved its sewing school and to the Lower Albina neighborhood on the East Side due to its fast-growing immigrant population.

<sup>83</sup> Flat-bottomed river barges common on the Willamette and Columbia rivers up through the early 20<sup>th</sup> century.

meant to arouse pity for the family of a disabled child that had no money for food or gifts on Christmas. Of special interest to her was another family of “German Russian” origin:

They could speak no English, but none was needed, for they knew what brought us there. The little girls hugged their dolls for joy, and the little boy jumped up and down clapping his hands with delight... It is not necessary to tell you just what we gave to Luodiwig or to Vertle... But I do want to tell you how your gifts were received.<sup>84</sup>

Her account, clearly meant for the perusal of the People’s Institute benefactors, emphasized the foreignness of targeted neighborhoods. The work of the organization, according to Nichols, was powerful enough to cross the barriers of language and class, especially where children were concerned. Further, while the holiday mission was not medical in nature, Nichols wrote of gift-giving as if it ameliorated physical conditions in neighborhoods commonly described as the sites of a “tide of poverty, ignorance, [and] disease.”<sup>85</sup> She likely intended to show donors that the mission had been a great success in building neighborly emotional connections between working immigrant families and the People’s Institute. Such a success would have appeared to strengthen the organization’s influence within these families. Like all home visits made by People’s Institute social workers, however, the Christmas gift distribution was in part meant to increase attendance at the organization’s sewing school, cooking classes, and Mother’s Club.

By 1910, the Portland Free Dispensary had dropped all formal and informal restrictions against immigrants benefitting from aid work. Instead, for example, People’s Institute kindergarten teacher Katherine Gilbert reported that “many nationalities are represented in our school—Chinese, Syrian, German, French, Japanese, Polish, and others.”<sup>86</sup> According to Valentine Prichard, there was a clear reason for inclusive classes. She believed that if organizations like the People’s Institute did not “Americanize” recent

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<sup>84</sup> Vida Nichols, “Christmas Distribution,” (1908), Valentine Prichard Papers 1.3.

<sup>85</sup> Valentine Prichard, “Fourth Annual Report of the People’s Institute,” (1910), Valentine Prichard Papers 1.3.

<sup>86</sup> Katherine Gilbert, “The Kindergarten,” in “Fourth Annual Report of the People’s Institute,” (1910), Valentine Prichard Papers 1.3.

immigrants, then those immigrants would “foreignize our beloved land of freedom.”<sup>87</sup> In reports on the People’s Institute and Free Dispensary, she insisted that other cities’ public institutions were coming under the influence of foreign priests and atheists and that such a thing could not be allowed in Portland.<sup>88</sup> From her position as the supervisor of the People’s Institute social work and the Free Dispensary’s medical care, Prichard could ensure that the distribution of charitable medical aid was deployed among the city’s immigrant populations. The ultimate goal of such aid was to encourage immigrant families to engage in the People’s Institute education programs. In addition to the kindergarten for young children, this included sewing and cooking classes, clubs for young women that taught proper housekeeping, and a “boy’s brigade” meant to keep male adolescents out of the city’s juvenile courtrooms. These classes and clubs, according to Prichard, together composed a program of “Americanization.”<sup>89</sup>



Figure 6: People’s Institute Albina Branch Mother’s Club.

Image courtesy of People’s Institute and Free Dispensary glass lantern slides, OHSU Historical Collections and Archives.

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<sup>87</sup> Valentine Prichard, “Fourth Annual Report of the People’s Institute,” (1910), Valentine Prichard Papers 1.3, 17.

<sup>88</sup> These anxieties about priests on the one hand and atheists on the other are clearly contradictory, but they suggest a dual suspicion toward Communists (closely associated with atheism) and toward European Catholics.

<sup>89</sup> On the classes and clubs see Prichard, “Fourth Annual Report of the People’s Institute,” (1910).



Figure 7: People's Institute Boy's Cooking Class.

Image courtesy of People's Institute and Free Dispensary glass lantern slides, OHSU Historical Collections and Archives.

Efforts to engender immigrants' assimilation and to modify working-families' home lives lay at the center of the organization's mission and typified its commitment to a vision of health reform that initially targeted social relations rather than public works and legal reforms. Over its first two decades of operation, the People's Institute offices relocated as immigrant populations moved toward the center of the city. As its program continued, health reformers and social workers focused on poverty and especially disease in neighborhoods which they perceived as holding a foreign character. The preservation of the city's health, then, was synonymous with its Americanization. To reformers like Valentine Prichard, the preservation of civic health required methods that differed from those of public health officials in city and state governments. In bureaus like the Portland Health Office, protecting the public from ill-health meant finding creative methods to improve sanitation and regulate commerce, especially the production and sale of food. At the People's Institute, public service in the interest of good health meant regulating behaviors within individual homes. In its broadly-defined public service agenda, the People's Institute and Free Dispensary asserted its role as a vanguard in territories of future state control. Their prediction that the state would expand its control over medical delivery never came to pass. In the following years, however, the People's Institute

would respond to the demands and incentives of the state by putting all its resources into clinical care. As their program evolved, the leaders of the organization aimed to introduce “efficiency” into chaotic urban landscapes, rooting out the social ills resulting from its absence. The city itself was thus the object of the institute’s care so that even home health visits to private families and medical care provided to individuals could be recharacterized as crucial to the city’s wellbeing. As these latter functions overtook social work in the People’s Institute’s program, public service medicine rationales became increasingly important.

## Sexual Health in Wartime

The clearest mark of the ascension of clinical medicine in the People’s Institute program was its decision to admit venereal disease patients in the mid-1910s. This decision brought a group of patients into the Portland Free Dispensary who had previously been ignored due to the assumption that their illnesses were borne out of immorality. The change was brought about partially through federal incentives and orders at the start of the U.S. involvement in World War I and partially through efforts of People’s Institute administrators to reconcile progressive morals with the realities of public service medicine. The treatment of men with syphilis, for example, was often rationalized as a protective measure to ensure that the disease would not infect innocent women and children.<sup>90</sup> Regardless of reformers’ justifications, the effect of this change was the completion of the Portland Free Dispensary’s transformation into a medical clinic for the general population such that public service medicine superseded the People’s Institute’s former emphasis on strict moralism in its social program.

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<sup>90</sup> See Oregon State Board of Health, “Twelfth Biennial Report of the State Board of Health to the Governor of Oregon and the Thirty-Fourth Legislative Assembly: Annual Reports for the Years Ending December 31, 1924, 1925,” (1927) *OHSU Digital Collections*.

### *Syphilis as a Civic Emergency*

In the fall of 1912, a large group of reformist Portlanders responded to what they saw as a moral and medical crisis in the city. They formed the Social Hygiene Society of Portland and single-mindedly addressed the rising rates of syphilis infection that they perceived in the city at that time. As an endemic disease, syphilis was likely not increasing at drastic rates. Still, the Social Hygiene Society insisted that the rates of infection constituted a crisis. The society disseminated moral education pamphlets regarding sex and attempted to amend what they saw as a lack of proper medical care with regard to venereal disease. Members of the society were dispatched to give talks on social hygiene at public venues such as churches as well as in workplaces, especially saw mills. One talk was given to a gathering of Oregon National Guard officers in a Western Oregon town. Of special concern to the volunteers of the society was the proliferation of irreputable medical “specialists.” Their report described one specialist who had diagnosed a young man with syphilis when he actually suffered from acne. Another young man, anxious about nocturnal emissions, found himself coerced into an unsanitary surgery, the results of which required hospital recovery. The Social Hygiene Society alleged that these “specialists” charged exorbitant prices for false care and took advantage of the city’s uneducated young men. Venereal disease also threatened young men’s families: the report suggested that the true threat was to new families: “Supposing themselves cured, [syphilitic men] are marrying our daughters throughout the State—in many cases to spread the contagion, causing great mental and physical suffering to both innocent wives and future children... that the very integrity of Portland homes is threatened.”<sup>91</sup> Notably absent from the response to this new threat to the city’s families were the leading officials of the Portland Free Dispensary.

In its early years of operation, the Free Dispensary ignored sexual health and did not treat venereal disease. Even in their capacity as officials of the People’s Institute, Valentine Prichard and other reformers expressed some ambivalence about regulating

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<sup>91</sup> “A Social Emergency: The First Annual Report of the Social Hygiene Society of Portland, Oregon,” (1912), OHSU Digital Collections, 5-7. On public talks, see pp. 21-25. On testimonials regarding “quackery,” see pp. 26-29.

sexual behavior and sexual health. Given the organization's strict stances against vice and its focus on "deserving" mothers and children, its officials likely sought to distance themselves from any service seen to be connected with such behaviors. Like the Social Hygiene Society, the officials of the Free Dispensary expressed some concern over the incidence of juvenile crime. Both, too, linked the growing popularity of vaudeville theaters and especially commercial dance halls to sexual impropriety.<sup>92</sup> Otherwise, through its first decade of operation, the Portland Free Dispensary was content to ignore what the members of the Social Hygiene Society saw as a venereal disease crisis. Treatment of syphilis did not easily fit within the People's Institute and Free Dispensary's doctrine of providing "friendly aid" primarily to children and mothers.<sup>93</sup> Beginning around 1917, however, federal intervention in the dispensation of medicine and charitable care shifted the operations of the People's Institute and Free Dispensary.

The U.S. involvement in the First World War sparked a dramatic rise in efforts at improving social hygiene and physical health among men within the United States. Nancy Bristow claims that during World War I social reformers concerted their efforts toward the enforcement of middle-class moral standards in domestic military camps. Moralists, she writes, insisted that the military act to prevent the spread of venereal disease; this was the central facet in a plan meant to improve social hygiene. Military moralists also discouraged drinking and prostitution while encouraging approved recreational activities. Bristow focuses on the Commission on Training Camp Activities, a federal body founded to inject Progressive Era notions of moral propriety into the social life of the expanding military. For working-class soldiers, athletics were meant to "remake recreation into a training ground for middle class culture" at the same time as

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<sup>92</sup> There was a significant moral scare regarding dance halls in Portland in 1914, see below. On attempts to censor vaudeville theater see "Minutes of the People's Institute and Free Dispensary," January 27, 1910, Valentine Prichard Papers, 1.4. This report details participation in the Affiliated Committee of Social Service and notes that "The first work of this committee was to attempt to create a censorship for the low theater and vaudeville."

<sup>93</sup> This phrase was commonly stated in reports and other public documents from the People's Institute and Free Dispensary. See, for example, "People's Institute and Portland Free Dispensary, 1920" (1920). *Public Health in Oregon: Discovering Historical Data*. This doctrine of care was also sometimes summarized as "general neighborliness. See "People's Institute History, 1907-1918," (1919) Valentine Prichard Papers, 1.1.

they combatted “the threat of feminization” among middle class intellectuals.<sup>94</sup> In all, Bristow claims that progressive reforms in the growing armed forces were meant to replace punitive controls with an “invisible armor” of internalized controls that would “protect the soldiers from the dangers posed to their physical and moral health.”<sup>95</sup> The commission’s ideological framework defined disease as a moral failing and thus as a miscarriage of masculinity. This maneuver was rhetorically useful for federal officials intent on demonstrating the success of the Commission on Training Camp Activities, but it certainly did not eradicate vice or stymie the spread of venereal disease among military personnel or the general population.

In the final years of World War I and in the postwar years, many civilian medical organizations took up the responsibility of providing care to those affected by wartime disease scares, notably those surrounding influenza and syphilis.<sup>96</sup> As the urgency of mass medical care heightened, the Portland Free Dispensary became by far the most significant department of the People’s Institute. While the organization continued to claim a special call to the care of women and children, it reoriented its actual services during and after the war toward the care of patients with venereal disease, most of whom were men. This shift fundamentally altered the Portland Free Dispensary’s definition of who deserved care, even as Valentine Prichard and other administrators attempted to reinforce its image as a charitable institution for women and children.

### *The People’s Institute and Prewar Sexual Morality*

The People’s Institute and Free Dispensary generally limited its prewar engagement with issues of sexual health and morality to interventions regarding dancing and theater. In December of 1913, Valentine Prichard wrote to the Portland Board of Education requesting the use of a gymnasium for a recurring folk dancing event. She wrote, “We recognize the fact that wholesome amusement is necessary for the physical

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<sup>94</sup> Nancy Bristow, *Making Men Moral: Social Engineering and the Great War*, (New York: New York University Press, 1996), 37-38.

<sup>95</sup> *Ibid*, 15.

<sup>96</sup> On responses to the influenza epidemic in the United States see Nancy K. Bristow, *American Pandemic: The Lost Worlds of the 1918 Influenza Epidemic* (Oxford: Oxford University Press, 2012).

and moral well-being of every individual. We believe dancing to be a perfectly natural and wholesome recreation when conducted under the right conditions.”<sup>97</sup> Folk dancing, she implied, was not sexual and would thus be a useful tool in the maintenance of public health and moral standards. This plan, however, had to be delayed due to an “agitation regarding dancing” in early 1914.<sup>98</sup> The board members of the People’s Institute described this agitation in more specific terms:

The initiation of this subject was brought about by the closing of the public dance halls by the license committee of the City Council, January 5th. This action was due to the presentation to the Council by the Department of Public Safety for Women of startling facts which showed conclusively the demoralizing influence of these dance halls, which in many instances cited had led to debauchery, vice, and immorality. Those interested realized that some form of recreation is necessary to take the place of the dance halls and desire to substitute something which shall be clean and wholesome in its influence.<sup>99</sup>

As the city government cracked down on dance venues that had been decried as places of vice, the People’s Institute promoted folk dancing as a cleaner alternative to commercial dance halls—the monetary benefits of which might be funneled into their own charitable work. Still, Prichard saw too great a possibility for controversy in holding a dance event under the auspices of the People’s Institute and the school board until the “agitation” around dancing had subsided. While these letters implied that commercial dance halls created an unhealthy sexual environment, they did not suggest the Portland Free Dispensary would have any hand in treating the infections that might result. Instead, they offered up communal activities as preventative remedies. The officials of the People’s Institute contrasted the abstract dangers of “vice” and “debauchery” with the concrete benefits that they saw stemming from physical exercise in the form of unproblematic folk dancing. The connection between physical health and forms of dancing deemed proper or improper was so evident that Prichard received a letter from the Episcopalian chaplain of

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<sup>97</sup> Valentine Prichard, “Letter to the Portland Board of Education,” December 23, 1914, Valentine Prichard Papers, 1.12.

<sup>98</sup> Prichard, “Letter to the Portland Board of Education,” March 5, 1914, Valentine Prichard Papers, 1.12.

<sup>99</sup> Institute Club of the People’s Institute, “Letter to the Board of Park Commissioners,” 1914, Valentine Prichard Papers, 1.10.

Portland’s Good Samaritan Hospital requesting to cooperate on the effort to “[provide] municipal or other non-commercial dances or other forms of recreation in our city.”<sup>100</sup> It is striking that for Prichard and the Good Samaritan chaplain the distinguishing feature of a moral dance event was its affiliation with the city government or with a charitable organization. In the early 1910s, the People’s Institute and Free Dispensary thus associated their brand of public service with sexual morality while deemphasizing the treatment of venereal disease.



Figure 8: Correctional Exercises—Nutritional Clinic.

Image courtesy of People’s Institute and Free Dispensary glass lantern slides, OHSU Historical Collections and Archives. This photograph and others like it were used by the People’s Institute to reiterate its commitment to children’s health as it expanded its clinical care to serve venereal disease patients.

### *The Shift to Clinical Care*

Following the United States’ entry in the First World War the Portland Free Dispensary began to address the spread of venereal disease as a primary concern due to the intervention of the federal government in matters of public health. Officially, the People’s Institute and Free Dispensary confirmed their commitment to the war effort. The organization immediately began cooperation with larger public and private agencies,

<sup>100</sup> Frederick K. Howard, “Letter to Valentine Prichard,” February 22, 1914.

namely the Red Cross and the federal Bureau for Civilian Medical Relief, which provided specifically for the medical care of soldiers' families.<sup>101</sup> The board of the People's Institute also willingly consented when in 1918 the city government requested to repurpose its headquarters to house ship builders. These adjustments to the charity work of the People's Institute and Free Dispensary did, however, cause some consternation among the organization's officials. They objected to refocusing their entire mission, writing that "it would be the greatest lack of wisdom to allow our own city to suffer for the need of Social Service Work, or to withdraw our hand at this time from the work we have furthered for fourteen years."<sup>102</sup> Prichard and others who had been especially drawn to Jane Addams' settlement work may have been given pause, especially when Addams herself expressed clear opposition to the war.<sup>103</sup> Whereas outpatient care had previously been only one part of the organization's broader settlement work, during and after the war it reoriented all its resources toward the clinical aspects of public service medicine.

Nonetheless, the main adjustment to the work of the People's Institute and Free Dispensary occurred without protest. This included the opening and enlargement of a special clinic for venereal disease patients. The organization's second report on wartime activities read:

In connection with the dispensary, we have this summer, at the request of the City Health Board and in cooperation with them, enlarged the clinic for syphilitic [*sic*] patients, providing for a clinic from 12 to 1 o'clock, twice a week, and another clinic from 5 to 7 o'clock on Friday afternoon, thus caring for both men and women. This came as a request from the [Federal] Government to the City, and as the City is assisting financially in the work of the dispensary, they requested our cooperation in this work.<sup>104</sup>

The incentive to open and continue the operation of this clinic came not only from federal and municipal funds, but also from promised support from the state government.

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<sup>101</sup> Helen Ladd Corbett, "Letter to Rufus Holman, Chairman of the Multnomah County Commissioners," October 24, 1918, Valentine Prichard Papers, 1.11.

<sup>102</sup> "Report of the Readjustment of the work of the People's Institute," (1918), Valentine Prichard Papers, 2.11.

<sup>103</sup> Louise W. Knight, *Citizen: Jane Addams and the Struggle for Democracy* (Chicago: University of Chicago Press, 2005), 405-406.

<sup>104</sup> "Report of the Readjustment of the work of the People's Institute," (1918).

Additional equipment and staffing came from the University of Oregon Medical School, thus compounding the clinic's value to the dispensary.<sup>105</sup> In taking up the position as the major provider of care for venereal disease in Portland, the officials of the Free Dispensary began to send monthly reports to the Oregon State Director for Venereal Disease Control and to the office of the Surgeon General in Washington, D.C. These reports detailed solely the numbers of venereal disease patients, and in return the Portland Free Dispensary received informational pamphlets from the Assistant Surgeon General to distribute in the city.<sup>106</sup> The venereal disease clinic served as a way of both fulfilling the request for medical work toward the war effort while satisfying the People's Institute's interest in maintaining its social service work in Portland. The Portland Free Dispensary's growth demonstrated that, in accepting this line of work, the organization had dramatically altered its medical program while coming under the increasing influence of state supervision and direction.

Opening the Portland Free Dispensary to venereal disease patients brought in an unprecedented number of men. With the concomitant growth in total patient numbers, the People's Institute emphasized its dispensary work above all other projects, even to the point of exaggerating its importance. In a letter to Valentine Prichard, Lola Baldwin, then a regional supervisor of the Commission on Camp Training Activities wrote, "I would advise that you give especial attention and play up the V.D. cases in your reports."<sup>107</sup> Clearly, treating syphilitic patients had become one of the highest priorities for local military officials who bluntly communicated that priority to clinical providers. Over the course of 1919, the Portland Free Dispensary reported that it treated 7,063 patients and dispensed 1,884 syphilis treatments, more than for any other disease.<sup>108</sup> One in every two

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<sup>105</sup> See "Tentative Agreement between the University of Oregon Medical School and the Oregon State Board of Health to establish a free venereal dispensary," (1919), *Public Health in Oregon: Discovering Historical Data*.

