Professionalizing and Masculinizing a Female Occupation: The Reconceptualization of Hospital Administration in the Early 1900s

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This paper examines the earliest boundary work for a female-dominated occupation that portrayed men rather than women as the appropriate practitioners. According to the concept of gender primacy, men would not enter a female-dominated occupation in large numbers because it is associated with gender essentialism. Hospital administration is one of the rare female occupations that did masculinize. Our analysis of archival texts on hospital administration in the early 1900s describes that in establishing a jurisdiction, body of knowledge, and educational requirements, the male-dominated professional association created a male sex boundary. Extracting and elaborating functions consistent with gender primacy and sloughing off functions associated with gender essentialism reframed the occupation as male. Rhetorical use of gender created a male image of the generic practitioner and the occupation, while an internal boundary segregated women within the occupation. The study points to differences in how occupations feminize and masculinize and suggests the latter does not occur solely in response to societal factors, as has been assumed, but can originate within the occupation.●

Scholars have long been interested in how occupations and professions come to be defined as distinct. They have theorized and found that occupational boundaries are social constructions that establish jurisdictional claims (Larson, 1977; Starr, 1982; Abbott, 1988), valorize some forms of knowledge over others (DiMaggio, 1992; Bowker and Star, 1999), and define which practitioners belong or are excluded (Starr, 1982; Gieryn, 1983; Abbott, 1988; Lamont and Molnar, 2002). Occupational boundaries not only delineate relationships with other occupations, they also differentiate practitioners within occupations (Gieryn, 1983, 1999; Van Maanen and Barley, 1984; Abbott, 1988; Witz, 1992), imbuing some with greater status and assigning "professionally impure" work to others (Abbott, 1988: 125; Witz, 1992; Davies, 1995).

Gieryn (1993: 781) referred to the process through which occupational boundaries are fought for, gained, maintained, strengthened, or lost over time as "boundary work" (see also Abbott, 1988; Witz, 1992; Davies, 1995). Two significant examples of boundary work are the establishment of sex boundaries and professionalization. The former are conceptual boundaries based on practitioners' personal characteristics. They categorize jobs as appropriate or inappropriate for men and women (National Manpower Council, 1957; Oppenheimer, 1968; Strober, 1984; Roos and Reskin, 1984; Cohn, 1985; Jacobs, 1989; Reskin and Roos, 1990; Anker, 1998) on the basis of cultural assumptions that associate the nominal characteristic sex with beliefs about competence (Ridgeway, 1991). Charles and Grusky (2004: 15) argued that the concentration of women in occupations that focus on service, nurturing, and social interactions reflects concepts about "essential" aspects of women's nature, while the concentration of men in the higher-level positions in any occupation reflects the concept of "gender primacy," that men are more worthy of status and appropriate for positions of authority. At times, sex boundaries are enshrined in laws (Rhode, 1989), but even without the force of law, conceptual sex boundaries

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are so widely agreed upon that they become "social boundaries" (Lamont and Molnar, 2002: 168), making it inappropriate for people to work in jobs associated with the other sex (Oppenheimer, 1968; Matthaei, 1982; Epstein, 1992; Greene, Ackers, and Black, 2002). Socialization and internalization of gender stereotypes, discrimination, and fear of sanctions sustain occupational boundaries (Jacobs, 1989; Charles and Grusky, 2004) and extensive sex segregation among and within industries and occupations (Weeden, 2004; Weeden and Sørensen, 2004).

New occupations emerge with an associated sex boundary (Strober, 1984; Cockburn, 1988). It reflects both the initial content of the occupation that makes women or men the appropriate practitioners and the alignment of job content with the initial practitioners (Charles and Grusky, 2004). When management first appeared as a distinct occupation, cultural assumptions linking men with rationality, science, and efficiency, combined with men's appropriation of the new occupation, let management emerge as a male occupation and introduced the businessman or captain of industry as a new hero (Kwolek-Folland, 1994). At the same time, it reestablished society's gender hierarchy within the organization, eliminating the threat posed by the influx of women into formerly male functions, such as clerical or secretarial work (Matthaei, 1982; Kwolek-Folland, 1994).

