The Doctor's Indispensable Assistant: Women and the Work of Medical Caregiving in Late-Nineteenth Century France

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Considerations of women and work more often than not focus on women's professional careers or paid employment outside the household. Interestingly, however, this approach to recognizing women's work reproduces the dichotomy that had previously been used to render women's work invisible: it is what takes place in the public sphere of wage or professional activities that constitutes "work"; this is what is interesting. That which is done within the household, among family, and most often not for pay, somehow does not belong to the category of "work." This assumption can be traced back to nineteenth-century political economy and its exclusion of any activities that could not be assigned a monetary value from analyses of "work" or the production of value (Scott 145). Yet up to the First World War, there were certain activities that people now associate with paid, professional work that were far more likely to take place in the home. One of the more dramatic illustrations of this transition from work performed in the household to work more commonly associated with a profession is provided by the history of medicine in industrialized, Western countries in the late-nineteenth and early-twentieth centuries.

Prior to the twentieth century, most sick people (except for the very poor or those without families) received medical treatment in their homes rather than in the hospital (Ackerman 137-164). The hospital was considered not the primary site of medical treatment, but rather a last resort, a place that one went to die. Sick people were more likely to experience medicine in the form of domestic caregiving than in the form of a professional consultation. Their primary caregiver was often an unlicensed, female relative, and the site of medical treatment was the household, a space commonly acknowledged as a woman's sphere of influence. Gradually, in the decades after the First World War, this began to change as the cultural stigma associated with hospitals diminished while the expansion of third-party payment systems (state-subsidized medical assistance and private health insurance organizations) rendered professional care more affordable to the general populace (Faure 228-233). Or, it could be said that as a result of the transition from rural, family-centered, pre-industrial medicine to urban, industrial medicine, medical care ceased to be a "use value" produced and consumed within the family and became a commodity with "exchange value" (Berliner 165).

In the latter decades of the twentieth century it has become commonplace to think in binary and oppositional terms--of "professional" medicine and "alternative" medicine, or certified and uncertified practice. Within this framework, domestic medicine--defined here as the treatment of the sick

within a household setting by members of the household, usually a female relative, utilizing anything from folk remedies to a combination of folk remedies and a regimen prescribed by a physician--is most often grouped among the varieties of uncertified medical practice, which share in common the fact that those doing the work of healing have not received any formal training in an officially-recognized setting nor do they have a license from the State to treat the sick. Since the lack of formal university and clinical training frequently served as a key criteria by which licensed physicians discredited their unlicensed rivals as "quacks'" or ignorant, marginal figures, grouping domestic caregivers with other unlicensed healers might seem to imply that domestic medicine was merely on the fringes of medical practice. In this binary framework, it is not immediately evident that domestic medicine had much to do with professional medicine.

However, domestic medicine and professional medicine were in fact closely tied to each other. This is most often recognized with respect to the therapeutic regimen employed in domestic medicine. The recipes and advice offered by popular home medical manuals have been characterized as outdated scholarly medicine: in other words, an approach to understanding and treating disease that has been preserved as homespun, "folk" medicine long after physicians cast it off in favor of a more scientific therapeutics. According to this characterization, domestic medicine and other varieties of folk medicine are not authentic, alternative approaches to health and disease. Rather, they mimic the scholarly medicine of physicians, borrowing from the abandoned therapeutics of centuries past without necessarily understanding the body's functioning or the cause of disease. Casting domestic medicine in such a light maintains the primacy of professional, scientific medicine by suggesting that the true work of medical practice is the intellectual labor of learning how the human body functions and devising more accurate, effective methods of diagnosing and treating the body's ailments. Hence the work that matters is the physician's intellectual labor. But for any treatment to be effective, it must be administered. And therein lies the other, less acknowledged connection between professional and domestic medicine in the nineteenth century: the role of the domestic caregiver, most often a female relative, in carrying out the tasks involved in treatment.