<sup>106</sup> See C.C. Pierce, "Letter to Dr. H.W. Howard," August 21, 1919, *Public Health in Oregon: Discovering Historical Data*. See also C.C. Pierce, "Letter to the Portland Free Dispensary," March 29, 1919.

<sup>107</sup> Lola Baldwin, "Letter to Valentine Prichard," December 16, 1918, *Public Health in Oregon: Discovering Historical Data*.

<sup>108</sup> "Statistical Report of the Portland Free Dispensary," (1920), *Public Health in Oregon: Discovering Historical Data*.

of these patients was an adult man. Regardless of whether these reports did, in fact, represent an exaggeration of the venereal disease numbers, this report showed that the Portland Free Dispensary was treating far more patients, and far more men, in the direct aftermath of World War I than it ever had before. Clearly the Portland Free Dispensary had, to some extent, departed in practice from its originally stated mission of providing friendly aid to the women and children in Portland's needy neighborhoods.

This shift soon became permanent because the demand for clinical care that focused on the treatment of infectious disease remained high. This was true for charity medical associations across the Northwestern United States especially during the 1918 influenza pandemic. Public use of free dispensaries as well as the services of the American Red Cross spiked during this period, and the organizations responded in turn with emergency services. Many handed out "epidemic masks" as soon as the gravity of the influenza infections became clear. In Seattle, the Red Cross headquarters for the Northwestern U.S. reported that "at one time during the first day the line [for epidemic masks] was two blocks long."<sup>109</sup> By the end of 1918, clinical treatment of patients with infectious diseases had become a heroic cause in its own right. The Northwest Red Cross' head of nursing connected this calling to the organization's broader wartime mission and lauded, "[the] nurses, nurses aids... and many other Red Cross workers—several even giving their lives for the cause—during our recent terrible epidemic."<sup>110</sup> Nurses, some of whom died in the line of duty, would continue to take up the mantle of clinical care characterized as a direct public service. Just as with the more long-term threat of venereal disease, the acute crisis over influenza the resultant public needs continued to reinforce the need for public service medicine.

While some officials at the People's Institute and Free Dispensary might have preferred to return to the prewar program of family-focused social settlement work, scaling back the Portland Free Dispensary's clinical work would have proved impossible. The wartime form of the dispensary came to dominate the program of the People's

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<sup>109</sup> *American Red Cross Society Scrapbooks*, no. 2, Pacific Northwest Scrapbook Collection, University of Washington Special Collections and Archives.

<sup>110</sup> May S. Loomis, "Nursing," in *American Red Cross Society Scrapbooks*, no. 2, Pacific Northwest Scrapbook Collection.

Institute in the postwar period, limiting the organization to funding clinical care. In 1918, Prichard's colleague at the Commission on Training Camp Activities expressed that it was vital "that the city clinics be put on a firm basis in the After War Program," in other words that they remain focused on the care of patients with infectious diseases.<sup>111</sup> In 1920, the People's Institute fully met this suggestion. A published statement on the organizations "Change in Work" read:

In 1920 the work of the Dispensary had grown to such an extent that it was deemed wise to discontinue all educational and industrial work, which included many clubs and classes for children and adults and in the future to carry on only the work of the Dispensary which includes medical, social, and friendly aid and health education.<sup>112</sup>

By this time, the clinical work of the Portland Free Dispensary had become the sole beneficiary of the People's Institute's funds. This was also the year when the organization was officially retitled as the People's Institute and Free Dispensary. While the organization continued to advertise itself as being primarily focused on the health of women and children, the 1919 trend of men comprising the majority of patients continued throughout the 1920s. Furthermore, venereal disease remained the most common condition treated, often followed closely by tuberculosis. From its broad origins in social settlement work focused on influencing mothers and educating children as well as treating patients, the People's Institute and Free Dispensary had fully transitioned to an outpatient medical clinic, expressing a narrowed, scientific understanding of public service medicine.

While the social workers of the People's Institute often saw medical care as a tool to exert control over working class families, the organization also worked to fit the moral principles of its operation to the ever-growing demand for clinical care. Many historians have claimed that the Progressive Era atmosphere of moral reform, social hygiene, and racial exclusion shaped the operation of medical institutions.<sup>113</sup> The ways in which

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<sup>111</sup> Lola Baldwin, "Letter to Valentine Prichard," December 16, 1918.

<sup>112</sup> "Statements Regarding the People's Institute and Free Dispensary," (1920), *Public Health in Oregon: Discovering Historical Data*.

<sup>113</sup> See primarily Sloane, "'Not Designed to Merely Heal': Women Reformers and the Emergence of Children's Hospitals," 331-354. See also Christopher McKnight Nichols and Nancy C. Unger, ed., *A Companion to the Gilded Age and Progressive Era*, Wiley-

medical practitioners and reformers shifted and expanded their definitions of who deserved care in response to civic needs have received less attention but are equally significant. The Portland Free Dispensary's place as a provider of public service medicine within the People's Institute demonstrates the extent to which medical projects could be fitted around broad notions of reform—in this case, Americanization of immigrants and the moral education of children and young mothers. The continuing development of the People's Institute and Free Dispensary, however, shows the ways in which the moral precepts and prerogatives of Progressive Era reform were used to justify the exigencies of clinical care, especially in situations of state intervention. This organization, at first content to ignore those men and women infected with venereal disease as deserving patients, entirely restructured its medical and social work around outpatient care, distributed in large part to those suffering from syphilis. This shift was a response both to federal power and to the alterations in state health doctrines that arose around the time of the First World War in response to new epidemics. While still claiming their positions as guardians of Portland's women and children, after the war the officials of the People's Institute and Free Dispensary cast their lots with the rising demand for clinical care. This meant serving large numbers of male patients and upending the delivery of the institute's gendered mission. They continued to assert the organization's roots in social settlement work but could not deny that the distribution of medicine had permanently altered their vision of public service. This alteration to the People's Institute program showed that clinical practitioners had a robust claim to guardianship of the public good—that medicine had become the most strongly-established facet of the People's Institute's many projects.

As Valentine Prichard and the board of the People's Institute oversaw a definitive shift to clinical care, and thus a crystallization in the delivery of public service medicine, the work needed to maintain the organization also changed. Professional social workers would no longer be the backbone of the People's Institute as the Free Dispensary grew in importance. Instead, medical practitioners became its most important care providers.

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Blackwell Companions to American History (Chichester: Wiley-Blackwell, 2017), as well as Andrew Wear ed., *Medicine in Society: Historical Essays* (Cambridge: Cambridge University Press, 1992), 4-12.

Specifically, the People's Institute became even more reliant on nurses. While university-trained physicians lent the organization an appearance of scientific expertise, their work was voluntary and intermittent. Therefore, a paid corps of full-time nurses was the most necessary element in continuing the expanded mission of the Portland Free Dispensary. This development occurred at a moment of similarly significant transition in the field of nursing as a whole, both in Oregon and throughout the United States. Nurses often led transitions to the clinical focus of public service medicine, and, in turn, deployed their service as evidence of their own professional status.



## Chapter 2. “Her Unspoken Creed”: The Making of Civic Ideologies in Nursing

Grace Phelps (1871-1952) began her career serving as a private-duty nurse, traveling to afflicted homes and providing care at a daily rate, and ended it as the most important leader among Portland’s hospital nurses in the 1920s. In the preceding decades, while the Visiting Nurses Association and the Portland Free Dispensary established their neighborhood-focused public service medicine programs, Phelps built credentials as a registered hospital nurse and Red Cross volunteer. Then, in 1917, she agreed to recruit and command a unit of Oregon nurses which would soon serve in France during the final year of the First World War. As hospital nursing expanded in postwar Portland, Phelps’ broad experience, and especially her widely-recognized patriotic service, resulted in her instatement as a superintendent of nursing at the University of Oregon Medical School. At the same time, the Visiting Nurses Association began to incorporate its well-established public service medicine projects into the university’s growing hospital system. Phelps oversaw the centralization of inpatient and outpatient care under the purview of university hospitals, which relied on the consolidation of multiple strains of nursing work. Approaching this moment during which Portland’s diffuse civic health associations entered increasingly close orbit with an emerging hospital system requires an examination of the work of the city’s visiting nurses and military nurses, whose claims to civic and professional duties departed from traditional private-duty nursing and anchored the practice of public service medicine.

In 1859, Florence Nightingale wrote her *Notes on Nursing* as a guide to anyone taking charge of the care of a sick person. She intended it not as an exhaustive textbook on the subject, but as a set of basic principles which could guide both trained and untrained nurses. Insisting that the practice of nursing involved far more than the “administration of medicines,” she wrote that “it ought to signify the proper use of fresh air, light, warmth, cleanliness, quiet, and the proper selection and administration of diet—

all at the least expense of vital power to the patient.”<sup>114</sup> The greater part of her advice lived up to this claim: she instructed readers on the proper manipulation of the household environment to promote good health in recuperating bodies. To the extent that she wrote about hospital work, she emphasized most of all its similarities with home nursing, suggesting that the best hospital environment emulated that of a clean, well-ventilated home.<sup>115</sup> Nightingale cast herself a reformer and a promoter of nursing as paid work, and in doing so she reaffirmed the traditional understanding that nursing was women’s work and that it relied most of all on a religious commitment to care.<sup>116</sup> For Nightingale and her contemporaries, the primary site of peacetime nursing was the home. Nursing, while optimally the domain of skilled, paid women, retained its status as an extension of domestic work.

Early 20<sup>th</sup>-century nurses, in contrast, pushed their work into the civic sphere, but still relied heavily on the practical methods of Nightingale’s handbook. Some historians have conflated this development with the emergence of “public health nursing” half a century after the publication of Nightingale’s work.<sup>117</sup> The central tenets of public health nursing were understood to be nutrition, home hygiene, obstetrics, and childcare.<sup>118</sup> These focuses drew directly on Nightingale’s environmental understanding of proper care, but applied it emphatically to the public sphere, rather than the home of an individual patient. While historians have traced clear differentiations between public

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<sup>114</sup> Florence Nightingale, *Notes on Nursing: What It Is, and What It Is Not*, First edition. (Philadelphia: Lippincott Williams & Wilkins, 1992), 11.

<sup>115</sup> *Ibid*, 10, 41.

<sup>116</sup> See Lynn McDonald, “Introduction to Volume 12,” *Florence Nightingale: The Nightingale School*, (Waterloo, Ontario: Wilfred Laurier University Press, 2009), 2-12.

<sup>117</sup> Barbara Melosh suggests that the term “public health nursing” was coined in 1912. She associates it especially with the work of Lillian Wald in Chicago and Mary Sewall Gardener in Providence, Rhode Island. See Melosh, *The Physician’s Hand’: Work Culture and Conflict in American Nursing*, 116-120; see also Mary Sewall Gardner, *Public Health Nursing* (New York: The Macmillan company, 1919). David Schuster places the origin of public health nursing much earlier in 1893 and also attributes it to Lillian Wald, see Schuster, “The Rise of a Modern Concept of ‘Health,’” Christopher McKnight Nichols and Nancy C. Unger, eds., *A Companion to the Gilded Age and Progressive Era*, Wiley-Blackwell Companions to American History (Chichester, West Sussex: Wiley-Blackwell, 2017), 255-267.

<sup>118</sup> See Melosh, *The Physician’s Hand’: Work Culture and Conflict in American Nursing*, 156.

health nursing and hospital nursing from the 1930s onwards, an examination of its emergence in the first two decades of the twentieth century brings up the ambiguities in this categorization.<sup>119</sup> The multivalent health programs pursued in this period by municipal offices, local hospitals, and medical charities like the Portland Free Dispensary all relied on nursing work. Often, the same nurses found work across these bodies and performed both patient care and civic service, such as home visits, child care, and health education. Importantly, nurses themselves formulated their own responses to city health problems by founding visiting nurses associations, which dispatched care providers to poor families for a nominal fee. These nurses adapted the home care techniques of private-duty nursing to the practice of public service medicine. Instead of claiming “public health nurse” as a specific title, they would have distinguished their civic work from the work of private-duty nurses, who provided independent home care.

In this period, both private-duty nurses and institutionally employed nurses were confronted with the question of professionalization. Between 1873 and 1900, the number of nursing schools in the United States grew from three to 432, and at the same time many states established nursing certification boards.<sup>120</sup> Consequentially, the proportion of formally trained nurses in the U.S. grew rapidly. By 1900, many American nurses felt that, like physicians, they should have legal and professional regulations governing their work. Other nurses asserted that this would mean reducing the nurse’s work to a cash-for-service transaction, robbing it of its traditional feminized meanings. In *‘The Physician’s Hand’: Work Culture and Conflict in American Nursing*, Barbara Melosh describes the situation of those who sought professional recognition for nurses as contradictory. Commenting on women’s virtual monopoly on nursing work, she writes, “I would argue there can be no women’s profession. We can identify female members of professions, but even our ways of speaking about them betray the anomaly of women in these positions:

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<sup>119</sup> The *American Journal of Nursing* did not dedicate a section of its publication to “Public Health Nursing” until 1919. Instead, it covered activities relating to “Visiting Nursing and Social Welfare.” On public health as a distinct medical field see Elizabeth Fee and Dorothy Porter, “Public Health, Preventative Medicine, and Professionalization: England and America in the 19<sup>th</sup> Century,” Andrew Wear, ed., *Medicine in Society: Historical Essays* (Cambridge: Cambridge University Press, 1992), 249-275.

<sup>120</sup> Schuster, “The Rise of a Modern Concept of ‘Health,’” 259.

we mark their exceptional character by referring to a ‘woman doctor,’ a ‘woman lawyer.’”<sup>121</sup> In essence, she claims, professions understood to be dominated by women struggle to find broad recognition as professions at all.

Nonetheless, historians must reckon with the fact that from the start of the 20<sup>th</sup> century many nurses, and especially leaders of nurse’s associations, doggedly asserted their and their colleagues professional standing. For nurses, this specifically meant attempting to alter the politics of civic service and medical care. Most studies of professionalization in nursing have pointed out the various central contradictions of the job. Fred Davis’ 1966 sociological collection *The Nursing Profession* describes one of the most important of these contradictions: “in popular parlance, the same, unmodified nouns ‘nurse’ and ‘nursing’ should be applied so indiscriminately to a wide variety of healthcare activities... that includes some of the least educated members of society... and some of the most.”<sup>122</sup> Melosh excavates this claim by describing the construction of a professional superstructure over top of traditional forms of nursing, which in turn led to the demarcation of an elite within the field. Technical training, she writes, was an attempt to rectify an even more basic paradox in nursing: “Men, to establish their professional legitimacy, had to assert a stronger claim to service; women, to achieve the same end, had to escape the diffuse notion of womanly service.”<sup>123</sup> This principle was especially apparent in the operation of free dispensaries at which physicians offered their labor for free in order to claim an exceptional dedication to their work. More recent studies have continued to shed light on the continuous devaluation of care work due to its perceived closeness with unpaid feminized service. Eileen Boris and Rhacel Salazar Parreñas write that professional care “loses its status as a labor of love and becomes regarded as unskilled work that anyone can perform because women have undertaken such activities without payment.”<sup>124</sup> Still, the origins of public health nursing lie within these

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<sup>121</sup> Melosh, *The Physician’s Hand’: Work Culture and Conflict in American Nursing*, 20.

<sup>122</sup> Fred Davis, ed., *The Nursing Profession: Five Sociological Essays* (New York: John Wiley & Sons, 1966), vii.

<sup>123</sup> Melosh, *The Physician’s Hand’: Work Culture and Conflict in American Nursing*, 25.

<sup>124</sup> Eileen Boris and Rhacel Parreñas, eds., *Intimate Labors: Cultures, Technologies, and the Politics of Care* (Stanford: Stanford Social Sciences, 2010), 11.

contradictions. Public-minded women sought ways to remake old assumptions about nursing in order to legitimize their work as a skilled, service-oriented vocation.

In Portland, these efforts reached their zenith during the First World War in concert with the People's Institute's expanding program of public service medicine. Nurses who remained in Oregon formed the backbone of this program through their service in the Portland's Visiting Nurses Association. Meanwhile, the unprecedented number of nurses who volunteered to serve in the Army Corps of Nurses returned to Portland with patriotic, as well as civic, justifications for their care. Practicing public service medicine led Oregon nurses to establish civic aid groups, professional registries, and eventually to invest in the creation of a professional association for educated and licensed practitioners. In the early 1920s, this final development was a critical piece of the expansion of the University of Oregon medical campus on Marquam Hill.

The later emergence of public health nursing was made possible first by a growing articulation of women's medical care as a service performed for the civic body, rather than for individual households. The impulses and projects that would later be understood as a concerted effort at public health nursing began in the first two decades of the 20<sup>th</sup> century in the form of nurses attempting to reorient their feminized service into the realm of public service medicine. Both doctors and patients tended to relegate the work of private-duty nurses to that of marginal domestic aid confined to the home space and associated strongly with feminized or familial service. Responding to these workplace constraints, nurses used their critical roles in public service medicine, and later in military medicine, to recast their labor as central to the wellbeing of the larger civic body. Service in visiting nurses' associations, free dispensaries, and in the Army Corps of Nurses substantiated this pivot toward public service, which straddled the distinctions between home care, outpatient care, and preventative care. Asserting a place in the public sphere, however, often prompted reactions that policed individual nurses' moral characters and the nature of their participation in public life.

## Imagining the Frontier Nurse

At the turn of the twentieth century, shifts in the social meanings of medical practice were becoming apparent especially in western states, including Oregon. The bulk of public health work took place in rapidly growing urban areas, while sparse networks of private medical providers remained the primary avenues for healthcare in rural counties. Private-duty nurses took up a critical role in these networks, serving as flexible care providers with or without the support of predominately-male physicians.<sup>125</sup> In some cases, alliances between rural nurses and philanthropic societies led to formalized systems for dispatching medical aid to remote communities. In Leslie County, Kentucky, for example, Mary Breckenridge founded the Frontier Nursing Service in 1925, mainly as an obstetrical service. She characterized the rural Appalachian zones of the country as a “forgotten frontier,” set apart from the medical advances of the urban United States, and understood mobile nursing to be the most efficient solution to public health problems in such areas.<sup>126</sup> Breckenridge wrote that “the rule of our service is simple—if a father can come for us, the nurse can go with him. On the stormiest winter nights, when the streams are half-covered with ice, the nurses go out on their calls, and they get about even when Uncle Sam’s muleback mail service stays home.”<sup>127</sup> With this statement, she asserted that her nurses could go toe-to-toe with Kentuckian fathers and mail carriers in the navigation of treacherous Appalachian hinterlands. Taking the opportunity to define the public service role that she and her colleagues played, she combined the feminized work of midwifery and infant care with a claim to mastery over the frontier landscape usually associated only with men. Much like Breckenridge, private-duty nurses provided critical care across the rural United States. their work, however, was more commonly defined in

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<sup>125</sup> On the requirements and risks of private-duty nursing, see Melosh, *The Physician’s Hand: Work Culture and Conflict in American Nursing*, 77-101

<sup>126</sup> Mary Breckenridge, “Maternity in the Mountains,” *The North American Review* 226, no. 6 (1928): 765-768. It has also been noted in recent historical descriptions of Breckenridge’s work, that she was a staunch eugenicist. Without a doubt, this commitment affected her obstetrical work.

<sup>127</sup> *Ibid*, 768.

relation to that of male physicians: voluntary rather than professional, and oriented toward domestic maintenance rather than public service medicine.