Sex boundaries may change over time. For example, women gained access to many occupations when legal barriers were removed or when concepts of what constitutes appropriate work for women changed (Rhode, 1989; Reskin and Roos, 1990). Occasionally a male-dominated occupation feminizes. Clerical work (Walby, 1988; Kwolek-Folland, 1994), book editing (Reskin, 1990), teaching (Strober, 1984), bank telling (Strober and Arnold, 1987), and typesetting (Roos, 1990) changed their sex composition when employers sought a change in their labor force, when changes in job content associated the work more with gender essentialism, or when men found the occupation less attractive. As women enter an occupation and men leave it, a "tipping point" (Strober, 1984: 150) is reached at which the occupation acquires a female sex boundary. If men remain in the occupation or when individual men enter a female occupation, they cluster in niches or administrative positions with higher economic benefits and status (National Manpower Council, 1957; Thomas and Reskin, 1990; Thomas, 1990; Williams, 1992), leading to a gender hierarchy within the occupation (Bradley, 1989; Charles and Grusky, 2004).

It is almost unheard of that a female occupation masculinizes. For one, the work reflects assumptions about gender essentialism, and men resist doing what is perceived as women's work (Greene, Ackers, and Black, 2002). For another, the jobs usually offer lower pay, fewer opportunities, and less status (Bradley, 1993; Jacobs, 1993). Men will enter female occupations in large numbers "only in very special circumstances" (Bradley, 1993: 16), that is, in times of social, economic, technological, or political change (Clark, 1968; Abbott, 1969; Bradley, 1993), but existing theory does not allow us to predict how a female occupation masculinizes.

We do know that professional associations influence boundaries based on practitioners' personal characteristics, such as sex, but their influence has been mostly in maintaining and enforcing exclusionary barriers (Bradley, 1993; Witz, 1992; Davies, 1995). Both the American Bar Association and the American Nurses Association once discriminated against African-Americans (Morello, 1986; Hine, 1989). Sex boundaries in medicine were maintained when the medical profession accredited medical schools that did not admit women or limited their number (Starr, 1982; Morantz-Sanchez, 1985) and when medical societies had policies of "strict ostracism" against female membership (Starr, 1982: 50). We do not know how professional associations influence how a female occupation masculinizes.

According to the gender primacy concept, individual men who work in a female-dominated occupation are concentrated in positions of greater authority (Charles and Grusky, 2004). In that capacity, they theoretically would be in a position to draw other men into the occupation, eventually decreasing the number of women in the occupation. According to the gender essentialism concept, however, a female occupation reflects essential female competencies (Charles and Grusky, 2004), associating it with a social boundary that makes it inappropriate for men to work in it in significant numbers (Lamont and Molnar, 2002). Thus while the limited number of men in a female occupation may be in a position to draw other men into the occupation, gender essentialism suggests that men will not respond in significant numbers.

The purpose of our paper is to address this conundrum by studying the boundary work of a professional association with predominantly male leadership in a female-dominated occupation that masculinized. We concentrate on the early boundary work so that we can isolate the actions of the professional association from subsequent interactions between continuing boundary work for the occupation and external factors. During the early 1900s, hospital administration was predominantly female. By the middle of the twentieth century, it had become largely male, and in 1975, an article in *Hospitals* could ponder that "much remains to be done to fully open the field of health care administration [to women]" (Appelbaum, 1975: 52). Although hospitals fill an important role in our social fabric, little is known about the very beginnings of hospital administration as an occupation (Neuhauser, 1995), let alone the roots of its masculinization (Reverby, 1987).

MASCULINIZATION OF A PROFESSION IN THE HOSPITAL INDUSTRY

Thousands of hospitals were founded in this country around the turn of the twentieth century. From 149 hospitals and sanatoria in 1873 (Ochsner, 1913), the number grew to 6,949 in 1918 (McClure, 1918). In addition to the 6,949 hospitals and sanatoria there were 1,705 "allied institutions," such as homes for children or the aged, rescue homes for fallen men and women, and homes for the deaf and blind. Thus, there were altogether 8,654 hospitals, sanatoria, and allied institutions. Of these, 1,665 were maintained by public funds, and

6,989 were privately controlled. Of the privately controlled institutions, 913 were operated by sisterhoods or brotherhoods of the Roman Catholic Church (McClure, 1918). Fewer than 200 hospitals were large, defined as 200 beds or more (*Modern Hospital,* 1914a). The vast majority (85 percent) was small, i.e., 100 beds or fewer, with almost 70 percent having no more than 50 beds (McClure, 1918).

In the early part of the twentieth century, hospitals were trying to shed their image as dangerous places or mere refuges for the poor and attract paying patients of the middle and upper class. Hospitals associated themselves with the image of science, upgraded their nursing service and facilities, and introduced new technology (Munson, 1913; Hannaford, 1914; Townsend, 1914; Hirsch, 1915; Hornsby, 1916; Pearce, 1916; Stevens, 1989). Many in the industry envisioned an encompassing role for hospitals as a "powerful influence on society . . . [and] the chief factor in the process of remolding and remaking the modern social fabric" (*Modern Hospital*, 1913a: 32). Not only would the hospital be the best place for the administration of medical care on the basis of scientific principles (Hornsby, 1913; Hurd, 1913), it would also contribute to public health and the prevention of disease (*Modern Hospital,* 1915a), engage in "social management" (*Modern Hospital,* 1920a: 114), and generally "help overcome the irregularities of birthright, to even the balances that have weighed so badly, and to bring to the lowly and the oppressed the beneficences of Faith, Hope, and Charity" (*Modern Hospital*, 1913a: 32).

The great majority of hospitals were headed by women (usually nurses), while the very few large hospitals were typically headed by men (usually physicians). In a salary survey by Weber and Ball (1921), 79 percent of the small hospitals had female superintendents. In the mid-size hospitals with 100 to 200 beds, half of the superintendents were women. Another small survey a year later revealed that 86 percent of the respondent hospitals with up to 100 beds had female superintendents (Weber, 1922). Parnall (1920: 417) referred to "the almost universal employment of trained nurses as hospital executives," while others referred to the superintendent as "generally a woman" (*Modern Hospital,* 1918a: 110), "usually a woman and a trained nurse" (Redwine, 1917: 197), or "nearly always . . . a woman who is also a nurse" (Riddle, 1912: 54). Attendance at the annual conventions of the American Hospital Association provided further evidence.[1] Of the 501 members who registered for the 1916 convention, 418 could be classified by sex on the basis of first name or title (e.g., Miss or Reverend). Of these, 284 (68 percent) were female (*Modern Hospital,* 1916a). Similarly, 80 percent of the superintendents who registered for the 1918 convention and could be classified by sex were female (*Modern Hospital,* 1918b). Thus during the early 1900s the occupation was female-dominated and may have been close to the 80-percent measure Anker (1998: 85) identified as an "extreme percentage" to define occupational dominance by one sex.

It was in this context that the first boundary work toward professionalizing hospital administration occurred. Establishing jurisdictional claims, a body of knowledge to guide practice,

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The association's active membership was limited initially to executive heads and trustees of hospitals (American Hospital Association, 1905) but was expanded over the next decade to include assistant superintendents and physicians (American Hospital Association, 1918). Institutional membership was added in 1918.

and educational requirements for practitioners are key aspects of boundary work for occupations that professionalize (Goode, 1957; Greenwood, 1957; Larson, 1977; Starr, 1982; Wilenski, 1962; Abbott, 1988). Successful professionalization confers "cultural authority" (Starr, 1982: 13; Kunzel, 1993) on the occupation, giving it a privileged position in shaping social reality in its domain. For example, the medical profession succeeded in reframing birth as a pathological event that required medical supervision and admission to the hospital. This conceptual change not only extended the jurisdiction of medicine, it simultaneously led to the delegitimization of another occupation, midwifery (Ehrenreich and English, 1978; Morantz-Sanchez, 1985). A new title also supports jurisdictional claims (Abbott, 1988) because it reduces identification with an existing occupation (Caplow, 1954; Wilensky, 1964), as when the designation hospital administrator replaced superintendent (Neuhauser, 1995).

A distinct body of knowledge to guide practice sets a profession apart and excludes or subordinates other knowledge and its adherents (Larson, 1977; Abbott, 1988). Gieryn (1999: 16) mapped out how the evolving definition of science associated some people with "pseudoscience, amateur science, deviant or fraudulent science, bad science, junk science, popular science" and excluded them from the profession. As physicians professionalized, they similarly drew on science to legitimize their quest for dominance over other healers (Larson, 1977; Starr, 1982). Social work, too, was reconceptualized as rational and scientific work, replacing its earlier identification with benevolence and "sentimental charity" (Kunzel, 1993: 43). To support claims of jurisdiction, professions' cognitive base for practice must require special education, making the establishment of educational credentials another important aspect of boundary work (Ashley, 1975; Larson, 1977; Starr, 1982; Kunzel, 1993). Thus, scientists claimed that their cognitive base was superior to that of engineers because they gained it through scientific education rather than in the workshop, as engineers did (Gieryn, 1983).

Professional associations play a key role in this boundary work. They pursue jurisdictional claims at the societal level (Caplow, 1954; Goode, 1957; Wilensky, 1964; Larson, 1977; Abbott, 1988; Halpern, 1992) as well as among and within occupations (Abbott, 1988; Witz, 1992). They are also central in the establishment of a distinct body of knowledge and educational credentials. Greenwood, Suddaby, and Hinings (2002) described the role of the professional leadership in expanding the domain of public accounting into consulting; and the American Medical Association's dominance over other healers and its role in securing control over medical school curricula have been documented extensively (Freidson, 1970, 1986; Larson, 1977; Starr, 1982).

METHODS

Data Sources

The primary data source is the *Modern Hospital,* which was the first journal to focus on the administration of hospitals. Founded in 1913, it targeted hospital superintendents and trustees, advising them on "the most intimate details of hos-

pital administration" (*Modern Hospital*, 1913b: 185). The journal's content represented the voice of the American Hospital Association's leadership. First, the journal published official bulletins of the association, reported on its activities, offered detailed accounts and proceedings of the annual conventions, and printed many of the papers given at the conventions. Second, leaders of the American Hospital Association (AHA) had control over the journal's content. The majority of the editors had recently served or were serving as president of the AHA during our study. Editors also served as trustees of the AHA and chaired or served on many of its key committees, e.g., the Committee on Legislation, the Committee for the Training of Nurses, and the Committee on Bureau of Hospital Information. One editor chaired the Committee to Propose Methods for the Training of Hospital Administrators. In 1915–1916, three of the five members of the AHA's Executive Committee were editors of the *Modern Hospital,* and a fourth committee member was a special correspondent to the journal. For several years, the entire three-person membership of the Committee on the Inspection, Classification, and Standardization of Hospitals came from among the journal's editors. Appendix A gives examples of the linkages between the individuals who served as editors during the time period we studied and their role in the AHA leadership. There were also close links between the AHA and associate editors who were special correspondents to the journal or in charge of regular columns. Individuals served, for example, on the AHA Executive Committee and on the Committees on Constitution and Bylaws, Membership, and Legislation; others served as trustee, vice president, and secretary of the association, or as head of an AHA section. Some of the special correspondents eventually became president of the AHA. In light of these linkages, it is not surprising that the journal was perceived as the AHA's official organ (*American Journal of Nursing,* 1915) and was anticipated to "wield an immense influence" (*American Journal of Nursing,* 1913: 4).

We also read other journals that were published at the time. The *American Journal of Nursing* and the *Trained Nurse and Hospital Review* focused on developments in the nursing field and paid little attention to management topics such as cost accounting, public relations, or efficiency. *Hospital Management,* first published in 1916, focused on the specialty area of industrial medicine. The *International Hospital Record,* which had been the official journal of the AHA, ceased publication in 1915 when it was purchased by the *Modern Hospital*. Lastly, we reviewed the index of the *Journal of the American Medical Association* and found that it carried virtually no information on hospital administration.

Our study covers the years from 1913 to 1920. The beginning coincides with the appearance of the *Modern Hospital.* We chose 1920 as the end point because our study focuses on the years when the management of hospitals first received attention as an occupation and on the early boundary work. By the end of the second decade, significant changes began that may have had an impact on subsequent boundary work, e.g., the Rockefeller Foundation's conference on the training of hospital superintendents in 1920, the first

steps toward implementing the American College of Surgeon's accreditation program in 1918, and later the founding of the American College of Hospital Administrators in the early 1930s. The cutoff at 1920 is also consistent with studies of other authors in the health care field who used it as a turning point. Starr (1982: 243) referred to 1920 as the end of the "grand illusions" of reform in the progressive era, and Stevens (1989: 105) considered 1920 as the start of "consumerism."

Analysis

We used qualitative analysis (Miles and Huberman, 1994; Locke, 2001) and applied an interpretative approach to a data base containing extended text on topics pertinent to hospital management. We created the data set in three steps. The first step involved reading every issue of the *Modern Hospital* from 1913 through 1920 and identifying management topics addressed in the journal. We did not approach the reading with an a priori list of topics because that would have reflected today's notions about the nature of hospital administration. Instead, we let the topics emerge inductively through the reading. Our method was similar to the constant comparative method (Glaser and Strauss, 1967), and we created, divided, combined, or abolished categories as the reading progressed. Eventually, 36 categories remained that had direct bearing on the management of hospitals, e. g., "board of trustees," "cost," "nursing service," "organization of hospital," "accounts receivables," "efficiency," "purchasing," "role of superintendent," and "training of superintendents." We excerpted verbatim information in articles that pertained to any of the topics. Transcription could involve excerpts as brief as a single phrase or as long as several paragraphs. We took care to retain the context in which the comment was made. The result was a chronological textual data base in the language in use at the time. The total immersion in the text yielded a "practical understanding" (Miles and Huberman, 1994: 8) of hospital administration during the time covered by our study. Because the focus was on the management of hospitals, we excluded areas such as home nursing, international news, and public health. The final list of categories is provided in Appendix B.

The second step focused on the creation of an occupational boundary for hospital administration. Because a jurisdiction, a body of knowledge to guide practice, and the education of practitioners represent key aspects of boundary work for occupations that professionalize, we used these factors to organize the data for the study presented here. We searched the entire textual data base for information pertinent to the topics. The third step focused on collecting information about the personal characteristics of practitioners. During this work, we performed additional content analyses of the journal and added the category "women and men in hospital administration" to the data base. As the patterns of findings emerged during the second and third steps of the analysis, we kept going back to the full journal texts for verification and to provide a test of the "sturdiness" of our findings (Miles and Huberman, 1994: 11).

HOSPITAL ADMINISTRATION AS PROFESSIONAL MANAGEMENT

The superintendent's responsibilities during the early 1900s included aspects that we would recognize today: to execute policies set by the trustees and supervise all day-to-day operations. For example, the rules and regulations of Sturdy Memorial Hospital (1913: 12) specified that "the Superintendent shall have the whole responsibility of the conduct of the hospital, under the direction of the Board of Managers, according to such rules as she may find necessary to prescribe and as approved by the Board of Managers." Significant differences existed in how superintendents of large and small hospitals discharged these responsibilities. The very few large hospitals had department heads for functional areas, but smaller institutions expected the superintendent to be familiar with all aspects of the hospital's work (Memorial Hospital, 1912; Milford Hospital, 1915; Neuhauser, 1995). Here the superintendent could participate personally in the daily tasks of ordering supplies, making out the payroll, admitting patients, even helping in the kitchen or with housekeeping if necessary (Gladwin, 1907; *Modern Hospital,* 1918c). The links to nursing were particularly strong. Nursing was a critical service if the hospital was to change its image from a place of dread to a desirable place of care (Starr, 1982), and the work of nurses permeated every aspect of hospital work:

> All the departments of the hospital—from wards and operating rooms to storerooms and kitchens—depended upon the continuous presence of nurses. For 24 hours a day, nurses were expected to be versatile in their skills, to demonstrate their ability to take care of whatever needs might arise, whether in the area of patient care, medical treatment, housekeeping, dispensing drugs, or supervising the diet and the kitchen. (Ashley, 1975: 17)

The superintendent was frequently a nurse herself and in direct charge of the nursing service (Riddle, 1912; Milford Hospital, 1915; Redwine, 1917). Her daily work could include direct patient care on the floors or in the operating room (Gladwin, 1907; Johns, 1915; *Modern Hospital,* 1918c). She participated in the training of nurses (Gladwin, 1907; Hornsby, 1917) and often was head of the training school as well (*American Journal of Nursing,* 1908; Johns, 1915; Milford Hospital, 1915; Weber, 1922). The symbiotic relationship between nursing and administration was illustrated by a regular column in the *American Journal of Nursing,* entitled "Hospital and Training School Administration."

A New Jurisdiction: General Management

During the time period studied, jurisdictional claims for hospital administration were advanced that elaborated the general administrative functions to include "all the administration of the hospital . . . taken up by the superintendent and made to count toward greater social efficiency for the institution" (Warner, 1918: 342). Reference was made to the "general manager" (Valentine, 1916: 264), whose responsibilities included coordination of functional areas and final authority over all management aspects and departments (Tipping, 1914; *Modern Hospital,* 1916b). This concept of hospital

administration as exclusively general management separated it from the nursing functions with which it had been so intimately connected, a separation that was further supported by the creation of the first journal dedicated to the administration of hospitals, the *Modern Hospital.* In contrast to other journals that dealt with nursing and might carry a column on hospital administration, the new publication was a management journal with a nursing column and occasional articles on nursing. An editorial in the first issue of the *Modern Hospital* pointed out that this was "another" kind of journal, one that would bring forth "new ideas" and "new methods" that would "make our hospital journals really interesting and relieve them of the necessity of filling space with this everlasting discussion of nursing" (*Modern Hospital,* 1913c: 34). The editors of the *Journal of the American Medical Association* (1913: 1468) agreed that "needless to say, there is need" for the new journal, but the editors of *Trained Nurse and Hospital Review* (1913: 232) were quick to ask, "Is there any phase of hospital work which more vitally affects the sick? Is there any department of hospital work which has in it greater possibilities for making or marring the reputation of the hospital than the nursing?" They pointed out that it would be hard to convince heads of hospitals "that nursing is not a proper subject for discussion in a hospital association." Nonetheless, the *Modern Hospital* implemented its editorial policy. Of the volumes published between 1913 and 1920, the indices for five contained a separate listing of 273 "original articles." The titles of only three of these articles referred explicitly to nursing.

The new title, hospital administrator, emerged during this time. Superintendent was the common title for the head of a hospital, but that title came to be seen as inadequately representing what should be the true scope of work (Walsh, 1915). At the annual meeting of the AHA in 1920, one speaker argued that the title was not sufficiently "dignified and definite" (Parnall, 1920: 418) for the executive head of a hospital and that other terms would be more appropriate. Although the title superintendent still predominated, we found references in the journal to a new title, "administrator," a term that would later become the standard.

A Body of Knowledge: Business Practices

As a new jurisdiction for the superintendent emerged, a "theory of hospital administration" (Goldwater, 1920: 275) consistent with this jurisdiction had yet to be defined. Absent a common knowledge base in administrative matters, hospitals were called "poorly organized and indifferently administered" (Parnall, 1920: 416), "wasteful," and "extravagant" (Ochsner, 1918: 124). The occupation was at a crossroads (*Modern Hospital,* 1918a). "Modern" hospital administration (*Modern Hospital,* 1914b: 175, 1920b: 189) would replace the inadequate administrator of the past by adopting the body of knowledge that guided management in the private sector. Throughout the years of our study, hospitals were admonished to adopt business practices. They were to institute cost accounting and bookkeeping (Mann, 1914; Townsend, 1914; Wechsler, 1914; Carter and Porter, 1918a, 1918b), budgeting and cash control (Townsend, 1914; Loder, 1915; Hurd, 1916),

formal purchasing and inventory practices (Greener, 1914a; *Modern Hospital,* 1920c), as well as formal admission and billing policies (Greener, 1914b; *Modern Hospital,* 1916c). Scientific management and efficiency received much attention. As Wechsler (1914: 148) explained, "It makes little difference whether the undertaking is operated for profit, or . . . is operated for a charitable purpose. The necessity for the application of scientific principles in order to efficiently and economically operate any undertaking has become imperative." The AHA invited the efficiency expert Frank Gilbreth to its conventions and established a committee on "Hospital Efficiency and Progress" (*Modern Hospital,* 1914c).

The occupational boundary for hospital administration as general management was further delineated through another practice from the private sector: an elaborated organizational hierarchy. Not only was the administration of the hospital to be a distinct function, it was to be positioned above functional areas and endowed with hierarchical powers: "Centralization of authority and responsibility in the hands of the superintendent" were essential for the successful organization of a hospital (Townsend, 1914: 240). The administrator was to be positioned "at the head" of the organization (Gilbreth, 1914: 323) with control over all departments (Tipping, 1914) and "giving line orders" (Valentine, 1916: 264). It was pointed out that "any large organization must have a single executive head" (Smith, 1916a: 314), or a "commanding officer" (Parnall, 1920; Warner, 1920: 176), and lack of "one head . . . over all departments" was identified as a source of laxity (*Modern Hospital,* 1919a: 61). Townsend (1914: 240) warned, "There can be no division of this authority . . . for so surely as any usurpation of power and direction is permitted to exist in any department, disorganization ensues, with the usual disastrous results."

Warnings were also issued against "petty, nagging rules" (*Modern Hospital,* 1919b: 41) or "meddlesome interference" by the board of trustees (*Modern Hospital,* 1919c: 45). The superintendent would "delegate work" (*Modern Hospital,* 1915b: 462), and employees "should be made to look up to the superintendent as the embodiment of knowledge and wisdom" (*Modern Hospital,* 1914d: 263). The envisioned hierarchical position of management, combined with jurisdictional claims to all matters administrative, also provided a basis for the AHA's extensive and at times adversarial participation in developments in the nursing profession. As early as 1908, an editorial in the *International Hospital Record,* which was the official AHA journal until it ceased publication in 1915, referred to the AHA as the "only organization in existence in America that seems fitted to broadly, impartially and effectively deal with this subject" (quoted in Ashley, 1975: 23). In our study, we found disagreements between nurses and hospitals over the purpose of nursing schools and educational standards (*American Journal of Nursing,* 1914; McKenzie, 1914; *Trained Nurse and Hospital Review,* 1916; Ochsner, 1918), working hours (*Modern Hospital,* 1914e; Gilman, 1919; Wetmore, 1919), and the use of pupil nurses for most of the direct patient care (Riddle, 1913; McKenzie, 1914; West, 1917). An AHA committee to develop a classification system

for different nursing jobs was fraught with controversy (*Modern Hospital,* 1913d, 1916d; *American Journal of Nursing,* 1914a, 1914b).

The Education of Practitioners

In the early years of the twentieth century, superintendents gained their knowledge and experience primarily on the job. Some participated in training courses or assistantships that were offered by a few large hospitals (Warner, 1920). Physicians and nurses also acquired insight into hospitals through their clinical training (Edsall, 1915; Johns, 1915; Bachmeyer, 1919). The only academic program existed at Teachers College, Columbia University. It had been founded in 1898 at the request of the Society of Superintendents of Training Schools for Nurses and offered a one-year course with lectures on hospital construction, governance, accounting, advertising, and buying (Nutting, 1907). The next academic program did not appear until 20 years later, when the University of Cincinnati announced plans for a division of hospital administration in the department of internal medicine and public health (Bachmeyer, 1919). The need to train superintendents "who will uphold and improve hospital administrative standards" (*Modern Hospital,* 1920d: 306) took on increasing importance during the years of our study. As early as 1913, the AHA appointed a Special Committee to Outline a Standard Course in Hospital Administration, and in 1920, the Rockefeller Foundation responded to a request from "50 representatives from the leading hospitals and medical schools of the country" (*Modern Hospital,* 1920d: 306) to appoint a special committee to study the topic.

In the absence of generally available formal training in hospital administration, the AHA's annual convention represented an educational opportunity for its members. Editorials in the *Modern Hospital* urged superintendents to attend and implored trustees to support their participation (*Modern Hospital,* 1915c, 1916e, 1918d). Topics addressed by AHA sections and committees included hospital construction, efficiency, and progress; the inspection, classification, and standardization of hospitals; and accounting and finance. At the same time, the programs began to deemphasize nursing. For example, the 1913 convention foreclosed debate on the nursing papers. Although nurses found this objectionable (Aikens, 1913), a report in *Modern Hospital* from the convention claimed that "there was no friction of any kind and perfect harmony prevailed" (*Modern Hospital,* 1913d: 116). A preview of the 1914 program in *Modern Hospital* reiterated that too much attention had been given in the past to nursing. It applauded the reduced emphasis planned for the program but also anticipated that the nursing session might be "vehement" (*Modern Hospital,* 1914f: 115). The decreased emphasis on nursing at the convention parallels the AHA leadership's editorial policies for the *Modern Hospital.*

Defining and Communicating Personal Characteristics of Hospital Administrators

The boundary work during the early years of the occupation's professionalization went beyond matters of jurisdiction, a

body of knowledge, and education. It extended to outright prescriptions for male practitioners and two more subtle processes: the rhetorical use of gender to create a generic male practitioner and an image of the occupation as though it were predominantly male and the creation of an internal occupational boundary for female practitioners.

The prescription for male practitioners. At a time when the occupation was female-dominated, we found prescriptions for male practitioners (Gilbreth, 1914; Edsall, 1915; Warner, 1920). Sometimes they occurred implicitly, as when the desirable superintendent was seen as a physician and, thus, most likely a man. Editorials in *Modern Hospital* asserted that the modern superintendent "usually" is a physician (*Modern Hospital,* 1920b: 189) or that "the modern tendency is unmistakably toward limiting the field to graduates of medical schools," giving them a "right to monopolize" hospital management (*Modern Hospital,* 1919d: 40). In an analysis of editorials in the *Modern Hospital,* 1913–1920, we also found that the new title of "administrator" was used significantly more often for men than for women, implicitly associating male practitioners with a new description of the occupation. Results showed 432 gendered references to men as superintendent and 69 as administrator, versus 134 references to women as superintendent and 4 as administrator (chi square = 13, $p < .001$).

At times, the prescription was overt and linked to the professionalization of the occupation: "We have come to the day when the superintendency of a hospital is almost a profession in itself . . . and I believe that the position should, when at all possible, be filled by a man . . . " (Bottomley, 1916: 320). At other times, the prescriptions for male practitioners provided an opportunity to loosen the ties between administration and nursing: "He—and never she because no matter how able and highly trained as a superintendent a nurse may be, she is never so satisfactory as an executive as a man . . ." (*Modern Hospital,* 1920e: 382). If men were the superintendents, this would also eliminate women giving orders to men (Parnall, 1920).

While an overt desire for male practitioners is evident in these quotes, it was difficult to attract men to the occupation. