

**(Un) Healthy Interiors: Contestations
at the Intersection of
Public Health and Private Space**



Editors

Aran S. MacKinnon
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Studies in the Social Sciences
University of West Georgia

Vol. XXXVIII
July, 2005

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Carrollton, Georgia

www.westga.edu

Volume XXXVIII, Number 1
July 2005
ISBN: 1-883199-15-8

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This special issue of journal *Studies in the Social Sciences* entitled, '(Un) Healthy Interiors: Contestations at the Intersection of Public Health and Private Space' is devoted to patients' interactions with public health institutions and policies. Historically, public health initiatives have revealed much not only about the nature of healthcare and the professionals who provide it, but also about the contexts in which they operate. This includes the nature of the state and how it wielded public health care measures and institutions as a tool to help categorize and control people. Indeed, much recent literature on health emphasizes the ways in which ill-health and disease and efforts to combat them reflect the fault lines of power and inequality between people, medical professionals and the state. Yet, as the articles in this issue so clearly show, individuals experienced and shaped public health initiatives and institutions in myriad ways. The experience of ill-health, on the one hand, and the experiences of health care and the institutions in which it took place on the other hand, had different meanings for different people at different times and places.

A recurrent theme in the history of health and disease has been the negative associations and stigma attached to ill-health and the places where it is treated. Since the Middle Ages, if not earlier, states have imposed restrictions on the movement and behavior of populations in order to protect society from widespread illness. Despite often laudable goals, such programs have also tended to stigmatize certain segments of society as being biological and even moral threats to the commonweal. While there have been compelling scientific arguments for these practices, and they have achieved some remarkable successes, they cannot be dissociated from broader aspects of socially constructed negative associations and ideals. Similarly, as health care progressed in terms of scientific improvements and patient management, so too did the abilities of practitioners and the state to define, control and mold patients. Yet there is no single normative model of how public health systems should operate to cure and contain their populations. Yet there is no single model of a hygienic state that could cure and contain its populace came to be seen as normative, in much of the world its goals proved be elusive. Thus, while patients in Anglo-America and Western Europe found themselves living under the kinds of conditions described by Foucault (the vigilant bureaucracy), patients elsewhere experienced public health in terms of social abandonment and neglect.¹

As the articles in this journal suggest, health care practitioners and public health bureaucrats often associated good health with moral behavior. By contrast, the public health model suggested that ill health, especially among subordinated groups (the poor, racial and ethnic minorities, etc) was a sign of deviance and immorality and was a threat to the social order. In some cases this meant patients would have to comply with regimens which doctors and nurses believed provided for good health through proper practices, proper mental attitudes and moral behavior. In other cases, the state pressed health care practitioners and institutions to use public health and its institutions to render 'deviants' proper model citizens, or to isolate them and their potentially 'contagious' behavior from the rest of society. Thus, as Diedrich, following Foucault, suggests in "Space, Language and Death in Two Twentieth-Century Memoirs of

Tuberculosis,” at least part of health care is aimed at individuals and the “disciplining of their bodies” and part is aimed at the “regularization of populations”. It is where these two practices meet that we see the contestations this journal is concerned with. At the same time, there is another set of conflicts, which pits the overly ambitious state and its attempts to discipline and regulate, on one hand, against individual and collective demands for access to what the general public may consider, in a given historical period, as advanced and scientific medicine.²

Public health institutions are at once public spaces where the state, doctors, nurses and patients meet to engage in health discourses and practices, and they are the site of deeply personal experiences. While clearly the experience of ill-health, including the diagnosis and categorization of a particular condition, and by extension the person’s moral fitness, is a transformative experience, so too is the experience of the various therapeutic and institutional regimens which comprise “treatment.” As these articles illustrate, the pathways to institutions and the modalities of treatments have multiple meanings. They also provoked a range of challenges and forms of resistance as individuals sought to shape their experiences and the settings these occur in. Thus, this issue illuminates not just the ways ‘patients’ were constructed, observed and controlled, but also the ways in which they participated in, resisted and made meaning out of public health.³

Synopses

This issue opens with Cynthia Hammond’s richly detailed analysis of British imperial hospitals in her ‘Reforming Architecture, Defending Empire: Florence Nightingale and the Pavilion Hospital’. In this article, we learn that Nightingale made a far more important contribution to the field of public health through her hospital designs than has hitherto been acknowledged. Hammond takes us into the interior confines of the military pavilion hospital as it was developed in the context of the Crimean War in Turkey. Here, as Hammond shows, British soldiers were at once part of a much broader imperial project in the ‘Orient’, as well as the subjects of reforms in sanitation, hygiene and military hospital architecture. Historically, the military has been the site of revolutions in public health as it has been the primary focus of concern for governments and medical professionals when it came to issues of hygiene and health. These hospitals, moreover, (as with the asylums discussed in the article by Di Liscia et al, see below) were designed to ‘heal’ patients in such a way that they could be restored to proper working order –or even improved upon, and could then return to active duty as citizens fit for work or war.

As Hammond points out, Nightingale’s role in designing military hospitals exercised a profound influence on gender relations, space, imperialism and architecture in the British colonial context. Nightingale’s designs reinforced emerging ideas about the containment and treatment of disease as they merged with and supported the building of the edifices of the British empire. Yet, Nightingale’s role was also equally important for the ways in which male soldiers experienced health care and hospitals. As Hammond states, ‘Her [Nightingale’s] concern for the bodies of soldiers was consis-

tently addressed to the spaces that surrounded them.’ Nightingale argued, moreover, for the extension of safe and sanitary housing and provisions for soldiers both in the field and in the hospital. This was to be how soldiers would be made safe, healthy, and ultimately come under hygienic control. Thus Nightingale sought to provide for the spatial control as a means of ensuring good health and healing. The picture that clearly emerges from Hammond’s piece is one in which the personal experience of health care is subsumed by the imperatives of the imperial project (much in the way that Kaplan-Myrth’s piece illustrates how Aboriginal health care issues were subsumed into the Australian national state bureaucracy, see below). Significantly though, for Hammond, as for other articles, health care was also about rendering patients as legible, compliant subjects.

Nightingale’s architectural reforms were perfectly consistent with the exigencies of imperial power and knowledge derived from surveillance. Indeed, the ‘Nightingale Ward’ provided not only for hygienic ventilation, but also for open yet rigidly organized spaces where patients could be easily observed and made immobile with tightly-drawn sheets and close supervision by nurses. Here we have the paradoxical construction of nursing whereby femininity and maternal nurturing are contrasted with Nightingale’s powerful character and the independent, indelible imprint she left on hospital reform.

The journal then turns to a more modern context with the case of public health care for Aborigines in Australia in Nili Kaplan-Myrth’s engaging ‘Black, White Brindle: Community Advocacy in Australian Aboriginal Health’. Kaplan-Myrth uses oral interviews to explore the broader dimensions of community-based health care in a country deeply divided by race and class. She contrasts the generally good state of health care for white Australians with the historically limited resources available to Aborigines. Yet, as she also shows, more recent developments in the area of the Aborigine-controlled health care sector have empowered certain elements within Aborigine society. They have also created new fault lines as it has raised questions about Aborigine identities and the meanings of these identities for the provision of, and access to, health care. While these are, as Kaplan-Myrth argues, socially constructed and imagined communities, as is the imperial ideal in Hammond’s article, there remains a stark material reality which shapes the discourses of public health within the context of the race and class divide in Australia.

According to Kaplan-Myrth, health care is a site for the meeting of communities and the emergence of multiple discourses about the meaning of public health for both state actors and private individuals. This is complicated in the case of Aborigine health care, in part because of historic inequalities—a major recurrent theme in the experience of both ill-health and differential access to health care— and in part by the ways that Aborigines blurred the boundaries between the public and private spheres of health care.⁴ Kaplan-Myrth contrasts the community-based Aborigine approach to health care issues with the highly bureaucratized nature of the Australian state’s approach. For the Aborigines, however, even their personal, individual experiences with health care

provisions are subsumed into wider community-oriented advocacy and activism. In many regards then, this article shows how the needs of individuals and marginalized small Aborigine communities can be lost in abyss of state bureaucratization. This poses some challenging questions. What will become of these grass-roots initiatives as the state retreats further from public health care? Will, for example, public health care become more relevant and personalized as it reverts back to local communities and private initiatives?

Of particular significance for Kaplan-Myrth's story is the role of Aborigine leaders –some self proclaimed- who distance themselves from their communities as they accrue power by straddling the worlds of the Australian state and Aborigine communities. These leaders have a deeply ambiguous role to play as far as the Aborigine communities are concerned. They both facilitate the expression of collective Aborigine needs in terms of public health, and they represent government authority and interests as they sit on community-based health committees. In sum, this article reveals and illuminates the limits of community-state health care initiatives and the ways in which various subjective meanings are derived from these initiatives. Thus, this contemporary case reflects the broader ambiguities of public health care, including differential access to and experiences of it, innate inequality, and confused motives and meanings.⁵

Lisa Diedrich's compelling analysis of two personal accounts of ill-health and institutionalization in her "Space, language and Death in Two Twentieth-Century Memoirs of Tuberculosis" brings us to the more personal and subjective experience of public health institutions. Through her critical reading of Betty MacDonald's *The Plague and I* and *Madonna Swan* (an oral history), Diedrich illuminates the very essence of the personal and private experience of public health in institutional settings. By using Foucault, she shows that people's personal experiences of tuberculosis hospitals were shaped by medical, professional, and state practices of social control which are deeply embedded in the nexus of power and knowledge derived from the patient-institution relationship. Diedrich's penetrating commentary reveals the ways in which the patient experience is conditioned by perceptions of and responses to race, class and gender. This is central to Foucaultian theories of knowledge and power as they applied to an understanding of the importance of observation and classification for medical patients and medical discourses. Defining and rendering legible the type and nature of the 'patient' was the key to public health success. As both Diedrich and Hammond show, the idea of Bentham's panopticon and knowledge derived from observation were central to the nature of institutional health care.⁶ Indeed, like several other articles in this volume, Diedrich draws our attention to the symbolic and medical importance of record keeping as a way to mark the boundary between different groups.

In a fascinating contrast, Diedrich's shows how Betty MacDonald and Madonna Swan create their own stories as a 'counter-narrative' to the patient life histories which the doctors produce. In these deeply personal and revealing counter-narratives, we come to a greater understanding of the ways in which people, as patients, see themselves and how they reflect on the how they are perceived by others. Yet, as with the Argentine

case (see below), defining patients in medical terms also entailed a blurring of categories. Patients with conditions perceived to be a threat to public health and well-being, such as TB or mental illness, were not just stigmatized socially. They became objects of concern for public security, and they were often associated with everything from criminality to threats to the nation state.

At the heart of these experiences lay a deeply ambiguous paradox. On the one hand, public health and health care institutions sought to prevent the spread of disease through often progressive measures for sanitation, nutrition and personal hygiene. On the other hand, public health and treatment schemes were often profoundly invasive as they sought to condition the personal lives of individuals. As Diedrich shows, TB patients were so isolated, observed and closely controlled that they even had limits placed on the most mundane of activities; ‘patients must not read...talk...laugh...sing...reach (etc.).’

Yet patients can have different experiences of both disease and health care and so derive very different meanings from these experiences. Yet, overall, what we learn from these stories is the considerable power that health practitioners and the state have to discipline patients and condition their responses to the demands of health care. In the end, many are compliant not just because they believe in the efficacy of treatment but also because they believe in the knowledge and authority of those who construct the hegemonic meanings of health care. Ill-health has a moral meaning. Good health then, is conditional upon the achievement of ‘good behavior’ as defined by medical professionals and the state, and those outside the norm (of health, race, class and gender) are subject to greater discipline.

While in northern Europe, North America and Australia we see the development of a highly bureaucratized and relatively efficient public health sector, other issues emerge when we direct our attention to areas of the so-called “Third World.” This is no where more evident than in the history of public psychiatric institutions. For decades, historians focused on places like Britain and the United States, where the state was able to elaborate a complex and dense network of institutions for the mentally disabled. Recently, scholars have begun to examine how psychiatry and its practice differs in areas characterized by low state capacity and economic instability.⁷ Di Liscia, Bassa and Billorou’s article “Institutional confinement of the insane in the interior of Argentina: La Pampa and the Insane, 1900-1945” suggests that the state is not always as vigilant, observant or controlling as one might expect and the “career” of patients can take unexpected turns. Although large public institutions existed in Buenos Aires by the end of the nineteenth century, with one exception, there were no public psychiatric hospitals in the rest of the country until the 1940s. For such a large country, the uneven geographic distribution of appropriate care meant that those diagnosed with mental illness, especially in small isolated towns and villages, were often shunted between police stations, local jails and prisons, and eventually one of the three national asylums located in and around Buenos Aires. Doctors at the time recognized that this state of affairs often aggravated individuals’ conditions, while it

also contributed to the tendency of families and communities to abandon and ultimately to forget those who had been sent away. Abandonment and neglect continued once patients were received at one of the national institutions in greater Buenos Aires. Overcrowding, poor funding and a shortage of adequate staffing meant that doctors were unable to attend the individual needs of patients. Di Liscia, Bassa and Billorou uncover the extent of this neglect through a careful analysis of the records from one of the national asylums.

Admission forms and clinical histories reveal that most patients received but cursory treatment once they were admitted. In some cases, the only record of a patient's existence in the hospital was an admission form. Thus, the authors suggest that the Argentine state's capacity to intervene in civil society, for purposes of social control and social welfare, have been historically much more diminished than scholars have hitherto recognized.⁸ Weak states with limited capacities have had a profound influence on the state and public health and the lives of patients (not to mention doctors) and this begs the question of how their experiences differed from their fellow patients elsewhere in the world.

Adriana Valobra's article "Public Health Policies, Women's Organizations and Mothers in the Province of Buenos Aires, 1946-1952", also suggests that the absence of an effective state is crucial to our understanding of Argentina's public health history. Although historians have traditionally explored the expansion of state intervention into civil society during the presidency of Juan Peron, Valobra's examination of maternal and natalist policies in the Province of Buenos Aires suggests that much can be learned by examining the tension between the formulation and enunciation of policy initiatives and their implementation. Valobra also pushes readers to consider how Peronism, which is typically analyzed from the perspective of national policy, played out in provincial politics and government. The province's maternalist and child care policies suffered the same set of contradictions as we find in inter-war Europe; what exactly was the state's interest in helping women to safely bear children and to raise them in a hygienic manner? Was the goal to help women better bear and raise children so that they could gain financial security and/or independence by providing child-care services? Or, alternately, did maternalist policies seek to encourage women to eschew work and remain at home? Was the state's primary interest to produce biologically fit Argentines? These debates about the purpose of state policy fit into a broader cultural debate about what the ideal woman and mother was. Health policy, however, tended to confuse womanhood and motherhood. Paradoxically, traditional ideas about women's roles were contradicted by a medical rhetoric that challenged working class women's competence to rear children. Valobra demonstrates how the provincial government sought to "rationalize" child rearing through the enforcement of universal kindergarten and primary school. There seemed, in the Argentine context, to be a medical and sociological imperative, to remove children from the influence of mothers as quickly as possible. Valobra further complicates our understanding of state intention by examining how both individual women and leftist women's organizations

challenged maternalist and childcare policies. Moreover, Valobra points out that while the provincial state argued for its important role in the process of child rearing, the government never invested any where near the levels that they claimed were needed.

Several important themes emerge from these examinations of psychiatric care and maternalist policies in Argentina. It is clear that the Argentine state's aspiration to create modern, scientific and hygienic institutions and bureaucracies was limited by economic and political factors. In this respect, we can expect to see that the Argentine experience bears closer resemblance to public health experiences in much of the so-called developing world.⁹ A successful public health system, after all, is predicated on political stability and economic prosperity. Witness the collapse of public health infrastructures in the former Soviet Union, or for that matter, parts of post-1990s neo-liberal Latin America.¹⁰

In the period before the 1930s, Argentine positivists modeled their approach to public health on an idealized scientific and hygienic state. Argentine public health advocates and bureaucrats were keenly interested in developments in Europe and in other countries of recent settlement (Canada, the United States and Australia). With the rise of Peronism, with its nationalist discourse, Argentina's public health promoters began to seek models of state-building in southern European fascism. The goals were nonetheless rather similar: to create a healthy, sane, and stable work force that was at once docile and loyal to the nation-state. The Argentine experience also stands in marked contrast to the more successful efforts to establish public health networks in the Anglo-American and Australian contexts, as demonstrated by the other essays in this volume. In those contexts, the question has often been more about how they function than if they function at all.

Argentine public health raises questions about how patients interact with public health policies and bureaucrats. Simply put, how do citizens interact with and shape state policy in a context in which state capacity is markedly circumscribed? Do individuals have greater say in their own treatment and that of family members? Likewise, is it easier, in case of psychiatric confinement, for individuals to manipulate hospitals to facilitate the hospitalization of bothersome neighbors or relatives? In the case of the mentally ill in the era before effective and safe psychiatric medicines, one might also be tempted to wonder if patients were better off in a place like Argentina where relatively few ended up hospitalized. A close examination of the archives of Argentine hospitals suggests that the ideal "hygienic state" of Argentine political elites (from the 1890s through the 1950s) never came into fruition and that public health bureaucrats, doctors and individuals recognized that the state was limited in its ability to contain, control and cure the populace.

Conclusions

How, then, are we to understand the imprint that public health institutions have left on the world? In addition to understanding the therapeutic efficacy of various treatments, we need to know what other meanings and outcomes reforms in hospital design achieved. We also need to analyze how the public, generally, views hospitals, and

how our personal experiences of these spaces connect with broader meanings whether intended or unintended. Is public health too embedded in the grasp of professional medical practitioners and state functionaries for it to be effective and relevant? With the retreat of the state from health care, what will take its place? At least in Western Europe and the United States, there has been a growth of both private, for profit, organizations and, on the other hand, community based care organizations such as the Hospice Movement. Will either the market or, in contrast, non-profit organizations, be able to provide more personalized and responsive approaches to patients needs and experiences? How do we reconcile state and medical professional's well-intentioned motives for public health with their demonstrated drive to accrue power by ascribing specific meanings of difference and deviance to those with ill-health, and to use this knowledge to effect social controls?

What is the relationship between broader public health policies and practices on the one hand, and the importance of individual's personal experiences on the other? As these articles show, we need to pay closer attention to the relationship between broader public health policies and practices on the one hand, and the importance of individual's personal experiences on the other. Additionally, as globalization continues apace, we will need to reconcile the exigencies of public health across the globe with the need to ensure that health care is relevant and efficacious for individuals and communities from markedly different cultures. Finally, we need to reinterpret public health in order to become more fully aware of the ways individuals and societies contest and shape it, and how it can be improved.

Footnotes

¹ R. Packard, 'Visions of Health and Development and Their Impact on Public Health Interventions in the Developing World', in F. Cooper and R. Packard, editors, *International Development and the Social Sciences: Essays on the history and politics of knowledge* (Berkeley, University of California Press, 1997); pp. 93-116

² For a critique of the social history of medicine, see 'Medical History without Medicine: Editorial,' *Journal of the History of Medicine* (January 1980): 5-7.

³ A. Carmichael, 'History of Public Health and Sanitation in the West before 1700' and J. Duffy, 'A History of Public Health and Sanitation in the West since 1700' in K. Kiple, Editor, *The Cambridge World History of Human Disease*, (New York: Cambridge University Press 1993): 192-206. R. McLeod and M. Lewis, *Disease, Medicine and Empire: perspectives on Western Medicine and the Experience of European Expansion*, (New York: Routledge, 1988).

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⁵ S. and E. Kark, *Promoting Community Health. From Pholela to Jerusalem* (Johannesburg, Witwatersrand University Press, 2001).

⁶ For a recent analysis of this see A. Butchart, *The Anatomy of Power. European Constructions of the African Body* (London and New York, Zed Books, 1998).

⁷ See Jonathan Sadowsky, *Imperial Bedlam: Institutions of Madness in Colonial Southwest Nigeria* (Berkeley: University of California Press, 1999)

⁸ For an analysis of the weakness of the state in Latin America, Asia and Africa see Miguel Angle Centeno, *Blood and Debt: War and the Nation-State in Latin America* (Pennsylvania State University Press, 2002) and Joel S. Migdal, *Strong Societies and Weak States: State-Society Relations and State Capabilities in the Third World* (Princeton: Princeton University Press, 1988).:-

⁹ See Packard, 'Visions of Postwar Health'.

¹⁰ See Marcos Cueto, "Stigma and Blame during an Epidemic: Cholera in Peru, 1991," in Diego Armus, editor. *Disease in the History of Latin America: From Malaria to AIDS* (Durham: Duke University Press, 2003).

Acknowledgements

The editors would like to acknowledge the intellectual and material support of numerous colleagues. We are grateful to the reviewers for the journal for their patience, diligence and collegiality. We would especially like to thank our friend and colleague Dr. Jeffrey Reznick, Senior Curator for collections at the National Museum of Health and Medicine for his insights and patient assistance with the journal and Dr. Elaine MacKinnon for her editorial assistance. We are also indebted to Dr. Pauline Gagnon, Interim Dean of the College of Arts and Sciences at the University of West Georgia for her support of this interdisciplinary journal and to Dr. Charles Clark, Chair of the Department of History at the University of West Georgia for his support of our initiative.

A note on the Editors and Contributors

Jonathan Ablard received his PhD from the University of New Mexico. He has published articles on psychiatry in Argentina, including “Authoritarianism, democracy and psychiatric reform in Argentina, 1953-1946” *History of Psychiatry* (2003) and “Law, Medicine, and Confinement to Public Psychiatric Hospitals in Twentieth Century Argentina,” in *Argentina on the Couch: Psychiatry, State and Society, 1880 to the Present* (University of New Mexico Press, 2003). He is currently assistant professor of Latin American History at the University of West Georgia.

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Lisa Diedrich is an Assistant Professor in the Women's Studies Program at Stony Brook University. Her current research and teaching interests include feminist cultural studies of health and illness, disability studies, global feminisms, and feminist theories and methodologies. She is completing two book projects: *Treatments: Negotiating Bodies, Language, and Death in Illness Narratives* (forthcoming from University of Minnesota Press) and *Feminist Time Against Nation Time* (edited with Victoria Hesford and forthcoming from Lexington Books).

María Silvia Di Liscia received her doctorate from the University Institute "Ortega y Gasset" of Universidad Complutense (Madrid). Currently she is associate professor of history at the National University of La Pampa. She is the author of numerous essays and books, including *Saberes, terapias y prácticas médicas en Argentina 1750-1910* (Madrid, CSIC, 2003); *Higienismo, educación y discurso en la Argentina, 1870-1940* (Santa Rosa, EDULPAM, 2004)

Cynthia Imogen Hammond is a postdoctoral fellow in the School of Architecture at McGill University, where she is studying the connections between nineteenth-century philanthropic work by women, and the modernist architectural movement. Dr. Hammond has a BFA from McMaster University, an MA in Art History from Concordia University and a Ph.D. in Humanities from Concordia. Her dissertation, which won the Governor General's Gold Medal for Doctoral Work (2002), addressed working class women's history in relation to the built heritage of Bath, England. She has published in *RACAR, Journal of Phenomenological Studies, Parachute* and in a locally-produced artist publication *La Petite enveloppe urbaine*, and continues to produce visual art in the form of performance and installation.

Nili Kaplan-Myrth is a medical anthropologist (PhD Yale University 2003) with expertise in Aboriginal health policy, social inequalities in health and participatory action-based research methodology. Her publications include "Health Research in Indigenous Communities: Overcoming Anthropology's Colonial Legacy." *Practicing Anthropology*, 26(4): 3-7. and "Alice Without a Looking Glass: Blindness and Body Image." *Anthropology and Medicine*, 7(3): 277-299. Dr Kaplan-Myrth held a post-doctoral research fellowship with the Department of Public Health Sciences at the University of Toronto in 2004. She is currently adjunct faculty with the First Nations University of Canada and a co-investigator with colleagues in Canada and Australia on projects to evaluate the design and delivery of health programs in Indigenous communities.

Adriana M. Valobra is a doctoral candidate at the Nacional University of La Plata where she is focusing on female citizenship during the first governments of Juan Perón. Her recent publications include "1943-1945. Continuidades y rupturas en la política argentina", *Boletín Americanista* (2004) and, with Karina Ramacciotti, *Generando el peronismo. Estudios de cultura, política y género. Buenos* (2004). with Karina Ramacciotti.

Reforming Architecture, Defending Empire: Florence Nightingale and the Pavillion Hospital

Cynthia Imogen Hammond

When we think of Florence Nightingale, we think of the Crimean War and nursing reform, of the Lady with the Lamp bringing order, skill, and pride to men and women sadly bereft of each. [...] To contemporaries, [however], she was identified with the reform of hospitals and military medicine as much as with nursing¹

Charles E. Rosenberg

[...]The question of military hygiene is rapidly becoming a question of vital importance to the interests of the empire. Upon the British race alone the integrity of that empire at this moment appears to depend. The conquering race must retain possession.²

Florence Nightingale, Report of the Commissioners, 1858

Florence Nightingale (1820-1910) is best known as an exceptional nineteenth-century woman, whose contribution to history was, foremost, to the field of nursing.³ During the late 1850s, Nightingale rose to public prominence as a nurse working for the British army, while stationed in Turkey. Later, Nightingale used this fame to forward her vision as a hospital reformer and sanitation advocate. During these years, Nightingale's quick ascendancy to iconic status intersected with British imperial interests and idealized femininity, with which she is habitually associated.⁴ The dovetailing of Nightingale-the-nurse with Nightingale-the-ideal-woman continues to be the engine powering discussions of her life and work, leaving largely untold the manifold nature of Nightingale's impact on the British reform movement in military and civilian hospital architecture, which reverberated throughout the British Empire.⁵ Nightingale's interest in architecture and the hospitals she championed and helped to create were, while remarkable and intelligent, also profoundly imperial in nature.⁶ Military hospital architecture was her first concern after her return from Turkey in 1856, and was conceived from the outset as an architecture that would guarantee surveillance, control, and of course, a healthy British army. Even more, the military hospital Nightingale sought to reform was a form of territorial occupation that would, like a hierarchical military camp, represent the imperial order while claiming space for the operation of that order. To highlight Nightingale's work within the scope of architectural history and gender theory is to complicate the lingering image of Nightingale as (only) a "ministering angel," and raises important questions about the relationships between gender, space, imperialism and architecture. The work that pushed Nightingale into the public eye is my focus: her reform of a makeshift military hospital in Istanbul,

Turkey, during the Crimean War (1854-56), and the ensuing hospital model she would spend the rest of her life defending.

Nightingale's longest-held ideas about hospitals are generally agreed to have originated during the Crimean War,⁷ a time that was also key for another discourse: the theory of sanitation and hygiene as preventative measures to block the spread of disease. Just before her departure for Turkey, Nightingale had begun to consider seriously the causes of intestinal disease and cholera as being related to the sufferer's environment.⁸ After her experiences in Turkey, Nightingale was deeply converted to the position that the cleanliness and ventilation of a given environment could either save or kill its users.⁹ The language of volition and pathology placed the responsibility for general health and welfare firmly in the hands of the patrician classes, not just doctors, but wealthy reformers, politicians, even the regent herself. Such responsibility was the natural burden of the privileged. The terms of such responsibility parallel the rhetorical expressions of responsibility for, and entitlement to the "Orient". Just as the impoverished and (therefore) helpless hospital patient required the intervention of the enlightened and benevolent hospital reformer, so did the childlike, deprived or fallen "Oriental" need the supposedly rational and mature governance of the European. As Edward Said writes, "The Orient was viewed as if framed by the classroom, the criminal court, the prison, the illustrated manual."¹⁰ The "hospital" could be added to this list after 1854.

In terms of British interests in Turkey in the 1850s, Said notes, "the British [...] saw the Orient as a geographical...entity over whose destiny they believed themselves to have traditional entitlement."¹¹ The view of the Ottoman Empire as "hopelessly ill"¹² or sick helped to justify the British presence, a soft occupation in the form of war against another imperialist threat. Russia, the putative enemy, was simply another imperial power eyeing Turkey with as much longing as the countries of western Europe. During the Crimean War, Britain sent its army to Turkey ostensibly to protect the Ottoman Empire from Russian advances. This campaign was, like its French counterpart, an attempt to assert and consolidate colonial interests in the region, a preparatory step towards formal rule.

Architectural historian, Mark Crinson has made a case for architecture as an imperial tool, if a conflicted and slippery one. He has examined how, in the years leading up to the Crimean War, the British constructed various administrative and financial buildings in Turkey, notably in Istanbul. Crinson situates these buildings as the material foundations of an "informal empire," an important prelude to formal imperial rule. "As an embodiment of British presence," Crinson writes, "architecture was the form in which British ambitions and identities were made physically apparent."¹³

Crinson cites Said's landmark analysis of Orientalism as "a form of cultural paternalism that reduced, abstracted and restructured a myriad variety of histories and societies into a totalizing tightly knit group of essentialist tropes and repetitious patterns, the 'complimentary opposite' to the culture of the imperialist."¹⁴ Crinson's understanding of early British imperial architecture in Turkey depends upon Said's analysis of

Orientalism, but departs from the notion that all practices and effects of Orientalist discourse resulted in an unwavering binary code. Material and visual culture, according to Crinson, is a filter for how colonial rule and presence manifested in “differentiated expressions – perhaps even ambiguous, compromised or ineffective”.¹⁵ What this nuance permits is the recognition that British imperialism in Turkey was, while undoubtedly a demonstration of power, also an uneven expression, whose conflicted origins may find an echo in built form. If these early, uneasy architectural incarnations of imperial authority were the armature over which the British could later weave a formal empire, then Nightingale’s reform of a British military hospital in Istanbul in 1854 would be a significant step in this journey.



Figure 1., Scutari Barrack Hospital by Lady Alicia Blackwood, c. 1854 [Copyright: Wellcome Institute Library]

When read as spatial and architectural in nature, Nightingale’s transformation of the barrack to a well functioning hospital becomes a concrete gesture supporting one empire’s claim over another.

There were thirteen British hospitals set up for the Crimean War, most in or near Istanbul. On the Asian side of the Bosphorus, the Scutari barrack “hospital” was only makeshift. Designed in the early nineteenth century by Kirkor Balyan for the Sultan Selim, Scutari barrack was never intended to serve as a hospital, but rather was donated to the British to aid them in their mission. The barrack is an imposingly large, three-story building positioned strategically on a steep hill that rises from the Uskudar boat landing. The rectangular shape encloses a quadrangle, and is marked by tall towers on each corner. As may be seen in Nightingale’s partial plan of Scutari, a corridor (approximately five metres wide) runs continuously around the building’s four sides of the building, on the side of the enclosed, central quadrangle.

On Nightingale’s arrival, she found soldiers housed in the large barrack rooms that led off this corridor. As a hospital, Scutari was an administrative and architectural failure, especially in comparison to another British military hospital built in Turkey, Isambard Brunel’s prefabricated design at Renkioi.

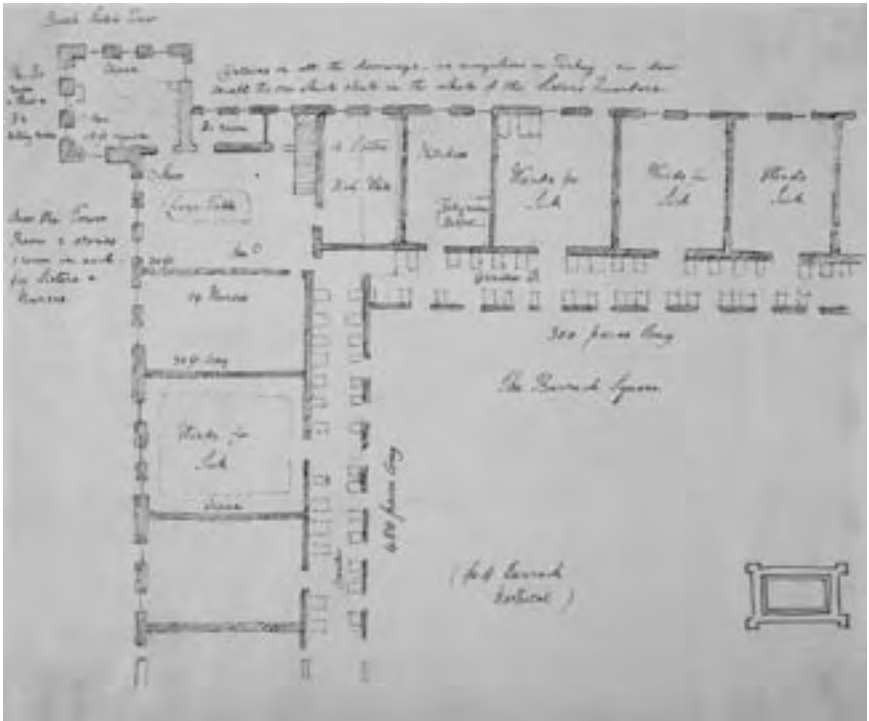


Figure 2. Florence Nightingale’s partial floor plan of Scutari Barrack Hospital, c. 1854 [Copyright: Wellcome Institute Library]

With its sophisticated sewage and ventilation systems and its development through public consultations, purpose-built Renkioi was a model for modern, efficient hospital construction.¹⁶ But economical and self-sufficient Renkioi was still unfinished by the end of Crimean War, as opposed to Scutari, whose infamously high death rates were far more important to British followers of the war than Renkioi’s exemplary design. Scutari represented the consequences of an unwanted war. The military campaign to “save” the Ottoman Empire was unpopular with British citizens from the start, and was infamously mismanaged. During the first summer of war, correspondents began to provide accounts of grossly inadequate hospital facilities, particularly at Scutari. On October 12th, 1854, *The Times* presented the following description of Scutari, after dysentery and cholera had become epidemic among wounded soldiers:

Not only are men kept, in some cases, for a week without the hand of a medical man coming near their wounds; not only are they left to expire in agony [...] but now, when they are placed in the spacious building, where we were led to believe that every thing was ready [...] it is found that the commonest appliances of a workhouse sick-ward are wanting, and that the men must die through the medical staff of

the British army having forgotten that old rags are necessary for the dressing of wounds.”¹⁷

Writing for *The Times*, William Howard Russell’s early accounts confirmed the anxiety of many readers, describing ill and wounded soldiers in brutal and revolting conditions, at greater risk of dying in Scutari Barrack Hospital than on the battlefield. Public outcry was immense. On the basis of Florence Nightingale’s well-known roles as upper-middle-class philanthropist, professional nurse, and self-taught expert on nursing and hospital administration, the War Office, via Stanley Herbert, invited Nightingale to lead a contingent of thirty-six female nurses to Scutari.¹⁸

On her arrival on November 4, 1854, Nightingale set to work on a comprehensive reform of the barrack, over time shifting its use as a makeshift hospital to what would be a model of modern nursing, hospital administration and spatial organization. As Sue M. Goldie explains, Nightingale “analysed the causes of the [...] disaster [...] formulated and developed a comprehensive scheme for administering the hospitals, for purveying, feeding, clothing the inmates, for raising and training an efficient corps of hospital orderlies”.¹⁹ To enable this administrative overhaul, Nightingale continually intervened in the space of the barrack, establishing and reorganizing wards according to function and degree of casualty. She also ordered the construction of rooms, laundry facilities, bathhouses, a reading room for convalescents, special kitchens, and organized segregated spaces for the female nurses.



Figure 3. Interior of Scutari Barrack Hospital, unknown artist [Copyright: Wellcome Institute Library]

Figure 3 shows men eating a meal on one side of the corridor, with beds neatly arranged on the right. Here, Nightingale and the nurses performed one of the tasks that would figure so importantly in her later studies of hospital organization and disease prevention. The cleanliness of the human body, its bandages, clothing and bedding, were central weapons in her battle against illness.²⁰

These images are a vital record of how Nightingale's battles against a massively inefficient bureaucracy resulted in a far more efficient and humane care-giving institution, and how such administrative changes manifested physically in changes to the space of Scutari. Her "production" of the space of Scutari Barrack Hospital may be related to Henri Lefebvre's discussion of how individuals effect, or "produce" their environments. Humans do not live, he argues, "by words alone; all 'subjects' are situated in a space in which they must either recognize themselves or lose themselves, a space which they may both enjoy and modify."²¹

Nightingale's concern for the army and spatial modifications went beyond the medicalized boundaries of Scutari. In letters to politically connected friends and members of the British government, she argued passionately for the construction of better housing for the army, from temporary huts to a new form of clothing to be worn in the trenches, which itself could be a form of shelter.²² Within a year of her arrival in Scutari, Nightingale was writing to Lieutenant General Richard Airey, advising him on measures to take to prepare "her" soldiers, spatially, for winter. She even went as far as consulting an engineer to ensure the viability of her plans for water filtration systems and for the winterizing and structural reinforcement of army huts.²³ Her concern for the bodies of soldiers was consistently addressed to the spaces that surrounded them.

Nightingale did not see herself as a beacon of femininity within the harshness of war. In private letters, she rejected the idea that her presence at Scutari was the "result of an indefinite feeling of feminine compassion";²⁴ on the contrary, she likened herself to an "officer in the heat of battle providing for his men's safety."²⁵ In a personal letter of March 1856 she described herself as having "joined the Army" and wrote, "I am struck with the soldier's superiority as a moral & even as an intellectual being."²⁶ From this position, Nightingale's letters to cabinet members and high-ranking officers resound with outrage over the general incompetence with which the Crimean War was managed, and the impending promotion of those she felt to be responsible for the disaster. She wrote to Lieutenant Colonel Lefroy in March 1856:

I [...] saw the men [...] all that long, long, dreadful winter [...] without other covering than a dirty blanket & a pair of old Regimental trowsers [sic], when we knew that the [army] Stores were teeming with warm clothing [...]. They were] living skeletons, devoured with vermin, ulcerated, hopeless, speechless, dying like the Greeks [...] in that month there were 1000 more burials than deaths registered. [How c]an we hear of the promotion of the men who caused this colossal calamity [?...] will the next thing be the "Decline & Fall of the" British "Empire?"²⁷

Within a year of her arrival at Scutari, Nightingale's reforms had coincided fruitfully with the assistance of Sanitary Commission, who implemented important changes to the environment of Scutari in March 1855. Improvements in hygiene, organization and overall sanitation cut the death rate from 578 deaths for every 1000 patients, to only 17 deaths per 1000 patients. By the time of her return to England, Nightingale could claim that "the Barrack Hospital at Scutari was the finest in the world,"²⁸ while her own iconic status as a lady of unstinting compassion and courage was firmly established. But there was one shift in perception that Nightingale had not yet achieved, and this was a general understanding of the effect of hospital design, construction, sanitation and administration on the life expectancy of its patients.

Before examining how Nightingale achieved this goal in England, some discussion of the nature of her interest, and its implications, would be useful. It should be emphasized that her focus on hospitals did not amount to the traditional emphasis on the architectural façade.²⁹ Her interest was rather to analyze the ways in which hospitals function, and to find language that would stir her readers' sense of justice, logic and liberal values. For Lefebvre, architecture is composed of connections between the individual, the physical (as opposed to the imaginary or conceptual), and the social spheres. How people enjoy, transform, resist, and acquiesce to the spaces in which they live and work, and how such responses affect larger political and economic realities, are central to his ideas.³⁰ He writes of affective knowledge and ideology, which "texture," or distinguish spaces from one another. He conceives of architecture "not as the building of a particular structure, palace or monument, but rather as a project embedded in a spatial context and a texture." "History," he continues, "would have to take in not only the genesis of these spaces but also, and especially, their interconnections, distortions, displacements, mutual interactions, and their links with the spatial practice of [a] particular society..."³¹

Drawing from these insights for the case of Nightingale's work at Scutari and later in England, means locating this work within the cultural values, imperial conditions, philanthropic imperatives and gender roles that Nightingale herself emerged from and reached for, rhetorically and perhaps most effectively, in her books, pamphlets and letters. As medical historian, Charles Rosenberg notes, Nightingale's written image of the hospital was in equal parts administrative, metaphorical and affective. He argues that Nightingale's "etiological views didactically underlined the connection between behaviour, environment, and health [...] Nightingale's emphasis on atmosphere was an emphasis on environment..." But this was no ordinary environment. The environment of the hospital was a constructive as well as a protective or nurturing entity; it was an

environment construed, so that hospital morale was as much a determinant of that atmosphere as was the placement of windows and fireplaces or the frequency with which walls and floors were scrubbed [...] The hospital seemed to [Nightingale] quite literally a microcosm of society, every part inter-related and all reflecting a particular moral order [...]

The hospital [...] determined the individual's health, on the one hand,
and that of society generally on the other [...].³²

If these are the implications of Nightingale's convictions and reform work, it may well be asked how one so well known as a nurse was equipped to make the spatial and administrative changes, and with such authority, especially in Turkey when she was still relatively young. Women were not permitted to formally study architecture in Britain until the 1890s, partially due to women's status as "property," which was law until the passing of the 1882 Married Women's Property Acts. As architectural historian, Lynn Walker notes, "property cannot design property".³³ Walker demonstrates, however, that women in England had engaged in architectural practices for centuries, working in the building trades, as philanthropists creating better housing for workers, and as upper-class, non-professional architects.³⁴ Well-educated, privileged women such as Nightingale were highly literate and were often skilled in mathematics, drawing and other skills needed for practising architecture, such as surveying.³⁵ Anecdotal evidence further suggests that Nightingale had very early on developed an interest in the architecture of hospitals. Of her father's renovation of the family home during her youth, Nightingale is said to have remarked, "Do you know what I always think when I look at that row of windows? I think about how I should change it into a hospital, and just how I should place the beds."³⁶ Well before her voyage to Turkey, Nightingale had studied multiple plans and layouts of existing hospitals, making analytical studies of their spatial efficacy, a practice she would continue for the rest of her life, and employed soon after her arrival in Istanbul. (See Fig. 2)

Nightingale's interest in hospitals, nursing and hospital administration also point to a larger, significant relationship between women, architecture and medicine, or health, in nineteenth-century British women's history. Architectural historian, Annmarie Adams has shown how middle-class women collaborated with doctors and architects to redefine the Victorian family home between 1870-1900.³⁷ In the battle to secure a clean, healthy and safe home for their families, feminist housing advocates actively lobbied for the reform of domestic architecture, and in so doing, "proved their readiness for changing ideals and exhibited their competence as mothers, managers, and healers."³⁸ Adams' book, *Architecture in the Family Way*, suggests a broad range of roles that ran across the supposedly disparate worlds of medicine, domesticity and architecture, indicating that non-professional women had significant spatial knowledge and expertise, as well as influence in terms of how houses were actually built.³⁹ Nightingale would become the example par excellence of how an upper-class woman could have an enormous impact upon the built environment, without actually having the professional status of an architect.⁴⁰

That Scutari was central to the development of her thoughts and convictions regarding hospital architecture is attested to by the first project she embarked upon after her return from Turkey. Her written contribution to the substantial government study, *Report of the Commissioners appointed to Inquire into the Regulations Affecting the Sanitary Condition of the Army, the Organization of Military Hospitals, and the Treat-*

ment of the Sick and Wounded; with Evidence and Appendix, was published in 1858. This lengthy volume examines the question of how and why the military failed to provide adequate medical care for its soldiers in the Crimean War, and elaborates on solutions to the problem. In the appendix devoted to Nightingale's ideas and research, Nightingale is asked to provide opinions about nursing in military hospitals, but this is the least of her contribution. The questions directed to her continually indicate her status as an expert on hospital design and administration. For example, Nightingale is asked to state what she feels is the "best plan of hospital construction, for fulfilling the requisites of good sanitary condition and facility of administration, with [her] reasons for preferring any plan or plans to others".⁴¹ Her extensive answer deals with hospital construction first, then the pavilion model, the design of the ward, hospital discipline, spatial proportions, building materials, staff accommodation, and issues of hygiene. In her comprehensive answers to examiners' questions, Nightingale repeatedly refers to French military use of pavilion plans and methods of sanitation and ventilation. The liaison between successful hospital design, construction and administration, and imperial goals becomes clear nearing the end of her contribution. An excerpt from the conclusion to her appendix is worth quoting at length.

In a country like ours with a limited population, an entirely voluntary system of recruitment, and colonies and possession in all climates and latitudes, the question of military hygiene is rapidly becoming a question of vital importance to the interests of the empire. Upon the British race alone the integrity of that empire at this moment appears to depend. The conquering race must retain possession. Experience has shown that without special information and skilful application of the resources of science in preserving health, the drain on our home population must exhaust our means. The introduction, therefore, of a proper sanitary system into the British army is of essential importance to the public interests. The Crimean experience...has shown that...England has nothing to dread but the results of her own inexperience and want of foresight.⁴²

The dread was quite real and consequently the reforming spirit was alive and well in England, and receptive to Nightingale's efforts. The research that went into Nightingale's report to the Royal Commission provided her with the raw material from which she would proceed, championing the pavilion model and stringent building and administrative models for military and civilian hospitals alike. In 1860, Nightingale published *Notes on Hospitals*, a study of hospital designs, locations, organization and their impact on mortality.⁴³ Reprinted repeatedly, Nightingale's central thesis was simply that good hospital design, construction and administration – not nursing – would save lives. Nightingale informed her readers that in mid-century London hospitals, nine out of every ten patients would die. "Only [i]f the function of a hospital were to kill the sick," she wrote dryly, would these numbers would be admissible.⁴⁴ Position-

ing herself at the forefront of current theory in the study of communicable disease, Nightingale asserted that “original defects in the sites and plans of hospitals...deficient ventilation and overcrowding”⁴⁵ were the cause for the dismal statistics with which she introduced her study.

Nightingale’s book was not simply a statistical critique of existing hospitals. As much an architectural manifesto as a practical guide to building, *Notes on Hospitals* included model floor plans, lighting and ventilation methods, and rules for spatial organization. The book addressed a diversity of issues, from the importance of concrete in construction, to the role of religion in hospital administration. The pavilion hospital, which in her opinion allowed for maximum efficiency, ventilation and observation, was the only architectural form that Nightingale believed would reduce the environmental causes of mortality rates in military and civilian hospitals alike. For decades Nightingale dedicated herself to this model and its adoption at home and abroad, in addition to her reforms of the nursing profession. Architectural historian, Jeremy Taylor notes her impact: “That the underlying pavilion design ideal was [emphasis in original]so clear and well-understood by architects and clients [in the 1860s] was in large part due to the formidable influence of [...] Florence Nightingale.”⁴⁶

Nightingale’s authority was mirrored in the broad adoption of the pavilion model in England and the British Empire after 1858. Two examples of hospitals that illustrated Nightingale’s opinions were the Herbert Military Hospital, constructed in Woolwich, England between 1859 and 1864, and St. Thomas’s Hospital in London, completed in 1871.

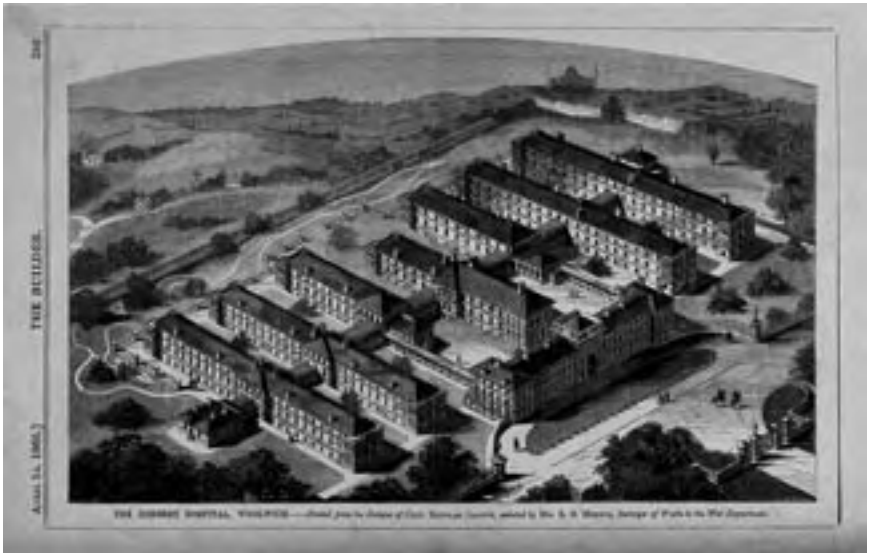


Figure 4. Captain Douglas Galton and others, plan of Herbert Military Hospital, Woolwich, England, 1859-64. [Copyright: Wellcome Institute Library]



Figure 5. Henry Currey, plan and bird's eye view, St. Thomas's Hospital, London, 1871 [Copyright: Wellcome Institute Library]

Architectural historians John D. Thompson and Grace Goldin assert that the Herbert Hospital was “the first hospital to be built entirely under her supervision”.⁴⁷ A series of letters between Nightingale and Colonel John Clark Kennedy, Commandant at Woolwich, in 1861 reveal the centrality of Nightingale’s role in advising, criticizing and approving plans for the soon-to-be completed hospital. On April 23, 1861, Nightingale wrote, “I am exceedingly struck with the ingenuity of the plan [crossed out in original] construction. It can be enlarged with so much facility, if necessary [...] I cannot conceive a better plan...at the same time, there are obvious defects in which it would not be difficult to improve on them.”⁴⁸

The 1863 edition of *Notes on Hospitals* shows no such ambivalence. Nightingale identifies Herbert Hospital as “the finest hospital establishment in the United Kingdom”.⁴⁹ From the implementation of concrete foundations, to the limit of twenty-six beds to a ward, Nightingale applied lessons learned at Scutari to buildings on English soil. With two floors of wards to each pavilion, high ceilings, whitewashed walls, polished floors, well-situated water-closets, careful attention given to the admission of light and air, and the separation of patients from administrators, Herbert Hospital met Nightingale’s basic requirements for a “healthy” hospital.

But, as Thompson and Goldin note, “Florence Nightingale was trained by the army. Her wards reveal, both architecturally and administratively, the barracks influence.”⁵⁰

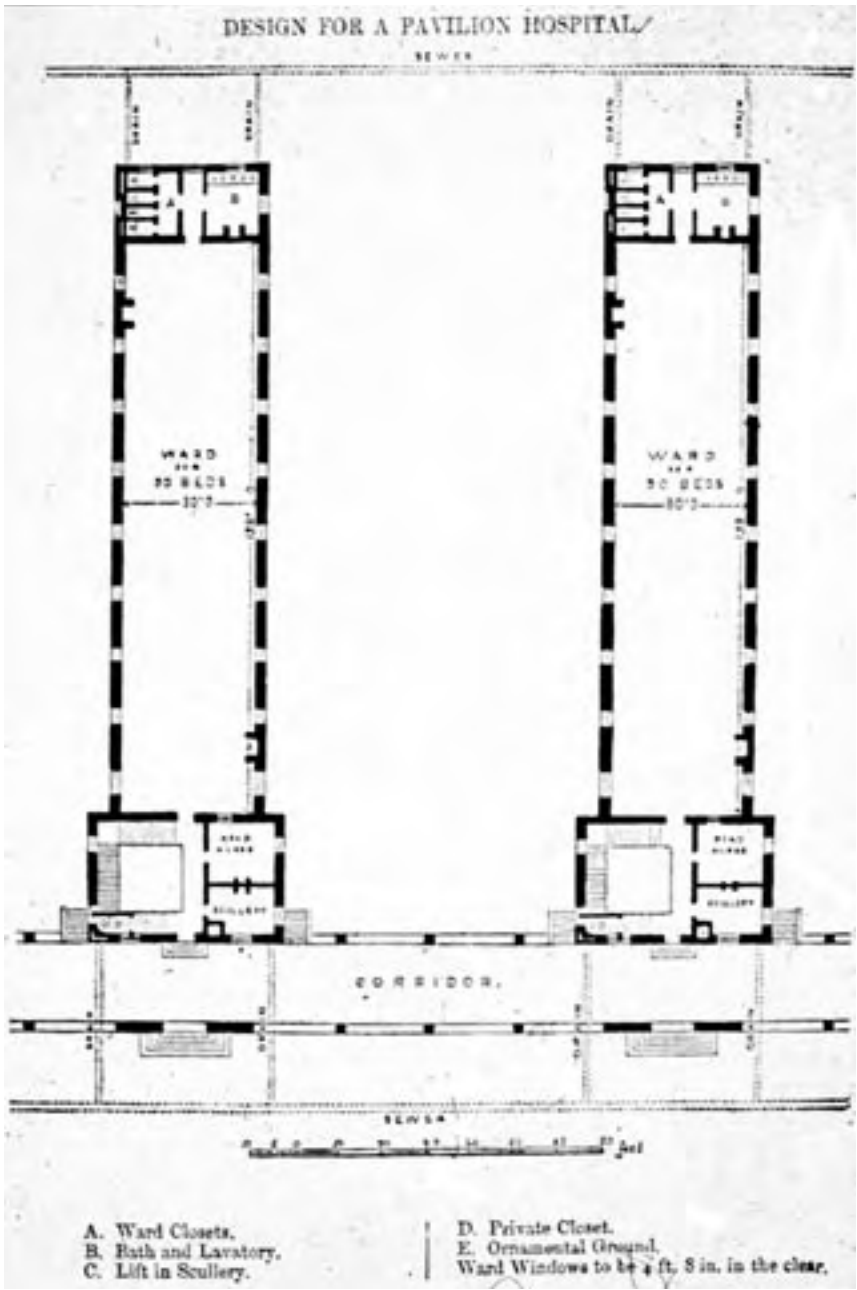


Figure 6. Florence Nightingale, Nightingale Ward, c. 1854-58. Note the “closet” is a toilet; the “lift” is a dumbwaiter. [Copyright: John D. Thompson and Grace Goldin, 1975: 160]



Figure 7. Interior, Nightingale Ward, circa 1930, Darlington Memorial Hospital. [Copyright: Wellcome Institute Library]

They also note the “military immobility” of the wards and beds, with their tightly drawn sheets, their rigid organization, and accessibility to the supervising eye. One senses the impulse, if not its forms, behind Jeremy Bentham’s Panopticon in these halls and in other hospitals built along the lines of the “Nightingale Ward”.

Michel Foucault has described how discourses and knowledge become manifest and empowered in what he calls “surfaces of emergence.” Paul Hirst describes developments in the nineteenth-century clinic; “The hospital is not merely a site of care, but a machine of observation – a central institutional condition for the clinical gaze. The new ‘surfaces of emergence’ in clinical medicine thus depend on definite institutions, and on their social and organizational, and not merely their discursive, conditions of existence.”⁵¹ According to Hirst and Foucault, surveillance is the action by which subjects of observation are transformed. An architecture that enables surveillance intersects with the power of those who observe, effecting “norms of performance” in the conduct of the ideal patient.⁵² In a lengthy chapter on Indian Hospitals in *Notes on Hospitals*, Nightingale explains the importance of visibility within an ideal ward.

In a sick ward, simplicity of construction is essential to good ventilation. There should be no transverse arches or thick pillars, no double verandahs [sic] nor corridors. The ward should be perfectly open from end to end, and from side to side. [...] The hospital sergeant’s room must always [...] overlook one ward, and if not both, the orderly’s room must overlook the other. [...] Each ward should [be...] so arranged

as to prevent the patient going out or holding communication with persons outside; and yet with a perfectly free cross ventilation between the closet and the ward.⁵³

While clearly concerned with enabling the free flow of air, so central to disease prevention and recovery in contagion theory, the Nightingale Ward also allowed for continual surveillance and control of the patients. These could be British civilians, soldiers, or – as in the case of hospital plans for India – colonized subjects. The design of an ideal hospital for Nightingale was bound up with notions of cleanliness, order, observation and education. The health of the patient was as dependent upon the order within her hospitals as the health of the empire was dependent upon the order of its subjects.

In 1871, architect Henry Currey built a 600-bed hospital on the banks of the Thames River in London. (See Fig. 5) St. Thomas's Hospital again followed the principles of Nightingale's wards and pavilion plans, and was considered a triumph within the hospital reform movement.⁵⁴ As part of her agreement to oversee the planning and construction of this hospital, Nightingale was given space within the structure, in which to continue and expand her training school for nurses.⁵⁵ Students in the Nightingale Nursing School were educated to perform locally and prosthetically, as the solicitous fingertips of the arms of the empire. After graduating from the School, writes Helen Gilbert, "the heroic nurse could then find a place for herself in other imperial ventures,"⁵⁶ some even in hospitals modelled on Nightingale's instructions, such as the Royal Victoria Hospital in Montreal, Canada.⁵⁷

During the latter half of the nineteenth-century in England, the narrow definition of public life for women had expanded considerably, with women entering into a variety of professionalized realms, even if not as professionals themselves. But no analysis of social roles for women in nineteenth-century England could be complete without consideration of the impact of imperial discourse and practices, which reverberated throughout every echelon of British life, at "home" and abroad. In the case of a woman who had enabled the British army to perform its operations more successfully, the question of the link between sanctioned gender roles and imperial politics is an essential consideration. Nightingale, despite describing herself privately as an "officer in the heat of battle," publicly held the opinion that nursing was universally feminine. In 1860, three years before she published the definitive edition of *Notes On Hospitals*, Nightingale released the book that would remain her most famous, *Notes on Nursing*. In the preface to , Nightingale wrote, "Every woman [...] has at one time or another of her life, charge of the personal health of somebody, whether child or invalid – in other words, every woman is a nurse. [emphasis added]"⁵⁸

Notes on Nursing is in effect a preface to *Notes on Hospitals*, and served to frame Nightingale's work in Turkey – and for the imperialist project – as fundamentally feminine in nature. Femininity, it must be emphasized, was widely understood in the Victorian era to be an undifferentiated ideal, timeless and without geopolitical boundar-

ies.⁵⁹ Nightingale's official mission, to bring female nurses to care for soldiers overseas, was unprecedented, and with its advent nursing also acquired these characteristics.⁶⁰ As scholars Edward Said, Linda Nochlin and Zeynep Çelik have established, the other nineteenth-century entity discursively constructed as undifferentiated, timeless and without geopolitical boundaries, was the Orient.⁶¹ One femininity – Nightingale-as-nurse – works in tandem with the British army to “save” the “Other” femininity, the Orient. The hospital thus became an extension of woman's domestic sphere, the rightful site of feminine ministrations and care. In a pamphlet published in 1860, Nightingale comments on high hospital mortality rates: “Were a trustworthy man [emphasis in original] in charge [...] not as office clerk, but as head nurse... the thing would not, in all probability, have happened. But were a trustworthy woman in charge [emphasis in original] in [...] the thing would not, in all certainly, have happened.”⁶² The ongoing emphasis, originating with Nightingale herself, on the universal and thus apolitical “feminine” activity of nursing has eclipsed Nightingale's spatial improvements at Scutari, and the territorial claim they helped to make.⁶³

Jill Beaulieu and Mary Roberts identify the “radicality” of nineteenth-century, western women's creative work in the “Orient” and the complicity of such work with imperial politics.⁶⁴ Like Deborah Cherry and Reina Lewis, these scholars identify the complex relationship between western feminine individualism⁶⁵ and so-called “Oriental” subjects and spaces. Beaulieu and Roberts argue that the axiomatics of imperialism allowed western women “to claim an authoritative position” and advance their own artistic, political and gendered identities within the context of cross-cultural encounters.⁶⁶ They write, “strategic and shifting alliances inflected by gender and nationality as well as race [enabled] the pragmatic articulation of Western feminine individualism in Orientalist visual culture,”⁶⁷ and, I would add, in “Oriental” space. Turkey gave Nightingale a locus, a physical space in which to enact an authoritative role implicated in imperialism, Orientalism, and discourses on gender.

Architectural historian and postcolonial critic, Zeynep Çelik understands colonial consensus as a common perception that serves to protect “economic, moral and strategic” interests over the long term in a colonized country.⁶⁸ In terms of British motives in Turkey, the Middle East and India, colonial consensus was often shaped by a notion of the colonized realm as “feminine” in nature, and therefore in need of “masculine” or paternalistic imperial rule. The case of Florence Nightingale and her spatial work in Turkey points to the fact that colonial consensus did not only depend upon the feminization of the “Orient” for its success; it relied equally upon idealized British constructions of femininity as domestic, nurturing and caring; with the Lady with the Lamp ministering to the sick and wounded, the Empire and all its present and future subjects were in good hands.

Charles Rosenberg notes that Nightingale's contemporaries associated her with hospital reform as much as with nursing reform. These contemporaries were, however, professional and parliamentary peers.⁶⁹ The popular press offered the general public a view of Nightingale centred around reports from Scutari, showing her to be both

the epitome of self-effacing, chaste and virtuous womanhood and the remarkable (and necessary) exception that proved the rules of femininity. Strong, independent and analytically minded, Nightingale's statistical work and political lobbying helped to establish wider margins in which women could effect change in the public sphere and yet not be tainted by its supposedly inherent dangers.⁷⁰ Yet the historical figure of Nightingale, and the vision of femininity she appears to embody, however much they are questioned, cannot fully yield their importance unless considered within the British "colonial consensus" over Turkey.

In the past two decades, scholars have begun to reconsider the nuances of the popular image of the "Lady with the Lamp". F. B. Smith's *Florence Nightingale: Reputation and Power* presents Nightingale as an egotistical, "titillating fabulist," whose "passion for fame" and "talent for manipulation" would appear to evacuate her life's work of any value or meaning.⁷¹ Despite the direction suggested by the title, this work does not employ a Foucauldian analysis of the labyrinth of powerful politicians, doctors and reformers (Nightingale included) who all schemed and negotiated for favour and power within the two governments that ruled during the Crimean War, and its aftermath. Rather, *Reputation and Power* isolates Nightingale biographically, simply reversing her status as heroine, as opposed to examining the ways in which political power, the culture of imperialism, and the discourse on reform intersected with her historical moment and individual personality.⁷² More recently, scholars such as Lynn McDonald and Sue M. Goldie have represented Nightingale through her own words, as opposed to familiar hagiographic or biographical strategies.⁷³ McDonald's remarkable compilation of letters and essays by Nightingale is an invaluable resource and, like Goldie's collection of Nightingale's letters from Turkey, allows the writer's contradictions, strengths, biases and interests to speak directly to the reader. Architectural history, for its part, recognizes her influence to varying degrees, from the occasional nod to a broader acknowledgement of her importance.⁷⁴ The biographical tradition continues, however, with Hugh Small's *Florence Nightingale: Avenging Angel* as the most recent contribution to the literature.⁷⁵

In March 1855, a Sanitary Commission from England visited Scutari. According to Small, the changes wrought by the Commission were the turning point in the battle to reform Scutari (and to win the war), and Nightingale did not realize this import until after her return to England. Small's argument is based upon the focus of her letters written during the first six months of her stay, before the Commission's visit. Small further argues that Nightingale did not fully embrace the concept of environmental hygiene until after her "indoctrination" by the reformer and statistician (and later, Nightingale's colleague), Dr. William Farr. Small suggests that Farr proved to Nightingale statistically that the hospital at Scutari (built over a cesspool, having a poor water source) had actually killed more soldiers than any other British hospital in Turkey during the first winter, and had more victims than the sum total of battles fought in the war. Small further argues that the shock of realization, and later, Nightingale's guilt, account for much of what other scholars have found contradic-

tory in Nightingale's life, and for the force of her later dedication to hospital reform. Small's conclusion – "through [Nightingale's] ignorance and arrogance, she let [the British] army die"⁷⁶ – is interesting perhaps not so much for what it purports to prove, but for what it assumes needs no interrogation at all: the scope of her responsibility to and within Scutari.

A review of Nightingale's letters from Turkey, and from the months after her return, indicates that Nightingale was fully aware of the benefits of cleanliness, and supportive of the Sanitary Commission's efforts. On the 18th of March she writes, "The Sanitary Commission is really doing something, & has set to work burying dead dogs & white washing walls, two prolific causes of fever...A Liverpool Inspector of Nuisances has been left us to do what we should have done long ago."⁷⁷ Nightingale also wrote several letters from Scutari after the Sanitary Commission's visit, arguing for better water quality and waste disposal.⁷⁸ Before writing to Dr Farr for the first time on January 8, 1857, Nightingale also penned the following:

the sickness from Epidemics from 60-80 per cent to 16 per cent. This, of course, is attributable to the excellent Sanitary arrangements in the Army, introduced by the Sanitary Commission – as well as to those in the Hospitals. The frightful mortality in the Barrack Hospital at Scutari diminished in like manner. During 54-5, that Hospital was literally living over a cess-pool - & the Military Medical Officers [mistakenly] ascribed the unmanageable outbreaks of Cholera which took place up to November/55 to a Cemetery 3/4 mile off"⁷⁹

These letters would seem to contradict Small's thesis of Nightingale's ignorance of the link between hospital design, hygiene, and mortality. What is more interesting, however, is that while Small never suggests that Nightingale's control of Scutari was spatial or architectural, he nonetheless attributes all Scutari's failings to her, or more precisely, he surmises that she believed herself to be accountable for the consequences of its failings.⁸⁰ What may be drawn from this point is that Small's argument does suggest, if in a backhanded way, that the relationship between Scutari and Nightingale was more than the relationship of a nurse to the hospital in which she worked.⁸¹ But Small's thesis also points to a significant problem inherent to the project of commemorating Nightingale first and foremost as a nurse. To understand the implications of Nightingale's relationship to Scutari in terms of imperial history requires more than the sifting through of Nightingale's rich repository of biography and letters, and more than understanding her position in the history of nursing and Victorian political struggles. What is required are the particular lenses associated with the study of architecture, postcolonial space and the role of powerful, educated women in such spaces.

The Crimean War marked a turning point in Britain's imperial strategies. Increasingly, the rhetoric and practices of order, obedience, surveillance and hygiene underpinned colonial expansion. The war had proved that Britain could lose its hold on one of its most desired objects, the Ottoman Empire, if it did not give full consideration

to the impact of these factors upon its forces.⁸² The actual function of Nightingale's hospitals and nurses – to keep soldiers alive – cannot be separated from the imperial power they were there to serve. Deborah Cherry identifies the “visual (re)inscriptions and framings of space and time [...] necessary to imperialism's projected control over land.”⁸³ Colonial interests are motivated by and dependent upon territorial claims, thus actions that support those claims are integral to the politics of that territory. Nightingale's reforms improved Scutari's capacity for the deployment of troops during a key moment in a territorial power struggle. Further, her designs for military and civilian hospitals in England and the British Empire, beyond providing the best possible conditions for the continued life of its patients, ensured the effective control of the military or colonized bodies within them. Without discounting the other ways in which the pavilion hospital functioned, Nightingale's ideal hospital is nonetheless a trace of western women's complicity with what Cherry calls “the planned epistemic violence of the imperialist project.”⁸⁴

Britain's soft occupation of Turkey, via the Crimean War, presented itself as a humanitarian effort. Working as nurses, Nightingale and her female staff's identity as ministering angels cloaked their imperial purpose under the guise of a “naturally” solicitous femininity. Turkey, struggling to resist the imperial advance of Russia, was cast as a vulnerable (feminine) country, incapable of defending herself. In creating her first hospital at Scutari, Nightingale helped to claim space upon contested Turkish soil, as did every British engineering and building project during that decade. Even when positioned within the limitations of ideal femininity, Florence Nightingale can be seen to have achieved great things. But in order to do justice to her actual power and influence, the hospitals she championed and helped to create must be understood in postcolonial terms. Only then can the femininity she perpetually represents begin to be complicate the “femininity” of the “Orient,” and reveal its true historical potency.

Acknowledgements

The author would like to thank Dr. Annmarie Adams and Dr. Janice Anderson for their helpful commentary on this text, and Ian Segal for directing my attention to Nightingale's work in Turkey. I am grateful to the editors of this journal for their encouragement and enthusiasm. My thanks go also to the Wellcome Library, in particular to Dr. Carole Reeves for her kind assistance and expertise, and to the Social Sciences and Humanities Research Council of Canada for supporting this research. I am grateful to the Wellcome Library for their assistance in making Nightingale's floor plan of Scutari available to me, and the Social Sciences and Humanities Research Council of Canada for supporting this research.

Endnotes

¹ Charles Rosenberg, introduction to *Florence Nightingale on Hospital Reform: Notes on Hospitals and Introductory Notes on Lying-In Institutions* (New York and London: Garland Publishers: 1989) 1.

² Florence Nightingale et al, *Report of the Commissioners appointed to Inquire into the Regulations Affecting the Sanitary Condition of the Army, the Organization of Military Hospitals, and the Treatment of the Sick and Wounded; with Evidence and Appendix*, Presented to both Houses of Parliament by Command of Her Majesty (London: George Edward Eyre and William Spottiswoode, 1858) 520.

³ While various aspects of her biography, tastes and talents are explored, the Florence Nightingale Museum in London, England, for example, emphasizes Nightingale's contribution to history primarily as a nurse. "Florence Nightingale," *Florence Nightingale Museum*, March 1, 2005 <<http://www.florence-nightingale.co.uk/index.htm>>.

⁴ Even in iconoclastic studies, such as F.B. Smith's, *Florence Nightingale: Reputation and Power* (London and Canberra: Croom Helm, 1982), Nightingale's femininity, appearance and sexual orientation are key, if vague and unsubstantiated, aspects of the effort to topple her monument. See pp. 21-23, where Smith speculates about her virginity, possible lesbianism and "infantile" sexuality.

⁵ Anthony King has discussed Nightingale's importance to the development of the pavilion hospital in architectural terms, but his emphasis is upon what he sees as the equally important role of lesser-known activists, such as the physician John Robertson. See "Hospital Planning: Revised Thoughts on the Origin of the Pavilion Principle in England" in *Medical History*. 10, 4 (October 1966): 360-373.

⁶ There is an important, emerging body of research that links Nightingale's key role in nursing history to the aims of the British Empire, but it does not address the architecture of hospitals. See Helen Gilbert, "Great Adventures in Nursing: Colonial Discourse and Health Care Delivery in Canada's North," November 2, 2003 <<http://social.chass.ncsu.edu/jouvert/v7i2/gilber.htm>>.

⁷ Smith is a possible exception to this view. He suggests that her ideas were undifferentiated and never matured: "nursing was for Miss Nightingale merely a form of applied housekeeping – a view she retained all her life" (43-4).

⁸ Small 77-78.

⁹ This position became synonymous with Nightingale's name, and while her efforts to convince others of this position are legendary, her opinions would ultimately cause her to fall out of favour. As Rosenberg explains in greater detail, germ theory (which broadly replaced faith in the environment as prime mover in preventable illnesses) became popular by the 1880s, and dictum by the 1890s. See "Florence Nightingale on Contagion: The Hospital as Moral Universe," in *Healing and History: Essays for George Rosen*, Charles E. Rosenberg, ed. (Folkestone, England and New York: Dawson Science History Publications, 1979) 116-136. Nightingale's relentless pursuit of the atmosphere of the hospital as crucial to the health and survival of patients has been somewhat vindicated in recent years with the "sick building" syndrome, and closed-system health crises such as SARS.

¹⁰ Edward Said, *Orientalism* (New York: Vintage, 1979) 41.

¹¹ Said 221.

¹² Said 220.

¹³ Mark Crinson, "Oriental Byzantium: Interpreting Byzantine Architecture, 1840-70" in *Empire Building: Orientalism and Victorian Architecture* (London and New York: Routledge, 1996) 7, 3. Crinson describes W. J. Smith's British Embassy in Istanbul, (1842-54) as an example of British spatial self-representation in Turkey at this time. The Embassy is an austere building whose neo-classical elevation was clearly intended to articulate its western cultural inheritance and allegiances.

¹⁴ Crinson 5.

¹⁵ Crinson 5.

¹⁶ John D. Thompson and Grace Goldin *The Hospital: A Social and Architectural History* (New Haven: Yale University Press, 1975) 153.

¹⁷ Quoted in Sue M. Goldie, ed., *Florence Nightingale: Letters from the Crimea 1854-1856* (Manchester and New York: Mandolin [Manchester University], 1997) 18.

¹⁸ The actual sequence of events is debated among Nightingale biographers and historians. The generally accepted account, for over a century, was that a written offer from Nightingale to lead the nurses to Scutari crossed in the mail with a request for the same service from Sydney Herbert, Secretary at War, and his wife, Elizabeth Herbert. F. B. Smith contests this version, arguing that Nightingale's ambition and propensity for manipulation would have spurred her to engineer a letter from the Herberts. (Smith 25-26) Smith does not quote the letter, but Sue M. Goldie prints it in full, in order to allow readers decide for themselves what transpired. She responds to Smith as follows: "There is no evidence in this letter of the long-term contriving on the part of [...] Nightingale in pursuit of personal ambition [...]." Goldie 19.

¹⁹ Goldie 70.

²⁰ Nightingale's letters from Scutari, particularly to Sidney Herbert illuminate her struggles to provide the basic necessities for cleanliness, such as soap, clean bandages and lint for dressing wounds, mops, chloride of lime, bedding, and even clothing for the soldiers, who often would arrive, in her words, "frost-bitten, demi-nude, starved, ragged." Letter to Sidney Herbert, 25 December 1854, quoted in Goldie 57.

²¹ Henri Lefebvre, *The Production of Space*, trans. Donald Nicholson-Smith (1974; Oxford, England and Cambridge, USA: Blackwell, 1991) 35.

²² Letter to Mr and Mrs Bracebridge, 7 August 1855, reprinted in Goldie 139.

²³ Letter to Lieutenant General Sir Richard Airey, 18 October 1855, reprinted in Goldie 163-4.

²⁴ Letter to Sidney Herbert, 8 January 1855, reprinted Goldie 70.

²⁵ Letter to Sidney Herbert, 3 April 1856, reprinted in Goldie 249. In this use of the masculine pronoun, Nightingale is referring to herself.

²⁶ Letter to Lieutenant Colonel Lefroy, 6 March 1856, reprinted in Goldie 221.

²⁷ Letter of same date to same, Goldie 222.

²⁸ Letter to Lady Canning, 23 November 1856, reprinted in Goldie 287.

²⁹ While this is overwhelmingly the case, I have located several sketches of hospital elevations in Nightingale's hand. These can be seen in the British Library, Add Mss 45825 f55, 199.

³⁰ Lefebvre 23, 34-36.

³¹ Lefebvre 42.

³² Rosenberg 1979: 123, 124-125.

³³ Lynne Walker, "Women and Architecture," (1989) in *Gender Space Architecture: An Interdisciplinary Introduction*, Jane Rendell et al, eds. (New York, London: Routledge, 2000) 249.

³⁴ Walker 2000: 246-249.

³⁵ Walker 2000: 246.

³⁶ Patricia Mowbray, *Florence Nightingale Guidebook* (London: The Florence Nightingale Museum Trust, 2001) 5.

³⁷ Annmarie Adams, *Architecture in the Family Way: Doctors, Houses, and Women 1870-1900* (Montréal, Kingston, London and Buffalo: McGill-Queen's University Press, 1996).

³⁸ Adams 165.

³⁹ Adams 165.

⁴⁰ The nineteenth century saw the professionalization of several fields, including nursing – a direct result of Nightingale's lobbying and reputation – and architecture. Medicine and law also became fields with professional standing. Architecture attained professional status in England in 1834 with the founding of the Royal Institute of British Architects (RIBA).

⁴¹ *Report of the Commissioners* 379.

⁴² *Report of the Commissioners* 520.

⁴³ An earlier version of this book was printed in 1859, but the 1860 version is that which was reprinted so often. The 1863 edition is the most readily available.

⁴⁴ Florence Nightingale, *Notes on Hospitals (1863) and Rosenburg Florence Nightingale on Hospital Reform: Notes on Hospitals and Introductory Notes on Lying-In Institutions*, Charles E. Rosenberg, ed. (New York and London: 1989) pp.4-5.

⁴⁵ Nightingale 1863: 7.

⁴⁶ Jeremy Taylor, *The Architect and the Pavilion Hospital: Dialogue and Design Creativity in England, 1850-1914* (London and New York, Leicester University Press, 1997), 1997: ix.

⁴⁷ Thompson and Goldin 165.

⁴⁸ Wellcome Library, RAMC 801/9/2.

⁴⁹ Nightingale 1863: 102.

⁵⁰ Thompson and Goldin Thompson and Goldin 165.

⁵¹ Paul Hirst, "Foucault and Architecture," *Architectural Association Files*, No. 26 (Autumn 1993): 56.

⁵² Hirst 57.

⁵³ Nightingale 1863: 151, 153.

⁵⁴ Taylor 67.

⁵⁵ Mowbray 21-22.

⁵⁶ Gilbert.

⁵⁷ Florence Nightingale gave direct commentary on the plans of the Royal Victoria Hospital, praising its adoption and adaptation of the pavilion model. Letter to Saxon Snell (the architect), December 2, 1889. British Library Additional Manuscripts, 45820, ff 145-63. Patricia Mowbray notes that nurses were trained in nursing schools based upon the Nightingale model in London, Liverpool, Edinburgh, Sydney and Philadelphia. [22] Annmarie Adams has discussed the role of gender in the design of the nurses' residences at the Royal Victoria Hospital, in "Rooms of their Own: The Nurses' Residences at Montreal's Royal Victoria Hospital" *Material History Review* 40 (Fall 1994): 29-41. See also Dianne Dodd's discussion of the role of the Nightingale model in Canadian, English and Protestant hospitals in "Commemorating Canadian Nursing" in *Cultural Resources Management* 24, 2 (2001) 30-31.

⁵⁸ My emphasis, Preface to *Notes on Nursing* (London, 1860) x, reprinted in Lucy Ridgely Seymer, ed., *Selected Writings of Florence Nightingale* (New York: Macmillan, 1954).

⁵⁹ This idea has a long and tenacious history. For an examination of its origins in western philosophy, see Moira Gatens, *Feminism and Philosophy: Perspectives on Difference and Equality* (England: Polity Press and Indiana University Press, 1991.)

⁶⁰ On prejudices against the nursing profession prior to Nightingale's training schools, see Catherine Judd, Chapter 2, "Thy Magic Touch": Nursing, Sexuality, and the "Dangerous Classes" (1829-1880) in *Bedside Seductions: Nursing and the Victorian Imagination, 1830-1880* (New York: St. Martin's Press, 1998).

⁶¹ Zeynep Çelik asserts, "the feminization of the 'Orient' is a common theme in European descriptions and representations...". In "Le Corbusier, Orientalism, Colonialism," (1992) in *Gender Space Architecture: An Interdisciplinary Introduction*, Jane Rendell et al, eds. (New York, London: Routledge, 2000) 326. Linda Nochlin's essay, "The Imaginary Orient," in *The Politics of Vision: Essays on Nineteenth-Century Art and Society* (New York: Harper & Row, 1989) 33-59, remains essential reading on the question of Orientalist discourse and gendered representations.

⁶² Florence Nightingale, *Notes on Nursing: What it is, and What it is Not* (pamphlet) (London: Harrison, nd) 23 (footnote).

⁶³ Smith is one writer who identifies the imperial character of Nightingale's attention to India, but he does not explore how her architectural recommendations, her lobbying for the presence of English nurses in India or her participation on the Barracks and Hospital Commission (dedicated to sanitation in British expansion in India) actually functioned to further British imperial interests. In *Reputation and Power* Nightingale is simply one of

many “crusading females” [82] whose work is “characterized by voyeuristic condescension, complacent parsimony and an unwavering resolve to use the state to underwrite their pursuits and coerce the subjects of their careers.” [132]

⁶⁴ Jill Beaulieu and Mary Roberts, “Orientalism’s Interlocutors” in *Orientalism’s Interlocutors: Painting, Architecture, Photography* (Durham and London: Durham University Press, 2002) 6.

⁶⁵ Beaulieu and Roberts 7. See also Reina Lewis, *Gendering Orientalism: Race, Femininity and Representation* (London: Routledge, 1996).

⁶⁶ Beaulieu and Roberts 6-7.

⁶⁷ Beaulieu and Roberts 7.

⁶⁸ Çelik, quoting Tony Smith, 328.

⁶⁹ This is a distinction which becomes clear after reading even a few years’ worth of Nightingale’s many thousands of letters (see Goldie, for example). She operated in elite circles, while her image performed far more broadly. See Small regarding the circulation of her “private” report on the condition of British military hospitals in Turkey as an indication of this dual function of her persona. Small estimates that “at least a hundred copies of the report went to the most influential citizens in the country.” (197)

⁷⁰ A comparable example is the censorious response to the activism of middle- and upper-class women who worked to reform prostitution laws. It was believed that such women would themselves be induced to “fall” if they encountered, worked for or talked about prostitutes. See Judith R. Walkowitz, *Prostitution and Victorian Society: Women, Class, and the State* (USA: Cambridge University Press, 1982.)

⁷¹ Smith 17, 22, 11.

⁷² Lynn McDonald’s rigorous critique of *Reputation and Power* is essential companion reading to Smith’s biography. See “An unscrupulous liar? Florence Nightingale revealed in her own writings.” *The Times Literary Supplement*, 8 December 2000. Republished in Lynn McDonald, The Florence Nightingale Project, April 18, 2004 <<http://www.sociology.uoguelph.ca/fnightingale/links/TLS-article.htm>>.

⁷³ See the *Collected Works of Florence Nightingale* (16 vols. Waterloo, Ontario: Wilfred University Press, 2001-), and Goldie, op cit.

⁷⁴ Jeremy Taylor notes that Nightingale raised the issue of hospital reform in the minds of the public and the government. See Taylor (1997) and *Hospital and Asylum Architecture in England, 1840-1914* (London: Mansell Publishing, 1991). Taylor is, however, writing a history of architects, not of social reformers (which is how he sees Nightingale), and so is reluctant to assign her a pivotal place in his study. Thompson and Goldin are more willing to see Nightingale as a prime mover in their useful survey (1975). These sources do not explore Nightingale’s actions or her ideal hospitals within the power dynamics of imperial England.

⁷⁵ Small, 2000.

⁷⁶ Small 203.

⁷⁷ Letter to Sidney Herbert, 18 March 1855, reprinted in Goldie 108.

⁷⁸ “[I suggest] Water Closets to each ward – with drain – two portable engines to flush them from the sea...A bath for each ward... To bore for spring water or to bore the rock...[or] rain-water might be collected - & with half-a-dozen rum puncheons, half filled with pebbles, charcoal etc., filters would soon be made. But this should be done immediately...” Letter to Lieutenant General Sir Richard Airey, 18 October 1855, reprinted in Goldie 163-64.

⁷⁹ Letter to Lady Canning (written from London), 23 November 1856, reprinted in Goldie 288.

⁸⁰ The slippage between these two positions in Small’s own writing accounts for the rather reductive way in which his argument has at times been taken up. Nightingale is now thought to be responsible for the deaths at Scutari, yet the corollary to this idea – that she was fully in control of the hospital’s spaces and organization – is not acknowledged. See Mark Bostridge’s account, in which he writes, “Historians are now waking up to the shocking truth that the death toll at Nightingale’s hospital was higher than at any other hospital in the East, and that her lack of knowledge of the disastrous sanitary conditions at Scutari was responsible.” From “The Lady with the Lamp.” *BBC1 Medicine History*, April 18, 2004.

< http://www.bbc.co.uk/history/discovery/medicine/nightingale_06.shtml >.

⁸¹ Small states that Nightingale was running a “death camp”. Small 88.

⁸² This is the fundamental thesis of the *Report of the Commissioners*.

⁸³ Deborah Cherry, “Earth into World, Land into Landscape: The ‘Worlding’ of Algeria in Nineteenth-Century British Feminism,” in Beaulieu and Roberts, eds., 107. Deborah Cherry, “Earth into World, Land into Landscape: The ‘Worlding’ of Algeria in Nineteenth-Century British Feminism,” in *Orientalism’s Interlocutors: Painting, Architecture, Photography*, Jill Beaulieu and Mary Roberts, eds. (Durham and London: Durham University Press, 2002) 107.

⁸⁴ Cherry 104.

Black, White or Brindle: Community Advocacy in Australian Aboriginal Health,

Nili Kaplan-Myrth

Introduction

The best things I've seen in health have happened in Aboriginal health, even though they're the population with the worst health profile. That's the irony of Aboriginal health and it's also the attraction (Non-Aboriginal government bureaucrat, Kaplan-Myrth 2003).

Australia is one of the healthiest countries in the world with one of the most dramatic examples of social inequalities in health; Aboriginal Australians experience a fifteen to twenty-year shorter life span and a significantly higher incidence of illness and disease than non-Aboriginal Australians (Commonwealth Department of Health and Family Services 1997). This is by no means news to anyone, yet the poor state of Aboriginal health hits the headlines daily in the Australian mass media and scholarly forums.

It is a formidable challenge to find reports on the positive inroads that have been made in Aboriginal health.¹ At least two significant changes have nevertheless occurred in the landscape of Australian Aboriginal health policy and politics in the past thirty years. First, the emergence of the Australian Aboriginal community-controlled health sector in the 1970s (Briscoe 1974; Foley 1975; Nathan 1980; Reid 1978)² and then, in the 1990s, the bureaucratization of Aboriginal organizations and the establishment of mechanisms and processes for the Koori (term of self-identification for Aborigines who originate in Southeastern Australia) Aboriginal community-controlled sector to collaborate with Commonwealth (national) and state governments (Anderson and Sanders 1996; Anderson et al. 2001; Anderson 2002; Commonwealth Department of Health and Aged Care 2001).

Out of an interest in the critical anthropology of health (Singer, Baer and Lazarus 1990), I traveled to south-east Australia in 2001 to analyze contemporary relationships between Aboriginal communities and government in the development of health policy and programs (Kaplan-Myrth 2003). This article is based on that ethnographic research.

I worked primarily in Melbourne with the Victorian Aboriginal Community Controlled Health Organization (VACCHO), a Koori-run organization that acts as the health policy advocate for twenty-five community-controlled health services across the state.³ I interviewed key stakeholders in the Aboriginal community-controlled health sector, including Koori health workers, hospital liaison officers, nurses, policy analysts, executives of health services, health researchers, and Koori bureaucrats. I

also interviewed non-Aboriginal bureaucrats and politicians in regional, state, and Commonwealth government.

Over a twelve-month period I became awe-struck by Aboriginal communities' achievements in health. The negative messages carried by the mass-media were juxtaposed against the challenges and successes in Aboriginal health policy and politics. My research brought to the fore the following questions: How are the concepts of community control and community-government collaboration defined by Aboriginal and non-Aboriginal stakeholders in the health policy arena? How is community-controlled health acted out on the ground? Were Aboriginal communities empowered or silenced when they adopted bureaucratic models and collaborative rather than adversarial approaches to government?

In this article, I present Aboriginal and non-Aboriginal Australians' responses to those questions. In order to understand contemporary community-government relations as an ongoing process, I begin by looking back over the past two hundred years of Australian settler colonialism. I then discuss the concept of community and the myriad complexities of Aboriginal community representation and community control. I also discuss Koori identity and the tensions faced by contemporary Koori leaders who straddle community-government divides. Taking my lead from public health researchers who argue that it is instructive to study group and individual influences on health policy agendas (Palmer and Short 2000), I evoke some of the challenges faced by Aboriginal Australians who dare to take the reins in health policy and politics.

Political and Historical Context

There are approximately 460,000 Aboriginal people in Australia, 2.4 percent of the total Australian population. A quarter of the Aboriginal population lives in remote areas of Australia, sixty percent live in rural and semi-urban areas – communities of 1000 people or more – and the remaining fifteen percent live in major urban centers. The Aboriginal population is most densely concentrated in the states of New South Wales and Queensland. Only 28,000 Aboriginal people live in Victoria, 0.6 percent of the state's population (Australian Bureau of Statistics 2001).

In 1770, the English navigator, Captain James Cook, landed on the southeast coast at what became known as Botany Bay. So began the invasion of territories that had been inhabited by Aboriginal people for at least forty thousand years. Although an estimated population of 750,000 Aboriginal people lived in Australia before British settlement, the British colonists declared Australia *terra nullius*, "empty land." Aboriginal people were without any rights in the colony and, later, in the new nation-state (Attwood 2000). The first British penal colony was established at Sydney in 1788 and the first free settlers arrived in 1793. Australia was divided into six colonies: New South Wales, Van Diemen's Land (now Tasmania), Western Australia, South Australia, Victoria, and Queensland. In 1879, the Torres Strait Islands – a series of islands between Australia and Papua New Guinea – were annexed by the state of Queensland.

On 1st January, 1901, the Commonwealth of Australia was founded. Australia remained linked to the British monarchy through the Governor General of Australia.

Under the Australian constitution, six state legislatures (the former colonies) make laws affecting their own internal affairs. Two territories – the Northern Territory and the Australian Capital Territory (ACT) – remain under the general control of the Commonwealth government. Canberra, ACT, has been the site of the Australian parliament since 1911.

Throughout Australia's history, governments and the Australian public have spawned debate after debate about how to deal with the "Aboriginal problem" (Franklin and White 1991). These debates are reflected in a flurry of policies that resulted in the dispossession, oppression, and segregation of Aboriginal people. As land was usurped by settlers, Aboriginal people were forced onto government and missionary-run reserves. There, they were to be civilized: Punished if heard speaking their native languages, they were given instruction in English literacy. Prohibited from hunter-gatherer lifestyles and their traditional ritual and customs, they were encouraged to become Christians and were expected to adopt colonial patterns of domesticity (Saggers and Gray 1991). Segregation extended to all domains of life, including medical care: Although forced sterilization and vaccination were common practice, Aboriginal people were barred entrance to hospital wards, were turned away by private practitioners, and were placed in isolation camps to curb outbreaks of venereal disease and other epidemics (Rowley 1971).

The realization that the Aboriginal population would not disappear except through racial inter-marriage and cultural assimilation led a joint Commonwealth-state ministerial committee in 1951 to adopt assimilation as official Australian policy (Saggers and Gray 1991). The policy stated that "all Aborigines and part-Aborigines are expected eventually to attain the same manner of living as other Australians and to live as members of a single Australian community, enjoying the same rights and privileges, accepting the same responsibilities, observing the same customs and influenced by the same beliefs as other Australians" (Reynolds 1972: 175). In 1965, the policy of assimilation became a policy of integration, though the underlying values did not change.

Under mounting political pressure from national and international lobbyists, Australia held a constitutional referendum in 1967. The significance of that referendum cannot be overstated; it provided a new social as well as political environment for relations between Aboriginal and non-Aboriginal Australians (Kunitz 1996). Until the referendum, Aboriginal people were not recognized as Australian citizens. Following the referendum, the welfare of Aboriginal and Torres Strait Islander people officially came under the jurisdiction of the Commonwealth Office of Aboriginal Affairs. With the Labor government of Prime Minister Gough Whitlam in 1972, that office changed to the Department of Aboriginal Affairs and the policy of integration was replaced by a policy of self-determination. The government's stance on self-determination, then as now, is criticized by Aboriginal community advocates as "illusory" (Tonkinson and Howard 1990). A policy of self-management has now replaced self-determination under Howard's Liberal government (Saggers and Gray 1991).

Reclaiming History

In defiance to the versions of Australian history promulgated by colonists and their descendents, Aboriginal people have re-written and reclaimed history (Foley 1993; Langton 1981). The new history begins with Aboriginal people. It asserts Aboriginal ownership of the land, describes the colonial invasion, violent dispossession, and oppression, and discusses Aboriginal people's resistance and survival (Attwood 2000).

In 1992, the High Court of Australia responded to mounting national and international pressure from Indigenous rights movements by rejecting the principle of *terra nullius* with the landmark Mabo judgment (High Court of Australia 1992). The High Court thereby recognized that the continent was populated before the arrival of European explorers. From the perspectives of Aboriginal and Torres Strait Islander people, however, the legal processes by which to reclaim land are fundamentally flawed: The onus is on Aboriginal people to prove that they are the traditional custodians of the land from time immemorial and that they have continued to practice their traditional customs on that land.

And so, colonial historiography shapes contemporary politics. Bearing this in mind, let us turn, now, from land claim tribunals to an analysis of identity politics in Aboriginal health.

“Dinkum” Aussies and “Blackfellas”

Classical ethnographic accounts of Australian Aboriginal society focus on traditional social structure, systems of land tenure, ritual, and cosmology (Berndt 1965; Elkin 1951; Radcliffe-Brown 1952; Shapiro 1979; Stanner 1965; Tylor 1871). The image of the Australian Aborigine in those texts is of a non-English speaking, dark-skinned, nomadic hunter-gatherer ensconced in secret Dreamtime activities in remote desert country. This portrayal influences Native Title legislation and a wide array of government policy and it is exported overseas as a cultural artifact to attract tourists. A slightly modified version of that image – the same didgeridoo-wielding person, but inebriated, unemployed, poverty-stricken, diseased – is perpetuated in Australian popular media. The “Blackfella” is the paradigmatic “Other”, a shadow set against the mythological “dinkum” (authentic) Aussie: Clean-shaven, enterprising, hard-working, team-player, middle-class, rural entrepreneur or suburban professional.

The Aboriginal population of southeastern Australia inhabits a liminal space, neither classical Aborigine nor dinkum Aussie: Aboriginal people in New South Wales, Victoria and Tasmania are of mixed heritage, with Irish and English ancestry. Skin color belies racial categories. Fluency in traditional languages is rare, although there is interest in preserving and reinvigorating what knowledge there is of those languages. The majority of Aboriginal people in southeastern Australia, as elsewhere in Australia, experience a lower socio-economic status than non-Aboriginal Australians. They are often indistinguishable from the non-Aboriginal working class and urban poor. Aboriginal people who are professionals and enjoy middle-class lifestyles transgress the characterizations of both classical and contemporary popular images of the Aborigine. In short, Aboriginal people are invisible in the southeast:

A lot of people in Victoria wouldn't know a Blackfella if they tripped over him. I'm sure you've met people who have told you there are no Aborigines in Victoria (Koori government bureaucrat, Kaplan-Myrth 2003).

One of the consequences of this invisibility is that proportionally less energy and government money goes into programs to improve the health and social status of Aboriginal people in the southeast, as compared with remote areas of Australia (AIHW 2001; Commonwealth Department of Health and Aged Care 2001).

Aboriginal people's perceptions of themselves, their personal identities, are influenced by their sense of liminality. Biases within and outside of Aboriginal communities marginalize individuals and families. Although young Kooris are encouraged to acquire tertiary level education, for example, getting that education in a mainstream institution raises issues within one's community about whether one has been assimilated. Kooris who have a non-Aboriginal biological parent, who lead economically privileged lives, who were adopted – even as part of the stolen generation⁴ – by a non-Aboriginal family, who married a non-Aboriginal person, as well as those who choose to work outside of the community-controlled sector, are sometimes discriminated against as though they were “coconuts,” black on the outside but white on the inside:

You're full of shit. You're a sell out. You're a bloody coconut. [Koori business owner]It is shocking, being called a coconut. It's double racism. Somebody telling you that everything you are, everything you've believed in, everything is just not true. It's just... It's racism on so many different levels. [Koori government bureaucrat] We've got a social hierarchy in our own community now (Koori hospital liaison officer, Kaplan-Myrth 2003).

Communities: Imagined and Experienced

One way in which Aboriginal communities are defined is by contrasting them with what exists outside of their boundaries; that is, the rest of Australian society. Just as the dinkum Aussie and the Blackfella are socially constructed ideas, so too are the ideas of Australian mainstream society and Australian nationalism.

What is Australia? To use Benedict Anderson's phrase (1991), Australia is an “imagined community.” Its characteristics are perpetuated by media, captured in policy and law, and reinforced through election campaigns and during periods of national crisis. “Mateship” and a “fair go for all” are celebrated as the founding values of Australian society. People consider behavior which contradicts those values un-Australian (Horne 1972). Political rhetoric about Australian cultural diversity is tolerated only insofar as it does not interfere with Australian-ness. Not surprisingly, Aboriginal people are wary of Australian nationalism:

The same guys that were the mates and believed in “fair go for all” were the same ones that were killing blacks and running them off their land.

And those same decent Aussies were the same blokes that lined up in cars outside our mission so they could rape our women and do all that sort of stuff. The decent fellas, the backbone of Australia's sense of identity (Aboriginal political activist, Kaplan-Myrth 2003).

The idea of the Aboriginal community, as an extension of the imaginary Blackfella, is also a social construct. The Aboriginal community is excluded from conceptualizations of Australian mainstream society; it is marginal, set apart as a distinct entity in and of itself. This belies the porosity and heterogeneity within Aboriginal communities. It is not that Aboriginal communities do not exist, but the variation within Aboriginal communities is as great as the differences between Aboriginal and non-Aboriginal communities. An Aboriginal community in remote Western Australia, for example, has very little in common with an Aboriginal community in Perth, let alone in a colonial city such as Hobart or in an urban sprawl such as Sydney. To appreciate this, it is instructive to examine the particularities and diversity of Aboriginal communities within the state of Victoria.

The Koori population of Victoria before colonization is estimated to have been between 15,000 and 20,000 people. That was reduced by eighty-five percent in the first generation due to contact and introduced diseases. By 1891 it hit a low of 565 people. The current population has risen to an estimated 21,500 people (Atkinson 1999). Victoria was the first state to introduce the *Aborigines Protection Acts of 1869-1957 which gave the state government power to control the lives and movements of Aboriginal people. Although the reserve system ended in Victoria in 1958, it permanently altered the geography and structure of Koori communities. Kooris who once lived in the state of New South Wales were relocated onto land in Victoria. Koori groups and families that traditionally fought were amalgamated as communities. These communities today are cross-cut by subtle alliances and divisions.*

In discussions about Aboriginal communities, many Kooris express exasperation that non-Aboriginal people – including government bureaucrats responsible for health policy – are unaware of the history of Aboriginal people in Victoria and have limited knowledge of contemporary Koori society:

They need to know the hard and fast facts about Aboriginal people. They need to know they do exist. They need to know they don't walk around with a laplap in Victoria. They live in suburbia, they eat normal food like everybody else, they drink, they smoke, they do what everybody else does... They might find out that we live the same. We just live with much more disadvantage than they do. And our health standard is much, much lower, our babies die earlier, our elders die earlier, all of those sorts of thing. But if they are dealing with Aboriginal people, they need to be made aware of how it is for Aboriginal people. Forget the fuckin' myths. Forget the spiritual and the religious and the traditional... And don't think for one minute that just because I dress well, I talk well, I work well, I drive well, whatever, that I don't have a disadvantaged life. I

mean, if half them people heard my life story they'd fuckin' be crying by the time I finished. But I'm all right. I survived (Koori business owner, Kaplan-Myrth 2003).

Social scientists argue that communities can be experienced as a physical, political, social, psychological, historical, linguistic, economic, cultural and/or spiritual space (Tuhawai Smith 2001). The concept of the community refers to any social group with a shared fate or common interest (Suttles 1973). For the most part, the Aboriginal community refers to extended family rather than to geographic locality (Nathan and Japanangka 1983). The sense of community that exists for Kooris in Victoria is created through extended family networks:

My view of it is that when we talk about community we mainly talk about family groups. And so the sense of community – and I use the model in community development terms – is that family groups determine an action and then they work together to get an outcome (Aboriginal Community Controlled Health Service – ACCHS – executive officer, Kaplan-Myrth 2003).

Boundaries between private and public spheres are blurred by Koori social networks (Anderson 1994). Most aspects of what people do – sports, health, social and political events – are driven by these networks, yet the networks are relatively opaque to outsiders:

Particularly in Aboriginal health, you find that it is more personal relationships than it is professional ones... You go anywhere in the Aboriginal community and everybody's related to each other or they know people: "That's me brother, that's me cousin..." (Koori government bureaucrat, Kaplan-Myrth 2003).

Even though Koori social networks are difficult to discern, they are more sustainable than some other networks. An example of a network that is formal and transparent, yet unstable, is the government bureaucratic structure: The internal hierarchies and lines of communication are navigable within the government. A government department such as the Office for Aboriginal and Torres Strait Islander Health changes leadership every time there is an election. Political networks that were established under one government are dismantled following the appointment of a new Minister for Health and new Division Heads. A new government network is quickly formalized, but it too has a limited lifespan. In Aboriginal community networks, there is an underlying continuity which does not exist in government because family relationships are sustained irrespective of other changes that occur within the communities.

Significant life events, funerals for example, bring together communities. Cooperatives and community-controlled health services also provide an important sense of community for those people who emigrated to cities and towns from other areas of the state or country, as described in the now classic text about the Victorian Aboriginal Health Service, *A Home Away from Home* (Nathan 1980). It is rare to hold conversa-

tions with anyone – Koori elders, youth, health workers, nurse-midwives, physicians – about Aboriginal health services without the narrators at some point emphasizing the role of health services as meeting places for communities. Aboriginal community-controlled organizations in Fitzroy are situated within a short walking distance of each other. The Koori community congregates in these organizations:

The physical community in Melbourne is a whole range of different families from all over the place as well as a number of organizations. The organizations are meeting places; that's where people come together, they're the physical... The actual community here is so big and so diverse and comes from so many places. And while I might have really close friends or family from other places in the state, we'll come together in Melbourne (Koori chairperson, Aboriginal and Torres Strait Islander Commission, Kaplan-Myrth 2003).

The health service is a meeting place. Not always a healing place. For some, yeah, it's a healing place. For others it's not, it's more of a meeting and a social and a cultural place, even though it's a health provider, it's a clinical setting, it's a coming together.... It's a sterile building. If they mop the floors and there's no one in there, it is quite sterile. But if you go in there, there's a crowd there, you catch up with people, people you haven't seen in a long time, you find out how people are goin' and if they're well or they're not well. You know what I mean? And that's community, there. You know what I mean? (Koori government bureaucrat, Kaplan-Myrth 2003).

Aboriginal community dynamics are highly charged. The boards of Aboriginal cooperatives and health services represent some families to the exclusion of others. This reflects the passion and ownership felt by local families toward their organizations. It also means that there is competition among families:

Family groupings mostly cause (internal political tensions). It is very much, everybody is related to everybody else. And people falling out. It is such a close-knit community, much more than the white community, that relationships can be more tenuous. Or there can be some groups that have all the power, and therefore it creates problems. Whoever's running the coop at the time can actually exclude other people from using those coops. So it just depends which family groups are in control (Koori chairperson, ATSIC, Kaplan-Myrth 2003).

The question, "What is the Koori community?" is raised in debates about community control and who has the right to speak on behalf of Kooris:

We talk about community, but one of the things that is said often to me is, "Well, alright, but who is community? So they say they're community, but we don't actually agree because we think that they don't

represent us,” etc. So that’s quite complex (Koori government bureaucrat, Kaplan-Myrth 2003).

Non-Aboriginal people in the Office for Aboriginal and Torres Strait Islander Health express concern about their inability to navigate what goes on within the politics of Aboriginal community representation:

There’s issues around in-groups and out-groups... Particularly in rural towns, you have a number of different Aboriginal groups and a reality that sometimes one particular group has taken over management of a health service. So another group will come to us and say, “We don’t have any access to the [Aboriginal medical service] because it’s run by this group.” We try to stay out of that and say, “This is about community management, community control. What you need to do is, if you’re unhappy about it, you need to get onto the board of the service because that’s what community management, community empowerment is about” (Non-Aboriginal government bureaucrat, Kaplan-Myrth 2003).

Representing Koori communities in negotiations with government bureaucrats is problematic because the diversity within and between communities is overlooked:

The bureaucracy and political parties don’t understand that there is more than the ephemeral “Australian Aborigine.” We are not one mob... It’s just really hard for people to come to terms with: In a geographic region as small as Victoria, what do you mean you people aren’t all the same?! Well, we’re more than just not all the same; we’re bloody different (Koori government bureaucrat, Kaplan-Myrth 2003).

With the emphasis today on collaboration between Aboriginal community-controlled health organizations and government, Aboriginal community representatives are key stakeholders in policy processes. In essence, Aboriginal political advocates are trapeze artists who swing between community representation and government bureaucracy. Their perceived failures and successes are influenced by the actions of their government counterparts as well as the stability of the support structures they rely upon.

At the beginning of this article I asked whether Aboriginal communities were empowered or silenced when they adopted bureaucratic models and collaborative rather than adversarial approaches to government. I turn, now, to a closer examination of the challenges of Koori political advocacy and activism in Victoria.

Koori Political Advocacy and Activism in the Health Policy Arena

In discussions today about Aboriginal health politics in Victoria, it is not uncommon for Kooris to describe their community representatives as “complacent”:

I think activism in Aboriginal Australia has virtually died on its ass. It’s not half of what it used to be... I think there’s a number of reasons: I

think some people are just tired of it. They just don't have it in them anymore. I think that activism hasn't been passed on to younger generations, to carry it on... Those who are working in the organizations are consumed with the business of the organizations. So we are constantly reacting to government policy and requirements the whole time. Who has time to be active? And if you are active you're going to rock the boat so much that you're not going to get your dollar, which means that people are going to miss out on a service. It's all hung over Aboriginal people's heads every day (Koori elder, Kaplan-Myrth 2003).

Instead of complacency, the Aboriginal community's collaboration with government could be viewed as a new form of activism. This requires a situated model of power that takes into account the broader social context within which power relationships are constituted and maintained (Foucault 1977; Wartenberg 1992; Young 1992;). Power rests with individuals, interest groups, the governing party, the bureaucracy, the private sector, corporate and transnational interests (Hancock 1999). In contrast to earlier activism in which individuals were autonomous political protestors, contemporary Koori political activism vests power in organizations. Those organizations interact with governments and they enter into negotiation with medical professional bodies such as the Australian Medical Association and the Royal College of General Practitioners, as well as with corporate interest groups such as the pharmaceutical industry. Anthropologists refer to this as a "medical-industrial complex" (Navarro 1986). The mass media is yet another plane in which political power is manipulated (Better Health Commission 1986).

All of these systems and structures are interdependent (Jessop 1995). Whereas power was once conceptualized as hierarchical or hegemonic (Gramsci 2000; Howarth 1995), it can be understood as a complex array of interactions: Aboriginal people use their organizations to garner political agency through relationships with other wielders of power. There are still significant power imbalances between organizations and in society more generally (Boston et al. 1996; Davis et al. 1997), but there are many sites of power such that no single structure or institution is politically omnipotent.

By taking an oppositional rather than a collaborative approach to activism prior to the 1990s, it was possible for Koori communities to make clear distinctions between adversaries and allies. That line is now blurred because Koori organizations are part of the bureaucratic system. As a consequence, community leaders are made accountable, with government, for the outcomes of policy and programs:

Aboriginal boards of management are the representative voices of the Aboriginal community that are both managing the programs and advocating for them. The politics changes when you have significant program responsibility, when you are actually responsible for the services. It changes in that the community not only sees the government at fault, but the organizations at fault. It changes because you can't as an activist say, "What are you guys doing about it?" without saying, "What are

we doing about it? How does this relate to us?" (Koori scholar, Kaplan-Myrth 2003).

Involvement in organizations, committees, and councils places a large burden and set of responsibilities on Koori advocates. Individuals who are adept at diplomacy and political analysis, who establish good rapport with Koori communities, with government officials, and with academic and professional institutions, are called upon too often, by too many players, to fulfill super-human expectations.

Community Controlled Health, Tuesday Morning 10am

On a Tuesday morning in November 2001, the Victorian Aboriginal Community Controlled Health Organization (VACCHO) held a state-wide forum for Koori stakeholders to respond to the Commonwealth government's draft revisions of the *National Aboriginal Health Strategy* (NATSIHC 2000). At that forum, panel discussions centered on the topics: What are the strategic priorities for Koori health policy in Victoria? What health programs have been most appropriate and effective in Victorian Koori communities? What is capacity-building in an Aboriginal community context? The question that generated the most debate, however, was prompted by a Koori bureaucrat. Frustrated by insinuations from his fellow community members that he represents government and not the Koori community, he turned to his peers at that forum and asked, "What does community control mean to you on a Tuesday morning at ten o'clock?"

The concept of community control was gradually popularized after the establishment of the community-controlled health sector in the 1970s. The concept has been taken up by social scientists, health researchers, and – in some contexts – by government, as a guiding principle for research, policy and programs. From an anthropological perspective, the disparate ways in which community control and community-government collaboration are defined by Koori and government stakeholders is fascinating. The interplay between these concepts is all the more complex because of tensions related to contemporary Koori identity: How does one define community control given that there are Kooris who collaborate with and work for government?

Koori participants at the VACCHO forum highlighted the importance of community control with the following remarks:

I think that we, as Aboriginal people, have got to stop accepting things as put in front of us. And say, right, this is it. Those days are gone. We don't accept that sort of situation anymore. We tend to say, This document's not right, as far as we're concerned, for A, B, C, or whatever reasons. It's got to have a Koori perspective. It's got to have a community-controlled perspective. It's got to have participation of all people, not just a few people who think they know what all Blackfellas want (Koori VACCHO representative, Kaplan-Myrth 2003).

When asked to discuss what community-control looks like on a Tuesday morning at ten o'clock, Kooris reflect:

Ten o'clock Tuesday morning means that an Aboriginal person, a community member, is able to go to a service that is provided that is relevant to the needs of that person. And that service is managed, controlled, run by the community (Koori ACCHS executive officer, Kaplan-Myrth 2003).

Community control means self-determination, ownership and togetherness... (At our coop), all of our staff, besides three of us, are volunteers. That's community controlled. That's community owned. All our programs that we have are run by volunteers. That's community controlled. That's community owned. We'd had a lot of trouble trying to get funding for programs to pay our volunteer staff. Because that's so hard down where we are, trying to get our volunteers to keep coming in, to keep them empowered, and trying to tell them that they are doing a good job is very hard. But, in a sense, they know that they're there for the community. It's community controlled. It's community owned (Koori health worker, Kaplan-Myrth 2003).

The above descriptions of community control are ideals – philosophies, principles, mandates – but how these ideals are translated into action, into what happens on the ground, is contingent on an array of factors, some operating from within the communities and others external to the communities. Tensions are produced where the philosophy of community control comes face to face with the practice of community-government collaboration. In part, this is so because the government brings to the table its own interpretation of community control. Non-Aboriginal government bureaucrats assert:

We work for the government of the day... And that's who we are first and foremost accountable to. Now, we don't think we can do our job and achieve that without working closely with the community, with consumers. But our mandate doesn't primarily come from Aboriginal people; it is the Minister's mandate to be responsible for the health of all Australians (Non-Aboriginal government bureaucrat, Kaplan-Myrth 2003).

Kooris who work in government are in ambiguous positions; once again, they can be likened to trapeze artists swinging between allegiances:

You are sort of between two worlds As a public service worker you more or less had three lives because you had community life, you had your Public Service life, and you had your own personal life. And we was very restricted and limited in what we could say.... A Blackfella in a white man's world. There's nothing harder.... We found it hard as an Aboriginal person working in that system because our loyalties wasn't just... They kept on telling us our loyalties was to the Public Service, to them, but we felt our loyalty also was to our people to let them know

what was happening. So we felt really caught, in between, and we had to be careful (Koori government bureaucrat, Kaplan-Myrth 2003).

Individuals who spent the better parts of their lives working in the community-controlled sector are not considered community representatives when they later make the choice to work within the government bureaucracy. This is a catch-twenty-two: Kooris become outsiders to their communities in the attempt to bring community voices to government. Koori government bureaucrats nevertheless firmly believe that they can bring about the most change by working within the government system:

I made up my mind fifteen years ago that it is easy to stand on the outside and tell people what's wrong. It is harder to stand on the inside and do something about it. But if nobody stands on the inside and does anything about it, the same crock of shit I had as a young bloke will go on to my children, and that sort of stuff. So, that's why I do it. Yes, we are viewed as the bad guys. But I've got to say, it's difficult. But if I didn't do it, who would, to be honest? It's that simple (Koori government bureaucrat, Kaplan-Myrth 2003).

In addition to withstanding the accusations that they undermine community control, Koori government bureaucrats struggle with the sense that they are taken advantage of by their colleagues in government who believe that they provide token representation for all Aboriginal people:

I know one of the dangers when I worked in government, that if anything Aboriginal came up I'd be asked about it. As if they had the instant expert on tap, you know? I'd say, "Hang on a minute. No, that's not me. You want to talk about that, mate, you go see them fellas" (Koori government bureaucrat, Kaplan-Myrth 2003).

Criticism is not just directed at Kooris who work within government: People who work in the Aboriginal community-controlled sector in executive positions that demand close, continuous contact with government – for example, the Chief Executive Officers of organizations such as VACCHO – also grapple with a sense of uncertainty because they straddle the perilous community-government divide. They are considered "polluted" (Douglas 1966) or "stigmatized" (Goffman 1963) through their association with non-Aboriginal institutions.

With all the complexities of contemporary urban Aboriginal identity, it is ironic that Kooris draw a boundary between who does and does not represent the Koori community. Indeed, the irony is more profound because contemporary Aboriginal political advocacy and activism is all about representing and sustaining community organizations, bureaucratic structures rather than individual interests.

Community Controlled Health, Incorporated

Community control is associated almost exclusively with a particular institutional structure, the Aboriginal organization. Given that not all Aboriginal people are active

participants in Aboriginal community-controlled health services and cooperatives, this model of community control does not equally empower everyone. The board of an Aboriginal organization directly represents the interests of that corporation, not its employees and not its clientele, unless they are voting members of the organization. There are no local or national advocacy bodies for the Aboriginal health workers who work in community-controlled health services. There are no advocacy bodies for Aboriginal individuals who are not members of a cooperative or a health service.

In literature on Aboriginal community control, it is rare to come across analyses of the primacy of organizations. Aboriginal community-controlled health services are described as “vehicles for community development” (Saggers and Gray 1991), but the extent to which communities rely upon those organizations to provide them with their political voice has not been fully examined by social scientists.

There are political advantages to the primacy of organizations. The Commonwealth government’s old political agenda focused on the individual, on giving handouts to this person or that person. The relationship between Aboriginal people and government perpetuated a system of welfarism (Anderson 2002). That is challenged by shifting the focus of health policy and politics from individuals to organizations.

Interestingly, the practice of community control in Aboriginal organizations relies upon the systems and structures that are part and parcel of the mainstream bureaucracy. Some Koori express disdain that their organizations mirror non-Aboriginal organizations:

Look, the community control model, as it stands, doesn’t reflect our way. We’re trying to apply our way to a White man’s structure that has been forced upon us (Koori elder, Kaplan-Myrth 2003).

Others feel that the current model is effective. Aboriginal representatives are elected by participating in democratic processes at community, regional, state-wide and national levels. Representatives of Aboriginal organizations feel strongly that their boards take direction from their local community members.

Is this the definitive model of community control? Certainly not. Although the way that community control is conceptualized has not significantly changed over the past twenty-five years, the model of how community control is practiced continually evolves. The current focus on particular organizational structures is only as sustainable as the organizations themselves. It may be that community control a decade from now will transfer power out of bureaucratic organizations to some other form of grass-roots collective. Change is inevitable because each generation of Aboriginal leaders brings a different perspective to activism and advocacy.

“Whitefellas” Working for “Blackfellas”

To this point I have focused my discussion on the complexities of Aboriginal community representation and issues of Koori identity. I would be remiss to omit one other dimension of political advocacy in Aboriginal health: the non-Aboriginal people who work within the Aboriginal community-controlled health sector.

There have always been significant roles played by non-Aboriginal supporters of

the Aboriginal rights movement. Concomitant with changes in models of Aboriginal advocacy and activism, relationships between Aboriginal and non-Aboriginal people within the community-controlled health sector evolved over time. Unlike the Aboriginal advocacy organizations of twenty-five years ago in which non-Aboriginal people held positions of authority, Aboriginal people now hold the executive and management positions within their own organizations. Some organizations insist that all board members must be Aboriginal, whereas other organizations allow non-Aboriginal people to sit on their boards if they offer valuable expertise. Almost all Aboriginal community-controlled organizations, however – regardless of whether or not they restrict the composition of their boards to Aboriginal community members – hire non-Aboriginal people as employees. Aboriginal community-controlled health organizations employ non-Aboriginal people as physicians, nurses, midwives, policy analysts, teachers for health worker training, coordinators of public health programs, accountants, and for a myriad of other positions.

Non-Aboriginal people who work in the community-controlled health sector are in the unique position of being “Whitefellas” who work for “Blackfellas”, an inverse of the situation for Aboriginal people who work in the mainstream. The history of animosity between Aboriginal and non-Aboriginal Australians colors the relationships between non-Aboriginal and Aboriginal colleagues in Aboriginal organizations. Non-Aboriginal people are welcomed insofar as they have something to contribute to the organizations, but they are always “outsiders” to some extent. My voluntary position at the Victorian Aboriginal Community Controlled Health Organization came about because I was introduced to the Chief Executive Officer by a highly respected member of the Koori community. Without that introduction, I could not have knocked on the door of the organization or any other organization.

I end this article with an anecdote from the first time that I shadowed the Chief Executive Officer of VACCHO to a community-government health policy meeting. I arrived at the meeting a few minutes early and chose a seat at the boardroom table. As the other participants arrived, they casually sat down at the table and, coincidentally or not, one side of the room ended up with community representatives while the other side ended up with government representatives. To my discomfort, I was on the government side. I did not yet know any of the Kooris in the room and to them I must have seemed like another government bureaucrat. By the time that the CEO of VACCHO arrived, there was one seat left on each side of the table. She could easily have chosen to sit with her Koori colleagues from the community sector. Instead, she chose the seat next to me and said something to the effect of, “She’s new at VACCHO. I don’t care whether she’s black, white or brindle, as long as she works for me.”

Contemporary Aboriginal advocacy and activism in the health policy arena is all about living and working at the interstices between the imagined community and the imagined mainstream. It entails the erasure of boundaries: Kooris structure their organizations in ways that mirror non-Aboriginal organizations, they cross from the community-controlled sector to the government sector, they collaborate with non-Aboriginal bureaucrats, they even hire non-Aboriginal people to represent their

interests. The refrain, “I don’t care whether she’s black, white or brindle, as long as she works for me,” succinctly encapsulates this moment in the history of Aboriginal health politics.

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Notes

¹ The state of Victoria is one of the leaders in the development of the Aboriginal community-controlled health sector. Fieldwork in Victoria is therefore extremely valuable for a study of Aboriginal health policy and politics. Unfortunately, however, Victoria is vastly under-researched. In a survey of 404 studies conducted in a ten-year period, only fourteen percent of studies were conducted in urban or rural settings (Lake 1992). Perhaps because Koori communities appear to be assimilated rather than traditional, urbanized rather than rustic, literature on Victoria is primarily historiography (Barwick 1998; Critchett 1980; Kiddle 1961; Massola 1970).

² Aboriginal community-controlled health services were established by activists at a political moment in which civil, labor, legal, land and health rights converged. The seeds for the concept of community-controlled Aboriginal health were sown at the same time as the mandate for self-determination. The international Indigenous rights movement in the 1960s and 1970s developed in parallel and in tension to the civil rights model, which focused on the twin rights of the vote and of equal treatment before the law (Anderson 1999).

³ The term “Koori” is used to refer to Aboriginal people whose family groups originate in southeastern Australia. The term was first recorded in New South Wales in 1834. It was the term chosen by Aboriginal people to refer to themselves with the founding of the Koori Club in Fitzroy, an area of Melbourne, Victoria, in 1969 (ATSIC 1990).

⁴ Aboriginal children were forcibly separated from their families and communities under Commonwealth and state/territory legislation from approximately 1910 until 1970. The Australian Bureau of Statistics estimates that ten percent of Aboriginal people today, aged 25 and above, were removed from their families in childhood (1995). Testimonies of members of the Stolen Generation are documented e report, *Bringing Them Home: National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from their Families* (Commonwealth of Australia 1997).

Space, Language, and Death in Two Twentieth Century Memoirs of Tuberculosis,

Lisa Diedrich

“This is a book about space, about language, and about death; it is about the art of seeing, the gaze” (ix). So begins *The Birth of the Clinic* (1973), Foucault’s “archeology of medical perception” that describes the emergence at the end of the 18th century of what he calls the “anatomy-clinical method” (4). In this essay, I examine two memoirs that are also about space, language, and death, in particular with regards to the experience of tuberculosis in the mid-twentieth century United States. Betty MacDonald’s memoir *The Plague and I* and Madonna Swan’s oral history *Madonna Swan: A Lakota Woman’s Story* might be read as exemplary cases that illuminate the spaces, practices, and objects of tuberculosis prevention and treatment in particular and the operations of ‘biopower’ more generally, which Foucault understands as the “numerous and diverse techniques for achieving the subjugation of bodies and the control of populations” (1978, 140). My interest in these two twentieth century memoirs of TB lies in how they might be read as both literary and cultural artifacts. I am concerned with the ways that these illness narratives are symptomatic texts in two respects: as texts that literally describe symptoms (and struggle with finding a form to describe the affective and physical experience of symptoms) and as texts that describe illness as an event that reflects wider cultural configurations and categories, including particular cultural constructions of gender, race, and class.

Foucault’s work provides several conceptual tools with which to read these memoirs. In particular, I read *The Plague and I* and *Madonna Swan* as demonstrating the disciplining of bodies and the regularization of populations, which are the two modes of biopower that Foucault delineates in his historical work. Both MacDonald and Swan describe their experiences of the diagnosis of, and treatments for, tuberculosis and sanatorium life. Both women are stigmatized as a result of their diagnosis, but their sanatorium experiences are different in many respects, reflecting the difference between the *event of tuberculosis* in a predominantly white community and in a poor Native American community. I highlight these differences by focusing my discussion on the subjugation of individual bodies as described in MacDonald’s text and on the control of populations, and the racism that justifies such control, as described in Swan’s text. In a number of his works, Foucault identifies health care as a primary technology in which the individual is subjected to discipline (1973, 1977, 1980).² Health care, in other words, is a form of discipline in which the cared-for body is a hyper-managed, ever analyzable, and, thus, “docile” and “intelligible” body. At the same time, public health institutions and programs expand these forms of discipline and regularization from the individual body to particular populations within the social body.

Although the publication history of these two texts is not the focus of my analysis, I want to touch on this history briefly because it reveals another difference between the two narratives of tuberculosis: simply put, this history suggests what particular stories of illness can be told and who gets to tell them. MacDonald's narrative is published not long after her sanatorium experience; initially parts of it were serialized in *Good Housekeeping* before being published in memoir form in 1948. When *The Plague and I* was published, MacDonald was already the well-known author of *The Egg and I* (1945), a humorous depiction of the trials and tribulations of life on a chicken farm. Madonna Swan's account is not published until 1991, and she does not write her story but tells it to Mark St. Pierre, who, as the cover of the book explains, "has lived among the Lakota people since 1971, both as an educator and as an encourager of American Indian Art." Although the cover also makes clear that this is a Lakota woman's story "as told through" St. Pierre, he is listed in the Library of Congress classification as the book's author. Questions about St. Pierre's role in the structuring of Madonna Swan's story are somewhat beyond the scope of this particular essay, but I do want to problematize, if briefly, his role. In his introduction, St. Pierre admits that he has arranged Madonna Swan's many stories "in a loose chronological order, creating the sense of a story line" (ix). *Madonna Swan: A Lakota Woman's Story*, then, is both Madonna Swan's "story" of tuberculosis and St. Pierre's "story line," a linear transformation of Swan's story.³ St. Pierre also explains that this is not only Swan's story, but also the story of three generations of Lakota women, and even more generally, a 20th century American story. Through Swan's testimony the particular becomes universal, or as St. Pierre explains it, from the particular standpoint of a Native American woman who survived TB, Swan has a "keen ability to teach us – perhaps in a way we've never known – the twentieth-century experience" (ix). But, as I will show, Swan's experience at Sioux Sanatorium is not at all a universal American sanatorium experience, but a distinctly Native American one.

There have been numerous histories of tuberculosis,⁴ and some of these cite patient narratives describing the experience of tuberculosis.⁵ TB also occupies a significant position in literature, particularly in the late 19th century, where, as Sontag (1978) has famously noted, it becomes a metaphor for expanded consciousness, artistic sensibility, and spiritual refinement. This 19th century understanding of tuberculosis, as somehow aesthetically and spiritually desirable, begins to change in the 20th century as tuberculosis becomes a disease associated not with supposed upper-class refinement, but with urban poor and immigrant communities. Although the metaphors associated with TB shift from the 19th to the 20th century, the sanatorium remains the space most closely associated with TB in the American public imaginary. As Katherine Ott notes in *Fevered Lives*, "[a]lthough only a small percentage of the tubercular ever spent time in a sanitarium, it became the representative twentieth-century site for tuberculosis" (1996, 136). Because most of those people able to write about their experience of tuberculosis were either middle or upper class, and, thus, could afford to spend time in a sanatorium, most fictional and autobiographical accounts of tuberculosis describe

the experience of sanatorium life (see Rothman 1994, 215-240). MacDonald and Swan provide accounts of mid-twentieth century sanatorium life that complicate our understanding of these representative sites for tuberculosis. The subjects of their narratives – working class and poor Native American women – as well as depiction of what they undergo challenge dominant representations of TB and sanatorium life.

At the same time, *The Plague and I* and *Madonna Swan* might be read as texts that are representative of a new genre – the patient's narrative of illness that emerges as a counter-narrative to the doctor's narrative of disease as exemplified in case histories and medical charts. In her groundbreaking work *Reconstructing Illness* (1993), Anne Hunsaker Hawkins uses the term "pathography" for such illness narratives, and she defines pathography as "our modern detective story," where we are transported out of the everyday, familiar world of health into the unknown, uncharted world of illness (1). Hawkins asserts that, as a genre, pathography "seems to have emerged *ex nihilo*; book-length personal accounts of illness are uncommon before 1950 and rarely found before 1900" (3). She wonders why this is so, and offers as a possible reason the fact that pathographies have replaced autobiographies of religious conversion that were prevalent in earlier, more religious, periods (31). Hawkins notes similarities between these two types of autobiography, most notably that they both give "special prominence" to what she identifies as the "myth of rebirth"; that is, that the experiences of religious conversion and of illness afford "a process of transformation so profound as to constitute a kind of death of the 'old self' and rebirth to a new and very different self" (33).

Both MacDonald's and Swan's narratives of TB describe their experiences of TB at around the time Hawkins pinpoints the emergence of pathography, and both exemplify the myth of rebirth that Hawkins delineates. MacDonald and Swan are removed from their everyday lives, and are sent to places from which they believe they might not return. Their emergence from the sanatorium, which signifies their unexpected survival of TB, is a kind of rebirth, but it is a rebirth that is haunted by the memory of those who did not survive. Because Madonna Swan's account is not published until 1991, the belatedness of her story in contrast to MacDonald's has everything to do with the public spaces available to tell particular stories, the dominant languages in which stories are told, and the impossibility of telling the stories of the literally countless Native American deaths from TB. *The Plague and I* and *Madonna Swan* are both exemplary texts that demonstrate the mid-20th century operation of biopower, but by providing the patient's perspective on the disciplining of bodies and the regularization of populations, they also reveal the possibility of resisting forms of discipline and regularization in and through narrative.

MacDonald's tuberculosis routine

In *The Plague and I*, the medical director at The Pines Clinic and Sanatorium diagnoses Betty MacDonald with tuberculosis based not only on what he sees inside her lungs but also on what he perceives of her disposition based on her outward appearance. MacDonald notes wryly:

He said, "Taking the cure is going to be difficult for you. You have red hair – lots of energy, you're quick, active, impatient. All bad for tuberculosis. Discipline will be hard for you. The cure of tuberculosis is all discipline." I said that I would do anything. Anything at all to get well. He stood up and put his arm around me and said, "That is the spirit." Which was very kind of him considering the fact that he had just written on my card, "Prognosis – doubtful" (1948, 43).

The medical director diagnoses MacDonald's character as the opposite of that which defines patienthood. The director discerns from her appearance alone that she is active and impatient, which makes her, he believes, unlikely to submit easily to the discipline that a return to health requires.

The Pines Clinic and Sanatorium is based on a clinic in Seattle and a Sanatorium called Firland in Richland Highlands, Washington just north of Seattle, where MacDonald spent nine months in 1938.⁶ Firland was not an elite institution catering only to people who could afford to be there; indeed, many patients were from poor and working class families who could not pay the fees. As MacDonald explains in *The Plague and I*, she is lucky to get a place at the Pines, and her account suggests that she may have been admitted because of a certain amount of health capital⁷ that she accrues through her relationship with her brother-in-law, a pathologist. When she tells him, "[i]n a shaky voice and close to tears ... about the diagnosis, the sanatorium and the \$35 to \$50 a week," he responds with the authority of a doctor and the assurance that comes with it: "The Pines, one of the finest sanatoriums in the world, is an endowed institution and free to anyone who needs care and cannot pay. There is a waiting list of over two hundred but mothers with small children are usually taken right in. I'll write a letter to the Medical Director" (34). When MacDonald meets the Medical Director for the first time, he is reading the letter that her brother-in-law has sent him about her particular case.

In *The Plague and I*, MacDonald presents colorful portraits of a diverse group of patients at the Pines, and through her rendering of this diverse group, she reveals as well the racial politics of sanatorium life expressed through practices of spatialization. Although the majority of patients are white, there are several Japanese and Black patients, including Kimi, a young Japanese woman who has a quirky worldview, thanks, she believes, to her decidedly un-Japanese 5' 6" height, which makes her tower over other Japanese women and, literally, not fit in well to Japanese society. MacDonald learns that many of her fellow white patients will not room with the Black or Japanese women. When the charge nurse tells MacDonald that she is going to put "Miss Sanbo [Kimi] in with you, if you don't mind," MacDonald is delighted and wonders why she should mind. The charge nurse explains that, "Some people would object to sharing a room with an Oriental," and MacDonald states simply, "I would prefer it" (130).

While the portraits of the patients and the nurses are drawn with precision and wit, the doctors are more elusive figures in MacDonald's account. She only encounters them periodically, and on these occasions there is no negotiation between doctor and

patient about her treatment. Rather, the doctors make decisions about her treatment without consulting her, and the only sign from her doctors that she is improving in her time at The Pines is that her privileges gradually increase. She is kept so in the dark about her condition that she doesn't know until the Medical Director tells her on the day she is told she can leave The Pines for good that her sputum has been negative since just after she arrived. Despite the lack of dialogue with her doctors about her treatment, the doctors are the heroes of this story. Their heroic status is first glimpsed in MacDonald's dedication. *The Plague and I* is "For Dr. Robert M. Stith, Dr. Clyde R. Jensen and Dr. Bernard P. Mullen without whose generous hearts and helping hands I would probably be just another name on a tombstone" (5). According to MacDonald, "[t]he staff at The Pines had but one motivating factor – to get the patients well" (60). She acknowledges that this motivating factor is "like a policeman's nightstick . . . [and] twirled over our heads twenty-four hours a day" (60). But MacDonald believes that this is necessary because, she asserts, the patients themselves often don't want to get better. MacDonald calls this the paradox of a tuberculosis sanatorium: "It should be a place where the patients are striving to get well, aided by the doctors and nurses, but is actually a place where the patients are trying to kill themselves but are prevented, in many cases, by the doctors and nurses" (60). The constant struggle with the patient's own death wish inevitably makes the doctors and nurses less sympathetic to the patients and less willing to engage with them as individuals who happen to be ill. Although as we will see, MacDonald is critical of the disciplinary regime practiced at the Pines and the impersonality favored by many of the nurses in dealing with the patients, she still agrees ultimately that this regime is for the patients' own good.

As *The Plague and I* demonstrates, MacDonald learns very quickly the moral meanings that are attached to disease in general and tuberculosis in particular. Indeed, she notices that the TB clinic where she is diagnosed shares a building with the police station, the city jail, the emergency hospital and the venereal clinic; thus, the link between criminality and disease is designed into the architecture of the building itself. The term "police," Foucault notes in his essay "The Politics of Health in the Eighteenth Century," was originally a generic word for the exercise of the functions of "order, enrichment and health" (1980, 170). The modern tuberculosis clinic and sanatorium might be conceived in Foucaultian terms as sites designed and "defined to correspond not only to the need to supervise, to break dangerous communications, but also to create a useful space" (1977, 143-144). The diagnosis of TB means that MacDonald will be classed as in need of policing and supervision, not unlike those criminals housed in the city jail. She will be sequestered from the rest of society in order to break the potentially dangerous communication of a contagious disease. According to Foucault, "discipline proceeds from the distribution of individuals in space" (141); such distribution allows bodies to be more efficiently monitored and made "intelligible" under the gaze of authority. Thus, according to this schema, a tuberculosis sanatorium is an example of a "carceral" institution.⁸ "Unhealthy" tubercular bodies are sequestered from "healthy" bodies in the world outside the sanatorium, and sub-

jected to constant monitoring and normalizing judgments to determine their precise relationship to the norm of health.

In her history and geography of tuberculosis, Katherine Ott explains that “[b]eing ill took place within a geographic space constituted by objects, tools, instruments, and people.” According to Ott, there “are distinctive sites of tuberculosis – spaces inhabited by living beings and shaped by material objects. Patients, practitioners, and the community came together to build the optimum environment for the illness and thus to define it and fix its identity within these spaces” (1996, 5). Tuberculosis as experience and event comes into being through the various spaces, objects, and people associated with its diagnosis and treatments. We will see when we take up Madonna Swan’s account of TB in the Native American community in the second half of this essay that there are multiple sites of tuberculosis, and that not all sanatoriums are sites where patients are prevented from, in MacDonald’s terms, killing themselves by the heroic will and expert knowledge of doctors and nurses. The “optimum environment for the illness,” as Ott understands quite well, changes over time and across communities.

In his genealogical work, Foucault identifies modern forms of power as not (or not only) repressive, but rather as productive, forming a “positive economy” of power/knowledge. Power is not exerted unilaterally from a single position above (for example, the position held by the “sovereign” or the “state”) downwards in an exclusively hierarchical manner; power is instead *dispersed* multilaterally, and its exercise, though invisible, permeates and, in fact, constitutes individual bodies within the social body. Discipline, according to Foucault, is the means by which modern power operates. In *Discipline and Punish*, he asserts that discipline “is a type of power, a modality for its exercise, comprising a whole set of instruments, techniques, procedures, levels of applications, targets; it is a ‘physics’ or an ‘anatomy’ of power, a technology” (1977a, 215). Where health is concerned, documentation forms the basis for differentiation, classification, and segregation. As Foucault notes in *Discipline and Punish*, “The examination that places individuals in a field of surveillance also situates them in a network of writing; it engages them in a whole mass of documents that capture and fix them” (1977, 189). At The Pines, for example, the temperatures of the “inmates” are taken at regular intervals, and the results are diligently recorded on charts, the slightest rise in temperature indicating a movement away from health, and the slightest decrease indicating a movement toward health.

When MacDonald arrives at The Pines for her indefinite incarceration, a nurse goes over the rules – the “tuberculosis routine” (1948, 94) – she must follow in order to be allowed to stay. For these are rules one must willingly submit to in the hopes of getting better:

“Patients must not read. Patients must not write. Patients must not talk. Patients must not laugh. Patients must not sing. Patients must lie still. Patients must not reach. Patients must relax. Patients must ...” (53, ellipses in original).

Patienthood, then, is not reading, writing, talking, laughing, singing, or, even, reaching; it is lying still, relaxing, and, most of all, obeying the rules. The norms of health are arrived at through surveillance by health care professionals, and by the patients themselves, through the interiorization of the medical gaze, the willing commitment to the “tuberculosis routine,” and the implementation of the most meticulous self-monitoring. The ability to monitor oneself effectively indicates one’s desire for health, and one’s desire for health indicates one’s fitness for citizenship in a normalizing society. One of the lessons of the tuberculosis routine, MacDonald explains, is that, in order to continue to receive the much-sought-after care that the Pines provides, patients must always be on their best behavior and “grateful to the nurses, the doctors, and to the sanatorium” (122). As MacDonald notes with irony, the final point of this lesson is a moral one that requires disciplining the body by disciplining the mind: “IF YOU THINK RIGHT, YOU WILL ACT RIGHT” (122; emphasis in original).

In his discussion of the constitution of docile bodies in *Discipline and Punish*, Foucault gives, as an example, methods for the “correct training” of the soldier. For the soldier, detailed exercises are imposed such that “[a]ll the activity of the disciplined individual must be punctuated and sustained by injunctions whose efficacy rests on brevity and clarity, the order does not need to be explained or formulated; it must trigger off the required behavior and that is enough” (1977a, 166). Foucault detects such forms of *dressage* not only in the particular situation of soldiers in military training, but also in general as the means by which modern power operates. At The Pines, however, the exercises the patients are subjected to are, paradoxically, *forms of rest*. In fact, according to the official code, “everything that is not rest is exercise” (1948, 72). But, like Foucault’s forms of *dressage*, this constant rest requires an infinite amount of attention to the body and the self: again, no talking, no laughing, no coughing, no singing, no reaching. What is required, it seems, is, virtually, no breathing at all; in fact, the closer to dead one is, paradoxically, the better one is, or, at least, the better one is for monitoring. Discipline, then, might be understood as a figurative form of death. When I discuss *Madonna Swan*, I will show that regularization, in the case of the Sioux Sanatorium for tubercular Native Americans that Swan describes, requires not the figurative but the literal death of the Native American population. In a sense, Native Americans are regularized out of existence within the spaces of the Sioux Sanatorium.

The “tuberculosis routine” that MacDonald and her fellow patients endure is not only enforced while they are at The Pines, but it is extolled as what Foucault might call an “art of existence” or “technology of the self,” which he defines as “forms of *elaboration*, of *ethical work* (*travail éthique*) that one performs on oneself, not only in order to bring one’s conduct into compliance with a given rule, but to attempt to transform oneself into the ethical subject of one’s behavior” (1985, 27). Thus, the most important lesson taught at The Pines, according to the rule book, is: “The cure of tuberculosis is not medicine but a new regime of living, not only during the sanatorium period, but for years and years, maybe for a lifetime afterwards” (128). It is this *new regime of living* promoted in the name of health that I am concerned

with here, in terms of both its hegemonic exercise and the possible disruption of its exercise. That is, what characterizes this hegemonic regime of living, and how might it be transformed and/or transgressed?

At The Pines, MacDonald learns, the nurses are in charge of enforcing discipline, and, therefore, “impersonality” between patients and nurses is mandated; such “impersonality” maintains and bolsters the border between health and illness, the normal and the pathological (45). In *The Social Transformation of American Medicine* (1982), Paul Starr argues against a critique of public health that posits public health clinics and the nurses and others who work at them as “agents of social control.” Although Starr admits that public health clinics were involved in transmitting “middle-class American standards of value” as much as “scientific information,” nonetheless, he asserts that “there can be little question that the new hygienic practices had value in preventing disease and preserving health” (1982, 192). While I think Starr is correct in pointing out the important disease-preventing work of public health clinics, it might also be said that a Foucaultian analysis of health would not describe tuberculosis clinics and sanatoriums like The Pines and the nurses and others who work at them as “agents of social control,” but rather would describe them as caught up in the same nexus of power/knowledge as their patients. Nurses at The Pines, for example, are neither agents of social control nor agents of reform; rather, the reforms they articulate and implement are imbricated in the disciplinary apparatus of health.

Although power, in Foucault’s formulation, is not hierarchical *per se*, nonetheless, its normalizing function does create hierarchical binary relations: between doctor and patient, doctor and nurse, male and female, rich and poor, white and non-white, citizen and immigrant. Despite these normalized hierarchical binary relations, the new regime of living is recommended not only for the patients at The Pines, but for everyone. The nurses at The Pines, therefore, are subject to the same discipline as their charges:

Molly told us some of the trials of being a nurse at The Pines. She said that the discipline was not limited to the patients as the nurses were not allowed to smoke on the premises, had to be in every night by ten-thirty, were required to attend school three nights a week and were under twenty-four-hour surveillance to be sure that they obeyed these rules and many others, including no indulgence in SEX, thoughts of SEX, actions which might eventually lead up to SEX, discussions of SEX, or literature concerned with SEX. She said that with the exception of the charge nurses, the nurses weren’t allowed to speak to the doctors, which made it rather difficult as she and one of the staff doctors were engaged (1948, 125; emphasis in original).

Note the explicit link between health and sexuality in this paragraph, demonstrating the operation of modern technologies of health as well as modern technologies of sex, both of which Foucault would call “techniques for maximizing life” (1978, 123). Both health and sex are “transfer point[s] for relations of power,” and, in MacDonald’s description, the two converge in the figure of the nurse, who might be conceived of as

a liminal (and, as such, potentially problematic) figure between doctors and patients. MacDonald's ironic portrait reveals as well what Foucault has called *scientia sexualis*, or procedures for telling the truth about sex, which are in operation even when sex itself is being inveighed against. Although everyone is subjected to this new regime of living, as MacDonald's discussion of The Pines nurses reveals, not everyone experiences it in precisely the same way. Those who are deemed outside the norm – by virtue of gender, race, class, disability, and/or illness – are subjected to greater discipline.⁹ Such hierarchical binary relations in terms of race and ethnicity will become more apparent when I turn to Madonna Swan's experience of sanatorium life in the second half of this essay.

The Plague and I presents an image of the patient as constructed within the institution of modern medicine and through the disciplining of individual bodies in space. MacDonald herself knows the ideal image of the patient, and although she attempts to conform to it, at times she fails to do so. Her acknowledgement of the inevitability of failure in conforming to the tuberculosis routine represents a form of subjugated knowledge that demonstrates the intrinsic absurdity of the patient's position. Foucault explains that subjugated knowledges are low-ranking, naive, or popular knowledges that remain marginal to institutional knowledges. For Foucault, the investigation into subjugated knowledges in the past opens up a space for thinking and being otherwise in the future. He asks that we actively seek these knowledges in the past because "it is through the re-appearance of this knowledge, of these local popular knowledges, these disqualified knowledges, that criticism performs its work" (1980, 82).

Through humor, MacDonald challenges the patient's position as constructed in the spaces of the sanatorium and through the tuberculosis routine. Yet, despite MacDonald's ironic narrative stance, nonetheless, she readily submits to medicine's techniques of discipline and surveillance in order to prove that she has both a healthy body and a healthy disposition. Moreover, although to some extent she challenges the relationship between tuberculosis and criminality, simply by making that implicit relationship explicit to her readers, she also accepts – indeed, she understands that she must accept – the conventional moral meanings ascribed to health and illness. Although she recalls certain non-compliant patients with humor, she nonetheless makes it clear to her readers that their behavior is preventing them from getting well. In *The Plague and I*, MacDonald attempts to de-link tuberculosis from criminality in her individual case, rather than more broadly. Hers is a personalized defense in the memoir form rather than a defense that seeks to undermine the binaries – health and illness, normal and criminal – that structure how we think and know the experience of tuberculosis. MacDonald's work, then, is both hegemonic and transgressive because she both submits to the tuberculosis routine at The Pines and subverts it in her narrative about The Pines. On the one hand, the memoir brings the tuberculosis routine to the reading public at large and promotes it as a way of life, an art of existence. On the other hand, MacDonald's irreverent treatment of the routine as it was promulgated and lived at The Pines is a form of resistance to it. With humor, MacDonald undermines

the sanctity of the routine even while she extols its virtues, and attempts to uphold its rules. Yet, despite the alleged problems of her supposedly impatient-like disposition, which seemed to disadvantage her at the outset, the moral of MacDonald's story is that she has followed the routine so well that she gets out of The Pines, apparently sooner than anyone else.

Madonna Swan's death diary

Unlike MacDonald's often ironic portrait of sanatorium life, the story of tuberculosis that Madonna Swan tells to St. Pierre, who then crafts it into a "story line" for late 20th and early 21st century readers, is introduced as an heroic overcoming narrative of an individual and her community. For St. Pierre, "this collection serves as a tribute to all those Native Americans who survived tuberculosis, as Madonna did, and represents a closing and healing of that terrible wound in Lakota and human history, a period darkened by the sheer magnitude of an epidemic whose impact on tribal societies has been largely overlooked in Native American literature" (x). While Swan's story of tuberculosis is situated within the larger and longer story of her family and her tribe, the centerpiece of the book is her chilling account of her experience as one of the many Lakota children and adults who contracted TB and were removed from their families, sometimes forcibly, and put in sanatoriums exclusively for Native Americans. In a study on the relationship between public health nurses and clients on Indian reservations in the 1930s, Abel and Reifel note that "most state and county sanatoria refused to admit American Indians," and so Native American tuberculosis patients had to be placed in institutions established first by the Office of Indian Affairs and later run by the United States Public Health Service (1999, 497; see also Raup, 1959). These institutions, according to Abel and Reifel, "were seriously deficient" (498), and Sioux Sanatorium, where Madonna Swan was kept from 1944 until she "escaped" in 1950, was no exception.

After a prairie fire that she and her fellow students at the Indian boarding school are called on to help fight, Swan develops a persistent cough, and gradually weakens until she can no longer get out of bed. A Sister at her school asks her why she is "so down," and she tells the nurse, "I think I'm going to die like Rita, Rosie, and those others" (61), all of whom have died of tuberculosis, a "word that [Swan] would hear so often and come to hate with [her] whole soul" (55). A doctor examines Swan, taking a sputum test and lung x-ray. He tells her, "All of your tests are positive and your lungs are all clouded over. That could be damage from the prairie fire, but you do have tuberculosis" (61). This is the "awful dreaded word" Swan does not want to hear. Among Native Americans at this time, a diagnosis of TB was frequently equivalent to a death sentence.

By the time she gets her own diagnosis, Swan herself has witnessed several TB deaths, and she associates TB not only with an actual and horrible death, but also with a social death, because it incurs shame and stigma on individuals and entire families within the Native American community and beyond. Like MacDonald, she too understands the stigma attached to those who are sent to a sanatorium. However,

the image of the sanatorium that Swan presents is quite different from the image of the sanatorium in MacDonald's memoir. Swan is less concerned with the association between TB and criminality than with the fact that the Sioux Sanatorium run by the United States Public Health Service in Rapid City, South Dakota is a place where Native Americans go not to be treated, but to die.

In the last chapter of *The History of Sexuality, Volume I. An Introduction* as well as in the recently published lectures given at the Collège de France in 1975-1976, Foucault returns to the anatomico-clinical method and disciplinary forms of power in order to supplement this analysis of "power over the body in an individualizing mode" with an analysis of a second mode, which he calls a "massifying" mode that is "directed not at man-as-body but man-as-species" (2003, 243). The first mode, as I described in the first part of this essay, is what Foucault, in March 1976, calls an "anatomico-politics of the human body," and the second mode, which does not replace but complements the first, is a "'biopolitics' of the human race" (243). The approach to tuberculosis prevention and treatment in the early to mid-20th century United States, just prior to the discovery of antibiotics that have been successful in treating TB, in many communities of the world at least, shows both of these modes at work.

In his lectures, Foucault describes the transformation in the 19th century from a right of sovereignty to "take life or let live" to a new state right to "make live and let die" (2003, 241). In the case of tuberculosis prevention and treatment in the 20th century, we see this new state right demonstrated: *The Plague and I* presents the right and practice of making live, while Madonna Swan's oral history presents the right and practice of letting die. MacDonald's memoir records the making live mode of population control, as well as the disciplinary power over individual bodies; Swan's oral history records the letting die mode of population control, in that the Native American sanatoriums are less concerned with helping people to live, and more concerned with letting them die – away from the larger population. Here we see exactly the relation between biopower and racism that Foucault describes in his lectures. The power to let die, which is deployed against particular populations, is rationalized through racial hierarchies. For Foucault, "The fact that the other dies does not mean simply that I live in the sense that his death guarantees my safety; the death of the other, the death of the bad race, of the inferior race (or the degenerate, or the abnormal) is something that will make life in general healthier: healthier and purer" (2003, 255). Foucault locates "[s]exuality . . . at the point where body and population meet" (252), but, of course, it is not only sexuality that must be disciplined and regularized in order to make live and let die, but also disease, which is, like sexuality, understood in terms of both individual bodies and populations. According to Foucault, "Medicine is a power-knowledge that can be applied to both the body and the population, both the organism and biological processes, and it will therefore have both disciplinary effects and regulatory effects" (252).

In MacDonald's description of the tuberculosis routine, we have seen disciplinary effects on individual bodies, and, because this routine is meant to be taken up by everyone in society, we can see that it is also meant to have a regulatory effect on an

entire population as well. Although Swan was also subjected to forms of discipline at Sioux San, I want to focus here on the methods by which the Native American population, or at least Madonna Swan's Lakota Sioux tribe, was subjected to forms of regularization, which amounted to letting those with TB die. One might think of the Native American population in the United States as regularized out of existence through both assimilation – and the Catholic boarding school where Madonna contracted TB is one such space for this form of regularization – and diseases, like TB, allowed to run their supposedly “natural” course through entire Native American populations. We might also think of tuberculosis in the Native American community as endemic not epidemic, if we take account of the distinction between the two that Foucault makes in his 1976 lectures. Endemics were “the form, nature, extension, duration, and intensity of illnesses prevalent in a population,” according to Foucault. “Death was no longer something that suddenly swooped down on life – as in an epidemic,” Foucault asserts. “Death was now something permanent, something that slips into life, perpetually gnaws at it, diminishes it and weakens it” (2003, 243-244). Although he was speaking more generally, in his delineation of the difference between endemic and epidemic diseases, Foucault could have been describing tuberculosis in the Native American community in the first half of the 20th century.¹⁰ In utilizing Foucault's understanding of endemic disease for analyzing TB among Native Americans, it is important to keep in mind that TB became endemic in this population only after contact with whites. As Georgina Feldberg notes in *Disease and Class*, studies in both Canada and the U.S. in the early 20th century showed a steady “tuberculinization” of Native Americans because of increased contact with whites (1995, 162).¹¹

While the possibility of death hangs over MacDonald's work, it is not pervasive and permanent in the manner Foucault describes. She admits before she goes to the sanatorium that in her mind's eye “[s]anatoriums were places in the Swiss Alps where people went to die. Not only that but everyone I'd ever heard of who had had tuberculosis had died” (33). And yet, once she arrives at the sanatorium, death is not as prominent a feature of life at The Pines as it is for Swan at Sioux San. This is partly because those patients at The Pines who are very ill are isolated from the rest of the patients, and partly because the tuberculosis routine requires a positive attitude, which doesn't include dwelling on death. As the charge nurse tells MacDonald, “We do not allow patients of The Pines to think about death, or other unpleasant things. You must have pleasant cheerful thoughts” (161). Death happens at The Pines, but it is rarely spoken of, or openly acknowledged by, the doctors and nurses. It is a ghostly presence, manifested mostly in discomfiting rumors of difficult deaths and strange noises in the night as the dead are disappeared. At Sioux San, on the other hand, all patients – those who are very ill and those who are less ill – are kept together. Swan speculates, probably correctly, that, “those of us who were highly positive kept reinfecting those that had negative sputum cultures” (73). Perhaps revealing the possible benefits of the disciplinary mode that would have separated very sick bodies from less sick ones, Swan notes, “They should have divided or separated us so we didn't reinfect the healthier

ones, but they didn't. I felt bad about that" (73). At Sioux San, the Native American patient population was massed together, seemingly not to prevent death but to allow it.

Both MacDonald and Swan describe the sanatoriums they are sent to as prisons, but MacDonald's experience as an inmate at The Pines is merely figurative, nothing is keeping her there but her own desire for a return to health, and, in fact, the main threat hanging over the patients at The Pines is that those who do not abide by the tuberculosis routine will be sent home. Swan's experience as an inmate is much more literal.¹² At the Sioux San, at least in its early years, the patients were "dressed all alike, like the inmates at the penitentiary in Sioux Falls, all dressed in stripes." Swan explains further, "I guess that was intended to keep us from escaping. If we could escape, we could not get far. Of course, our regular clothes were locked away" (74). Although the patients could stand on balconies to get some fresh air, they were not allowed to set foot outside the buildings.¹³ Swan understands this in terms of the stigma attached to diseased bodies:

Living in the san would make you feel like an outcast with some filthy disease like leprosy. We couldn't go outside. We were allowed only to stand out on the little balconies and look out across Rapid City, watching people go about their daily lives, enjoying life. From 1944, through 1945 and 1946, until 1947, we were not allowed to go outdoors, not stand on the ground, Maka Ina, Mother Earth, even once. Just going to the window or a balcony was all we could do, but even that was a relief – at least it was fresh air (80).

But, we might also understand this literal incarceration as a form of regularization in which an always already diseased Native American population is kept separate from a supposedly non-diseased white population. As I've already noted, the irony of this healthy white/diseased Native American binary is that, in the case of TB at least, it was Native Americans who needed protection from whites.¹⁴

In her first week at the San, Swan meets an old friend, Margaret Halfred, who is very ill. Rather than feeling comforted by seeing a familiar face in an unfamiliar place, Swan feels uneasy because she sees her future in Margaret: "just seeing what she had become made me fearful" (71). In fact, Margaret is the first person to die after Swan's arrival at Sioux San. Swan learns quickly why Margaret has been moved to a private room; those who are dying are moved out of sight to a part of the sanatorium that the patients call "death row." Being on death row does not mean, however, that one is formally isolated from the other patients. One of Swan's tasks at the sanatorium is to bathe women who are too sick to bathe themselves, and to wash the hair of women on death row. Swan explains, "We always helped out with the sick ones, I guess, because they were short of staff" (75). By caring for those who are sicker than she is, Swan risks reinfecting herself, and at the same time must face again and again a death that she senses will be her own. This is not just pessimism on her part, but reality for the patients at Sioux San:

There were no patients going out on leave or dismissed in 1944 or 1945. Not until 1946 did the first few patients leave alive. Death was the only way anybody left before that, and there were many. I had a diary, and in it I wrote down the little things that happened each day, things girls outside the san would never have bothered to write down. I wrote down whatever happened, no matter how ordinary, things like the kind of day it was, how I felt, and if an outsider came to visit. I wrote down why and when they came, and I wrote down the names of those that had died. (74)

Swan's diary, unlike MacDonald's memoir, becomes a diary of death. She and another patient and diary keeper, Bernice Long, review their diaries together in 1950, and count five hundred deaths. Swan and Long note a pattern: "It seemed that when one would die, two more would die soon after. That was something both of us had noted in our diaries. When one would die, we would wonder who the other two would be. We wrote that at varied times, always wondering if the next one would be us or one of our friends" (74).

After six years at Sioux San, the doctor there, Dr. Sedlecheck, still insists Swan cannot leave. When she asks if she will soon be able to leave, he tells her, "No, your tests are very bad. Your sputums are bad and your x-rays are bad! I can't let you go home because your germs are very bad" (101). In 1950, Swan's younger brother Orby also becomes sick with TB and joins her briefly at Sioux San. But, from the beginning, he has no intention of staying. He tells his sister, "I'm not going to be like you. They're not going to keep me here and not let me go home. I know I'm going to die. I want to die at home" (101). Orby simply tells his father to come pick him up, and he walks out of Sioux San. When he dies at home shortly thereafter, Madonna Swan is unable to leave to attend his funeral. Haunted by her brother's words and actions, Swan decides to escape, and just the idea of escape gives her life new meaning. She arranges to have someone meet her at the sanatorium with a car, and even when she is being driven away from the Sioux san, she fears that "the Rapid City police will arrest me like a common criminal" (104). There are reprisals for her escape; a red tag is put on her home marking it as a "TB house" (104). But her father decides she will not go back to Sioux San, and he begins to use connections to try to get her into the white sanatorium known as Sanator. When her father is told that Madonna cannot go to Sanator because Sanator is for whites and Sioux San is for Indians, he protests that Indians fought bravely for the United States in WWII, including two of his sons, one of whom died in battle.

Swan is eventually admitted into Sanator, and the difference is dramatic: "The grounds were pretty, with trees and flowers and all. The patients were walking the grounds with their own clothes on" (108). But, even more than the fact that it is less prison-like than Sioux San, Sanator has doctors who apparently want to make Swan better, not just let her die. Swan is given a new experimental surgical treatment, in which the ribs and upper and lower lobes of one lung are removed (113). She agrees

to this experimental surgery in the hopes of helping herself in the present and countless others who might contract TB in the future. After the surgery, Swan's recovery is arduous: she is bedridden for six months, because she can't support her spine and head, and is numb from her fingertips to her shoulder (117). Her doctor is grateful for what he learns from her surgery, and tells her, "We are already making many changes in our technique because of you and those other brave ones who went first" (121). Miraculously, Madonna Swan finally does begin to recover, but apparently not because of the experimental surgery. Just before the close of the mid-section of her oral history, which describes the ten years she suffered from TB, she mentions that "[t]hey had put me on antituberculin medicine, and for the first time since 1944 I knew I would be cured" (121).

In the end, Swan herself, with the help of St. Pierre, presents a narrative not only about overcoming TB but also about overcoming racism. It is Sanator and its white doctors that save her, and the grateful former patient continues to work as a receptionist at Sanator even after she has recovered from TB. Madonna Swan's story is a story of survival: if she had not gone to Sanator when she did, if she had not been given antibiotics when she was, she very well might have died, and her oral history would never have been told and published for others to read. This is the dominant narrative that she tells, but this narrative paradoxically both covers over and reveals the racism that led to the countless Native American deaths from TB. Within the biopower mode as Foucault describes it, racism becomes the justification for "the need to kill people, to kill populations, and to kill civilizations" (257). Foucault maintains, "When I say 'killing,' I obviously do not mean simply murder as such, but also every form of indirect murder: the fact of exposing someone to death, increasing the risk of death for some people, or, quite simply, political death, expulsion, rejection, and so on" (256). Madonna Swan's story may be about overcoming, but it is haunted by another story of racism that "justifies the death-function in the economy of biopower" (258). What we hear in Madonna Swan's testimony is an echo of the diary of death she kept at Sioux San, which is an echo of all the Native Americans who were killed there.

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Endnotes

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² For an application of Foucault's theory/method in the area of health, see Rose (1994, 58).

³ In a review of *Madonna Swan* in *The Journal of American History*, St. Pierre's role is not at all problematized, but celebrated. In fact, a significant portion of the review is about what the reviewer takes to be his heroic role in bringing this story to readers. The reviewer describes at length St. Pierre's shaping of Madonna's account, and asserts that he shaped her personal anecdotes "into a unified vignette that captured the essence of Madonna's spirit" (Price 1992, 1224). The review begins and ends with St. Pierre; in a sense, his story gives shape not only to *Madonna Swan* but to the reviews of it as well. After asserting that *Madonna Swan* is a testament to remarkable women so often ignored in Native American history and biography, the reviewer ends by noting: "This book is also a testament, however, to the foresight and sensitivity of Mark St. Pierre himself, who, unlike other collaborators and 'interviewers,' had the courage to allow Madonna's words to speak loudly and clearly for themselves" (1224). One really must ask, as Gayatri Spivak has, "Can the Subaltern Speak?" (Spivak 1994).

⁴ See, for example, Bates (1992), Craddock (2000), Dormandy (2000), Feldberg (1995), Ott (1996), and Rothman (1994).

⁵ For example, Craddock analyzes writings in *Hi-Life*, a newsletter written and produced by patients at Arequipa sanatorium outside San Francisco (2000, 184).

⁶ For an interesting discussion of the history of Firland, see the website Seattle/King Co.HistoryLink.org.

⁷ This is a term I use to highlight the importance of the field of health and illness in understanding class differences, and I derive it from and in relation to Bourdieu's other forms of capital: economic, social, cultural, and symbolic (Bourdieu 1984). Health capital refers to access to material objects, including water, food, and housing; institutions, including preventive and emergency health care, health insurance, and health education; and relationships with trusted friends or family members who may act on one's behalf as a health advocate or authority in health care emergencies.

⁸ For a historical account of a sanatorium as a carceral institution, see Craddock's chapter about Arequipa Sanatorium for Working Women near San Francisco entitled "Reforming Bodies: Poverty, Discipline, and the Sanatorium Experience" (2000, 161-197).

⁹ For a Foucaultian analysis of the "reproduction of gender" norms in the 19th and 20th centuries through the practices of diet and exercise, see Bordo (1990 and 1993).

¹⁰ He also could have been describing AIDS in Africa in the late 20th and early 21st century. While AIDS in Africa is spoken of as an "epidemic," it has been approached, particularly by western governments and organizations, as something that has become endemic, and therefore not cost effective to treat. For a discussion of the apparent permanence of death from both TB and AIDS in Africa, despite effective treatments, see Farmer (1999).

¹¹ According to Feldberg, "By the early 1930s, Americans had become critically aware of the extent to which tuberculosis was decimating Native American communities. The calls for 'Indian assimilation,' first made at the turn of the century, had taken their toll as Native Americans, both off the reservations and on, adopted an impoverished and crude facsimile of the 'white' lifestyle, which compromised their health" (1995, 168-169).

¹² I should note that MacDonald remains at the Pines for nine months, whereas Madonna Swan is at Sioux San for six years.

¹³ The image one gets of Sioux San is contrary to the popular image that MacDonald alludes to of sanatoriums as places that promoted access to pure air for patients. For more general discussions of sanatorium life, see Dubos and Dubos (1952), Bates (1992), and Rothman (1994).

¹⁴ As Abel and Reifel note in their study of health care on reservations in the 1930s, "Tuberculosis was, in the words of the Merriam Commission, 'without a doubt the most serious disease among Indians.' The tuberculosis death rate was seven times that of the rest of the population."

Institutional confinement of the insane in the interior of Argentina: La Pampa and the insane, 1900-1945¹

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Translated by Jonathan Ablard

This article seeks to demonstrate the medico-legal experience of presumed-insane persons in the Territory of La Pampa, with special attention to the geographic, procedural and historical context, from the end of the nineteenth century through the middle of the twentieth century. Our focus is on the pathways that individuals whom the courts had deemed insane took from the capital of the Territory, Santa Rosa, to the *Hospicio de las Mercedes* [National Insane Asylum for Men] in Buenos Aires. Generally, once patients from the territory had arrived to Buenos Aires they were transferred to the Hospicio's rural colony-asylum, which was situated in the province of Buenos Aires.

What was the relationship between the medical rhetoric of the time and the therapies that doctors used to treat patients?² An analysis of institutions for the confinement of the insane offers useful insights into both the structure of the territorial state and its bureaucracy and criminological and psychiatric discourse about social control. These themes are central to an understanding not only of the experience of patients, but of the territory as well.³ This essay, furthermore, will discuss discrepancies between the ideal medical and scientific treatment of the mentally ill and the fiscal and institutional limitations under which professionals operated. In sum, the ideal of rationalizing the care and control of the mentally ill was rarely realized.

A Difficult “social control”

La Pampa, which is located in the center of Argentina, was a national territory from 1884 until 1951, when it was designated a province. Migration by newcomers, both native-born Argentines from neighboring provinces and immigrants alike formed the overwhelming bulk of the population after the decimation of the indigenous population in the Campaign of the Desert of 1879. As Argentina's economy opened up to world markets, the Territory transitioned from a pastoral economy to one devoted heavily to grain production for export.⁴

Following national reorganization in 1880, the Argentine state began a concerted effort to regulate and contain individuals who were perceived to threaten the social order because of mental or physical infirmity. Such reforms were spearheaded by a cadre of professionals who ascribed to Positivism, a social theory that emphasized “order and progress” and application of science to solve social ills. Following positivist ideology,

such policies sought to create a citizenry of obedient and hardworking individuals who would reproduce equally fit and useful citizens.

Public psychiatric policy was deeply shaped by the burgeoning field of public hygiene, (often referred to as *higienismo*), which sought to employ a combination of medical, juridical and penal instruments to control a population, which in the eyes of Positivists, was characterized by disorder and chaos. Social policy, thus, was predicated on a social defense model that argued that it was the state's mission to target society's dangerous sectors and to confine, contain and treat them accordingly. In Argentina, professionals tended to blur the distinctions between socially marginal groups, and viewed prostitutes, criminals, the mentally ill, alcoholics and immigrants as a set of overlapping deviant populations. At the center of these intellectual curiosities rested the field of psychiatry. The educated classes viewed madness and social deviance as tightly linked phenomenon because of the reigning belief that a wide range of abnormal and anti-social behaviors were linked to inheritable biological traits. As this fit neatly with psychiatry's perennial search for the biological and somatic origins of madness, mental illness was therefore foundational to understanding all social ills.

Our case study concerns the cases of 168 individuals who were deemed insane in the Territory of La Pampa between 1898 and 1930. (Roughly 4.09 cases per year). This number probably only represents a fraction of the total number of persons who were processed through the courts. The overwhelming majority was foreign born men, mostly from Spain or Italy, who were single and with no family in Argentina. Almost all of them worked in the agricultural sector, either as day laborers, farmers, or lumberjacks, and most lacked much education or property. In this respect, the cases reviewed here fairly represent the background of most men of La Pampa. The overrepresentation of immigrants among the sample reflects the fact that those without family network were more likely to be hospitalized and brought into the judicial maze. Furthermore, anti-immigrant attitudes that associated immigration, madness and criminality amongst the police and professional classes may have also contributed to immigrants' higher rate of confinement.

Statistical information on the number of mentally disabled persons in individual provinces and territories was extremely unreliable and probably tended to under-represent the actual numbers, as it was often based not upon house to house samples but on an examination of hospital records. The Second National Census of 1895 reported that of La Pampa's 25,914 inhabitants there were five mentally disabled individuals. Although the figures were imprecise, many professionals were alarmed that the Third National Census of 1914 did not bother to list the number of insane. The desire to enumerate the mentally disabled was both a product of, and encouraged by often lurid reports of the republic's apparent growing population of mentally ill. These writings argued for the implementation of rigorous policies to contain, confine, and cure the mentally ill. Emblematic of these writings were those of Arturo Ameghino. He displayed a remarkable preoccupation with the relationship between the impending degeneration of the Argentine population and immigration, and he noted that La Pampa had 101,336 inhabitants in 1914 and that 13 of its inhabitants were patients

at the men's asylum in Buenos Aires (Ameghino, 1927: 500-501).⁵ Ameghino, who was a psychiatrist, proposed a wide range of initiatives, including tighter immigration controls, to stem the problem.

Responses to the perceived rise in social and biological threats varied greatly between the different regions of Argentina. In the major urban centers of the Argentine littoral (the littoral includes the temperate farm lands around the cities of Buenos Aires, Santa Fe and Rosario), criminologists, psychiatrists, jurists and educators articulated a rhetoric that emphasized the connection between the threat of immigration to the nation's future prospects. In their zeal to forge a modern and harmonized nation of mentally and physically normal citizens, a tremendous effort was made to build and maintain a network of welfare and sanitary institutions that had repressive elements. Most notable was the construction of the National Penitentiary, the Criminological Institute, the Police Service for the Observation of the Insane and the model psychiatric colony-asylum, *Colonia Nacional de Alienados*. All of these institutions, which were located in the littoral zone, were viewed by Argentine professionals and foreign visitors as emblematic of the republic's bright prospects to continue to grow and develop into a prosperous and "civilized" corner of Latin America. (Gomez, 1912; Loudet, 1932)

By contrast, responses to social threats in peripheral areas such as La Pampa were decidedly more muted. Demographic, fiscal and bureaucratic constraints limited the extension of state institutions into regions like La Pampa where the population was sparse, tax revenue was thin and the presence of the state was ephemeral. La Pampa, like other national territories (Patagonia, Chaco, Los Andes, and Misiones) was administered by the National Executive and the only elections were those at the municipal level. This further contributed to considerably weak budgets and hence the territories generally lacked an adequate number of state-employed functionaries. Moreover, justice and policing were given preferential treatment in budgets at the expense of social and sanitary institutions. Thus, although there was great interest in containing social deviance, the territorial governments lacked the resources to attack the problem in the same way that urban areas could.

Of all the areas of social welfare and control, the most notable deficit was in mental health care. Until the inauguration of a psychiatric ward in the Regional Hospital in 1943, La Pampa had no services available for the confinement or treatment of the mentally ill. Thus, prior to 1943, the question of what to do with persons deemed mentally ill was a vexing one. In the case of men, who were the overwhelming majority of the cases, they were generally sent to the Territorial Public Assistance office, the Central Police station or the Pre-Trial Jail.⁶

For many years, Public Assistance, which was located in the territorial capital, was the only state institution in the territory devoted to public health.⁷ Its only building was small and designed to dispense basic medication, provide inoculations and to offer some attention to women and children. Thus, it was far from appropriate as a site to house those deemed mentally ill, and less so for those who were violent and/or unruly. Public Assistance doctors and staff generally requested, and were granted,

permission to transfer such persons to one of the Territory's more secure (but less humane) institutions.

During the judicial process to determine individuals' sanity and legal status, the supposed insane were thus housed with common criminals, which was a situation that pleased no one. As it was impossible to adequately segregate the two populations, there were frequent conflicts and incidents. Oftentimes, the police would argue that the supposed insane were either the butt of prisoners taunts, or conversely, that the patients posed a risk to the prisoners. Not surprisingly, during court proceedings, one of the first requests made by petitioners who sought to have someone ruled insane and legally incompetent was to have the individual transferred to an institution appropriate to their care and oversight.⁸

If police stations were clearly designed for temporary confinement, the jails represented sites where one might have expected to find evidence of the more specialized control projects found in urban areas. According to the 1905 report of Territorial judge Baltasar Beltrán, the territory's jails were horribly unsanitary and lacked both workshops and adequate security.⁹ In 1912, the governor closed the jail in the town of General Acha, which resulted in severe overcrowding by both prisoners awaiting trial and the supposed insane. (Gómez, 1912: 421) The frequent reconstruction and redesigning of the Territorial jails epitomized this institutional confusion. Between 1900 and 1940, institutions and specialized wards were built and then closed at Santa Rosa, General Acha and finally in General Pico. As a result, there was a constant transfer of prisoners, both those under arraignment and those already convicted, from one institution to another. Each institutional reordering was less a product of long range planning than of emergency efforts to resolve problems of overcrowding and, of course, the mixing of psychiatric patients with common criminals.¹⁰

The case of Emilio Presnos is representative of the challenge of housing the supposedly insane.¹¹ In March of 1924, a neighbor of Presno's in the town of Intendente Alvear became concerned that he had become delirious and was violent and requested that the police detain him as a matter of public safety. His initial confinement was in the local police station, where a police doctor examined him and determined that he should be transferred to an asylum "to protect society." A few days later, he was transferred to the central police station in the capital of the territory, where another medical examiner determined that he had an altered mental state, with the "delirium of a degenerate." They recommended that he be confined to an appropriate institution. A judge named a legal guardian in May of 1924, but no action was taken on his transfer until January of the following year. In this case, his transfer to an unnamed psychiatric institution in Buenos Aires was delayed by eight months between the initial proceeding and the execution of the judge's order, this despite the fact that both medical reports were unequivocal in their findings. Moreover, there were no other extenuating circumstances to explain this delay. Meanwhile, Presno, whose mental condition remained the same, together with several other mentally ill individuals, was being held in a space that medical and legal experts considered wholly inap-

propriate.¹² Housing of the insane in jails not only impeded the recuperation of the mentally ill, but it also was believed to have a deleterious effect upon the morale and morals of the common prisoners. That the detained mentally ill person in La Pampa suffered the same discomforts and problems as prisoners awaiting trial contradicted the ideals of Argentine professionals for whom, paradoxically, the scientific treatment of the criminal and the mentally ill called for different regimens for their moral and physical regeneration.

From La Pampa to the Asylum

For many of the mentally ill of La Pampa, the ultimate destination was the National Colony for the Insane in the town of Open Door/Luján, Province of Buenos Aires. The institution, which dates from 1899 when Congress approved it, was modeled on the Scottish “open door” system. This model was based on minimizing restrictions on patients’ movement, most notably by doing away with encircling walls. The system was premised upon an ethical agreement on the part of patients to respect the rules and to not escape and to participate in obligatory work. Work, paradoxically, served as both a mode of control and of therapy. Moreover, key to the “open door” model was the appearance of liberty, yet patients were subjected to constant vigilance and discipline by what in theory and design was to have been an amply manned staff of well trained nurses and auxiliaries.

Because the National Colony for the Insane had originally been designed as an agricultural colony, its first patients had been selected as much for their prospects for recovery in such an atmosphere as for the trades and skills that they possessed. Thus, patients who had experience in agriculture, carpentry, construction, and metal work seem to have been more likely to be sent to the institution. The therapeutic goal of the Colony was to regenerate the mentally ill and to reintegrate them into society as “moral subjects,” who would follow bourgeois norms, through the discipline of work and constant vigilance. The institution also relied upon, paradoxically, more effective sedatives and a more professional and reliable staff. In cases of unruliness or violent behavior, staff was trained to confine patients in secure and safe padded cells. Their isolation was intended to both calm the patient and to isolate disruptive individuals from the rest of the patients.

Over the period under consideration, the medical profile of admissions shifted. Perhaps as many as 80% of patients admitted in the early years were deemed to be chronic (ie, not likely to ever recover), yet the hospital soon was admitting acute cases, who were treated with bed rest, under intense scrutiny, until they were deemed well enough to engage in one of the hospital’s many work projects. Ironically, although the hospital had been conceived in large part to alleviate overcrowding in urban institutions, the Colony soon faced similar problems. The first group of 11 patients were admitted to the Colony in August of 1901 but by 1918, there were 1250 patients, a number that was significantly higher than the institution’s patient capacity. (Ingenieros, 1919: 248; Ameghino, 1923: 170-213) By the 1960s, the Colony (now renamed after Cabred and under provincial, not national, authority) held 2000 patients who were

under the care of a mere four doctors. Ward attendants were each in charge of upwards of 300 patients. This was a far cry from Cabred's original design, which mandated 10 patients for each attendant. (Iacoponi, 1996) Predictably, patient overpopulation impeded the transformation of the Colony into a true rehabilitative institution, as had been the goal of its founder, Dr. Domingo Cabred. It no doubt also contributed to problems in maintaining the paperwork of individual patients

These conditions also impaired the proper development of medical interventions. The renowned psychiatrist and historian Osvaldo Loudet noted that at the beginning of the twentieth century, therapies for mental illness were limited to treating the symptoms of agitation, detoxification through diet, and confinement. By the eve of the Second World War, a wide range of somatic interventions, including pharmaceutical interventions and surgeries, had in theory revolutionized the treatment of the mentally ill. New treatment modalities offered hope that the role of large state-run asylums would diminish and that in their place, the government could develop a network of psychiatric clinics. In small facilities, diverse treatment approaches could be used and patients would have an easier time with social reintegration at the end of their hospitalization. Yet, as will be demonstrated below, a survey of existing patient records indicates that many patients received little medical attention.

With the growing ideal of the medicalization of treatment, record keeping became increasingly important to the operation of the hospital. The Argentine model for Clinical records, which had originally been implemented to monitor and track the progress of penitentiary convicts, reflected a growing desire on the part of doctors to study and monitor patients more closely. This model, which was presented and discussed at professional conferences, was designed to observe, classify and monitor the confined, was rarely applied anywhere close to the ideal because psychiatric institutions, designed originally as scientific and medical institutions, had essentially become human warehouses. Record keeping, which included both a "Life History" that was taken at admission (known in Spanish as *Boletín Anamesico*) and a clinical history (which was in theory to evolve and develop during the patient's institutional "career") came to constitute a virtual science. According to the psychiatrist Osvaldo Loudet, each file consisted of a "physical, intellectual and moral biography that was to be executed with scientific rigor and the zeal of the inquisitor." Thus, Loudet saw in the patient records an extension of Pinel's belief that the patient must fall under the beneficent but absolute control of the medical director. (Loudet, 1938; 1958)

las Mercedes
NAMNÉSICO

PREGUNTAS **RESPUESTAS**

1 - ¿Es el primer nombre o apellido el que se escribe?
12 - ¿Se escribe el apellido en otra forma?
13 - ¿Cuál es el primer nombre?
14 - ¿Cuál es el primer apellido?
15 - ¿Cuál es el primer apellido?
16 - ¿Cuál es el primer apellido?
17 - ¿Cuál es el primer apellido?
18 - ¿Cuál es el primer apellido?
19 - ¿Cuál es el primer apellido?
20 - ¿Cuál es el primer apellido?

Castro
ti
no, respondiendo con el nombre de la
que se le ha hecho el primer nombre
mejor de la

La esposa
Legionario
esta de dulce
al castro

Don
1921




1371

Maxime Castro
Diciembre de 1921
Casa: 63 No. Colón n. 44
Legionario. Roma primer



Title: "Life Histories"



Hospicio

BOLETIN

PREGUNTAS	RESPUESTAS
1.-Nombre y apellido del enfermo.	Dato: _____
2.-Nombre y apellido del padre y de la madre.	Dato: _____
3.-Causa de padecer esta enfermedad.	
4.-Estado social - voluntario.	
5.-Lugar de su nacimiento.	
6.-Lugar y fecha precisa del nacimiento del enfermo.	Dato: _____
7.-Estado civil (casado, soltero o viudo).	Dato: _____
8.-Edad y edad de los hijos, salud de estos.	
9.-Profesion, posición social y manera de su vida habitual.	Dato: _____
10.-Religión.	
11.-Profesión.	Dato: _____
12.-¿Cuáles son causas de origen de esta enfermedad? ¿hereditaria, debilidad, etc. causas orgánicas, disencéfalo, etc.?	
13.-¿En qué circunstancias se produjo la enfermedad?	
14.-¿Cuál fue el estado de ánimo del enfermo al ingresar?	

San Pedro de Atacama

497875 - 1920

No. _____



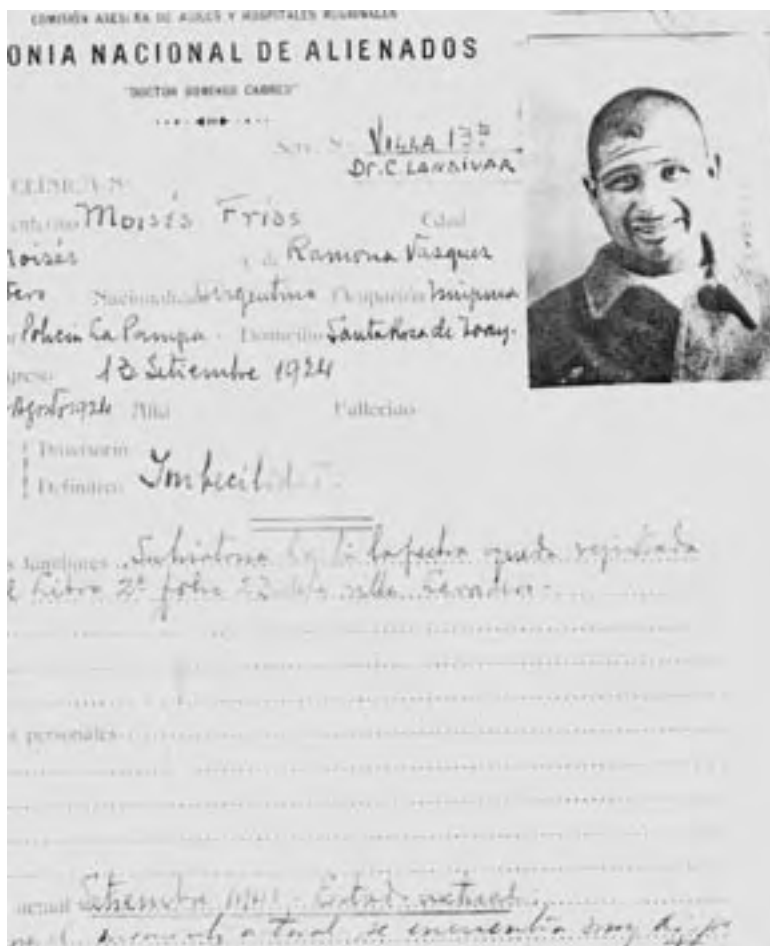
Provincia de San Pedro de Atacama, Chile

Municipalidad de San Pedro de Atacama

Calle _____ N.º _____

Teléfono _____





Our interest now turns to an examination of the ways in which these scientific and administrative techniques are reflected in the Patient Records of sixty men who were sent from the Territory of La Pampa to the Colony. Of the sixty files, 43 only contained the the “Life History file” (Boletín Anamnesico) which in most cases had already been started at their initial admission to the Hospicio de las Mercedes. (Readers will recall that provincial patients were typically first sent to the Hospicio before being transferred to the rural asylum). These files tell us very little other than the basic information about the patient. Why and when patients were transferred from the Ho Hospicio to the Colony and the evolution of the patients’ conditions are notably absent. The information, then is minimal, and is usually no more than what the patient’s police escort might know about the individual.

The other 17 files contain the “Life History”, clinical history, lab test results, medical reports, etc. that were performed at the Colony. In some cases, the files contained

internal communications or requests for information from family or the police about the health and welfare of the patient. There are also death certificates, correspondence from the national Registry of Foreign Persons and photographs that were taken of the patients upon admission to the Colony. The photos are striking for how much they reflect what must have been the rapid deterioration of patients' physical and emotional well-being.

Clinical histories, then, reflect the wide array of psychiatric and medical attention that was available to patients. Psychiatric treatments included bed rest, isolation, purgatives, tonics, electroshock, sedatives and work therapy.¹³ There was also monitoring of patients' physical well-being around issues like infectious disease, accidents and trauma.

Yet, patient records' historical significance is ambiguous. On one hand, they can be a rich source of information on how an institution adopted psychiatric knowledge and techniques. Yet, for every file that contains rich source material on patients, many more are strikingly threadbare and contain but the most basic information, and nothing more. This overwhelming evidence of poor record keeping, in tandem with other evidence, suggests that the positivist objectives of doctors were rarely achieved, even in institutions that professionals viewed with admiration. Furthermore, the Patient Files herein discussed reveal the absence of protection for patients who remained invisible and abandoned to their fate due to the negligence and disinterest of doctors and staff and because of the deficiencies of the health bureaucracy. The lack of supervision and oversight of records is especially striking for an institution where record keeping would have been seen as a fundamental part of the professional medical endeavor.

There were two main reasons that patient files were rarely up to date and complete. First, doctors and staff often were unable to obtain background information on patients. The reasons varied: if they were foreign born and with no family, in addition to suffering from psychiatric distress, the police, courts and guardians were often unable to acquire such information. Second, extreme overcrowding and the shortage of basic administrative equipment [forms, typewriter ribbon, etc] made it nearly impossible to maintain accurate and up-to-date records. These challenges had been a problem really since the 1880s, but became more noticeable as, on one hand the patient population grew and, on the other hand, the ideal standards of record keeping grew more rigorous and scientific.

For patients who arrived to the Colony from distant provinces, such as those from La Pampa, the situation was even worse because their presiding judge [who oversaw their guardianship, property, and supposedly monitored their care at the hospital] was often unable or unwilling to track the progress and status of their wards. Distance, then, fostered a precarious legal situation for many patients, and especially if the patients did not have family or friends who filed requests for information periodically. And indeed, as most of the men who were sent to the Colony did not have immediate family in Argentina, few benefited from petitions for information from the outside. This isolation was further aggravated by their mental condition, which

may have already served to alienate the men from whatever family or social contact that they may have had.

A review of patient files of men from La Pampa reveals that the Colony rarely maintained adequate records of treatments, illness evolution or any other information that might reveal insight into the lives of patients. It is noteworthy that despite links between doctors and patients, there is little information to help shine light on the dynamic between patients and doctors, or between patients.

The absence of adequate recordkeeping on patients' clinical experiences reflects the vast chasm between bureaucratic norms and bureaucratic behavior. It also suggests that doctors and staff were indifferent to the fate of their wards. This is all the more striking, when we compare the social, political, and ideological context of Argentina, which emphasized not only social control, but also the eradication of social deviance which supposedly threatened the nation to the actual behavior of state functionaries.

Conclusions

Argentine historiography, following Michel Foucault, has stressed the ways in which Positivist psychiatry generated and outlined the social and economic marginalization of so-called deviant classes. Indeed, his writings sparked a wealth of studies on the social history of madness, which emphasized social control of the under classes by a scientific and intellectual elite. However, a comparison of this rhetoric with life inside institutions, especially outside of the major urban areas, suggests a new interpretation of social control.

For the case of La Pampa, a variety of functionaries, including the police, Public Assistance doctors, court and jail officials, based on their training and education, were well disposed to implement social control policies on the population. Yet in terms of concrete action, they rarely could execute their tasks in an efficient manner. This was so despite a clear and unequivocal ideological and professional imperative to contain, control and cure "deviant" populations.

The constant movement of the supposed insane from one institution to another (from town jails to police stations to public assistance and then back to the provincial jail, and from there out of the Territory to a national asylum) reflected the lack of an appropriate and legitimate space in which to confine such people. Most galling to officials at the time was that the mentally ill were obliged to share space with criminals. The cases where we see justice being dispensed quickly is most likely a product of the incapacity to generate institutions and professionals who were capable of providing therapies. Already in 1880, two famous alienists denounced this situation and further noted that it was common practice for families, the police, general hospital authorities or even the Beggars Asylum to send the troublesome and rebellious to the insane asylum, thereby further contributing to overcrowding. (Melendez y Coni, 1880). In 1920, José Ingenieros bitterly observed that many of the mentally ill from the provinces had been abandoned to the asylums of the capital, thereby giving the false impression that insanity rates were much higher in Buenos Aires¹⁴

The abandonment, for months on end, of people who legally had already been deprived of their civic rights, which necessitated their confinement outside of the Territory, should be understood in the context of an official discourse that mandated the exclusion of “abnormals” beyond the mark of the scientific and positivist state. Yet the execution of this policy was rendered near impossible because of resource shortages and the inability of different public sectors to coordinate actions.

The notion that medicine, and especially psychiatry, could provide “security and hygiene,” to Argentine society raises interesting questions about how the lives of patients fit into that ideal. Given the wholesale indifference of state bureaucrats and functionaries to the fate of the mentally ill, and other confined populations, one must conclude that the goal of institutions, either by intention or accident, was simply to secure them from contact with society at large. Security and hygiene, then, did not refer to the internal life of institutions, but on how they situated themselves and their populations vis a vis society at large.

This study has offered some insight into the experiences of patients from the Territory who were sent to national asylums. Clearly, institutions of confinement, as well as the professionals who worked in them, were restricted in their therapeutic and administrative effectiveness and the ideal positivist regeneration was more dream than reality.

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Endnotes

¹ This work was part of a broader Project, "Género y Discurso Médico-Psiquiátrico en Argentina (1880-1930)", which was developed in la Facultad de Ciencias Humanas de la Universidad Nacional de La Pampa (Argentina) starting in 2001.

² This study is based on 168 files of Insanity proceedings in the Archivo Historico Judicial in Santa Rosa, La Pampa. The files date from 1898 to 1930. Of the 168 files, we excluded 74 files where, for a variety of reasons, the subject was not sent to a national asylum. Reasons included death, remanding of the individual to family guardians, judicial decision that the individual was not insane, etc. We selected the 94 remaining cases as well as 60 cases from the Archive of the Colonia "Open Door" (hereafter HC en AOP). These refer to 53 individuals, seven of whom were confined more than one time.

³ Almost all of the studies have focused on Buenos Aires. See Vezzetti, 1985, Salvatore, 2001; Ablard, 2003.

⁴ See Sergio Maluendres, 2001 and Ander Egg, 1958. In 1895, Victorica and General Acha, two of the most important towns in the territory had 1323 y 883 inhabitants respectively. In 1914, cities in the east of the Territory had outpaced those of the west. General Pico had 6404 habitantes, Santa Rosa 5487 and General Acha, 3266.

⁵ By 1947, the Fourth National Census reported 105 mentally ill and 99 mentally retarded individuals in the Province (population was now at 170,549). (Ander Egg, 1958)

⁶ Of the seven women deemed insane during this period, all were sent to the Hospital de Santa Rosa (which was run by a charitable organization).

⁷ Its foundation corresponded to a plan to medicalize the interior of the country through the development of state institutions that would be run through the Departamento Nacional de Higiene. See María Silvia Di Liscia,

⁸ See Exp. N° 719 Rufino Lucero; Exp. N° 688 Máximo Castro; Exp. N° 212 José Blanco Villares; Exp. N° 743 Federico Meltz y Exp. N°232 Juan Beraud, *et otros*, AHJ.

⁹ AHP, *Diario La Capital*, 5-2-1905 y 12-2-1905, Memoria y Estadística de 1904, a cargo del Juez Baltasar Beltrán.

¹⁰ See, Informe del Inspector O'Connor en Antonio Sagarna, *Anexos a la Memoria presentada al Honorable Congreso de la Nación por el Ministro de Justicia y Educación Pública Don Antonio Sagarna. Tomo I. Año 1924*. Buenos Aires, Departamento de Justicia, Talleres Gráficos de la Penitenciaría Nacional, 1925.

¹¹ Exp. N° 123 Emilio Presno, AHJ.

¹² See also, Exp. 455 Pedro Alpa, Exp. 9 Constanzo Garnero, Exp. 575 Eugenio Scheffer, Exp. 761 Ramón Sequeira y Exp. 202 Jaime Andreu, AHJ.

¹³ See the clinical histories of the following patients. Manuel Lorenzo Castro, 1922, H.C. N° 7176; Valentín Álvarez, 1909, H.C. N° 12.814; Francisco Cindano, 1924, H.C. N° 17.677; Juan Cuniolo, 1930, H.C. N° 11.055; José D'Elia, 1921, H.C. N° 6423.

¹⁴ J. Ingenieros, *La locura en la Argentina*, Buenos Aires, Cooperativa Editorial Limitada, 1920

¹Public health policies, Women's Movements and Mothers in the Province of Buenos Aires, 1946-1952¹

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“[Before Peronism], a woman had to continue being where she was...house wife, raise the children and nothing more...and as a servant and laundrywoman, period. [By contrast] Evita wanted women to advance. She wanted women to achieve positions that she deserved.” This is how a female worker remembered the Peronist state's impact on ideas and rhetoric about women. Indeed, Peronism gave many women the impression that a shift from a traditional to a liberal role occurred with Perón. However, notwithstanding popular perceptions, it was neither as linear nor as dichotomous as the image given in the above quotation. This study seeks to understand the interrelations between the Argentine state and civil society on questions of women's roles in society. Our focus will be on the maternal and infant health policies of the Province of Buenos Aires during the governorship of Domingo Alfredo Mercante during the period 1946-1952. We are especially interested in conflicts between the provincial state and the leftist women's organization, the *Union of the Women of Argentina (UMA)*.

The first part of this essay examines provincial health policies as they affected women. The second part will examine how the UMA challenged certain official health policies while it supported others. On this point, we will also consider how other civil organizations, including ones aligned to the state, questioned official health policy. Finally, this work will recuperate the perspective of women through the use of oral interviews and institutional documents. In centering this study on the subtle power game that was played out between Governor Mercante's public health policies and the women's movements and private infant and child-rearing practices we hope to inaugurate a field of study that has hitherto been unexamined. The symbolic dispute over the meaning of citizenship is the fabric upon which we can understand the role of women, the reach of public policies and the resonance that women's movements had upon them and upon women's lives.

During the first presidency of Juan Domingo Perón (1946-52), Argentina saw political and economic reforms that changed the way social forces in the country related to one another. At the same time, new political subjectivities emerged which helped to create a new and unique political configuration. Peronist rhetoric was grounded in “social justice” and advocated the redistribution of income, social security laws, and advances in workers' legislation. In this sense, socio-economic advances were the pillars of widening notions of citizenship for the poorest sectors of Argentine society: the working class. Perón, and his first lady, Maria Eva Duarte de Perón, used their authority to project the idea that the working class was to be transformed into new

men in a nation that was ‘just, free and sovereign.’ At the same time, they reinforced traditional images of women as guardian of the domestic sphere through both propaganda, and as we will see below, through concrete policies.

This study also hopes to broaden our understanding of Peronism by examining how it functioned outside of Buenos Aires. Historians have generally ignored how Peronist policies were developed or implemented in provinces. This is due to two historiographic trends. On the one hand, until recently, historians looked at Peronism as a single and homogenous movement and they ignored regional differences. On the other, the tremendous historical significance of Ramon Carrillo as the first Minister of Perón's newly created Ministry of National Health occupied historians' attention at the expense of examining provincial health policies.

Provincial health policy in Buenos Aires

As governor of the province of Buenos Aires and loyal promoter of Justicialist (Peronist) proposals Domingo Mercante went far beyond what Perón could or even wanted to do. Mercante's scope of political action was so strong that many authors recognize his position within the Justicialist movement as *mercantismo*. Mercante, however, became increasingly marginalized from the movement, especially as Peronism grew homogenous and even authoritarian after 1949. (Navarro, 1994; Mateo and Gonzalez, 1998; Guy, 2000)². In this section, we will analyze Mercante's health policies and the image of women that they created.

In general, Mercante's health proposals sought to rationalize governmental and non-governmental health care. Law 5116 of the province of Buenos Aires, of February 1947, created the *Provincial Ministry of Health and Social Welfare* (MSPAS). The position of minister was held first by the governor's cousin, Héctor Mercante³ and later Carlos Alberto Bocalandro.⁴ Coordination, centralization and rationalization were MSPAS's crucial strategies. The beneficiary of this Law according to Article 2 was “the population of the entire Province.” The law targeted children, the elderly, and the disabled as groups for whom the state would provide special protections. Women were not viewed as a protected group unless they were mothers. In fact, to protect this specific group a special unit was created: the *Division IV of Maternity and Infancy*, under the *General Office of Medical Social Assistance*, a sub-department of the MSPAS. This division grew and in 1950 became a full Directory.

The central concern of this office was only with women in as far as their relation with children, who were considered the true beneficiaries of the policy. Indeed, maternity had been a prominent area of concern for both ministers of health prior to their tenure in public health. H. Mercante had written several journal articles on the question of maternal-infant health.⁵ Likewise, Bocalandro had published numerous articles in specialized journals where he examined the deficient medical condition of military conscripts and found the causes in their family.⁶ Both men felt that the state had an obligation to create institutions to assist mothers and their children as part of a broader effort to foster the public health of the general population.



The period between birth and three years of age was of critical concern because this was the only phase of life where the state had no influence. After age three, children were in kindergartens and public schools. The state, therefore, sought to exercise some influence on children prior to their reaching school age. In the health policies of this division, the mother – child relationship (the rhetoric privileged sons over daughters) became paramount. Paradoxically, while the mother was portrayed as an ally of the state functionaries tended to disregard fathers' role.

The state aimed to intervene in two major areas with the intention of guaranteeing the health of future generations of patriotic Argentines. First, it stimulated policies which promoted the bond between the mother and child through the expansion of facilities called *Centers for Maternal-Infant Hygiene (CMIH)* as stipulated by Provincial Law 5368. The second area of governmental intervention focused on supplanting the influence of mothers through the development of daycare centers and holidays camps by the *MSPAS* and the Ministry of Education.

These centers were supported by the provincial government, possibly because it was less onerous than complying with Law 5368. This law obliged business owners to install daycares centers in factories and commercial houses. However, the law was openly transgressed and the child care facilities were inadequate.⁷ Furthermore, the law only applied to establishments that had more than 150 female employees (permanent or transitory), thereby offering little or no help to those women employed in smaller establishments. Also, the law and traditional practices disregarded the possibility that fathers might use the facilities.

Pro-maternal policies:

Centers for Maternal-Infant Hygiene (CMIH)

The *CMIH* was the pillar of the *MSPAS* policies on motherhood. It was an “institution of scientific research and study of the problems formulated by children’s life and health” and promoted “popular sanitary education and medical action and social hygiene.” The objective was “to preserve woman’s health -in her condition as mother and future mother- and the child -from his conception to adolescence.” (Bocalandro

Public Health Policies, Women's Organizations and Mothers in the Province of Buenos Aires, 1946-1952 y Carvajal: 1947, 29 -30) These institutions and their employees (doctors, midwives, social workers and others) focused attention on the mother-child dynamic.



Title: Center for Maternal-Infant Hygiene

The attempt of the state to intrude in the domestic realm is revealed by the fact state's decision to favor domestic over institutional architectural designs for its centers. Rather, the *CMIH* buildings privileged the "California design" that were in vogue at the time in Argentina. Their intention was to create institutions that appeared to be home-like, and to thereby link domesticity and medical rationality. Moreover, this homelike design was intended to attract women who typically sought medical help from traditional healers and mid-wives.

The *CMIH* served as health centers and were in charge of "the eugenic formation" of mothers. This involved the cultural disciplining of women through puericulture, or the scientific approach to child rearing, and *maternalism*, whose objective was to improve the race through racial hygiene and a proper functioning of biological maternity (Nari, 2004). This education recovered the most important pro-motherhood principles of Buenos Aires's public health policy. Alarmed by high rates of infant mortality, which the state often blamed on careless mothers, the state aimed to guarantee the mother's training so she would better care for her children, especially before they entered in the school system. Mothers, linked to state policies, were recognized as supporting a biological link that was endangered because of psycho-social factors.⁸ The growing interest in social medicine would favor policies that focused on nutrition, child rearing and education in order to achieve long lasting improvements and strengthening of the so-called national "race."⁹

An important aspect of the program was propaganda through posters, radio programs, public talks, Mothers' Clubs (in which Mothers' Schools operated) and the extension of "childrearing assistance".¹⁰ The state sought to assure by these means a greater control over the most intimate of parental responsibilities, the "proper rais-

ing” of the child. This effort at “rationalization” was accompanied by medical training that meant to overcome supposedly unsanitary “maternal” habits, including kissing babies (Mercante, 1946, p. 44), mother-infant co-sleeping and the folk tradition of not washing infants’ heads. (Danieri, 1946, p. 48).

State –sponsored institutions: kindergartens and holiday camps

The principal state-sponsored child-rearing institutions were schools (preschool and kindergarten), vacation camps, boarding schools, and youth homes.¹¹ They allowed the state direct access to children and teenagers. Public health efforts were centered on nutrition, basic medical attention and public health awareness.¹² In the field of public health, the state favored the use of these institutions to supervise the health of the children through the *Division of Medicine School*. This depended upon the *General Office of Education*, which after law 5650 became *the Ministry of Education and Culture*.

Law 5096 of 1946 had initially established mandatory kindergarten for children of three to five years old. (DGE: 19478, 5). In fact, the law fostered a lively debate. Proponents of the law had recognized that large numbers of women were employed in the textile and meat packing industries of Buenos Aires state. They saw the law as beneficial to the working mother. By contrast, the Minister of Education, Julio César Avanza, argued that if the motivation for many of the reforms was the suffering of working class women under capitalism, with the arrival of Peronism the situation had changed. Therefore women should return to their home “since they are, by nature, the perfect educator of children in their first years.”¹³ The debate eventually resulted in a decision to make kindergarten optional.

Another function of kindergarten was “to channel deviations that used to incur excessive maternal affections.”¹⁴ The image created was of an excessively emotional mother who was incapable of properly raising or educating her children. This approach was, paradoxical, considering that Peronists exalted an emotional, yet highly patriarchal, approach to politics. Nonetheless, it was imperative for children to advance in their independence from the mothers, and to accede to a rational and virile subjectivity which was the bridge to the national essence. The provincial General Inspector of Kindergarten noted in the official “Instructions and Guides” that this institution was the appropriate environment for the child, “as good as, if not better, than his own home...”¹⁵ Outside the home, the inspector continued, children sought to identify with masculine models, and especially president Perón. While the state questioned mothers, and sought to supplant their role in the family, similar critiques never seemed to fall upon fathers.¹⁶

Governor Mercante began to multiply the number of state institutions devoted to the care and raising of children. In descending order, the number of schools, holiday camps, youth homes and boarding schools began to grow. They guaranteed the specific functions in which they had been designed—education, recreation and social control, and also replaced the family for relatively long stretches of time and served

to bond together health and education together. According to the director of Tandil's Holiday Camp,

from the medical point of view, the holiday camps broadly achieve the postulates of the modern trend: early diagnosis, prophylactic for treatment and health education. They do even more, they exceed those limits since they nurture children's intellect, orient his morals and foment his patriotism. [...] Our camps (...) bring to fruition the old saying that the little tree can be set to grow straight."¹⁷

This provides an eloquent testimony to the health objectives of these organizations and to the implicit contrast between this space and the one of home

In sum, the Buenos Aires *MSPAS* was characterized by maternalist policy and state sponsored child rearing. Maternalist policies granted women a fundamental role as propagators of knowledge and incorporation of practices for the improvements of the health of the child (nutrition, care, hygiene, integration of children into public health institutions). Yet this maternal function was not linked to supposedly "natural conditions" and therefore the public health bureaucracy supervised and sought to teach the care and protection of children to women. Once children reached three years of age, the state stepped up its intervention in child rearing and questioned women's capacity to care adequately for their children.

UMA and public health policies.

The Union of Argentine Women (UMA) was a movement that emerged in 1947 as part the Argentine Communist Party's strategy to arrest the growth of the Peronist movement by developing a mass movement capable of raising the consciousness of women and of influencing government policy through diverse mechanisms including self agency, petitions and demonstrations. During its first two years, the UMA managed to unite dissimilar political and ideological factions (including Catholics, some Peronists and independent persons).¹⁸ In this section, we will analyze how the *UMA* and other civilian organizations and even members of the state put Mercante's healthcare policies into question.

The *UMA* was based upon the value of women as agents of social and political action. According to one of the founding members: "my experience is that when women put themselves in action for a determinate issue or one that directly affects her family and fundamentally affects her children, and she involves herself in an determinate activity, no one can stop her!"¹⁹ Doubtless, the *UMA* mobilized women to political action through appeals to both domesticity and maternal devotion. Thus, "traditional" values could spark radical action. This generated an ideological struggle with the government around the political and ideological shaping of women.

UMA shared the paradigm of modern medical science:

The protection of childhood must begin before the child is conceived.
That is what modern medical science tells us. The youth of both sexes

must be educated to the enormous responsibility involved in engendering new beings. The knowledge of eugenics (eu: good, geno: engender) must be given in special courses.”²⁰

However, UMA still considered mothers as experts and confronted doctors and the government in their questioning of maternal knowledge. In August 1948, the Argentine Feminine League Pro Motherhood and Childhood organized the International Conference of Mothers in Buenos Aires. This was criticized by *UMA* since mothers were not represented there. With regard to the governmental critics of the nurturing capacity of the popular sectors, which implicated mothers, *UMA* answered

“It is possible that the majority of the people ignored the quantity of vitamins in an orange or a tomato, but we can assure that there is not a sole mother, not a sole housewife, who does not know the nurturing value of fruits and vegetables, and who makes enormous sacrifices so her son can eat an apple or an orange.”²¹

UMA envisioned, not without contradictions, the caring capacity of women as innate, since “Nature itself has given to the woman the right to be guardian of childhood”²². The state should guarantee the resources to help mothers but not to replace them. If women should have self management, the state should be the last guarantor of health.²³ Yet this organization with many communist members was suspicious of promoting female work since it was widely held that women workers were more easily exploited and more difficult to organize into unions. Thus, paradoxically, the *UMA*, with its focus on women in the domestic sphere, was closer to Minister Avanza’s position than one might have expected.

UMA and daycare centers and kindergartens

Even if it did not call for a division of labor in housework, *UMA* defended women’s rights as workers since, in reality, they worked and publicly demanded ‘equal work, equal pay’. In this trend, of central concern to the *UMA* was that daycare centers and kindergartens were not available in factories or closer to the work places yet holidays camps and boarding schools were of secondary concern to the organization. The *UMA* believed that daycare centers not only offered protection to infants but also benefited mothers “who, ...[would know] that their babies were well cared for, or at least free from danger. They will not suffer that terrible anguish that means not being able to safeguard their children. Thus, the alarmingly high mortality in the first few months will diminish.”²⁴

UMA pointed out the limits of governmental policies and demanded the enforcement of Law 5368 for the creation of daycare facilities and kindergartens at work places. *UMA* publicized that the law was not being followed and advised workers to organize around this issue and demand that that state and the employers obey the law.²⁵ In some cases the provincial authorities responded positively to these petitions.²⁶

In 1949, Domingo Mercante was the President of the Constitutional Convention which would reform the Constitution. This assembly encouraged female participation. Many women sent letters to highlight the critical issues surrounding infant and child care. UMA demanded that the state polices become effective by the "massive construction of maternity centers in the whole country"²⁷. It did not, like an increasing number of doctors, question the logic of this policy²⁸. UMA explained "Normally, in the country thousand of beings are lost because of the lack of these institutions [maternities or *CMIH*] and are exposed to dangers, also the lives of the mothers [are endangered by] ... traditional healers"²⁹. In the same trend, the Health Minister, Bocalandro noticed that the *MSPAS* could neither "ignore nor remedy the destitution of the country population in terms of the care of health, which is translated as less longevity, high maternal and infant mortality, high impact of illnesses, which, at the same time is one of the causes of both traditional healing and urban migration" (Bocalandro, 1949).

Of primary concern to the government, however, were fiscal constraints that impeded the full development of a province-wide network of services and institutions.³⁰ As a result, the *CMIH*, pillars of the pro-maternal policy, grew in number in haphazard fashion. Between 1946 and 1947, for example, there were several plans developed to construct new centers, but none were built. Faced with the embarrassment of having built so few new buildings, the *MSPAS* often claimed credit for centers that had been built during the military regime that had ruled Argentina between 1943 and 1946.³¹ In 1948, UMA exposed the fact that Governor Mercante was not accomplishing his health goals and demanded that he "put in practice the triennial Plan of the government of the Province of Buenos Aires, which projects the creation of 86 maternal-infant centers, 10 nurseries, with 20 beds each."³² Their campaign was of limited success, and by 1949 the Province had only opened 30 centers and nurseries. Such a slow growth in the number of facilities proved inadequate to meet the growing demand for infant and child services. The problem was aggravated by a shortage of doctors in rural areas and inadequate transportation services between rural areas and urban centers.³³

In addition to providing for institutions, Law 5326 stipulated that poor women could be attended to by midwives in their own houses. The state supported this interventionist approach out of a desire to reach the poorer sectors of society and especially women who had borne children out of wedlock.³⁴ As Adriana Marshall says, the expansion of the public sphere had to address private action in order to help the most vulnerable groups (Marshall, 1988).

Attempts to provide universal social welfare found practical limits that were insurmountable for state action alone. Despite their ideological differences, the government and UMA agreed to promote daycare centers, kindergartens and health centers for the mother and the child. Both agreed with the notion that the state must care for children since they were the future of the nation. Yet they parted way on approach, with the government stressing a scientific, and hence non-traditional approach, while the

UMA, paradoxically, stressed a more traditional vision of mothering that emphasized innate mothering skills.

Working women and child care

In this section we will analyze private maternal practices in order to appreciate how women understood state policy and rhetoric about femininity and women's private and public roles. One woman explained

When you have a kid... you are learning with them. It is true; nobody gives you a diploma to be mother. We know nothing! They give us this kid, and we say: 'well, what do we do now', we want to die! If it cries, if it breaths... I used to wake up to see if it was breathing.

The state and UMA, however, had other ideas. They believed that motherhood required state intervention and guidance through institutions like nurseries, kindergartens and nursing centers.³⁵

While the state did not build a sufficient number of institutions, the private sector managed to evade implementing the law. The magazine *Nuestras Mujeres* observed that the law requiring daycare centers was often not respected and when it was, like in the meat industry, the place was "a miserable little room where the working woman did not dare to leave their children"³⁶. Four years of Peronist government had not improved the situation of those spaces. "The female workers know about the pain of working full of anxiety since the children are alone, exposed to streets' thousand dangers, because of the lack of daycare centers and kindergarten close to the factory."³⁷ Of the approximately 200,000 children between the ages 3 to five in the province, only 30,000 were enrolled in state-run programs. The significance of these figures is somewhat ambiguous. On one hand, it shows that the pretension of universalizing pre-school education was too optimistic. Only 60 new buildings were constructed after three years of the government of Mercante and this clearly did not cover the need of the 112 counties of Buenos Aires.³⁸ Yet, critics also suggested that it may have signaled reticence of some mothers to break with their traditional roles.

Most of the interviewed women for this project wished for a husband, the 'bread winner', who could support them. However, when this dream failed they add work to their other roles. They had also been raised to accept with self sacrifice their husband's destiny. Only when they were mothers they could escape from working outside. The female labor market was flexible: "I left... for a while when [my son] was born, later they took me again and I worked for Campomar until the factory closed." Female teachers and clerks also returned to work before their children entered into the school system. The difference was in how they resolved the problem of taking care of the children. The female 'white collar' workers could choose between staying at home, that is, leaving their work, and taking some domestic help. The following testimony reflects this problem:

With whom did you leave the baby? Perhaps... if in the factories they would have put those daycare centers... I, thank God, did not need to go out to work". The fear of the factories daycares centers moved the female workers to search for other strategies of caring: neighbors, big brothers and sisters, the grandmother or other relative. The story of the only single sister of one family is eloquent: "after each birth of a kid, they took me in. The children of my brother were born, I went to the house of my brother; the children of my sister were born, I went to the house of my sister. So, my nieces today, the ones who live, are like my own daughters since I had raised them.

The promotion of paid domestic work (weaving, dressmaking, etc.) was a way for the state to make child care and household duties compatible and allow women to help economically in their own home. In this trend, the Law of Domestic Weaving of Buenos Aires was passed. The advantages of this law were praised by public opinion: "Not only does this create a new source of work, but the network of referrals (used to link seamstresses to clients) help to consolidate the stability of homes while avoiding women and children having to occupy themselves with matters outside their homes and often in different regions"³⁹. Girbal de Blanca asserts that according to the National Census of 1947, there were almost 33,000 dressmakers with more than 10,000 working at home (Girbal: 1997).

Breastfeeding was another area that raised conflicts between the state, women, and women's organizations. The state promoted breastfeeding and wet nursing and extolled the virtues of 'maternal' milk in the first years of the child's life. Public health officials observed that malnutrition and infant mortality resulted from the irresponsibility of some women who had abandoned their maternal "instincts." Feeding babies in artificial ways with animal milk was strongly condemned. However, the Ministry of Health of Buenos Aires oscillated between the diverse medical opinions on lactation and the implicit demands of the population. On the one hand, it praised maternal lactation, but on the other, it recognized cases where artificial suckling or mercenary lactation was justified⁴⁰. In this sense, artificial suckling contributed to breaking the naturalization of the mother-child dyad and mercenary lactation furthered it.

It was a concern for the Ministry that the suckling nurseries decayed in their function⁴¹. Wet nurses did not go to donate their milk to the 'lactarios', and mothers did not ask for milk, even when they couldn't suckle them. At the same time, there was an increase in cows milk distributed by the government and there was an attempt to improve its commercialization. The decay of the 'lactarios' signals a change in the feminine habitus (Bourdieu: 1997, 92), one that the sanitary policy had to acknowledge.

Conclusions

While the state tried to shape an ideal woman, there were deep internal divisions about exactly what that was. As a result, state policy tended to fluctuate and programs that were inaugurated with great fanfare often did not come to fruition. (Oszlack and

O'Donnell, 1976). At the same time, in Argentina, as elsewhere non-state actors such as women's movements were successful in influencing the course of public policy (Bock and Thane: 1991) Thus, women as individuals and in collectives used their social, cultural and economic capital to shape social policy and traditional women's issues.

The public health action of Buenos Aires presents was characterized by a eugenic pro-maternal ideal that oriented the action of the state toward the recuperation of the natural bond between mother and child. The policies sought to construct a model of womanhood that was close to synonymous with motherhood. As a result, women, who were not mothers, were almost completely excluded from consideration by the designers of public health policies.

Historians have generally seen the rising number of children and women who received care in health centers as evidence of the democratization of health. Surely, in quantitative terms there was a widening of citizenship which improved the quality of the medical care. However, the eugenic model generated spaces where nature was domesticated. In this sense, mothers were the object yet not the subjects of social justice. Nevertheless, an important group of the female population founded traditional or new strategies to avoid the rationalization of motherhood.

Finally, it is interesting to note that if the state presented itself as the legitimate protector of society and guardian of the woman-mother in particular and spread a model of the woman as mother, these two images were accepted by wide sectors of society. The fact that an association such as *UMA*- at ideological cross purposes with the government- agreed with these images was not a coincidence but the result of a process of representation, which we have tried to elucidate.

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Endnotes

¹ This project was originally done as Progress Report (November-December 2003) of the Doctorate program at the National University of **La Plata** under the direction of Dora Barrancos and Javier Balsa. Special thanks are due to: Karina Ramacciotti for her generosity with sources, ideas and bibliography; and for being an unconditional travel companion on the scary and stimulating leaps into the unknown; to my lovely and old friend, Sol Peláez, and to my new friend, Pete di Gabriel, for helping in translation and editing of this paper.

² Nonetheless, only recently have historians examined the governor's maverick leadership style (Rein, 1998; Aelo, 2002; Quiroga, 2003), his economic and financial policies (Girbal, 1993 and 1997; Mateo and Gonzalez, 1998), his agrarian policies (Mateo, 2001; Gutierrez, 1996) and to a lesser extent, his educational policies (Ciarniello, 1992).

³ Héctor Mercante was a doctor and the governor's cousin. He had been director of Provincial Health in 1945. His tenure as minister extended from February 1947 until July 1947.

⁴ Bocalandro, served as minister from July 1947 until June of 1952, he was Mercante's personal physician and chief physician at Campo de Mayo Army base during the events of October 17, 1945. He had an extensive career as a military doctor. Interview with his

widow, Nina P. de Bocalandro, March, 2004.

⁵ See for example, Mercante, 1939, 1942, 1943a; 1943b, 1943c, 1943 d.

⁶ Bocalandro, 1934; 1940a, 1940b, 1941, 1943.

⁷ See select issues of *Nuestras Mujeres* and *La Hora*.

⁸ In some parts of the province, infant mortality rates were reported as a high as 100 per 1000 live births. "Plans to construct provincial Maternal-Infant Centers," *El Plata* (April 23, 1948).

Several journals that were devoted to public health dealt with the issue of fear of giving birth. See, "Child birth without Pain *El Médico Práctico* 4:49 (1949) and A. Da Silva Mello, "La mujer frente a la maternidad," *Viva 100 Años* 23:265 (1948).

⁹ The most eloquent postulates of eugenics for racial improvement were in physical education. See, *Memoria* (1947-1948).

¹⁰ The institution provided a modest sum of money in return for poor and working class mothers coming to receive medical attention. Such an approach was also designed to avoid abandonment or infanticide." Sbarra, Salas and Falabella, 1946.

¹¹ We will not discuss institutions that were created by the Eva Perón Foundation after 1948 but **institutions under state administration directed by religious orders or private and civil personal**. Alzugaray, 1988; Carrillo, 1974.

¹² Article 25, Fourth Chapter and the law creating MEC. MSPAS sustained that "unfortunately, we lose time in our province, from the educational-sanitary perspective, if we do not create a clear awareness in all aspects of racial eugenics, from many distinct points of view."

¹³ *Avanza* (1951)

¹⁴ *Revista de Educación* (November 1947): 52.

¹⁵ *Revista de Educación* (April 1949): 65.

¹⁶ *Revista de Educacion* (April 1949): 75.

¹⁷ *Urriabbarri Abbadie*, (1947): 7.

¹⁸ As the notion of citizenship was expanding, women began to achieve more visibility within political parties which started to create female branches; especially notable was the presence of the Peronist Female Party.

¹⁹ "Salas cunas, gran solución," *Nuestras Mujeres*, (June 15, 1948).

²⁰ "Asegurar a nuestros niños el derecho a la salud, la instrucción y la alegría". *Nuestras Mujeres*. (1 de enero de 1949).

²¹ "Un congreso de madres sin madres," *Nuestras Mujeres*, (1 de agosto de 1948): 2.

²² "Política alimentaria," *Nuestras Mujeres* (1 de junio de 1949): 7

²³ "Un congreso de madres sin madres" *Nuestras Mujeres* (1 de agosto de 1948).

²⁴ Op. cit.

²⁵ *Nuestras Mujeres* 15 de junio de 1948. Even when the law ordered the building of kindergartens in “urban and industrial districts”, few were ever built. “Mar del Plata, como una burla” *Nuestras Mujeres*, (febrero de 1952): 6.

²⁶ The Neighbor Committee for the Help of Woman demanded a kindergarten in Dock Sud, *Nuestras Mujeres*, (1 de febrero de 1948): 5. In Adrogué and in Turdera the Feminine Committee for Improvement petitioned to the local authorities for a kindergarten. Indeed Turdera was successful. *Nuestras Mujeres* (10 de abril de 1949). See The Women's Group of Ramos Mejia *Nuestras Mujeres*, (17 de julio de 1948): 2.

²⁷ NM, 1 de enero de 1949. “Asegurar a nuestros niños el derecho a la salud, la instrucción y la alegría”.

²⁸ Doctors do not ask for maternities but defended hospital care (Rodríguez, 1947, p. 16). They argue that huge maternities were justified only in cities with big populations like La Plata or Bahía Blanca (Rodríguez, 1947, p. 17). For others, to build up independent CHMI was uneconomical, administratively irrational and broke the logic of family practices since it not care for the other members of the family and raised questions about the theoretical centralization of the health system (Menchaca, 1951).

²⁹ “Asegurar a nuestros niños el derecho a la salud, la instrucción y la alegría”. *Nuestras Mujeres* (1 de enero de 1949).

³⁰ The newspaper *El Día* referred to the SPAS as “the budget's Cinderella”. Of the total budget of the provincial state, Public Health was never above the 10,45% with the exception of 1946 when it was the 16.28%. *Memoria MSPAS. 1951-1952*. Although the sanitary buildings under the Plan of Public Work should be added to this budget, it is still low in comparison to other budgets as for example the one of the Ministry of Agrarian Matters and, in particular, with the Education Ministry which was three times bigger. In fact, the area of pre-school increased but it was not a priority in comparison with primary school which was mandatory. *Boletín Estadístico de 1946 a 1953*. For human resources see *Memoria: 1947-48*. Also, the decree 26316 from October, 29th, 1948, passed as Law 5582 in 1950, authorized foreign doctors to work in places where there were no doctors. Remorino, 1948.

³¹ MSPAS, Memoria 1947-1948, p. 60. Perón and Mercante were members of that government.

³² *Nuestras Mujeres* (February 1, 1948), Boletín del Congreso de la *UMA*, 2.

³³ *El Argentino* stated “the population of the Province should dispose around 37000 beds, in a way, counted the actual ones it would registered a deficit of 23000. this deficiency affects notably the facilities for motherhood”. *El Argentino*, (July 14, 1947, “Extensión de servicios en la acción médico-social”. *El día*, (July 16 1947), “El servicio médico en las pequeñas poblaciones”.

³⁴ “Protección a la maternidad”. *El Día* (July 1, 1947)

³⁵ In the ‘lactarios’ milk was rcollected and bottle-fed to infants.

³⁶ “Informe sobre los derechos de la mujer argentina,” *Nuestras Mujeres* (February 1, 1949)

³⁷ *Nuestras Mujeres*, (May, 1950).

³⁸ “La Muestra de Actividades” *RE*, (1950): 114.

³⁹ “El régimen de tejeduría doméstica”, *El Día* (August 5, 1946,): 3.

⁴⁰ Memoria, 1947-1948: 61.

⁴¹ Memoria, 1951-1952:71.