The biographies of medical professionals often served to express the perceived transition from frontier to urban society. Additionally, such accounts also served to assign domestic or maternalist qualities to nursing in contrast with the masculine professionalism associated with the work of physicians. Popular narratives included those of late-19<sup>th</sup> century doctors who, instead of being tied to any particular institution, served entire communities. These short biographical accounts commonly emphasized the long journeys that country doctors were reputed to make to see to patients, making note if a doctor was well-known for being an “excellent horseman.”<sup>128</sup> In his 1937 history of medicine in Oregon’s John Day Valley, Roderick Begg alleged that Dr. William Franklin Pruden would travel over ninety miles using relays of horses. These frantic medical races were, according to Begg, usually to perform amputations or other desperate surgeries with the help of candlelight and “anesthetic... administered by the country veterinarian.”<sup>129</sup> Other physicians were singled out for their business sense. In his account of doctors in Oregon, Olof Larsell mentioned one doctor who owned a quicksilver mine and another who “practiced medicine and ran a hotel and feed barn.”<sup>130</sup> These stories, retold in published works beginning in the 1920s, fed the idea that the landscape of the rural Northwest required a certain sort of masculinity from its doctors. A combination of unsightly treatments, decisiveness, public service, and profit seemed to define the successes and failures of the archetypical country doctor.<sup>131</sup>

Nursing practices were far less visible in narratives of this type, but by no means invisible. The prosecution of urgent medical care in isolated places did often fall on nurses, but Larsell gave only slight recognition of the role of nursing in *The Doctor in Oregon*. Still, his sources reveal that the peripatetic frontier doctor could hardly be relied

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<sup>128</sup> “Notes,” OHSU Historical Collections and Archives, Olof Larsell papers, box 4.1.

<sup>129</sup> Roderick E. Begg, *A History of Medicine in the John Day Valley*, (1937). See also Olof Larsell papers, box 4.1.

<sup>130</sup> Olof Larsell papers, box 4.1. Larsell suggested that the mine ownership was very common on the West Coast among doctors “and other professional men in the old gold-rush days.”

<sup>131</sup> Larsell also tended to valorize doctors for service in the Civil War or in the Rogue River War and other hostile actions against the Indian nations of the Northwest.

upon for care in all cases. In an 1868 letter to the *Oregon Sentinel*, one doctor admitted that in the case of a smallpox outbreak, “medicine will not arrest the disease,” and that “a skillful nurse can do almost as much as a doctor.”<sup>132</sup> He then noted that the most effective action against the disease had to do with controlling the patient’s diet and the cleanliness of their environment. This, he assumed, was the realm of the nurse. A similar characterization of rural, in-home nursing appeared in a short biography memorializing the life of Grace Phelps.



Figure 9: Portrait of Grace Phelps in Red Cross Uniform (1918).

Image courtesy of OHSU Digital Collections.

By the time of her death in 1952, Phelps was known in Portland for her role as a senior army nurse during World War I and as the founder of the Oregon State Graduate Nurses Association. Her biography, written by her brother-in-law Sylvanus Kingsley, focused instead on her time as a private-duty nurse before she took up official positions at the Red Cross and later at the University of Oregon Medical School on Marquam Hill in

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<sup>132</sup> F. Grube, “Letter to the Editor,” *Oregon Sentinel*, December 19, 1868. Cited in Larsell, *The Doctor in Oregon*, 258-259.

Portland. Kingsley wrote of a situation in which Phelps' role as a medical professional coincided with his sense of her as a provider of familial care:

In those days a nurses' hours were practically continuous as long as she was on the case. The going wage was \$25.00 per week, where she could get it. In one instance Miss Phelps took care of a mother and four children, all of whom had typhoid fever, on a farm, water drawn from a well, outside toilet. She did the washing and cooking, with some help from the father. All survived.<sup>133</sup>

Kingsley certainly recognized that the services of a private nurse constituted paid labor, but the story also revealed certain doubts about professional work done by a woman inside a home. His mention of "practically continuous" hours and the uncertainty of receiving even a comparatively low wage implied that Phelps' labor in maintaining the health of a household was not seen as fully professional. This is especially clear in the fact that the only specific tasks which Kingsley enumerated were washing and cooking. In retelling the story, Kingsley reduced the expertise which Phelps must have applied to treating her three typhoid patients to the domestic labor which, the reader might guess, would be performed by the mother were she not incapacitated. Kingsley placed his sister-in-law within the broad category of medical professionals who traversed rural Oregon combatting disease, but in doing so he also separated the work of the nurse from that of the physician, characterizing the former as most closely related to the work often expected of married women.

The perceived relationship between nursing and familial ties also appeared in Kingsley's recollection of first meeting Phelps. His account centered on a disease he himself had suffered from, and detailed Phelps' uncanny ability to provide medical care, which even eclipsed that of an involved doctor:

I came to know Miss Phelps first in 1905. She was doing private duty nursing in the home of my aunt when I walked in one hot day in July out of my head with typhoid fever, a great scourge in those days, now practically unknown. She took care of me for eleven weeks with but a few hours off at a time. In the course of the case the doctor gave up hope for my recovery. The nurse, however, said she had not lost a typhoid patient and did not want to begin with me. The doctor said:

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<sup>133</sup> Silvanus Kingsley, "Letter to Helen B. Campbell," October 1, 1958, OHSU Historical Collections and Archives, Grace Phelps Papers, Box 1.3.

“The case is yours. Do whatever you think should be done.” When he saw I would pull through, he shook his head: “Too bad, he’ll never be right mentally - too long and hot a fever.” Later, after I had married one of Miss Phelps’ younger sisters, the family was apt to silence me with the remark: “Hush! You’re still delirious.”<sup>134</sup>

Kingsley underscored Phelps’ confidence and optimism through his recollection of the unnamed doctor who did not believe that he would survive the bout of typhus without serious brain damage. While this account aimed to communicate the exceptional dedication of Phelps as an individual, it also suggests that nurses around the turn of the century could be expected to have more patience than doctors in caring for those with difficult and prolonged illnesses. Finally, Kingsley connected his time spent bedridden with typhus to his later marriage with Phelps’ younger sister. By giving this context, he laid out a contradiction between, on the one hand, the image of Phelps as a dedicated professional, and on the other the suggestion that she was most of all a provider of familial care. As Barbara Melosh suggests, this conflictual view of nursing created a conundrum for nurses themselves whose professional expertise in their field was often interpreted solely through the feminine or maternal qualities ascribed to them.<sup>135</sup> Such assumptions, of course, could also undermine nurses’ claim to recognition as professionals and medical experts.

The ambivalence toward the professional achievements of nurses found its counterpart in the memorialization of tales regarding the most unusual or grisly feats of country doctors. As Olof Larsell collected narratives of the achievements of Oregon doctors beginning in the 1920s, he showed a penchant for such stories, many of which would appear in his historical account two decades later. He was in part concerned with the individualistic nature of his rural predecessors. From the other side of increasing regulations on the physician’s profession, Larsell paid tribute to what he saw as a wilder medical past.<sup>136</sup> One account told to Larsell by Rachel A. Good of Klamath County was emblematic of this aim:

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<sup>134</sup> Silvanus Kingsley, “Letter to Helen B. Campbell.”

<sup>135</sup> See Melosh, *The Physician’s Hand: Work Culture and Conflict in American Nursing*, 79-94.

<sup>136</sup> Olof Larsell, *The Doctor in Oregon*, (Portland: Oregon Historical Society, 1947), ix-x.

Dr. William Masten, who had been called to attend the injuries of R.W. Marple, a pioneer freighter, who had been thrown under his wagon by a runaway team on the road from Ager, California, in April 1904. Dr. Masten was returning to Klamath Falls in a light rig accompanied by the daughter of the patient, Mrs. Lydia Lenox. An unpaved road in April is a fearsome thing in Klamath, and there were no pavements then. In the darkness a front wheel dropped into a rut and the doctor was thrown from the seat so that his leg was caught in the spokes of the wheel. The horses [took] fright, [and] the leg was practically twisted off above the knee before they could be stopped. With the help of Mrs. Lenox, Dr. Masten finished severing the limb and Mrs. Lenox found it under his direction. He lived almost exactly four years afterward, dying in April 1908.<sup>137</sup>

Both this account and that of Phelps' typhus treatment detailed moments of extraordinary medical care. The appearance of Kingsley's biography of Phelps against the backdrop of stories like Masten's demonstrated the idiosyncratic interpretations levied onto the professional work of nurses. Good's retelling of Masten's injury centered around the man's amputation of his own leg with the help of Lenox. She expressed the dangers inherent in the urgent journeys required of physicians. In doing so she suggested that Masten's ability to perform such a drastic surgery on his own body with limited tools was an extraordinary feat of both professional competence and personal bravado. For Phelps, on the other hand, the setting of medical care was the home rather than the wilderness, and the object of care was the family rather than the self. Even the methods of Phelps' care seemed, in the retelling, divorced from the realities of the injured or diseased body in comparison to Masten's auto-amputation. Finally, Lenox's assistant role in Masten's story seems to suggest that the work of the nurse might have been replaced with that of any woman at hand.<sup>138</sup> While exceptional nurses like Phelps may have been recognized for the efficacy of their care, recollections of frontier medicine separated nurses from the visceral realities of treatment of the body.

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<sup>137</sup> Rachel A. Good, "Dr. William Masten Who Amputated His Own Leg with a Pocket Knife," Olof Larsell int., Olof Larsell Papers 4.2. While Larsell's notes name the physician in this story as William Masten, it is more likely that Good was referring to George Maston. The latter is the name that appears in *The Doctor in Oregon*, see pp. 235, 237.

<sup>138</sup> On the conflation of private service nursing with general feminized care, see Melosh, pp. 77-101.

Larsell reproduced this gendered stratification of the medical professions in the few accounts he wrote of medical professionals whose work he perceived as feminine. In his description of Dr. William Davis' service in Linn County during the 1890s he wrote, "at that time there was no hospital in Albany, the home of a Mrs. McNeel, who was a practical nurse being used when occasion demanded."<sup>139</sup> McNeel's work as a nurse was thus conflated with the extension of personal hospitality to her and Davis' patients. Larsell also described a notable nighttime childbirth that occurred in McNeel's at which the doctor and nurse were assisted by Mrs. Davis, who was tasked with holding the lantern. "It was her first attendance at a childbirth," according to Larsell, "and she became nauseated, hurriedly walking out of the room with the lamp, thus leaving the doctor, nurse, and patient in complete darkness. The nurse quickly followed her and rescued the lamp so the doctor could complete the delivery."<sup>140</sup> In this anecdote, the success of the delivery rests on the nurse's willingness to take up the role assigned to the spouse of the doctor. Such associations marked nurses' labor as feminized and therefore voluntary as opposed to the unambiguously professional work of the physician. This distinction appeared even in the case of one of the few women doctors Larsell described. Although he wrote that Sarah Dodson of Polk County "read medicine under the tutelage of a Dr. Dederick of Athens" and registered in 1889 as a practicing physician, Larsell referred to her solely as "Mrs. Dodson."<sup>141</sup> Furthermore, he wrote that when making calls near her homestead "[she] always responded by night or day, travelling by horseback in a side-saddle... She often remained with her patients for days when they were seriously ill, helping with the nursing as well as serving as physician."<sup>142</sup> While Dodson clearly shared the same traits as the male country doctors that Larsell described, her peers had clear interest categorizing the work of women like Dodson with

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<sup>139</sup> Larsell, *The Doctor in Oregon*, 235. Larsell ascribed further importance to Dr. William Davis due to his service of three terms as the mayor of Albany. This detail and others like it complement the sense that it was natural for male doctors in the American Northwest to take up other roles oriented toward public service.

<sup>140</sup> Larsell, *The Doctor in Oregon*, 236. Note on the attempt in this anecdote to separate women from knowledge of childbirth. Perhaps mirrors national attempts to wrest control of childbirth away from midwives, who were viewed as non-professional.

<sup>141</sup> *Ibid*, 250.

<sup>142</sup> *Ibid*.

that of nurses. Women medical professionals could thus expect their services to be defined not by education or expertise, but by its perceived femininity.

Although these stories of medical feats on the diminishing frontier mainly served to bolster the reputations of Northwestern practitioners as opposed to the East Coast transplants who wielded considerable influence in Portland, they also revealed common assumptions regarding the role of the nurse around the turn of the 20<sup>th</sup> century. Kingsley reproduced his memory of an instance in which he was the recipient of highly competent nursing care. Larsell and Begg based their lengthy accounts on oral testimonies that they collected in the 1920s and 1930s. While they had no access to the meanings that nurses themselves assigned to their own work, they did reproduce the stories that had been remembered and retold about prominent nurses and physicians in the rural Northwest. These stories attempted to constrict the role of the nurse by defining it in contrast to the exaggerated masculinity assigned to country doctors. Descriptions of transportation and recollected details from medical procedures bolstered these characterizations, but the most sweeping perceived difference was in the object of care. In their work, physicians were understood to be caretakers of the public, being described as doctors to entire counties. Their mobility was consistently emphasized, and so was the public nature of their work. The nurse's work, on the other hand, was often framed within the construction or repair of familial ties—the family, rather than the civic body, was the object of their care. By superimposing a domestic role on the work of private-duty nurses, these accounts cast their professional knowledge as strictly incidental. Thus, while the dedicated nurse might, in fact, provide better care than the physician, her successes would always be attributed to her gender and to her domestic training rather than to medical skill.

## **The Visiting Nurses**

Among the local medical institutions that sprang up across the United States in the early-20<sup>th</sup> century, visiting nurses associations were some of the most ubiquitous. These associations, formed in most major U.S. cities between 1880 and 1910, transposed

the unrelenting home-visit efforts of private-duty nursing into the public sphere.<sup>143</sup> Visiting nurses provided in-home care for a nominal fee to families who could not afford to pay full freight for physician care. The wages of the nurses were generally provided through the charitable funding that was available from among wealthy residents of the cities that the association served. While visiting nurses associations maintained loose national affiliations with the Department of Visiting Nursing and Social Welfare of the Nurses Associated Alumnae, the movement was, in most respects, a diffuse one with each association operating on its own, connected to other visiting associations only by their shared name.<sup>144</sup> These organizations pushed the work of nursing into the civic sphere. While nurses' roles in medical ideology had traditionally been limited to the work that could be linked to motherhood, visiting nurses asserted their right to civic engagement beyond maternalism and into the realm of public service medicine. In this arena, they sought greater professional recognition and also faced increased scrutiny by both women social reformers and men who claimed traditional civic authority.

As in the case of free dispensaries, the work of visiting nurses in the American West has been consistently underestimated and mischaracterized. Recent accounts of the social history of medicine in the Western United States describe these medical practitioners as participants solely in feminine or maternal care networks. The ideologies and institutions supported by the slowly growing class of women doctors in cities like San Francisco, Seattle, and Portland commonly relied on the support of visiting nurses. These included newly founded children's hospitals which, according to historian Rickey Hendricks, officials aimed to establish maternalism as their chief medical doctrine. She writes that the efforts of women medical professionals were usually "an extension of the private feminine sphere into public life rather than of a feminist impulse in politics and the professions," or, at most, they "sought entry at the periphery of the male medical academy."<sup>145</sup> She characterizes the visiting nurses as auxiliaries to the maternalism of

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<sup>143</sup> See Sandra Lewenson, *Taking Charge: Nursing, Suffrage, and Feminism in America, 1873-1920*, Garland Reference Library of Social Science (New York: Garland, 1993).

<sup>144</sup> See Mary Beard, "How to Form a Visiting Nurse Association," *American Journal of Nursing* 8, no. 11 (1908): 920-921.

<sup>145</sup> Rickey Hendricks, "Feminism and Maternalism in Early Hospitals for Children: San Francisco and Denver, 1875-1915," *Journal of the West* 32, no. 3 (1993): 61-69.

women doctors and reformers, such as those who had founded the Pacific Dispensary for Women and Children in San Francisco. This is most apparent when she describes the role of visiting nurses as limited to aiding nursing mothers while under the supervision of male doctors. Subsequent historical accounts of San Francisco's children's hospitals that argue for an expanded interpretation of women medical professional's feminism still consign the visiting nurses to a limited obstetrical role.<sup>146</sup> This well-trodden narrative does not account for the fact that most of the work of visiting nurses was performed without the support of physicians. Assessing the entry of women medical professionals into the realm of public service medicine requires not only scrutiny of early children's hospitals, but also of the separately elaborated civic programs of the visiting nurses associations. These programs adapted the techniques of private-duty nurses in order to claim a place for women medical professionals in the civic sphere. They defined municipalities as the objects of nursing care, rather than households. In doing so, visiting nurses built alliances with social reformers who aided in the pursuit of city-wide health programs while seeking to exert their own control over the requirements of women in public service.

### *Civic Nursing Before the Free Dispensary*

In 1902 a group of nurses and society women founded the Portland Visiting Nurses Association. They were led by Louise Waterman Wise, the wife of the Reform Rabbi Stephen S. Wise. The leadership of the association also included Helen Ladd Corbett as a supervising director; two years later she would leave that role to found the People's Institute. Like the Portland Free Dispensary which followed, the Visiting Nurses Association described its aim as "to benefit and assist those persons who are unable to secure skilled assistance in time of illness, to procure cleanliness, and to teach the proper care of the sick."<sup>147</sup> Its founders hoped that home visits by nurses might serve an

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<sup>146</sup> See Meredith Eliassen, "The San Francisco Experiment: Female Medical Practitioners Caring for Women and Children, 1875-1935," *Gender Forum; Köln*, no. 25 (2009) and Mary Ann Irwin, "Sex, War, and Community Service: The Battle for San Francisco's Jewish Community Center," *Frontiers: A Journal of Women Studies* 32, no. 1 (2011): 36-70.

<sup>147</sup> "Aid for the Sick Poor," *Morning Oregonian*, April 18, 1902.

educational purpose for the city's poor, and that by training household members to provide "proper care," visiting nurses might cut down on unsanitary conditions making future visits unnecessary.

While the work of the organization initially took the form of home-care nursing rather than clinical care, there was no doubt that its mission was to serve the public and the city. In addition to collaborating with Portland's health board and school board, the Visiting Nurses Association supported the charitable aid work of the city's religious organizations. "A Catholic patient will be visited by a Catholic member of the board," reported the *Morning Oregonian*, "and she in turn will present her patient's particular need to her parish society. The little Jewish woman, whose new baby came two weeks ago, is now being cared for by the Jewish Ladies Aid Society."<sup>148</sup> The association thus saw Portland as a plural city, split among various demographic groups, each of which was aided by separate charitable societies. Like the Portland Free Dispensary, the visiting nurses entered this environment and took up the work of facilitating medical care across religious and ethnic boundaries. In this way, visiting nurses construed their role as that of caring for the civic body as a whole.

Public health organizations in other U.S. cities, however, were not always able to unambiguously define this sort of civic service as under the purview of visiting nurses. By 1908, the national Graduate Nurses Association had begun to use the *American Journal of Nursing* to promote the operation of visiting nurses associations across the country. While national nursing leaders fully endorsed the possibilities of civic nursing, they also implicitly affirmed that women's participation both in public service and in medicine required the supervision of professional men. Mary Beard, the director of the New York Visiting Nurses Association, wrote a brief article in the *American Journal of Nursing* entitled "How to Form a Visiting Nurse Association." Of the ideal director for a fledgling visiting nurses association she wrote, "let him be a practical man with a working knowledge of the town and its needs and a progressive turn of mind and the lines

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<sup>148</sup> "The Work of the Visiting Nurse," *Morning Oregonian*, November 27, 1904. On cooperation between the Visiting Nurses Association and civic bodies, see "Aid for the Sick Poor," *Morning Oregonian*, April 18, 1902.

of the new visiting nurse have fallen in pleasant places.”<sup>149</sup> She continued by assuaging the fear that such a man might be impossible to find, writing that “It is astonishing how strongly this kind of work appeals to practical men and how ready and anxious they are to help support it; so I say, first have one individual and let him be a man, for your managing director.”<sup>150</sup> Her words echoed those of doctors who assumed that in-home nursing care would always come under the supervision of a male medical professional, even when that was certainly not always the case in practice. In this case, Beard suggested that making nursing into a respected form of public service required “practical men” to usher nurses into civic life.

Even with the support of philanthropists and municipal leaders, both men and women, maintaining the integrity of a visiting nurses association could prove difficult. In the fall of 1912, Edna Foley, the national superintendent of the Department of Visiting Nursing and Social Welfare, began to contemplate the modern difficulties of visiting nurses across the United States. Foley was committed to the notion that no matter the nature of their mission, visiting nurses were, first and foremost, trained medical professionals. For most visiting nurses associations, however, upholding members’ professional status to the general public meant taking up a broad range of auxiliary functions. In vindicating overworked nursing groups, Foley was especially preoccupied with the demands that religious and political figures made of civic care providers. In one situation that had come to her attention, a visiting nurses association found itself in contention with “the pastor of a large and prosperous church in the West [who denounced] their association from the pulpit for what he considered its irreligion.”<sup>151</sup> She recorded the protestation of the pastor as follows:

We hear that the work of the Visiting Nurse Association is successful... but how long can this temporary worldly success be maintained if the spirit of faith and prayer be absent? In the old days the nurses carried spiritual comfort as well as healing ministrations

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<sup>149</sup> Mary Beard, “How to Form a Visiting Nurse Association,” *American Journal of Nursing* 8, no. 11 (1908): 920.

<sup>150</sup> *Ibid.*

<sup>151</sup> Edna L. Foley, “Department of Visiting Nursing and Social Welfare,” *American Journal of Nursing* 13, no. 2 (1912): 123.

into the homes of the poor, but nowadays a nurse never thinks of praying with or for her patient.<sup>152</sup>

In the same way that private-duty nurses were so often regarded as familial caregivers, this pastor insisted that if visiting nurses were to take up the mantle of public service medicine, they must also justify it by fostering Protestant faith in their localities. In addition to such critiques from religious leaders, she also noted situations in which both pro- and anti-suffrage lobbying groups approached visiting nurses and demanded that they distribute leaflets at the homes of their patients. Although many prominent women medical professionals were ardent suffragists, Foley and other nursing leaders contended that combining home calls and political organizing could only undermine their professional status.<sup>153</sup> In the midst of these attempts to harness nursing in the interest of broader social agendas, nursing leaders insisted that “the wise visiting nurse will remember that by the ministry of her hands she may teach her patients to respect her unspoken creed.”<sup>154</sup> This statement suggested that the spirit of successful nursing was to use skilled treatment, rather than words, to substantiate the value of the profession. Instead of championing any outside notion of social tradition or social progress, the nurse’s mandate was to use every visit to bolster public and private respect for the nursing profession.

### *A Contested Alliance*

In Portland, the support of the Visiting Nurses Association was perhaps the most critical piece in the continuing operation of the city’s free dispensary. The fact that the dispensary’s staff of visiting nurses were some of its few paid employees revealed the

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<sup>152</sup> Foley, “Department of Visiting Nursing and Social Welfare,” 123.

<sup>153</sup> On women nurses and physicians in Oregon who were active suffragists, see Kimberley Jensen, *Oregon’s Doctor to the World: Esther Pohl Lovejoy and a Life in Activism*, (Seattle: University of Washington Press, 2012); Michael Helquist, *Marie Equi: Radical Politics and Outlaw Passions* (Corvallis: Oregon State University Press, 2015). On suffragist medical professionals in the United States at large, see Carla Jean Bittel, *Mary Putnam Jacobi and the Politics of Medicine in Nineteenth-Century America*, *Studies in Social Medicine* (Chapel Hill: University of North Carolina Press, 2009), 195-225.

<sup>154</sup> Foley, “Department of Visiting Nursing and Social Welfare,” 123.

extent to which it required reliable, full-time nursing support. Additionally, the Portland Free Dispensary sought voluntary labor from the city's nurses at large when dealing with high volumes of patients.<sup>155</sup> In fact, from the very beginning of its operation, the Portland Free Dispensary required the supervision of trained nurses. This was especially apparent during the San Francisco earthquake relief work in 1906 when the sudden and critical need for outpatient care demanded nurses' expertise and full-time labor.<sup>156</sup> With each intended expansion of the clinical care provided by the Portland Free Dispensary, arrangements had to be made for additional nursing support. In 1910 the board of the People's Institute agreed on the need for a separate tuberculosis clinic; however, this plan was only understood to be feasible once the board had secured the services of a "tubercular nurse."<sup>157</sup> As the free dispensary's patient volume increased steadily in the late 1910s, its reliance on nurses, and especially those from Visiting Nurses Association, grew as well. Finally, in the late 1910s, the skilled and regimented work of visiting nurses enabled the People's Institute's full embrace of the dispensary as outpatient clinic. While this alliance proved fruitful, its moments of tension demonstrated underlying conflict over nurses' professional duties and the nature of public service medicine itself.

The leaders of the Portland Free Dispensary understood nursing to be a matter of social change in addition to medical aid. At the dispensary, visiting nurses were employed as full-time clinical care providers in addition to making home visits. Due to this mixing of medical work and social work, the nurses employed at the clinic confronted a broadened definition of their own responsibilities. While some nurses asserted that the only route to true professionalization was to recast their role as that of an expert technician in increasingly complex hospital environments, members of local visiting nurses associations were more likely to accept some of the responsibilities of social work.<sup>158</sup> Some affirmed that "attempts to persuade the city fathers to correct bad

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<sup>155</sup> On volunteer nursing see "Annual Report of the Portland Free Dispensary," (1921), *Public Health in Oregon: Discovering Historical Data*. It is important to note that volunteer nurses at the Portland Free Dispensary were often public school nurses.

<sup>156</sup> "Minutes," May 17, 1906, Valentine Prichard Papers, 1.4.

<sup>157</sup> Valentine Prichard, "People's Institute Yearbook, 1909," (1910) Valentine Prichard Papers 1.3.

<sup>158</sup> On the idea of the nurse as technician, see Melosh *'The Physician's Hand': Work Culture and Conflict in American Nursing*, 168-182.

drains and open sewers” and to “assail the patients’ ignorance of ventilation or insanitary way of living” did indeed fall under the purview of the visiting nurse.<sup>159</sup> Claiming these responsibilities placed the nurse not only in the role of a caregiver, but also in that of a civic advisor and educator. At the Portland Free Dispensary, the reform-minded trustees often relied on nurses to ensure that the lessons given in moral improvement by the People’s Institute stuck:

Educational work for the better health of infants will be conducted and clinics will be established in connection with the Free Dispensary and in other districts of the city where mothers may bring their babies for examination and receive instructions [on] how to feed them and how to keep them well. A nurse provided by the Visiting Nurses Association will visit these mothers in their homes and see that the instructions are followed.<sup>160</sup>

This 1919 description of the educational plans of the People’s Institute suggested that nurses would serve additionally as auxiliary social workers. Valentine Prichard and the directors of the institute planned for the education of poor mothers to occur at the free dispensary but understood nursing visits to be the only way to ensure that mothers were, in fact, holding to the instruction that they received. In matters of hygiene and infant care, the Visiting Nurses Association was well prepared to accept this role from the People’s Institute. These home visits, then, combined the traditional notion that nurses ought to attend to the wellbeing of households and families along with the developing civic mission of visiting nurses associations across the United States summarized by the directive to “assail the patients’ ignorance.”

Most visiting nurses seem to have agreed with social reformers, like those at the People’s Institute, on the basic tenets of an effective public service medicine program. But their common ground had clear limits. While she recognized that nurses should be involved in all matters closely relating to a city’s health, Foley expressed the concern that visiting nurses were often expected to do far more than they had been trained for. She evoked the frustrations of rank-and-file nurses who found that by shouldering some

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<sup>159</sup> Foley, “Department of Visiting Nursing and Social Welfare,” 123-124.

<sup>160</sup> “Annual Report of the People’s Institute,” (1919), Valentine Prichard Papers, 1.3.

responsibility for the maintenance of civic wellbeing, they had opened themselves to unreasonable demands:

A visiting nurse needs a strong sense of humor these days to keep herself sane in the midst of many critics who demand that she must be a well-trained graduate nurse with some social training, some home dietetics, a knowledge of play-ground work, an ability to manage boys' clubs, a strong bent for organization, an ability to teach in Sunday-school, and a keen desire to post-graduate in order to supply her deficiencies in these and similar works. There is a real danger in these criticisms, however, in that they serve to arouse discontent in nurses who are doing their work well and make them desire to attempt too much.<sup>161</sup>

This account of the extra tasks and skills that some might expect of nurses clearly matched the broader agendas of the People's Institute and organizations like it. Foley insisted that nurses could not be reasonably expected to supervise playgrounds, clubs, and religious education, but the directives of social workers and reformers could clearly have significant effect on the work of visiting nurses. That Foley compiled this list of outrageous overextensions of nursing work pointed to significant frustration growing among nurses who found that they could not satisfy attempts by social reformers to expand the definition of the nursing profession. It was difficult, they felt, to be seen as a good nurse in the public sphere without consenting to feminine work that, from their perspective, fell outside of the medical realm.

In Portland there was even direct conflict, in a few instances, between the People's Institute and Free Dispensary's commitment to moral reform and the visiting nurses who they relied on. Florence Baldwin was the first supervising nurse at the Portland Free Dispensary, and in 1908 she volunteered as one of the early representatives of the Oregon State Nurses Association.<sup>162</sup> In the spring of 1910, however, Baldwin abruptly left her role at the Portland Free Dispensary. That year, Valentine Prichard wrote to Dr. K.A.J MacKenzie, the chief of staff of the physicians who volunteered at the

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<sup>161</sup> Foley, "Department of Visiting Nursing and Social Welfare," 123.

<sup>162</sup> On Baldwin's role in the opening of the Portland Free Dispensary see "Poor Will be Helped," *Morning Oregonian*, January 9, 1910. On her role in the Oregon State Nurses Association, see "Oregon State Nurses Association," *Nurse's Journal of the Pacific Coast* 4, no. 5 (1908): 239.

dispensary, urgently requesting that “the matter of supplying another nurse be attended to at as early a date as possible.”<sup>163</sup> She also made brief mention in the minutes of the People’s Institute board that because Baldwin had resigned, “an untrained attendant is in charge until the first of June.”<sup>164</sup> In aiding with the creation of the clinic, Baldwin had been the earliest and most important link between the Portland Free Dispensary and the Visiting Nurses Association. Accordingly, it was notable that the curt recognitions of Baldwin’s disappearance from the Portland Free Dispensary stood in such stark contrast to the usual procedure of briefly honoring volunteers and paid nurses alike who resigned from the clinic or from the People’s Institute at large. As it turned out, Baldwin had been “obliged to resign” due to circumstances that were known by Prichard and the other dispensary officials, but only once mentioned. During the meeting of the People’s Institute board on November 25, 1910, it was “Moved and carried that action of Miss Prichard in sanctioning Mrs. Baldwin in the late trouble with the Pantages be approved.”<sup>165</sup> The Pantages was a vaudeville theater in downtown Portland. Between 1906 and 1920 it was one of the most well-known and popular theaters in the city, but like commercial dance halls, patronage of vaudeville theaters was completely contrary to the goals of the People’s Institute. Prichard especially construed Baldwin’s conspicuous and regular attendance of vaudeville shows at the Pantages as a deep betrayal of the dispensary’s moral and medical mission.

The People’s Institute’s dismissal of Baldwin due to her known public attendance at a popular vaudeville theater demonstrated the true expectations of nurses who contributed their expertise to charitable efforts led by civic-minded moral reformers. Although Baldwin was a prominent nurse who held a leadership position in the Oregon State Nurse’s Association, her failure to conform to the moral standards delineated by the People’s Institute made her, in their eyes, unfit for public service. Nonetheless, Ollie Marquiss, another Portland nurse then working at the charitable Good Samaritan Hospital, plainly stated that nurses of all stripes commonly and casually attended shows

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<sup>163</sup> Valentine Prichard, “People’s Institute letter to Kenneth A. J. Mackenzie, Chief of Staff of Physicians, regarding need for a nurse,” (1910), *Public Health in Oregon: Discovering Historical Data*.

<sup>164</sup> “Minutes,” April 29, 1910, Valentine Prichard Papers 1.4.

<sup>165</sup> “Minutes,” November 25, 1910, Valentine Prichard Papers 1.4.

at the city's waterfront theaters.<sup>166</sup> Marquiss and her coworkers were regulars of many theaters, including the Pantages, and saw plays ranging from *As You Like It* to Clyde Fitch's *Sapho*, which had been subject to an indecency trial due to its sexual themes.<sup>167</sup> Clearly, Baldwin's dismissal was something of an unusual case which revealed the extent to which nurses and reformers could clash over their own moral duties and private prerogatives. Edna Foley, in her complaint about the critiques that visiting nurses commonly received, referred mainly to unrealistic expectations about nurses' professional training. The Baldwin incident, however, clarified both the professional and personal pressures that charity work exerted on nurses whose commitments were more to the medical care of patients than to the moral education of the civic body.

Visiting nurses used professional organization and civic service in an attempt to disengage from the moral and social valuations placed on women's work. Still, they often contended with efforts to control their medical work and personal behavior from both traditionalist "city fathers" and from their own reformist allies. The public demands made of visiting nurses denoted the extent to which existing social structures resisted their arrival into the civic sphere. In the late 1910s and into the 1920s, Grace Phelps' influence, and that of military nursing as a whole, redoubled attempts to systematize nurses' contributions to public wellbeing. Nurses like Phelps were seen to imbue the practice with discipline, regimentation, and even semi-masculine associations. In combination with the civic programs of the Visiting Nurses Association, the professional aspirations of nurses returning from wartime service prompted growing postwar medical institutions to co-opt nurses' contributions to public service medicine.

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<sup>166</sup> Ollie Marquiss, *Diary of a Student Nurse*, Philip Mulkey Hunt, ed. (1910-1913), 11-34. Marquiss detailed not only her own theater-going habits, but also those of her fellow nurses. She attended the theater at least once a month during her entire time as a nurse at Good Samaritan Hospital.

<sup>167</sup> See Katie N. Johnson, "'Damaged Goods': Sex Hysteria and the 'Prostitute Fatale,'" *Theatre Survey* 44, no. 1 (May 2003): 48.

## The Base Hospital

Like the officials of the Portland Free Dispensary, nurses in Oregon defined their civic service in relation to both wartime and peacetime work. In Portland, nursing leaders estimated that the majority of the city's visiting nurses had volunteered to serve in France during the First World War. Describing a postwar reception for the city's visiting nurses, one reporter noted the "opportunity for Portland citizens to pay tribute to these women, the greater number of whom served overseas."<sup>168</sup> Wartime nursing has commonly received more attention in the historiography of the field than any form of peacetime nursing. This is evidenced, for example, by the fact that Florence Nightingale's service in the Crimean War garners far more attention than her later opposition to the germ theory of disease.<sup>169</sup> So, too, has Clara Barton's Civil War service appeared in far more historical accounts than her peacetime leadership of the American Red Cross.<sup>170</sup> Regarding the period between 1890 and 1920, a period of momentous changes in nursing, scholars focus more on women's nursing service in the Spanish American War and in the First World War than on the intervening periods of peacetime.<sup>171</sup> Furthermore, few studies have addressed the developments in nursing between the Spanish American War and the First World War.<sup>172</sup> The entry of nurses into public service roles in the first two decades of the 20<sup>th</sup> century led to a significant difference in the meanings assigned to

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<sup>168</sup> "Visiting Nurses to Be Honored with Reception," *Sunday Journal*, July 2, 1922, Grace Phelps Papers 1.3.

<sup>169</sup> Melosh, "*The Physician's Hand*": *Work Culture and Conflict in American Nursing*, 157.

<sup>170</sup> See Lewenson, *Taking Charge: Nursing, Suffrage, and Feminism in America, 1873-1920*, 91.

<sup>171</sup> See Barbra Mann Wall, "Courage to Care: The Sisters of the Holy Cross in the Spanish-American War," *Nursing History Review* 3 (January 1995): 55–77; Mary T. Sarnecky, "Nursing in the American Army from the Revolution to the Spanish-American War," *Nursing History Review* 5 (January 1997): 49–69; Mercedes H. Graf, "Women Nurses in the Spanish-American War," *Minerva: Women & War* 19, no. 1 (March 2001): 3–38.

<sup>172</sup> For one of the few comparative accounts of nursing in the Spanish American War and the First World War, see Mercedes Graf, "On Two Fronts: American Nurses Who Served in the Spanish-American War and the First World War," *Minerva: Women & War* 1, no. 2 (July 2008): 47–62.

wartime service. In turn, wartime service leant enhanced public credibility to nurses' efforts in casting their work as a vital public service. These effects are only comprehensible through the combination of wartime and peacetime nursing narratives. especially because both rank and file nurses and influential leaders, such as Grace Phelps, gained their standing from both wartime service and peacetime work as visiting nurses or hospital nurses.

Arguably, the modern era of military nursing in the United States began during the Spanish American War with the widespread use of organized civilian nursing units. The position of the nurses who returned from service in the Philippines and Cuba, however, was far more tenuous than that of later veteran nurses. High disease mortality rates led the U.S. Army to invalidate its previous proscription on nurses serving in field hospitals, and many nurses did see their service as an opportunity to "prove that their care could affect outcomes of morbidity."<sup>173</sup> Mercedes Graf writes that even as army nurses deployed professional credentials, "many conservative citizens and Army surgeons still objected to using them during wartime."<sup>174</sup> As a result of this disapproval, nurses faced little recognition for their service during the Spanish American War, and, after the war, the Army retroactively limited their definition of nursing to disqualify most who had served from receiving pensions. Black women who served as nurses faced the harshest conditions; like black soldiers, these women were falsely assumed to have immunities from many of the diseases that ravaged Army hospitals and were thus consigned to menial work in extremely dangerous conditions.<sup>175</sup> After the war, however, black women were entirely excluded from the Army Corps of Nurses in a development clearly meant to deny these women any sign of regular service or professional standing.

By the start of the First World War, the white women who pursued service in the Army Corps of Nurses had built a stronger case for the necessary specialization of their work and thus for their inclusion as medical professionals. In Oregon, Grace Phelps led a

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<sup>173</sup> Mary T. Sarnecky, "Nursing in the American Army from the Revolution to the Spanish-American War," *Nursing History Review* 5 (1997): 60.

<sup>174</sup> Mercedes H. Graf, "Women Nurses in the Spanish-American War," *Minerva: Women & War* 19, no. 1 (March 2001): 26.

<sup>175</sup> See Sarnecky, "Nursing in the American Army from the Revolution to the Spanish-American War," 61.

contingent of volunteer nurses and deployed their wartime record as a paramount public service argument for standardizing nursing as a profession. Although she identified herself as a woman of “Quaker stock,” she eagerly left her position as superintendent of nurses at Multnomah County Hospital in favor of military service.<sup>176</sup> In 1917 she began to organize nursing volunteers for Portland’s Red Cross branch. She quickly became the city’s most important nursing leader in its mobilization for the First World War. In the following two years she served as the chief nurse of Base Hospital 46 in Eastern France, a unit made up entirely of volunteers from the University of Oregon Medical School. She did not return to Portland until late 1919.<sup>177</sup> Phelps’ wartime service was a brief chapter of her career, but in the following years she attempted to transpose the status afforded to army nurses into the world of civilian nursing, especially to those nurses engaged in public service medicine.

Like other nursing leaders, Phelps saw military service as a way to demonstrate the alacrity and expertise with which nurses responded to public need. As a Red Cross organizer, Phelps was especially lauded for her effectiveness in quickly yielding volunteers from among employed nurses across Oregon. She then used the Red Cross chapter as recruiting grounds for the Army Corps of Nurses, emphasizing to the press the sacrifice that each nurse made to serve in the war effort. Each recruit, wrote one newspaper, “is holding a position paying at least \$100 a month. They will relinquish these for the \$50 a month paid [by] the Army Nurses’ Corps to which they will belong as soon as they take the oath of allegiance.”<sup>178</sup> Foregoing pay was one way in which those seeking to professionalize might attempt to prove individualized moral commitments to the work in question, apart from any economic value such work might have. Melosh suggests, however, that for nurses the notion that service commitments were inherent to womanhood invalidated this strategy. “As professional leaders strove to distinguish their work from women’s unpaid domestic nursing,” she writes, “they had to dissociate

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<sup>176</sup> See “Who’s Who in the Nursing World: Grace Phelps, R.N.” *American Journal of Nursing* 27, no. 2 (1927): 118.

<sup>177</sup> Beth Hoover, “Grace Phelps, 1871-1952,” *Notable Women in the History of Oregon* (Portland: Oregon Lung Association, 1983).

<sup>178</sup> “Nurses Are Ready,” (1917), Grace Phelps Papers 1.13.

themselves from the sentimental conception of womanly service.”<sup>179</sup> Melosh sees this gendered expression of service ideology as creating a puzzle for trained nurses who aspired to professional status but could not denounce “womanly virtue.” To nurses like Phelps, however, military service provided a plausible answer to this problem because it afforded an opportunity to undermine the most feminized and least compensated notions of service.

Phelps emphasized the discipline required of rank-and-file army nurses and the authority vested in nursing leaders during wartime. These characteristics within the military setting, similar to the resoluteness of the peacetime visiting nurses, provided deep contrast to the private-duty nursing of Phelps’ earlier career in which she had been seen mainly as an aide to the wellbeing of households rather than a medical professional. The photographs that Phelps collected and distributed from her time as the chief nurse of Base Hospital 46 attested to this contrast. They presented a view of nurses that drew on the perceived masculinity of front-line service to naturalize the women’s civic participation.



Figure 10: Parade of Personnel from Base Hospital 46 (1917).

Image courtesy of OHSU Digital Collections.

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<sup>179</sup> Melosh, *The Physician’s Hand: Work Culture and Conflict in American Nursing*, 25. In this light, the work of visiting nurses at the Portland Free Dispensary takes on some ambiguity: these nurses were paid through state appropriations as opposed to doctors who used volunteered time to profess an extraordinary commitment to profession and community. The nurses’ status as employees essentially on the state payroll may have, according to Melosh, garnered a more effective claim to professionalism.



Figure 11: Occupants of Barracks 4, Base Hospital 46 (1918).

Image courtesy of OHSU Digital Collections.



Figure 12: Base Hospital 46 Personnel in Formation (1919).

Image courtesy of OHSU Digital Collections.

Photographically, Phelps' time at Base Hospital 46 was the most well-documented period of her life. She ensured that in their organization, embarkation, and wartime service, Portland's volunteer army nurses were portrayed as having the same

discipline as enlisted men. Figure 10 shows a parade of the volunteers joined by the base hospital's chaplains. A nurse, rather than a physician or officer, lead the column with the flag. Taken before the unit had left Portland, this photograph communicates solemnity and resolve, rather than pomp, especially given the headstones appearing in the midground. Taken at the end of their service, Figure 12 portrays the nurses of Base Hospital 46 with even greater precision and gravity. The low angle, stark shades, and the barren French field that serves as a background give the nurses' formation a dramatic effect. It emphasizes in particular their straight postures, sober faces, and dark uniforms. These photographs enlist the imagery of military photography to demonstrate the seriousness of the nurse's task, even to the point of charting traditionally masculine qualities onto the assembled nurses. Figure 11 strays from this embrace of discipline. It is a more casual group portrait of a group of nurses housed in one of the hospital's barracks. They appear out of uniform and in varied poses. Their dress, however, is quite utilitarian and displays the grime of the barrack-room environment. Furthermore, the general quality of the figures is confident, some smiling, others standing with squared shoulders. To some degree, this photograph recalls the imagined frontier environment in which Oregon's rural nurses and doctors served. In the image, however, the nurses are undoubtedly the focus, appearing to be in control of the base hospital environment. From blatant patriotism to nonchalant camp camaraderie, Phelps' photos extrapolate the nurses' civic duties to match those of Portland's men—specifically the masculine-coded duty to represent one's civic body in armed conflict if necessary.

These images portrayed the life of the Oregon nurse in wartime France as rugged, cooperative, and disciplined. Phelps and those who knew her gave special emphasis to her leadership role, making it into something which transcended the feminized associations that surrounded nursing. In a 1918 letter, Phelps' sister wrote of Base Hospital 46: "The female personnel comprised 100 registered nurses, and 6 women clerks, recruited and commanded by Grace Phelps, who ranks as a Captain."<sup>180</sup> She identified Phelps with her rank and her status as a recruiter and commander, rather than with the title "chief nurse." While this certainly implied much about Phelps' authority at

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<sup>180</sup> Mary Melissa Phelps, "To Those Assembled in Reunion," August 23, 1918, Grace Phelps Papers, 1.10.

the base hospital, it was a premature statement given that the U.S. Army did not instate officer ranks to the Corps of Nurses until 1920.<sup>181</sup> With claims like these, volunteer nurses ignored their auxiliary status and presented themselves as integral to the function of a modern military. Phelps herself built this conception in her own letters, expressing ambivalence toward war alongside a desire to serve in the most active role possible:

Everybody knows Sherman expressed the opinion of all sane people when he said ‘War is Hell’. I believe that expression is quoted more than any other just now. Somewhat fitting. I would like to be able to carry a gun and wade into the real thing. The shades of my forefathers may not like that wish... I have a confession to make - hold your ear close - I haven’t had an honest to goodness bath for days and days. I expect to be a complete wreck when I get back.<sup>182</sup>

Phelps knew the horror of the French front lines better than anyone who she corresponded with in the United States, and even with that knowledge she wished she could “wade into the real thing.” She continued by noting that this fantasy was certainly transgressive, and contrary to her family’s pacifist Quaker roots, though she in no way disavowed it. Finally, she described her own unsanitary living condition as if it were a secret. The letter was, however, meant for a far more public audience as her sister shared it at the following family reunion. Despite her request to “hold your ear close,” Phelps clearly meant for this negation of the nurse’s domesticity to receive a broader audience.

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<sup>181</sup> See Ellwynne M. Vreeland, “Fifty Years of Nursing in the Federal Government Nursing Services,” *American Journal of Nursing* 50, no. 10 (1950): 626.

<sup>182</sup> Grace Phelps, “Letter to Mary Melissa Phelps,” 1918, Grace Phelps Papers, 1.10.



Figure 13: San Francisco Training School for Nurses Class of 1895 (1895).  
Image courtesy of UCSF Library Special Collections.



Figure 14: University of Oregon Nursing Students (1900).  
Image courtesy of OHSU Digital Collections.

The correspondence and photography that Phelps used to define her wartime experience and that of the Oregon nurses she commanded stood in strong contrast to earlier compositions of nurses' official group portraits. In Figures 13 and 14, the use of outdoor staircases for the group poses and of house-like buildings for the backgrounds evoked the domesticity that was associated even with highly trained nurses. The nurses' uniforms differed between the two photographs—the pared down white frocks of Figure 14 perhaps approached the utilitarianism of the later military uniforms. Still, the uniforms of both groups, and especially the sitting poses in Figure 13, contrasted sharply with the uniform and postures of Phelps' photographs from France. The white uniforms in this photograph had significant utility in hospital settings: the differences in head and neckwear denoted rank.<sup>183</sup> Unlike the later military uniforms, however, the white frocks reinforced the perceived femininity of nursing to any onlooker.

Like the visiting nurses who backed the Portland Free Dispensary's outpatient program, military nurses also faced the tenuousness of their positions in highly masculinized settings. Even as Phelps challenged the diminution of feminized medical roles, others around her attempted to reinforce traditional understandings of nursing. While her achievements in recruitment often found praise in the newspaper reports published in Oregon regarding the work at Base Hospital 46, she was more commonly referred to as personnel of the hospital, rather than as an officer.<sup>184</sup> In France, Phelps was well-liked especially by the officers and enlisted men who passed through the hospital, but the affection they expressed for her could doubly serve as a rejection of her status as an authority. Brian Donlevy, who later became a well-known film actor, was one enlisted soldier who expressed special affection for Phelps during his stay at Base Hospital 46:

This bein' boss just makes you cross,  
It really is a shame,  
I'll be your brother big and bold  
What say you, are you game?<sup>185</sup>

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<sup>183</sup> Hendricks, "Feminism and Maternalism in Early Hospitals for Children: San Francisco and Denver, 1875-1915," 63.

<sup>184</sup> See "Staff is Complete," *Morning Oregonian*, July 8, 1917. See also "Unit Has Excellent Record," *Morning Oregonian*, April 12, 1919.

<sup>185</sup> Brian Donlevy, "Miss Phelps," Grace Phelps Papers 1.12.

This was only one of the many comic poems he wrote for Phelps during the war in which he referred to her often as his “little sister.” Phelps was, however, thirty years his senior. While intended to be harmless, his expression of support questioned her ability to perform the role of a “boss.” Furthermore, he construed her authority as ineffective without the support of a younger, inexperienced man. This sort of playful statement sought to resolve the tension caused by a woman medical professional claiming authority at a military encampment. By coding her station onto an imagined kinship relation, Donlevy reified the traditional femininity and domesticity of nursing. Phelps was no doubt flattered by her young admirer at Base Hospital 46 as she saved all the poems he wrote for her and informed other veterans from the base hospital when she realized that he had found success as a movie star. His manner of expressing affection for her demonstrated that even friendly relations between nurses and patients for could serve to reinforce traditional notions of feminine care. It was these traditional boundaries of nursing work that Phelps and others looked to supersede by transferring the authority and professionalism of the base hospital to their peacetime work in public service medicine.

### *The Return of the Wartime Nurse*

After returning to Portland in 1919 from her service in France, Phelps worked to engender the sense of civic duty present in wartime nursing among the trained nurses of the city’s hospitals. She promoted a nurse’s professional registry, advocated for clear definitions of the trained nurse’s work, and oversaw the expansion of nursing education at the hospitals on Marquam Hill. By 1923, Phelps had helped to consolidate the state’s nursing associations into one organization, the Oregon Graduate Nurses Association. As its name suggested, this organization privileged nurses with degrees and supported the application of licensing board standards to all practicing nurses in the state. In consequence, the *Oregonian* recognized the association as the body at which “all nursing activities in the state of Oregon will be centered.”<sup>186</sup> One of Phelps’ first objectives for this voluntary professional organization was to compile a registry of all the trained nurses in the state. It was important to Phelps that this registry received proper recognition as a

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<sup>186</sup> “Women’s Activities,” *Morning Oregonian*, April 8, 1923, Grace Phelps Papers, 1.13.

service to the public rather than a business scheme. “The registry,” read one report, “is a professional not a commercial registry, where calls for nurses, night or day, may be made and the best possible service given to the public.”<sup>187</sup> In this case, the actual distinction between a “commercial” registry and a “professional” registry was ambiguous. Clearly the registry could be used by those with medical needs for hiring a nurse, but still it was defined explicitly as not commercial. For the members of the Graduate Nurses Association, the difference was more likely ideological: through the registry they asserted membership in a class of nurses for whom the call to medical care transcended economic relations. For Phelps and other nursing leaders, especially those who had served in the Army Corps of Nurses, nursing was not an extension of women’s work but rather a specific job performed by trained and registered practitioners in the service of improved civic health. The postwar period appeared to these women as a fruitful opportunity for renewed claims regarding their place in the public delivery of medical care.

The influence of Phelps’ military service on her later work as a superintendent of nursing was most clear in her promotion of formal education programs for nurses. While serving as the chief nurse at Base Hospital 46, Phelps demanded that all volunteers under her purview receive standardized training. At her direction, the Red Cross sought out “able and educated young women... to enter the regular training schools” in preparation for service in France.<sup>188</sup> This emphasis on education applied not only to the nurses at the base hospital, but also to the aides and orderlies who Phelps recruited to work at refugee hospitals. “The applicants as nurses’ aides,” wrote Phelps in a publicized call for volunteers, “must have taken the Red Cross courses and the practical duty in the hospital, or some experience that can be recommended as equivalent. It is most essential that they speak French.”<sup>189</sup> For Phelps, the supposed feminine knack for the provision of care did not in itself qualify volunteers for the work of the Corps of Nurses in France. She insisted on clear training parameters and, after the war, instituted similar parameters in taking charge of nursing and nursing education at a series of Portland hospitals. In doing so, she left a clear mark on the educational standards of Oregon’s growing hospital networks.

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<sup>187</sup> “Women’s Activities,” *Morning Oregonian*, April 8, 1923.

<sup>188</sup> “15,000 Nurses Listed,” *Morning Oregonian*, November 25, 1917.

<sup>189</sup> “Nurses’ Aides Are Called for Service,” *Morning Oregonian*, January 30, 1918.

While serving as one of Oregon's state examiners for the registration of nurses, Phelps authored a number of articles and public letters in which she advocated for the standardization of nursing education and the recognition of such specialized education as the primary credential of a practicing nurse.<sup>190</sup> She especially proposed a continuous effort to clarify the public opinion of nurses, partially through improving the legal regulation of the nursing profession:

Better nurses, better nursing and better nursing conditions will result from the establishment of high aims within the profession and the education of the public to know, understand, and appreciate the service rendered and the heights to which nursing aspires. Better laws will help. But to write the best of laws on the books and then to stand idly by would be to stultify.<sup>191</sup>

She put forward a progressive model of medicine in which professional regulations would be continually remade, state by state, in order to optimize outcomes for patients and care-providers alike. Consistent educational standards were the core of this process for Phelps, and, she wrote, this was a matter demanding the attention of both nursing leaders and lawmakers. Nursing, she claimed, would no longer be a private transaction between a domestic care-provider and a family in need. Instead she envisioned a process through which nurses would gain professional status and public recognition that mirrored her own experience as a Red Cross recruiter and army volunteer. This status, she reasoned, would have delivered on "the heights to which nursing aspires," by placing the majority of nurses directly in the practice of public service.

Phelps substantiated these rhetorical assertions through her participation in the Graduate Nurses Association. In one instance she composed a lengthy letter pushing back against regulations for nurses employed by the federal government who were designated as either "professional" or "subprofessional" and paid accordingly. Phelps felt certain that no nurse applying her training to work in the public interest could be identified as subprofessional. She asserted that all the nurses in question had to be understood as

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<sup>190</sup> This included a 1927 article in *Cosmopolitan* entitled "Shall I Study Nursing." This brought Phelps position that education was the first step in starting a nursing career into the public view.

<sup>191</sup> Phelps, "Uniform Nursing Laws," Grace Phelps Papers 1.14, 12.

professionals given that they were registered through their state's examination system. Meanwhile, the terms professional and subprofessional made an entirely different distinction: between those who had received university education and those who had only received the "technical training" required of nurses. Phelps noted in particular that nursing required a specialized knowledge such that "in the matter of professional education nurses stand on exactly the same footing as other professions."<sup>192</sup> This was especially obvious to her and other registered nurses due to the fact that "no graduate from the general courses of learning in a college or university... could pass the average examination before a state board of [nursing] examiners, without the special education provided by the schools of nursing."<sup>193</sup> Phelps had spent years insisting that care providers needed to be properly educated and properly registered to be considered nurses. With standardization in training underway, she demanded fair treatment and better pay for those who had sought professional status through work in public service medicine.

In 1926, Phelps took up her most important position up to that point as superintendent of nursing at the newly founded Doernbecher Children's Hospital on the University of Oregon Medical School Campus. In doing so she accepted responsibility for the outpatient and clinical nursing of the Portland Free Dispensary, which had by that time become an extension of the university's hospital system. Phelps' dogged pursuit of professional standards in wartime and peacetime nursing would thus serve to cohere a rank-and-file of both visiting nurses and hospital nurses. This development rested on the foundation of public service medicine represented by the Portland Free Dispensary and the Visiting Nurses Association. Public service medicine in the 1910s, and especially during World War I, relied largely on the work of nurses who, in turn, deployed their civic credentials in postwar claims to professional status.

In the first decades of the 20<sup>th</sup> century, nurses like Grace Phelps did not often differentiate between public health and other forms of nursing. Instead, they cast civic service as the duty of any nurse interested in the benefits of professionalization. Public

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<sup>192</sup> Phelps, "Letter to Chief of Bureau of Efficiency regarding allocation of nurses into subprofessional service," Grace Phelps Papers 1.14, 4-5.

<sup>193</sup> *Ibid*, 4.

service medicine, defined by clinical care, home visits, and later military service, was thus embraced by a wide set of female care providers. These included visiting nurses, military nurses, and hospital nurses. In sum, nurses expressed their move into the civic sphere through both medical practice and ideology. They adapted well-established techniques of their field and wrought alliances with social reformers in order to broadcast their work as professionals in public service. Serving the city, they reasoned, made them professionals rather than replaceable domestic auxiliaries. Still, the reassertion of gendered norms of morality and care, even by allies, was a common reaction to these steps and ensured that those nurses most interested in professionalization could never attain the security of status that physicians had claimed decades before.

In the direct aftermath of the First World War, nurses sought to support the growth of nursing education and capitalize on the technical specialization it provided. They accepted wartime service as a window through which their continuing commitments to health service might be understood. In Portland, Phelps' use of military service records to legitimate nurses' civic standing built on nearly two decades of efforts by visiting nurses associations and other nurses' voluntary organizations to redefine the object of their work. Visiting nurses, for example, asserted that it was the nurse's duty "to persuade the city fathers to correct bad drains and open sewer."<sup>194</sup> In doing so, they extended the scope of organized nursing care to claim responsibility over an entire civic body, rather than just the individual homes they visited. These efforts at organized, public service nursing greatly modified the administration of healthcare in the urban areas while serving as arenas in which nurses could define the meaning of their own work in opposition to narratives that sought to limit the importance of private-duty care.

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<sup>194</sup> Foley, "Department of Nursing and Social Welfare," 123.



## Chapter 3. From Civic to Individual Care: The Expansion of the Marquam Hill Campus

Doernbecher Memorial Hospital for Children was one of three major hospitals built on the University of Oregon Medical School campus in the early- to mid-1920s. In 1926, when Grace Phelps became the superintendent of nursing at Doernbecher, the university hospitals were already becoming the center of public service medicine in Oregon. Many of Phelps' staff brought experience from the Visiting Nurses Association or from the Army Corps of Nursing. Alongside an influx of public and private funding, the expertise of these nurses fueled Portland's rapid hospital expansion in the years after the First World War. This resulted in the rise of inpatient care as the primary focus of Portlanders interested in public service medicine. This relocation of public service medicine, and especially of children's care, to the hospitals on Marquam Hill disrupted the existing ideological connection between clinical care and civic wellbeing and reemphasized prior definitions of the deserving patient.

In January of 1921, Frank S. Doernbecher, furniture magnate and Portland resident, died at the age of sixty. He left roughly a quarter of his estate to "the benefit of the people of the State of Oregon or the people of the City of Portland."<sup>195</sup> Many noted afterward that this was meant as a return on the generosity that Doernbecher found in Oregon upon moving to the state from Wisconsin in 1900 in order to build his manufacturing business. The fund he left for the public good was valued at \$200,000 and left in the charge of his children, Ada Doernbecher Morse and Edward Doernbecher. At Morse's suggestion, the two determined that the state's greatest need was for the construction of a modern children's hospital that could serve the University of Oregon Medical School's teaching and research needs. This pediatric hospital, named after Doernbecher, was built on Marquam Hill in Southwest Portland, adjacent to the medical school. It was completed in 1926. A teaching hospital, they reasoned, would fuel medical

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<sup>195</sup> "A History of Doernbecher Memorial Hospital for Children," (1931) Grace Phelps papers 1.13, OHSU Historical Collections and Archives, 2.

advances in the state for decades to come. They presented the gift as a way to create a long-lasting font of medical charity which would continuously provide returns to the public. Doernbecher Memorial Hospital for Children formed part of a significant expansion of the University of Oregon Medical School. It was built concurrently with the Shriner's Hospital for Crippled Children and the Multnomah County Hospital, which was relocated to Marquam Hill from a previous location near the city's waterfront. All three served as teaching hospitals from their perch on Marquam Hill.

The construction of Doernbecher Children's Hospital in Portland came at the very end of the first wave of children's hospitals in the Western United States. The founding of dedicated children's hospitals in the United States began in 1855 with the construction of the Children's Hospital of Philadelphia. Other major cities on the Atlantic coast quickly constructed their own pediatric institutions, and in the 1870s a handful of children's hospitals opened in the American West, the first two being in Denver and San Francisco.<sup>196</sup> Many historians have noted these early children's hospitals as sites of "maternalist" reform—institutions founded by wealthy women reformers who intended to replicate the environment of home care in inpatient wards.<sup>197</sup> Many of these hospitals, in fact, were focused on obstetrics and infant care and so in practice provided care to mothers and children at once. This model of healthcare delivery sought to treat the family, especially mothers and children, as a single object of care. Educating mothers on nutrition and hygiene, for example, was commonly seen as the most effective way to ensure the continuing health of infant patients.<sup>198</sup> In contrast, Portland hospitals tended to separate the care of children from the care of the family. Inpatient care of the individual,

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<sup>196</sup> See Barbara Mandelco and Carma Miller, "A History of Children's Hospitals in Utah," *Utah Historical Quarterly* 76, no. 4 (2008): 338–56.

<sup>197</sup> For a comprehensive account of early children's hospitals in the United States see David Sloane, "'Not Designed Merely to Heal': Women Reformers and the Emergence of Children's Hospitals," *The Journal of the Gilded Age and Progressive Era* 4, no. 4 (2005): 331–354. See also Rickey Hendricks, "Feminism and Maternalism in Early Hospitals for Children: San Francisco and Denver, 1875-1915," *Journal of the West* 32, no. 3 (1993): 61–69. On the San Francisco hospital in particular see Meredith Eliassen, "The San Francisco Experiment: Female Medical Practitioners Caring for Women and Children, 1875-1935," *Gender Forum; Köln*, no. 25 (2009).

<sup>198</sup> Sloane, "'Not Designed Merely to Heal': Women Reformers and the Emergence of Children's Hospitals," 349.

by that time, had grown in both scientific and social authority, displacing the maternalist administrations of early children's hospitals and increasing the power of male doctors, especially those associated with research institutions.<sup>199</sup> In Portland, women like Phelps and Valentine Prichard did continue to exert influence in the university hospitals' inpatient and outpatient programs. They did so not through their claims to maternal care, but through substantiated professional status and ongoing claims to civic duty.

In his history of the Toronto Hospital for Sick Children, David Wright notes that public conceptions of hospital care shifted beginning in the late 19<sup>th</sup> century. Before the 1880s, he writes, "hospitals were predominantly religious and charitable institutions for the destitute of society dubbed 'gateways to death.'"<sup>200</sup> This was certainly the case in Portland. In the late 19<sup>th</sup> century there were two major hospitals in the city, St. Vincent's, founded by the Catholic Sisters of Providence order, and Good Samaritan, affiliated with the Episcopal Diocese of Portland.<sup>201</sup> Both were understood to serve mainly the indigent, and in the 1910s Good Samaritan Hospital was publicized most often as the destination for those who became victims in the city's increasing number of automobile accidents.<sup>202</sup> The transition away from this conception of hospitals began, Wright claims, in the early 20<sup>th</sup> century when "hospitals emerged at the centre of a new, modern, and scientific infrastructure," eventually becoming "the defining element of medicine."<sup>203</sup> In Oregon, Doernbecher and the other Marquam Hill institutions built in the 1920s largely represented this shift. Their administrations professed a public service mission which was civic and charitable, and linked it to the technical prowess associated with the University of Oregon Medical School.

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<sup>199</sup> Sloane, "'Not Designed Merely to Heal': Women Reformers and the Emergence of Children's Hospitals," 351-354.

<sup>200</sup> David Wright, *SickKids: The History of the Hospital for Sick Children* (Toronto: University of Toronto Press, 2016), 2.

<sup>201</sup> See Sydney Clevenger, "St. Vincent's and the Sisters of Providence: Oregon's First Permanent Hospital," *Oregon Historical Quarterly* 102, no. 2 (2001): 210-21.

<sup>202</sup> See "Accidents Are Many," *Morning Oregonian*, February 22, 1913. There was often public suspicion aimed toward those treated at charitable religious hospitals. In one case, the *Morning Oregonian* published a long series of sordid stories about a patient at Good Samaritan Hospital whose son allegedly sold all her clothes while she was ill in order to buy whisky. See "Neglects Dying Mother," *Morning Oregonian*, January 18, 1910.

<sup>203</sup> David Wright, *SickKids: The History of the Hospital for Sick Children*, 2

In the years preceding the foundation of the hospitals on Marquam Hill, the Oregon state government passed two laws signaling the state's growing investment in the distinctive medical and social reform ideas current at that time. The first and most notorious of these was a 1917 bill creating the Oregon State Board of Eugenics and calling for the forced sterilization of "all feeble-minded residents of state hospitals and prisons."<sup>204</sup> The act was not enforced until the early 1920s under the purview of Governor Walter Pierce. It represented the culmination of efforts by a group of medical professionals led by Dr. Bethenia Owens-Adair to stop those they saw as mentally, physically, or racially unfit from reproducing. This included "moral deviants and sex perverts," categories which likely would have included some of the patients of the Portland Free Dispensary.<sup>205</sup> While the dispensary officials and most medical professionals associated with the University of Oregon eschewed the eugenics movement, they had for some time embraced the same impulses of civic control, efficiency and improvement that undergirded the scientific violence of forced sterilization. It speaks volumes, for example, that the leaders of Portland's Anti-Sterilization League were those who had also ardently opposed mandatory vaccination and saw themselves as total critics of the authority claimed by the physician and the state over the patient's body.<sup>206</sup>

The physician's authority was further solidified in the other significant medical reform bill passed by the Oregon legislature in 1917. The Children's Hospital Service law of 1917, sometimes referred to as the "Crippled Child's law," provided funds to guarantee medical and surgical care to children under the age of sixteen deemed to be of indigent parentage.<sup>207</sup> This law was most commonly described in charitable terms, but according to one senior doctor at the University of Oregon Medical School, the true

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<sup>204</sup> Mark A. Largent, "'The Greatest Curse of the Race': Eugenic Sterilization in Oregon, 1909-1983," *Oregon Historical Quarterly* 103, no. 2 (2002): 199. There had been a 1913 eugenics bill passed by the Oregon state legislature, but it was struck down by referendum before it could be enforced.

<sup>205</sup> *Ibid.*, 193.

<sup>206</sup> See Robert D. Johnston, "The Myth of the Harmonious City: Will Daly, Lora Little, and the Hidden Face of Progressive-Era Portland," *Oregon Historical Quarterly* 99, no. 3 (1998): 248-97.

<sup>207</sup> "Children's Hospital—Why?" *Portland Telegram*, June 21, 1921.

function of the law was to allow any child of a poor family to be “committed” to an inpatient ward by a county judge if medical care was considered necessary.<sup>208</sup> Cast in this light, the law was measure of control derived from the neighborhood public health projects of the Portland Free Dispensary and commensurate with the aims of the eugenics bill of the same year. In combination with the 1917 children’s healthcare legislation, the establishment of large teaching hospitals on Marquam Hill applied the ethos of public service medicine to inpatient care. In practice, this allowed for one of the central tenets of the inpatient ward, the patient’s separation from family and environment, to be introduced to the care of children, and especially to the children of the urban poor. Under this centralized iteration of public service medicine, practitioners thus prioritized the care of the innocent, and therefore deserving, individual rather than describing the neighborhood-in-need as an object of care.

## **A Crisis in Healthcare Delivery**

While the People’s Institute and Free Dispensary extended its services to prioritize outpatient care, especially that of adults with syphilis, tuberculosis, and other infectious diseases, it reinforced the notion that pediatric care was the central pillar of medical public service. Historians who have sought to define the character of medicine in the Progressive Era have commonly noted that the same impulses which compelled “states to enact labor legislation to protect women and children from unhealthy exploitation in factories and sweatshops” and eugenicists “to limit the ability of ‘undesirable’ people to have children” also led to the construction of new children’s hospitals.<sup>209</sup> Some make the broader claim that, for the most part, “large scale efforts at

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<sup>208</sup> Richard Dillehunt, “Letter to Supporters,” January 29, 1925, Doernbecher Children’s Hospital Records 3.10.

<sup>209</sup> Schuster, “The Rise of a Modern Concept of ‘Health,’” Christopher McKnight Nichols and Nancy C. Unger, eds., *A Companion to the Gilded Age and Progressive Era*, Wiley-Blackwell Companions to American History (Chichester, West Sussex: Wiley-Blackwell, 2017), 261.

social reform focused in the United States on the welfare of mothers and children.”<sup>210</sup> In fact, demands for improvement in institutionalized pediatric care persisted longer than the Progressive Era itself, traditionally thought to last from 1890 to 1920. In early-1920s Portland, social reformers began to find the city’s capacity for inpatient care, and especially the care of children, to be increasingly inadequate. Generalized health scares were reframed as threats to the health of children. In turn, children’s health was equated with the health of the civic body as a whole.

### *The Limits of Dispensary Care*

By the early 1920s, the Portland Free Dispensary’s volume of patients had begun to grow past manageable levels. Between 1920 and 1921, while operating with limited hours, the clinics of the dispensary treated about sixty patients per day, a figure that had doubled from the previous year.<sup>211</sup> Over the course of the decade, the demand for treatment would grow another threefold, far surpassing the capacities of the charitable clinic.<sup>212</sup> As it continued its operations in the aftermath of the First World War, the Portland Free Dispensary also continued to be one of the primary institutions in the American Northwest involved in the treatment and control of venereal disease. In its reports of 1924 through 1926, the Oregon State Board of Health indicated syphilis, gonorrhea, and chancroid to be of greatest concern to the public. The board singled these diseases out as urban problems, noting that the vast majority of cases in the state were recorded within Portland’s city limits. As such, they relied on the Portland Free Dispensary to both treat patients unable to pay and to report the volume of venereal cases they received.

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<sup>210</sup> Jane Lewis, “Health and Healthcare in the Progressive Era,” Roger Cooter and John V. Pickstone, eds., *Medicine in the Twentieth Century* (Amsterdam: Harwood Academic Publishers, 2000), 81.

<sup>211</sup> See “Annual Statistical Report of the Portland Free Dispensary, 1921” (1921) *OHSU Digital Collections* and “Annual Statistical Report of the Portland Free Dispensary, 1921” (1921) *OHSU Digital Collections*.

<sup>212</sup> See *ibid* and “Annual Statistical Report of the Portland Free Dispensary, 1931” (1931) *OHSU Digital Collections*.

This period also saw the crystallization of a moral stance toward sexual health with regard to race. The health board indicated two clear reasons for alarm over diseases like syphilis. The first was that “a large number of sufferers from venereal disease are innocent persons, especially women and children,” and second that “the presence of these diseases in the community is a menace to the maintenance and advancement of the physical and intellectual standard of the race.”<sup>213</sup> These justifications for focusing the attention of public health professionals on venereal disease suggested that the state’s concern was limited only to occurrences of these diseases among white Oregonians. Moreover, they prioritized the protection of women and children as presumed “innocent persons.” The state government, newly under the control of the eugenicist governor Walter Pierce, problematized venereal disease as a threat to whites’ reproductive health and therefore to what they perceived as racial progress.<sup>214</sup>

Through reports like these, medical professionals and government officials recast the continuing prevalence of syphilis and gonorrhea as a menace to white families and children. In one contemporaneous study, a doctor at the University of Oregon Medical School claimed that nearly half of all premature births were caused by the mother contracting syphilis.<sup>215</sup> While the state’s public health officials made distinctions regarding whether patients deserved treatment for venereal disease on the basis of gender and race, the nurses and doctors at the Portland Free Dispensary administered care in a more indiscriminate manner. Its clinics generally purported to accept any patient in need, and over the course of its operation the People’s Institute touted immigrants’ participation

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<sup>213</sup> Oregon State Board of Health, “Twelfth Biennial Report of the State Board of Health to the Governor of Oregon and the Thirty-Fourth Legislative Assembly: Annual Reports for the Years Ending December 31, 1924, 1925,” (1927) *OHSU Digital Collections*.

<sup>214</sup> Pierce was elected governor in 1922 with significant support from the Ku Klux Klan. He is known primarily for his laws banning Catholic schools and instating forced sterilization. On eugenics in Progressive Era Oregon see Mark A. Largent, “‘The Greatest Curse of the Race’: Eugenic Sterilization in Oregon, 1909-1983,” *Oregon Historical Quarterly* 103, no. 2 (2002): 188–209. On Pierce’s career, see Robert R. McCoy, “The Paradox of Oregon’s Progressive Politics: The Political Career of Walter Marcus Pierce,” *Oregon Historical Quarterly* 110, no. 3 (2009): 390–419.

<sup>215</sup> See “Premature Births,” (1929) Doernbecher Children’s Hospital Records 1.9, *OHSU Special Collections and Archives*.

in its programs, especially the “Americanization classes.”<sup>216</sup> In the changing political environment of the 1920s, however, the organization did reorient its focus away from social work, instead publicly reaffirming its commitment to pediatrics. A 1921 report from the organization emphasized plans to establish more locations across the city for clinics “where mothers may bring their babies for examination and receive instructions on how to feed them and keep them well.”<sup>217</sup> These plans undergirded the Portland Free Dispensary’s self-appointed “responsibilities in ‘saving the babies.’”<sup>218</sup> Meanwhile, the majority of the clinical work was aimed at preventing and treating infectious diseases, mainly among adults. This, too, was billed by the dispensary and the relevant state institutions as a service to innocent children.

As innocent victims of disease, children were deemed to be most deserving of care, leading to the reaffirmation of pediatrics’ moral claim as the highest priority in public service medicine. The images that the Portland Free Dispensary used to advertise its continuing work nearly exclusively showcased the clinical care for children. Figure 15 shows a doctor and two nurses examining young children at one of the dispensary’s baby clinics. These clinics were established at regular hours between 1919 and 1923 and served to consolidate the times at which mothers would bring their children for check-ups.<sup>219</sup> In the photograph, a group of six women, perhaps mothers or dispensary officials, crowd watchfully around the back of the examination table. The two rooms appear moderately crowded, and the clinic as a whole seems to serve doubly as a social occasion and as a medical assembly line with the children taking turns on the scales and examination tables. Even as infectious disease treatment, and especially venereal disease treatment, became the primary business of the Portland Free Dispensary, its leaders made efforts to maintain and publicize their work in the ensuring the health of the city’s young children. As a major ideological constraint on charitable outpatient care, the urgency of

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<sup>216</sup> See “People’s Institute and Portland Free Dispensary, 1920” (1920) *OHSU Digital Collections*.

<sup>217</sup> “Outline of the Work of the People’s Institute and Free Dispensary” (1921) *OHSU Digital Collections*.

<sup>218</sup> *Ibid.*

<sup>219</sup> See “People’s Institute and Portland Free Dispensary, 1920.”

wartime care had, to some extent, de-emphasized the notion of the deserving patient. This renewed focus on pediatrics, however, brought it again to the forefront.



Figure 15: Portland Free Dispensary Infant and Pre-School Clinic (c. 1919).

Image courtesy of People's Institute and Free Dispensary Glass Lantern Slide Collection, OHSU Special Collections.

### *The Public Call for Hospital Construction*

As the children's health clinics at the Portland Free Dispensary became more crowded its leadership began to publicly call for the expansion of the city's network of hospitals. The nurses and doctors of the dispensary specifically pointed out the need for a charitable children's hospital. Dr. Richard Dillehunt, the dean of the University of Oregon Medical School and chief of staff of the Portland Free Dispensary, began in 1920 to insist that Portland could become a major center of medical education provided that modern teaching hospitals could be funded. He also aimed to demonstrate the efficacy of recent advances in equipment and training at the medical school. The *Telegraph* reported that Dillehunt gave an "object lesson" to the state legislature by presenting the cases of "crippled children who are being transformed into normal children through the skill of

trained men in the medical college faculty.”<sup>220</sup> The height of medical achievement, in this case, became the ability to remove disabilities through advances in medical technique. For Dillehunt, pediatrics and medical education fed into each other: with more teaching hospitals medical education in Oregon would improve, and improved medical education would lead to even more miraculous services to the state’s afflicted children. The first step in this process had been to designate the Portland Free Dispensary as a teaching clinic. By 1921 the medical school relied so heavily on the dispensary’s space and patients to conduct advanced training that an expansion of the dispensary building allowed the school to expand its incoming class size from 70 to 350.<sup>221</sup> Developments like this fueled claims in the early 1920s that “within the past fifteen years Oregon has advanced in medical education from third rank to first rank.”<sup>222</sup> Around this time, Oregon newspapers also began to report that Dillehunt and other senior medical professionals in Portland envisioned the Marquam Hill campus becoming the premier medical institution of the West Coast, rivalling universities like Harvard and Johns Hopkins in the east.

The public call for the construction of new hospitals in Portland began in earnest in 1921 based more upon the shortage of beds at the city’s existing hospitals than on any grand design to grow the prestige of the University of Oregon. Some outlets inflated the need for hospital construction to crisis proportions. Fred L. Boalt, a noted sensationalist news editor, raised the alarm that summer by claiming that every hospital in and around the city was full and that patients in need were dying as they languished on wait lists.<sup>223</sup> Other newspapers took a more moderate approach while still promoting the idea of new hospital construction. An editorial in the *Telegram* read:

That state is not great that permits ignorance and poverty to bar the door against relief to the sick and deformed. Our legislature of 1917

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<sup>220</sup> “High Medical Education,” *Portland Telegram*, December 22, 1920 in “Scrapbook,” Ada Doernbecher Morse Papers 1.3, *OHSU Historical Collections and Archives*.

<sup>221</sup> See “Free Dispensary Larger,” *Morning Oregonian*, August 28, 1921.

<sup>222</sup> “High Medical Education,” *Telegram*, December 22, 1920.

<sup>223</sup> See Fred Boalt, “There Are not Enough Hospitals,” June 25, 1921, in “Scrapbook,” Ada Doernbecher Morse Papers 1.3. Boalt was the editor of the *Portland Journal* and was commonly lampooned for fanning the flames of moral panic. He was known especially for his critiques of the Portland Police Bureau for failing to rid the city of vice. See Tom J. Burns, “Saint Fred Boalt of ‘The Portland News’ Operated on in Heaven for Crime Wave Hysteria,” *The Harpoon* (Portland, 1927).

recognized this fact when it passed the Crippled Child's law providing for free hospital and medical and surgical service to every child under 16 of indigent parentage. It has long been the vision of a number of altruists, particularly a group of women of Portland and of Eugene, to build a hospital designed and administered for children only, a place where afflicted children, segregated and centralized, might laugh and play or even cry without disturbing adult patients of a general hospital, and where they might have specialized attention in their professional care; nurses by temperament and training fitted for children's needs; books, periodicals, and toys, floor and wall art, special diets suited to childhood, [and] regular pursuit of school studies.<sup>224</sup>

This statement of support for the construction of a new children's hospital portrayed the plan as a convergence of legislative and philanthropic efforts. The state's efforts, according to the newspaper, would "segregate" children of "indigent parentage," recognizing their need for care only as individuals separated from family and neighborhood. Like Valentine Prichard, the *Telegram* characterized care for sick children as a mission which must eventually be picked up by the state. Any centralized endeavor as complex as a children's hospital fell within the public interest and could not, they reasoned, be left to the ad hoc measures of private philanthropists. This matched Valentine Prichard's assertion during the Portland Free Dispensary's first years of operation that charitable institutions simply blazed the path for services that would soon be provided by government bodies. The clear difference in clinical rationales, however, was already evident: unlike the Portland Free Dispensary, the proposed hospital would the needs of afflicted children as separate from their place in familial and civic life.

Ironically, this call for the expansion and modernization of Oregon's hospital network was initially met not by overwhelming state intervention, but by a new wave of charitable ventures. In 1920 and 1921 Richard Dillehunt made multiple trips to the East Coast in search of a large donation to the University of Oregon Medical School. He meant to supplement funding from the state legislature that he had deemed insufficient for the school's needs.<sup>225</sup> In the fall of 1921, the Shriners, a masonic fraternity,

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<sup>224</sup> "Children's Hospital—Why?" *Telegram*, June 21, 1921.

<sup>225</sup> See "Big Gift Offered to Medical School," *Morning Oregonian*, December 13, 1920. See also "School to Get \$542,000," *Morning Oregonian*, February 24, 1921. In these articles, the donor to the medical school was reputed to be a large eastern philanthropic foundation, but the name of the foundation was not disclosed.

announced plans for the construction of a small hospital for disabled children on Marquam Hill.<sup>226</sup> Finally, by the fall of 1923, Ada and Edward Doernbecher had announced the \$200,000 gift that would fund the construction of a larger general hospital for children.<sup>227</sup> Over the course of the first half of the 1920s, these ventures transformed the landscape of the University of Oregon Medical School's Marquam Hill campus. By 1926, three newly built hospitals overlooked the city of Portland. They had been conceived as responses to the perceived crisis in hospital care in the early 1920s and as expansions of the public health services rendered by the Portland Free Dispensary to the city's public.

## The Hospitals on the Hill

Predictably, few who were involved with the effort to build new hospitals on Marquam Hill in Southwest Portland truly comprehended the volume of funding which would be required. Prior to the construction of Multnomah County Hospital on Marquam Hill in 1922, the University of Oregon Medical School had relied entirely on the Portland Free Dispensary to facilitate the practical training of physicians. The Portland Free Dispensary had, over the years, received funding from government sources on the local, state, and national level, but these sums had always been nominal from the perspective of the granting bodies. For the most part, the rigorous program of outpatient care and visiting nursing had been made possible by charitable donations from within the state of Oregon. Freedom from the obligation to provide monetary compensation to its physicians was the final key that allowed the dispensary to operate and expand. The proposed teaching hospitals were to be affiliated with the University of Oregon such that they too would benefit from the work of physicians already on the university's payroll, as well as medical students and recent graduates. In all other manners, however, these teaching hospitals were to be nothing like the Portland Free Dispensary. They required millions of dollars for construction, equipment, and maintenance. Large staffs of nurses and other paid employees would also be required. The commencement of these hospital projects

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<sup>226</sup> "Portland Will Get Shriner's Hospital," *Morning Oregonian* September 26, 1921.

<sup>227</sup> "Index of Today's News," *Sunday Oregonian*, October 14, 1923.

precipitated conflicts between proponents of medical public service and state officials who resisted what they saw as unrealistic upkeep costs.

The initial search for money to fund the expansion of the University of Oregon's teaching hospitals appeared to be wildly successful. While the Doernbecher gift constituted a dramatic instance of a local contribution, the medical school's plans saw it competing on the national stage for high-profile philanthropic support. In May of 1921, the *Oregonian* reported that the anonymous donor secured by Richard Dillehunt was in fact the Rockefeller Foundation. The University of Oregon would eventually need over \$1 million for the first of its expansion projects, and the state legislature had earmarked less than \$300,000. Rockefeller, reported a number of news sources, had agreed to match the legislature's amount, committing what was claimed to be his foundation's first contribution to a university on the West Coast.<sup>228</sup> In light of this gift, Oregon newspapers defended Rockefeller and his foundation against critics of large-scale philanthropy. One editorial lauded Rockefeller for renouncing all formal say in the General Education Board of his foundation. "It is doubtful," read the article, "that Mr. Rockefeller ever has had in mind any deep-laid and nefarious plan for controlling the currents of thought of coming generations such as some have supposed must have actuated him in giving vast sums for educational objects."<sup>229</sup> The General Education Board was, of course, the body that made the gift to the University of Oregon. Together with the gifts from the Doernbecher family and the Shriners, this fund gave the leaders of the medical school the impression that their ambitions for the Marquam Hill campus could be fulfilled through extravagant philanthropic funding. Thus, little more than a decade after Valentine Prichard had predicted the benevolent state takeover of charitable medicine and social work, the actual role of the state and federal governments in supporting charitable medicine appeared to have diminished.

The Rockefeller fund was used primarily for moving the Multnomah County Hospital from its outdated building near the city's waterfront to the new location on Marquam Hill where it would become a teaching hospital. The true costs of keeping a large teaching hospital in operation, however, had only just begun to emerge. While in

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<sup>228</sup> See "U. Medical School Will Have Annex," *Morning Oregonian*, May 28, 1921.

<sup>229</sup> "Mr. Rockefeller's Renunciation," *Morning Oregonian*, February 16, 1922, 8.

the planning stages, the medical development of Marquam Hill had been publicly cast as a philanthropic effort organized by Dillehunt under the auspices of the medical school. The commencement of construction, however, elucidated the true scope of the project and the extent to which state support would be necessary. When it became clear that the University of Oregon intended to rely on the state to fund the hospital's maintenance, a state supervisory board called a public hearing to question county officials about the hospital's funding. One state senator demanded to know why there had been no explanation of the expected operating costs, which were later estimated to be between \$100,000 and \$150,000 per year.<sup>230</sup> This represented a significant increase in comparison with previous operating costs of the county hospital. Furthermore, the teaching clinics that the University of Oregon Medical School had relied on previously had been those of the Portland Free Dispensary, supported by minimal city and state government grants of less than \$100 per month. Instead of a smooth transition from private philanthropy to centralized state planning of hospital systems, the plan for Marquam Hill appeared as if it might produce conflict and mistrust between reformers, medical professionals, and government officials.

At the hearing, those who supported the construction of new hospital buildings claimed certain public responsibilities to justify the considerable funding needed to operate a teaching hospital. Reports on the hearing noted that those who favored the hospital had put out a call to the public to attend the hearing to voice support for the hospital plans. This was an effective strategy considering that “without exception the invited taxpayers urged the necessity of the new county hospital.”<sup>231</sup> In this way, oversight from the state was cast as a brake on the public will. Importantly, many of the city's doctors also appeared before the supervisory board to declare the new hospital an absolutely necessity. Reports also noted the hyperbole with which the university's physicians asserted the new hospital's importance, coupled with uncertainty about the actual equipment needed:

A physician or two predicted that the magnificent monument on the hill would be doing active service as a hospital centuries hence—‘a thousand years from now’—and spoke of the stone churches and

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<sup>230</sup> See “Hospital to Need \$150,000 Yearly,” *Morning Oregonian*, October 25, 1921.

<sup>231</sup> “Hospital to Need \$150,000 Yearly,” *Morning Oregonian*, October 25, 1921.

hospitals built in Europe hundreds of years ago. Pinned down, however, doctors and architects admitted that there is such a thing as obsolescence in buildings and that in a few years repairs must be made to modernize the structure—any structure. It was Dr. A. E. Rockey who declared that the new hospital on the hill ‘gives the county commissioners their real claim to immortality’... The second guess was that \$100,000 would be sufficient for equipment. The man who made the guess admitted that he had no idea as ‘to what equipment was contemplated or needed,’ and the county commissioners had nothing to give an idea on the subject.<sup>232</sup>

For the hospital’s planners, the vision of an elevated “monument” to medicine’s capacity for public service preceded a clear idea of the hospital’s material or technical needs. The doctors advocating for the new building described it as a boon to the state and the general public rather than to the hospital’s individual patients, primarily those who could not afford unsubsidized medical care. This hearing resulted in chastisement from the supervisory board officials, who asserted that the state government should have had control over the project and its funds from the start. The hospital’s construction, however, did not halt, and the building was completed and opened in 1923.<sup>233</sup> It marked the first step in the concentration of medical education and services on Marquam Hill, but the political struggles over hospital funding had not ended.

### *Contesting Pediatric Care*

After the construction of the new Multnomah County Hospital, the fulfillment of the Doernbecher bequest became the next test for public service-minded medical professionals. For Edward Doernbecher and Ada Doernbecher Morse, meeting the guidelines of their father’s gift meant funding an institution that would be widely seen as a lasting public good for the state of Oregon. Given the continuing agitation regarding insufficient hospital space, they quickly agreed to fund a pediatric hospital. The \$200,000 from the Doernbecher estate was expected to cover the construction of the children’s hospital, but again the University of Oregon intended to rely on state funding for

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<sup>232</sup> “Hospital to Need \$150,000 Yearly,” *Morning Oregonian*, October 25, 1921.

<sup>233</sup> See “Staff Meeting Minutes,” Multnomah County Hospital Records 2.5, OHSU Historical Collections and Archives.

operating costs. Like the first hospital constructed on Marquam Hill, Doernbecher Children's Hospital was conceptualized as "a teaching hospital used as unit of an educational system," and one that would be "of necessity kept up to the highest point of scientific progress."<sup>234</sup> Ensuring the hospital's affiliation with the University of Oregon undergirded the Doernbecher family's stated public service mission. The hospital's supporters also later admitted that "another reason for designating the University of Oregon Medical School as the beneficiary of this trust was because its permanence and steady support from the state would be assured."<sup>235</sup> Steady state support, however, was far from an assurance, especially in the aftermath of tensions between state officials and the proponents of the new Multnomah County Hospital just a few years prior.

In the case of Doernbecher Children's Hospital, the University of Oregon sought a \$60,000 annual appropriation from the state legislature in 1925, a year before the hospital opened. The appropriation bill passed through the state legislature "practically unanimously," but was then vetoed by Governor Pierce.<sup>236</sup> His veto found widespread condemnation, especially among those who had accepted the construction of pediatric hospitals as a central pillar of modern public health programs. Dillehunt cast the veto as undermining the state's 1917 mandate that medical institutions provide cost-free care to the children of "indigent" parents. He further commented:

[Pierce] knew the state's need of the hospital and that the medical school attracted more gifts in biennium than the state appropriated and that wills have been made for hospital endowments... How can he veto this and approve appropriations for institutions not owned or operated by state action? It destroys the incentive to obtain further gifts, endowments or foundation aid to the Portland medical center and inclines one to devote his time to more profitable and appreciative service.<sup>237</sup>

With the 1925 veto, the brewing conflict over the state's responsibility to fund medical research and healthcare for the urban poor was fully revealed to the public. Dillehunt's

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<sup>234</sup> "A History of Doernbecher Memorial Hospital for Children," (1931) Grace Phelps papers 1.13, 2-3.

<sup>235</sup> *Ibid.*, 4.

<sup>236</sup> See "A History of Doernbecher Memorial Hospital for Children," 9.

<sup>237</sup> "Veto Fails to Halt Plans for Hospital," *Morning Oregonian*, March 4, 1925, 6.

blunt statement to the *Oregonian* accused Pierce of debasing the state government's duty to the public by refusing to adequately fund the children's hospital. He provided evidence that the University of Oregon had been diligent in seeking out charitable funding and that some portion of the remaining funds necessary must fall on the state. Pierce, he claimed, was instead lending state support to "profitable" ventures. Like Valentine Prichard and the social reformers of the People's Institute and Free Dispensary, Dillehunt had posited a mutualistic relationship between charitable donors, medical professionals, and the state in the expansion of the public's options for medical care. The funding struggles that plagued the Marquam Hill hospitals threatened this vision of service-oriented mutualism between public and private interests.

This setback was met not only with public ire, but also with redoubled funding efforts that bypassed the governor's office. The construction of the hospital continued, and within two months of the appropriation veto the Oregon chapters of the American Legion had raised a considerable percentage of the amount that the medical school had originally asked from the state.<sup>238</sup> The organization claimed that it would procure the entire \$60,000 estimated for the hospital's first-year operating costs. In reality, they raised about half the requisite amount.<sup>239</sup> This sum allowed for Doernbecher Children's Hospital to open in 1926, but throughout the following decade it would often operate using less than its full complement of beds due to lack of funds. In 1927, the Oregon State Legislature again presented Governor Pierce with a bill to fully fund the hospital. On this occasion, he finally allowed for state funding of the medical school's pediatric hospital but cancelled about one-fifth of the requested appropriation.<sup>240</sup>

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<sup>238</sup> See "Legion Workers Rally for Drive," *Sunday Oregonian*, May 10, 1925, 4. Ironically, Governor Walter Pierce was the first name listed on the register of donors that the American Legion sent to regional newspapers. Pierce had insisted that his veto of the appropriation bill was due to budgetary restrictions rather than to opposition to the hospital's mission. Pierce likely meant to save face after an unpopular decision, and perhaps he was also signaling that his administration did not approve of significant public funding for projects like Doernbecher Children's Hospital.

<sup>239</sup> See "A History of Doernbecher Memorial Hospital for Children," 9.

<sup>240</sup> *Ibid.*



Figure 16: Duniway Park Area Looking Toward Marquam Hill (1920).

Image courtesy of City of Portland Archives and Records Management, Auditor's Historical Records.



Figure 17: U.S. Veteran's Hospital Southwest Portland, Marquam Hill (1930).

Image courtesy of City of Portland Archives and Records Management, Auditor's Historical Records.

In light of these continuing funding dilemmas, the medical school relied especially on the fundraising skills of women associated with Doernbecher Hospital who were well versed in Oregon's civic life. Valentine Prichard was commonly consulted by

the Doernbecher Guild, the body charged with closing the gap between state appropriations and needed funding. On one occasion, C.C. Colt, president of the guild, sent Prichard a summary budget expressing the need for an additional \$60,000 and wrote that the guild meeting required her “counsel and advice.”<sup>241</sup> Grace Phelps, who became the superintendent of nursing at Doernbecher, also led active fundraising efforts for the hospital. On multiple occasions she traveled to local Rotary Clubs throughout Oregon in order to drum up more funding for the hospital’s continuing operations.<sup>242</sup>

That Prichard and Phelps leant necessary support to the Doernbecher Guild in its fundraising efforts suggests a continuity between Oregon’s patchwork of charitable healthcare efforts of the 1900s and 1910s and the institutionalization of public service medicine. As healthcare missions shifted and delineations between public health, hospital care, and private-duty care oscillated, the difficulties of securing state funds for public care persisted. Valentine Prichard had assured the People’s Institute donors in its early years that philanthropic effort was simply a temporary stopgap to relieve the suffering of the urban poor before government programs swept in to expand and standardize needed social services. It was certainly the case that as public interest in adequate and reliable healthcare delivery grew, the scale of such programs and institutions swelled. The role of the state, however, remained ephemeral even as the notion of public responsibility for civic health undergirded the construction of a new hospital network.

## **The Hospital as ‘Fairyland’**

Though not the largest of the new hospitals on Marquam Hill, Doernbecher Children’s Hospital became the central feature of the University of Oregon Medical School’s public image in the mid-1920s. David Sloane writes that “the formative

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<sup>241</sup> See C.C. Colt, “Letter to Valentine Prichard on Behalf of the Doernbecher Guild,” (c. 1928), OHSU Digital Collections.

<sup>242</sup> See O.F. Stanford, “Letter to Grace Phelps,” (1928), Doernbecher Children’s Hospital Records 3.10.

generation of children's hospitals was cloaked in the metaphor of home."<sup>243</sup> He claims specifically that reformers and physicians replicated what they saw as the "polite home" so as to not only heal the children, but also to change them and their families."<sup>244</sup> In Portland, the People's Institute and Free Dispensary purported to pursue a mission similar to that of these early children's hospitals, albeit in a less centralized manner. Its staff and volunteers attempted to enforce generalized health behaviors across households in the city's immigrant and impoverished neighborhoods. These efforts had united waterfront hygiene projects, pure-milk lobbying, and venereal disease clinics all under the auspices of one charitable organization. With the founding of Doernbecher Children's Hospital, the neighborhood focus on reform and education declined. Those who publicized the hospital's work did not portray it as a means of improving civic life through controlling family practices. Instead, the pediatric hospital became a "castle on the hill" at which nurses and doctors renewed the health of individual children above and apart from the vicissitudes of urban life.

After both the Shriner's and Doernbecher hospitals had been completed, the involved medical professionals asserted that the urgency of providing pediatric care had only expanded. Making pediatric services available, one nurse claimed, led to the discovery that Portland contained a greater proportion of afflicted children than previously believed. "The experience of the individual hospitals have shown," she wrote, "that the number of crippled children is enormously greater than was suspected," and she further noted that some children's clinics had been receiving up to ten times the number of patients expected.<sup>245</sup> These developments served to increase the sense that pediatrics, and especially charitable pediatrics, occupied a central place in providing for the health of a growing city. Even with unanticipated demand, the administrators of the two hospitals still insisted that the hospitals would focus on providing care to children whose parents

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<sup>243</sup> David Sloane, "Not Designed to Merely Heal: Women Reformers and the Emergence of Children's Hospitals," *The Journal of the Gilded Age and Progressive Era* 4, no. 4 (2005): 335-336.

<sup>244</sup> *Ibid.*, 339, 351.

<sup>245</sup> Florence J. Potts, "The Shriners' Hospitals: A General Outline of the History of the Founding of the Shriners' Hospitals for Crippled Children," *American Journal of Nursing* 26, no. 10 (1926): 747.

could not pay. In light of the high demand at Shriner's Hospital, which opened in 1924, Dillehunt reaffirmed that "the great part of the work of [Doernbecher] hospital will be service to patients from all parts of the state whose parents can pay nothing."<sup>246</sup> His promise was borne out during the first year of the hospital's operation when, despite the funding shortage, four out of five patients paid no fees at all.<sup>247</sup>

In addition to the volume of patients received after opening the children's hospitals, nurses and doctors began to recognize that the care of children in an inpatient ward was very different from that of adults. It required specifically trained care providers and specialized infrastructure. They thus planned the pediatric hospitals around caring for children as individuals rather than as parts of family units. As the superintendent of nursing at Doernbecher, Grace Phelps noted that young patients needed to be entertained and stimulated within a controlled environment. Some children, in her experience, had to be supervised and cared for round the clock, whereas others needed to be allowed to socialize with each other but prevented from causing any mayhem. "Special education in the technique of nursing children's diseases is necessary," she wrote, and "special equipment, beds, instruments, and so forth are required. All these things tend to increase the difficulty of operation of hospitals for children, and add greatly to the cost."<sup>248</sup> Despite the cost and effort, Phelps strongly supported the idea that children's hospitals should care for their patients outside of the family setting while supplementing their social and educational development:

Parents are naturally dubious about leaving young children alone in hospitals. Even if they completely trust the nurses they feel the child will fret at the separation. The fear is generally needless. It is remarkable how quickly the children adjust themselves in the new situation—they are so interested in what is going on about them.<sup>249</sup>

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<sup>246</sup> Richard Dillehunt, "Letter to Supporters," January 29, 1925, Doernbecher Children's Hospital Records 3.10.

<sup>247</sup> Adelaide V. Lake, "Castle On Marquam Hill Is Fairyland for Sick Children," *Sunday Oregonian*, December 25, 1927, 2.

<sup>248</sup> Grace Phelps, "Hospitals for Children in the Pacific Northwest," Grace Phelps Papers 1.14.

<sup>249</sup> *Ibid.* On the process of admission to Doernbecher and the requirements placed on parents and regional physicians see "Application for Admission to Doernbecher Hospital," (1926), Doernbecher Children's Hospital Records 1.4.

This perspective represented a significant change from the public health strategies of the Portland Free Dispensary and the Visiting Nurses Association. These organizations relied on the authority and care of parents to effectively monitor and improve the health of the city's children as a whole. Now, instead of being seen as trainable auxiliaries to the efforts of nurses and doctors, parents were politely dismissed to the margins of pediatric care relationships. Phelps even suggested that the conglomeration of children in the wards of Doernbecher might form a small-scale model of the civic body itself. She recalled hearing "two little boys arguing over the merits of the respective church denominations to which their families belonged."<sup>250</sup> For her, this sort of lively social behavior was a positive sign among her patients. It testified, she claimed, to children's "brightness" and individuality in the midst of trying situations.

To fully ingratiate this new form of consolidated pediatric care with the city at large, those who publicized the beginning of Doernbecher's operations borrowed the language of fantasy and fairy tale. They capitalized on the geography of Marquam Hill, the hospital's charitable mission, and the modernization in education and equipment that it represented to transform Doernbecher into a site of miraculous medical achievements. Adelaide Lake, the "church editor" of the *Sunday Oregonian* summed up the hospital's public image in an article on Christmas Day, 1927, describing the Doernbecher's first year of operation:

Fairy tales are happening every day to boys and girls in Portland in a handsome white castle at the top of Marquam hill. Magic of the most benevolent sort goes on there, by which sick boys and girls come out well and strong and those with crooked bodies emerge straight and beautiful. And while the people of Oregon proudly call the castle on the hill Doernbecher Memorial Hospital for Children, there are already hundreds of boys and girls who refuse to believe it is anything but a fairyland... Only doctors and nurses know the secret of the magic. This fairyland is a gift to all the children of the state, and it does not cost a cent for boys and girls whose parents cannot afford to pay.<sup>251</sup>

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<sup>250</sup> Grace Phelps, "Hospitals for Children in the Pacific Northwest," *Grace Phelps Papers* 1.14.

<sup>251</sup> Lake, "Castle On Marquam Hill Is Fairyland for Sick Children," *Sunday Oregonian*, December 25, 1927, 2.

Lake's sentimental discourse on the value of the children's hospital departed even from the romanticized narratives of Christmas gift-giving published by the People's Institute and Free Dispensary in the decades prior. Doernbecher's supporters suggested that the hospital's promise was to transform the body of each sick or injured child whose parents lacked the means to pay a doctor. While maintaining the hospital's claim to providing a necessary service to the city and to the state, accounts like Lake's transposed the site of affliction from the neighborhoods and homes of working class patients to the idealized, curable body of the sick child.

The use of fantastical imagery to define the work of pediatric medical professionals was not necessarily an anomaly. In 1923, Marion Crowe, then the head of Portland's Visiting Nurses Association, wrote a profile for the *American Journal of Nursing* describing one of the city's visiting nurses as a "Health Fairy" and christening her as the "Twentieth Century Pandora." In this case, the nurse referred to as Pandora earned the name by dressing as a fairy for her school visits and handing out decorative boxes full of health essentials including vegetables, soap, washcloths, and toothbrushes.<sup>252</sup> At Doernbecher, however, the use of pediatric fantasy was meant to encompass and define the entire institution—including the work of nurses and doctors alike.

In Doernbecher's early years, its administrators attempted to bolster the sense that their pediatric care aspired to not only heal children's bodies, but also to enrich the imaginative lives that reporters like Lake ascribed to them. Figure 18 shows the first Christmas celebration at Doernbecher Children's Hospital. Two men dressed as Santa Claus and "Twinklefoot" visit the hospital beds, which have been brought outdoors for the photographed event. Alongside, one of the beds, a small boy with a crutch pets a calf dressed up as a reindeer. Nurses populate the background of the photograph, holding and attending to small children who wait for their turn with the guests. In this photograph, the choreography in place to please the young patients far surpasses any that had been present at the Portland Free Dispensary.

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<sup>252</sup> Marion C. Crowe, "The Twentieth Century Pandora," *American Journal of Nursing* 23, no. 4 (1923): 309-312.



Figure 18: The First Christmas at Doernbecher Memorial Hospital for Children (1926)  
 Image courtesy of Ada Doernbecher Morse Papers, OHSU Historical Collections and Archives. Verso reads, “Santa and Twinklefoot from the Oregon Journal.”

The hospital beds were placed outside likely because fresh air was thought to aid tuberculosis patients. In fact, this technique turned out to cause more harm than good for consumptive children. At the time, this photo would have served to demonstrate competent spiritual and physical care of Doernbecher’s children. For this reason, it was published in the widely circulated Oregon Journal. As a publicity image, it served mainly to promote Doernbecher Children’s Hospital as a worthy executor of the public goodwill toward sick and injured children. Additionally, the photograph posited that children’s wishes could be met even while they were confined to an inpatient ward and separated from their families. In this way, they found recognition as individual patients within a hospital that aspired to serve the public at large through pediatrics. The conversations between the bedridden children and the man playing Santa Claus, for example, left the

viewer to surmise what Grace Phelps described as the “bright, interesting, and amusing” natures of the individual children being cared for at Doernbecher.<sup>253</sup>

The promoters of Doernbecher’s mission played on the fantasies of children and adults mainly to justify a new organization of pediatric care—one in which sick and disabled children were separated from parents, massed together in hospital wards, and cared for by professionals with specialized training. This differed greatly from the model used by free dispensaries and visiting nurses associations by which sporadic clinical care simply supported mothers’ home nursing. Under this model, writes Nancy Tomes, “the ‘helping’ professions [nurses, social workers] created a greater sense of women’s responsibility for stopping the spread of germ diseases without necessarily supplying the resources to do so.”<sup>254</sup> Children’s hospitals like Doernbecher, however, were predicated on the implementation of rigorous planning based on the germ theory of disease. In 1926, Doernbecher was the only hospital in the state of Oregon to admit patients suffering from infantile paralysis: “because of its unique facilities for the strictest isolation of children in the hospital the institution was able to accept these cases in spite of the fact that victims of contagious disease are usually barred.”<sup>255</sup> Essentially, a quarantine system separated patients such that infectious and epidemic diseases could be safely treated within inpatient wards. Previously, victims of such diseases had been generally left to the care of their families who might receive aid from a visiting nurse, for example. Medical care aimed at safeguarding a civic body, in light of this development in hospital organization, could be more safely pursued by treating child patients as individuals and separating them from their families and neighborhoods.

As the three hospitals on Marquam Hill opened their inpatient wards, which together totaled over 200 beds, the scope of care and service that the Portland Free Dispensary provided through its own means diminished. Only a few years prior, the free

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<sup>253</sup> Grace Phelps, “Hospitals for Children in the Pacific Northwest,” Grace Phelps Papers 1.14.

<sup>254</sup> Nancy Tomes, *The Gospel of Germs: Men, Women, and the Microbe in American Life* (Cambridge: Harvard University Press, 1998), 185. On the balance between hospital care and home healthcare in the first decades of the 20<sup>th</sup> century see p. 146.

<sup>255</sup> Lake, “Castle On Marquam Hill Is Fairyland for Sick Children,” *Sunday Oregonian*, December 25, 1927, 2.

dispensary's forays into the provision of outpatient care had eclipsed the People's Institute's previous mix of education, social work, and hygiene projects. By the mid-1920s, the centralized, low-cost inpatient care of the Marquam Hill hospitals transposed the public service mission of the free dispensary to an inpatient model. The Portland Free Dispensary continued to run clinics in the city for five years after the opening of Doernbecher Children's Hospital, but these clinics had been redefined as auxiliary to the effective pursuit of hospital care. By the late 1920s, there were nine clinics run across the city by free dispensary officials and visiting nurses. Each one reported directly to Richard Dillehunt and referred all serious cases to the medical school hospitals. In this way, the clinics had become extensions of the teaching hospitals, serving to collect and screen the "charity cases" eligible for hospital admission. Furthermore, the clinics continued to shift toward the exclusive provision of pediatric care with the majority serving children under two years of age, and one clinic meant for children up to age twelve.<sup>256</sup> Through its gradual integration into the University of Oregon Medical School, and specifically with Doernbecher, the Portland Free Dispensary reaffirmed its originally stated mission to provide care oriented toward the children and mothers of Portland's working-class neighborhoods. It abandoned, however, its more proximate commitments to providing widespread care to adult patients with syphilis, tuberculosis, and other infectious diseases, especially those diseases that retained strong associations with moral or economic failure.

The public focus on Doernbecher Children's Hospital revealed the extent to which clinical inpatient care of those perceived as innocent and therefore deserving had taken center stage in the practice of public service medicine. Like the Portland Free Dispensary before it, Doernbecher provided the University of Oregon an effective theater for the training of nurses and doctors. The hospital also laid claim to a similar public service mission as the free dispensary had. The inpatient ward, however, provided a wholly different style of care in practice. Children at Doernbecher were treated as individuals separate from their families and neighborhoods. They were singled out by the city's public medical apparatus as the members of poor neighborhoods who deserved

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<sup>256</sup> "Special Report to Dr. Richard B. Dillehunt on Clinics and Charity Cases," (1928) Doernbecher Children's Hospital Records 1.7.

care. In this way, the hospital's construction fulfilled the mandate created by Oregon's Children's Hospital Service Act of 1917. Instead of relying on a mobile network of clinics and nursing stations to care for the children of poor families, the professionals of Marquam Hill's growing medical complex sought to center inpatient pediatrics as the primary focus of public service medicine. Accordingly, as the Portland Free Dispensary was absorbed into the university hospital system, it further distanced its efforts from those of the public health professional and affirmed the primacy of clinical care. This organizational shift was made possible by technical shifts in the theory of hospital organization, as well as by an ad hoc mixture of state and philanthropic funding. Finally, as the hospital opened, its supporters used the press to cast it as a place of pediatric fantasy; in the newspapers it became a site of extravagant efforts to treat the souls of afflicted children.



## Conclusion

The public service medicine programs described in this thesis began, in part, with a concerted effort to provide care to strangers. The refugees who arrived in Portland after the San Francisco earthquake catalyzed the city's alliance between visiting nurses and social reformers. Early in the history of this alliance, its contributors retained traditional constraints on charitable, feminine care. On the one hand, People's Institute reformers initially attempted to limit charitable care to those who they deemed both needy and deserving. On the other, most women care providers understood their public roles as confined to maternalist or familial health projects. These social restrictions on the public service medicine performed by charitable associations resulted in, for example, the People's Institute and Free Dispensary's initial focus on the care of mothers and children. The events that disrupted and remade this limited model of care began with the 1906 earthquake relief, saw the expansion of clinical care rationales to aspirational coverage of the entire civic body, and finally led to the partial incorporation of public service medicine into the dramatic growth of Portland's hospital network in the 1920s.

The local renegotiations of civic healthcare that occurred across the United States in this period had an outsized effect on medical delivery, especially in urban areas, in comparison to the attention that they have received in historical scholarship. Organizations like Portland's People's Institute and Free Dispensary are too often explained as minor precursors to centralized hospital systems or, especially, as the brief formations of an eccentric moment in the history of public health. Historians who hold the latter view argue that at some point in between 1900 and 1930 the field of public health began to shed its quality as a vehicle for an eclectic mix of social reform initiatives. According to this argument, public health emerged from the interwar period more or less free of the moralizing social control efforts that had defined it in the 19<sup>th</sup> century. Instead, pulling on the stature of germ theory and epidemiology, it accrued the ethos of an applied science. Jane Lewis describes this shift in the following manner: "the late-nineteenth and early-twentieth centuries saw the end of public health as a prism for all sorts of social reform, although the strong link made between health and welfare and

between health and morality continued to exercise a powerful effect on particular campaigns for social reform.”<sup>257</sup> Her account of this claim approaches the resilience of the associations between morality and the practice of medicine or public health. This view, however, collapses the public health superstructures funded by governments and large philanthropic organizations with the patchworks of smaller healthcare delivery schemes that also claimed to provide indispensable services to the public. The latter, including free dispensaries and visiting nurses associations, could never be strictly defined as public health enterprises. Instead, these institutions wedded the justifications and goals of public health to programs that increasingly prioritized the clinical treatment of patients with infectious diseases.

Clinical outpatient care proved to be the most resilient service that these institutions provided due to federal support and public demand. In the 1910s, the reformers and medical practitioners involved in the Portland Free Dispensary and in the Visiting Nurses Association worked to match the ideological justification of their work to the realities of medical delivery. Valentine Prichard’s increasing emphasis on the notion of civic “efficiency” was one rhetorical maneuver by which these organizations could extend their services to patients previously deemed to be morally unfit. In doing so, reformers, nurses, and doctors, made the city into an object of care by connecting, for example, the “ministry” of the clinical nurse’s hands to the wellbeing of not only the individual body, but also of the civic body. For nurses, this meant actualizing a dramatic shift from the domestic associations of private-duty nursing to the civic duties of nursing in the service of the public. Although many of the visiting nurse’s techniques mirrored those of the private-duty nurse, visiting nursing sought to establish a professionalized relationship between practitioner and public. The nurse attending to the home of a working-class family would then be construed as a servant of the public good rather than a temporary domestic aide. In this way, service traditionally understood to be a feminine

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<sup>257</sup> Jane Lewis, “Health and Healthcare in the Progressive Era,” *Medicine in the Twentieth Century*, Roger Cooter and John V. Pickstone, eds. (Amsterdam, The Netherlands: Harwood Academic Publishers, 2000), 83. Elizabeth Fee and Dorothy Porter also state that the professionalization of public health required a certain distancing from social reform. See Fee and Porter, “Public Health, Preventative Medicine, and Professionalization: England and America in the 19<sup>th</sup> Century,” 249.

duty could be disassociated with its gendered confines. Practitioners of public service health also reacted to the demands of the public, selectively applying shifting notions of morality to the charitable clinic. The Portland Free Dispensary's cautious expansion into the treatment of venereal disease demonstrated the extent to which methods of medical delivery altered due to popular, governmental, and bacteriological pressures. Charitable health in this period was thus a patchwork of ideology and technique through which congregations of reformers and medical professionals sought to engender progress and control in unruly urban centers.

In balancing the values of individual and collective health, the ethos of public service medicine had implications that extended past the delivery of charitable healthcare. Tomes' paradox, that between autonomy of the individual body and deference to medical authority was also a primary driver in the eugenics movement. The same urges to monitor individual health in the interest of collective wellbeing that drove the Portland Free Dispensary were present in state rationales for forced sterilization.<sup>258</sup> In this light, Valentine Prichard's veneration of "efficiency" as an aspiration for all social and moral reform finds connections to the eugenicist's exhortations against racial degeneration. Although these were two largely different strands in Oregon's history, there is no doubt that those who advocated eugenic sterilization found ideologies of public service medicine to be commensurate with their own goals.

The clearest successors to the Portland Free Dispensary were Doernbecher Children's Hospital and the outpatient clinic at the University of Oregon Medical School. To publicize the value of teaching clinics, these institutions borrowed the same notions of public service that the dispensary had levied to promote its cause. At the inpatient wards of the University of Oregon, however, medical care was further divorced from public health practices. Instead of caring for the city, the nurses and doctors of Doernbecher cared for individual children, plucked from their families and neighborhoods. Broadly, then, this thesis traces the rise of a civic health model—one in which the city is the object of medical care—and its halting transition into medical practice that took the individual

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<sup>258</sup> On problematizing the tension between individual and collective in the eugenics movement see Mark A. Largent, "'The Greatest Curse of the Race': Eugenic Sterilization in Oregon, 1909-1983," *Oregon Historical Quarterly* 103, no. 2 (2002): 189.

body as the primary object of care. Interestingly, Nancy Tomes suggests that paradox between “the elevation of individualism and of personal autonomy, on the one hand, and the deference to scientific authority on the other” from the 1920s onward transformed the patient into a “patient-consumer.”<sup>259</sup> This was a model of medicine that nursing leaders as well as the reformers of the People’s Institute and Free Dispensary found anathema to a healthy civic body, and yet it followed close on the heels of the centralization of medical delivery that the organization pursued.

Today, the entrenchment of this patient-consumer model into the fabric of American life is well-known as an era-defining political issue. Still, the remnants of public service ideology in medicine underlie and permeate the debates surrounding Medicare expansion, opioid distribution, and home-care nursing. I would argue that nursing, especially, remains a stronghold of civic care rationales. In the policy debates surrounding the care of aging populations, the term “right to care” is often used to argue for an expansion in the home healthcare labor market.<sup>260</sup> Conversely, nursing organizations use this same term to denote the nurse’s right to provide care—in other words, their right to the necessary workplace protections that will allow them to pursue work that combines personal and public service missions.<sup>261</sup> Nursing organizations’ claim that true public service relies on certain workplace rights has generated conflicts that recall the ideological formations of early-20<sup>th</sup> century public service medicine. In recent years, the Oregon Nurses Association, a labor union which grew out of Grace Phelps’ graduate nurses association, used such civic rationales to break with a long tradition of nurses organizations eschewing strike tactics.

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<sup>259</sup> Nancy Tomes, *Remaking the American Patient: How Madison Avenue and Modern Medicine Turned Patients into Consumers*, Studies in Social Medicine (Chapel Hill: University of North Carolina Press, 2016), 10, 19.

<sup>260</sup> See, for example, Adam D. Reich, “Contradictions in the Commodification of Hospital Care,” *American Journal of Sociology* 119, no. 6 (2014): 1576–1628; Olivia Smith, “How Far From a ‘Right to Care’? Reconciling Care Work and Labour Market Work in Ireland,” *Irish Jurist* 47 (2012): 143–67; Antonia K. Bernhardt et al., “Making It Safe to Grow Old: A Financial Simulation Model for Launching MediCaring Communities for Frail Elderly Medicare Beneficiaries,” *The Milbank Quarterly* 94, no. 3 (2016): 597–625.

<sup>261</sup> Patricia Schechter, “The Labor of Caring: A History of the Oregon Nurses Association,” *Oregon Historical Quarterly* 108, no. 1 (2007): 12

This Oregon nurses strike occurred in 2001 and pitted nursing professionals against the growing trend of healthcare privatization. In 1995, the Oregon Health and Science University, the successor institution to the University of Oregon Medical School, separated from the state's university governance system. By 2001, the pressures concomitant with the privatization of services at hospitals like Doernbecher had precipitated a fifty-six-day strike by the institution's nurses. During the strike, the university defended its budgetary decisions by claiming its status as "a business...in today's depressed economy."<sup>262</sup> Meanwhile, signs on the striking nurses' picket lines declared their priority to be "Defending Patient Care," with some asserting that "*You* Deserve an OHSU Nurse."<sup>263</sup> These nurses attempted to reaffirm that the responsibilities of the hospitals on Marquam Hill was to the public good. A secure work environment for care providers, they argued, was the foundation on which that responsibility would rest. Conflicts like the 2001 strike suggest a disaggregation of Progressive-Era Portland's alliance between the institutions of public service medicine and its rank-and-file practitioners.

In Portland, during the 1900s and 1910s, the groundwork of public service medicine preceded all overarching notions of a universalizing state program. Local expressions of civic ideology came first and precipitated calls for both partial and complete government takeovers of healthcare infrastructure. This local expression relied on an alliance between social reformers, nursing leaders, and rank-and-file practitioners. Further, it combined the goals of public health with the techniques of clinical health. The flexibility and civic determination of these programs resulted in the growth of a universalizing ideology of healthcare delivery. While Beatrix Hoffman's account of failed state health insurance legislation in New York warns of the pitfalls of top-down medical reform, this thesis presents the eclectic mix of successes and failures that attended the local construction and dilution of an aspirational, universalizing medical program. In a time of renewed strength in socialized medicine proposals, the examples of the Portland Free Dispensary and Visiting Nurses Association suggest that robust civic

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<sup>262</sup> "Facts About the OHSU Nursing Strike," *OHSU News*, December 27, 2001.

<sup>263</sup> Patricia Schechter, "The Labor of Caring: A History of the Oregon Nurses Association," 27.

alliances, grounded in locality, must accompany any gesture toward a universalized justification of state-funded public service medicine.

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