Treating the sick was long described as a "natural" extension of the maternal instinct. Nurturing as a quality inherent to all females was evoked so frequently by male scientists and social theorists of the eighteenth and nineteenth centuries that it became a standard rhetorical device for those who sought to limit women's social roles to the biological functions of reproduction and childrearing. The assumption that it was part of women's natural, biological function to look after the health of their children was so strong that doctors who wished to extend their influence to family health matters could not discount the maternal "nurturing instinct"--they were forced to circumvent it. With the

acceleration of industrialization in France after 1830 came increased concerns among politicians and social elites about the misery of the working classes. Scientists and physicians went to industrializing towns such as Lille, a center of textile manufacturing, to study working conditions in the factories but also to observe living conditions in working-class households. The self-proclaimed mission of these early sociomedical investigators was to discern the relation, if any, between the organization of production in the factories and the perceived decline in worker health. The conclusions of one of the more influential investigators, Dr. Louis-René Villermé, established a pattern that would be reproduced by public health professionals throughout the nineteenth century, both in France and in England. In a report presented to the Academy of Moral and Political Sciences in 1840, Villermé argued that workers themselves contributed to their own poor health through "habits of improvidence, drunkenness, and debauchery" and that a large part of the problem stemmed from unhygienic, disorderly conditions within the household (Villermé 209). This, in turn, brought new scrutiny to bear on the ability of working-class women to fulfill what were considered to be the "natural" duties of their gender: feeding their families, maintaining a clean household, and safeguarding the health and well-being of their children. The physicians who claimed that their intervention was necessary in working-class families did not refute the idea that women possessed an inborn drive to nurture and care for their children. Rather, they argued that working-class women had become so "denatured" by the work environment that they had forgotten their "natural" maternal functions. Doctors thus could replace women as the principal authorities over family health because women had abandoned their "natural" calling as mothers (Cole 421). To some degree this was ironic since in rural areas women had often been called upon to act as healers or midwives, not because of any professional qualifications or training, but simply because of their experience as mothers (Andries 12).

If domestic medicine has long been studied by scholars as an alternative to professional treatment, it is due largely to an epistemological distinction which physicians themselves drew upon to distinguish themselves from folk healers and empirics. The opposition between scientific and "empirical" care was integral to the professionalization of medicine because it gave physicians criteria by which to identify the boundaries between themselves and other healers. Yet if we consider the question of legally defined boundaries between legitimate and illegitimate healing activities, women and domestic caregiving remain in a gray zone. This can be seen in the evolution of the legislation that governed medical practice in nineteenth-century France. Through much of the century, French medicine operated within the legal framework established by Napleon, despite repeated efforts by physicians to persuade the government to take a harder stance against illegal medical practice by empirics, priests, nuns, and pharmacists. When the Chevandier Law on Medical Practice was finally passed

in 1892, after at least a decade of lobbying by the medical profession, it did levy stricter penalties against unlicensed healers. Yet it also made an exception for routine medical care provided by mothers when it defined what activities should constitute illegal medical practice. During the discussion of this law in the Chamber of Deputies on November 22, 1892, the government commissioner insisted that penalties for illegal medical practice were not applicable "to the mother of a family who, in the doctor's absence, habitually provides care for her husband, her children and her relatives" (Gridlet and Vergé 113). Women--not only nurses but women in general, as mothers and laypeople--were commonly expected to perform many medical tasks, despite their non-professional status. Thus, despite efforts by French physicians to acquire a monopoly over medical practice, women continued to wield considerable influence over medical care, especially within the family, to the point that their role in family health care was recognized by the framers of legislation governing medical practice.

Thus, despite a changing legal context that increasingly discouraged healing by anyone other than a licensed professional, basic hygiene and medicine continued to figure in educational literature written for female readers, such as home economics manuals. Part of a long tradition of advice books written for "the good housewife," home economics manuals were especially prolific in France, Great Britain, Germany, and the United States during their transition to industrialized societies. Medicine had long been an important element in housekeeping advice manuals. For example, Gervase Markham's *The English Housewife,* first printed in 1615, opened with a discussion of domestic medicine that took a woman's role in medical caregiving for granted, arguing that, "sith the preservation and care of the family touching their health and soundness of body consisteth most in her diligence, it is meet that she have a physical kind of knowledge" (Markham 8). This view of women as responsible for their families' health was not restricted to seventeenth-century England, as can be seen from even a brief perusal of home economics manuals published in the nineteenth century throughout France, the United States, and Germany. One of the most popular home economics manuals in France, which went through twenty-one editions between 1844 and 1920, Cora Elizabeth Millet-Robinet's *La maison rustique des dames* (*The Ladies' Rustic Household*), offered nearly one hundred pages of medical recipes in its 1868 edition (Hellerstein, Hume and Offen 292). And yet, like most other authors of household advice manuals, Millet-Robinet did not overtly challenge the conceptual framework which privileged professional medicine and treated unlicensed healing activities as incidental to the "real" work of medical practice. She claimed that the intent of her book was only to teach women to treat minor ailments and provide emergency first aid, advising her readers to summon a physician for more serious cases and follow his instructions dutifully (Millet-Robinet 1-2).

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A systematic perusal of home economics textbooks approved for use in girls' secondary schools in France suggests that doctors actually needed women to possess a certain amount of medical knowledge. Or, at least, the authors of these texts and the committee members who approved them for inclusion in the curriculum seem to have been convinced that a patient's female relatives were the doctor's indispensable assistants. What sets these home economics texts apart from earlier manuals is the degree to which they adhered to a specific formula articulated by centralized authorities that had decreed what was to be included in the official curriculum for all French girls in the public schools. In addition to its overhaul of the system of public instruction already available to boys, the comprehensive reform of the French educational system in the years 1880 to 1882, most closely associated with the passage of comprehensive educational legislation referred to as the Ferry Laws, created a state-funded system of secondary education for girls.

Central to the rhetoric of the middle-class, republican architects of the new program of girls' public education was the idea that "future mothers" should possess a rudimentary education in health care and hygiene. This would be a recurring theme in the writings and speeches of Jules Simon, who became the Third Republic's first Minister of Public Instruction in 1871. Arguing that "vigorous women produce vigorous generations," Simon defined the "true woman" as she who "knew how to be her child's first doctor and teacher…" (Simon 408). This sentiment would be echoed by the renowned anthropologist Paul Broca in his testimony to the French senate in 1880, during the debates about the proposed law on public secondary education for girls. Broca argued in support of including hygiene courses in the curriculum, asserting that "there was no telling the extent to which women's knowledge, opinions, or prejudices in matters of hygiene influenced the health of families and the development of the population" (Broca 264). Despite such calls for a program of study that would require subjects such as hygiene and rudimentary health care for the family, male politicians left much of the work of designing the official home economics curriculum to women. The schedule of topics to be covered in home economics courses throughout France was drawn up by the director of a women's teacher-training college and adopted with minimal discussion by the national committee that oversaw the vast overhaul of the public education system. This left authors of home economics manuals a certain latitude to shape the content of their texts, and many of them accorded a significant place to domestic hygiene and medicine.

Indeed, there is a notable increase in attention to medical and hygienic matters in home economics textbooks published after 1882. Although, as noted earlier, medical recipes and tips on how best to preserve health had long figured in household advice books, treatment of this aspect of a woman's domestic role became more systematic in the manuals written for the new, public secondary education curriculum for girls. By 1901, with the appearance of Charlotte

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Chappoz Sage's *Domestic Education* (*L'Enseignement ménager*), the work of Louis Pasteur was being integrated into the hygiene lessons for girls. Sage's manual included no fewer than nine chapters on hygiene and domestic medicine. She discussed health and disease with great sophistication and attention to detail, invoking Pasteur's work on microbes and insisting that mothers, more than anyone else, needed to stay abreast of current scientific research if the remarkable advances of science were to exert any benefit on the health of French citizens (Sage 194). The increasingly systematic elaboration of lessons on family health care may be seen as a result of the officially mandated program of study, yet it is also important to place this within the context of the medical profession's sustained efforts to *reduce* competition from unlicensed healers and to exclude all who lacked a medical degree from practicing medicine.

The home economics manuals published after 1882 and approved for use in girls' secondary schools provide a picture of the middle-class cultural norms surrounding a woman's role in medical care, especially the division of labor between the female relatives of a patient and the doctor. Since physicians left much of the actual labor in medical treatment to a patient's wife or mother, lessons on domestic medicine were concerned primarily with creating a para-medical role for women and emphasizing the physician's supreme authority over all decisions where treatment was concerned. Louise Murique's *Économie domestique et hygiène à l'usage des écoles primaires des filles (Home Economics and Hygiene for Girls' Primary Schools)* counseled girls that although they should understand the basic principles of health and hygiene, the doctor was nonetheless a learned man who would know better than they and their female neighbors how to treat illnesses (Murique 172). Aline Valette's *La Journée de la petite ménagère (The Little Housewife's Day)* likewise warned that those outside the medical profession could provide only provisional care and that the doctor was always the definitive authority over medical treatment (Valette 232). The division of labor between female relatives and the male physician was spelled out clearly in several cases as a distinction between the intellectual labor of diagnosis and prescription, and the manual labor of administering prescribed care. In Rose-Elise Chalamet's *Première année d'économie domestique (First-year Home Economics),* a fictional physician advised young readers that

> We doctors prescribe the treatment but it is up to you to make it succeed by following it with care and intelligence. The good caregiver (*garde-malade*) is the *doctor's indispensable assistant.* (italics in the original) (Chalamet 144)

Similarly, Maria Piétrement's *Le bonheur au foyer domestique (Happiness in the Household),* described "an intelligent and affectionate female caregiver" as the physician's best auxiliary (Piétrement 36). Thus, as professional

medicine and domestic care giving were presented to the young readers of home economics textbooks, the two were far from being separate and distinct approaches to health care. Indeed, they were portrayed as being so closely integrated that professional medicine could not have functioned without domestic medicine.

By assigning to women a "natural" penchant for healing which rendered them the primary physicians to their children, the moralistic rhetoric of domesticity set the stage for potential conflict between professional jurisdiction over medicine and women's responsibility for their family's health. This conflict was expressed in home economics manuals in terms that opposed scientific expertise acquired through years of study and observation to maternal instinct (which was dubbed a "science of the heart"), and which pitted qualifications against emotional bonds. The emphasis on scientific expertise was strategic. Education was one of the principal criteria which doctors used to control access to their own ranks and to legitimate their authority over medical practice. However, it was difficult to enforce any theoretical exclusion of women from the practice of healing. Such legal barriers were unenforceable because women were still widely seen as "natural" healers. Thus, "in the revenge of reality over juridical principles, most women practiced medicine without a diploma..." (Léonard).

While home economics manuals (and much of prevailing opinion) preached that a woman was responsible for her family's health, they nonetheless emphasized that this responsibility did not necessarily grant them authority when it came to treating sick family members. Although home economics texts acknowledged that the mistress of the household performed services that were indispensable to a patient's recovery, they nevertheless reminded young female readers that a good *"garde malade"* (a term used for a female caregiver and often for a nurse) was the doctor's assistant, there to carry out whatever measures he prescribed.

This emphasis on the doctor's authority (as a man of science) was complemented by passages that discredited older women who had traditionally served as sources of medical advice to mothers. Several of the official home economics textbooks warn against listening to *commères* ("busybodies" or "gossips"). The *commère* was most often an older woman who possessed a considerable repertoire of folk remedies. But young readers of home economics textbooks were warned that they should avoid the advice of these older women like fire (Juranville 218; Valette 2-3). In this way, the expertise of older women in the community, based largely on the experience of child-rearing, was delegitimized, and the male physician's scientific training held up as the only true and reliable basis of medical knowledge. This, despite the fact that up to the First World War, many general practitioners prescribed remedies that differed little from the standard repertoire of folk remedies that women employed on their own.

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A close analysis of the division of labor between the mistress of the household and the doctor reveals a slight tension in the message conveyed to students that left room for potential conflict between the physician's authority over treatment and the wife or mother's need to exercise her own judgment. While home economics manuals insisted that the doctor's authority was unquestionable, it was nonetheless up to the female caregiver herself to know when to call for the doctor and when an ailment was minor enough not to disturb him. Considerable detail was devoted to the remedies for different illnesses or injuries, rendering the readers of many of these textbooks capable of treating the most common situations themselves: cuts, bruises, burns, mild fevers, etc. Thus, a dual lesson was presented to female students: that they must call the doctor for emergencies and serious illnesses, yet also possess enough rudimentary medical knowledge to manage without him in the case of "minor ailments." And it was left to the woman herself to determine what counted as serious enough to warrant a physician. The injunction to make do without recourse to a doctor's consultation might be as subtle as the advice that Chalamet provided on various remedies that could be obtained from a pharmacist "without a doctor's prescription" (Chalamet 138). Or, it could involve an appeal to an idealized vision of womanhood that associated women's "nurturing" tendencies with charitable work, as in the case of Ernestine Wirth's *La Future ménagère (The Future Housewife)*, which praised both the "grand dame" who cared for the sick poor and the "humble housewife" who found time in her busy schedule to lend a hand to her neighbors when they fell ill (Wirth 56).

However, authors of home economics texts were careful to assert that they were not teaching medicine, and that their lessons in the treatment of "minor ailments" posed no threat to physicians. This was largely a tactic to avoid any accusations of promoting illegal medical practice. Still, doctors themselves insisted that there was no such thing as domestic medicine, only domestic *hygiene.* Medicine, they argued, required years of study and certainly couldn't be mastered by reading a single manual. In the end, women who read home economics manuals were presented with two messages: that their contributions to a patient's recovery were essential, and that the care they administered did not constitute medicine, despite the fact that the actual treatments prescribed by most general practitioners in late-nineteenth century France often resembled cures that women might already have drawn from past experience or the recipes of another female relative. How, then, can one reconcile the rhetoric?

As an answer, I would like to suggest that this dynamic, in which the active involvement of women in medical work was de-valued and rendered subordinate (or even invisible), was certainly not unique to the division of labor between professional medicine and domestic medicine. Although political economists and other social commentators in the nineteenth century acknowledged that domestic life could exert a powerful moral influence over

society, the relationship between domestic work and work performed in the marketplace was rarely considered. When political economists did discuss women, they rarely analyzed the value of women's domestic work in anything other than moral terms. In a persuasive analysis of the rhetoric about women workers in nineteenth-century French political economy, Joan Scott argues that French political economists assumed that work and family were mutually exclusive, and therefore that by definition domestic activities had nothing to do with the production of value (Scott 157). Scott's assertion is supported by the entries about women's work which are included--or, more significantly, not included--in some of the standard French dictionaries of political economy in the nineteenth century. There is no entry for "menage" (household) in Ganilh's *Dictionnaire analytique d'économie politique* (1826), Charles Coquelin's *Dictionnaire de l'économie politique* (1873) or in Léon Say's *Nouveau dictionnaire d'économie politique* (1892). When political economists did discuss women's labor, more often than not they stressed the negative consequences of women working outside of the home.

The opposition in much of French political economy in the nineteenth century between private and public venues for work involved more than just a critique of women's work (what constituted women's "natural" activities, where it was appropriate for women to work, etc.). Equally significant was the reluctance to acknowledge the degree to which work performed in the public arena of market exchange relied upon work performed within the domestic sphere. By excluding women's domestic activities from analyses of the production of economic value, political economists -- whether of the classical, liberal school or Marxist -- rendered the status of women's work in the household ambiguous, even negligible (Scott 156-157). Coupled with the pervasive tendency to distinguish "skilled" work from women's work -- in other words, to reserve the label "skilled" for work performed by men while classifying that performed by women as "unskilled" -- this has reinforced the notion that what male professionals do comprises the real substance of an activity (Phillips and Taylor 318). In the case of medicine, it thus became a matter of course to treat the history of medicine as if it were limited to the historical development of the medical profession, its institutions, and activities.

However, by considering women's active role in administering treatment to patients within their households in late-nineteenth century France, my goal was to reveal the distinction between the public image of a monopoly over healing (which was actively cultivated by French physicians and which long persisted in accounts of the history of medicine), and some of the practical necessities of medical care giving in which jurisdiction over treatment was more often than not shared between a male physician and the patient's female relatives (Abbot 78). In this, I have drawn upon sociologist Andrew Abbott's conceptual framework of professional work in industrial societies as a complex,

interacting ecology in which certain tasks are shared with auxiliaries *in practice* (Abbot 33). Abbott raises a salient point: namely, that possession of a legal monopoly over a certain set of tasks (such as the treatment of disease) does not necessarily correspond to exclusive control in daily practice.

Viewing medical care through the lens of an ecological model yields a markedly different picture of the consolidation of professional authority over healing that accompanied the bacteriological revolution at the end of the nineteenth century. Much of the history of medicine has concentrated on laboratory and hospital-centered professional medicine (a sphere largely dominated by men), or on popular medicine and folk healers as part of a persistent, rival sphere of health care. The period after 1878, when Louis Pasteur presented his arguments to the French Academy of Medicine in support of the theory that micro-organisms were responsible for disease, has often been portrayed as a momentous turning-point that culminated in the triumphant progress of medical science in the twentieth century -- an era that would see the progressive decline of folk healers and kitchen medicine as they were supplanted by more effective professional treatment (Porter 431-461). Within this narrative, the continued interaction between the scientific medicine of the physician and the care giving activities of women who looked after sick family members in their households is largely overlooked.

Histories of the professionalization of nursing in France after 1880 have indeed taken into account the division of labor between male physicians and female caregivers; however, the focus on medical care within the hospital or clinical setting ultimately reinforces a narrative that privileges the medical profession's definition of what constitutes medicine and obscures the full extent to which professional medical treatment continued to rely on the unpaid activities of women within their households well into the twentieth century. It has long been recognized that the professionalization of medicine involved the progressive displacement of traditional healers and that very often this entailed a redistribution of competence (over diagnosis and treatment, for example) on the basis of gender (Witz 75). My analysis of French home economics textbooks published for use in girls' primary and secondary schools after 1880 confirms this emphasis on redistributing competence and further suggests that a reconsideration of the dynamics of professional work is warranted. In the case of medical care in late-nineteenth century France, women continued to engage in activities that had long constituted "domestic medicine," and the success of professional medicine actually depended on women performing these activities. The professionalization of medicine did not involve an elimination of this work of healing so much as it did a redefinition of what counted as medicine, which gradually caused women's work in treating the sick to fade from the historical picture.

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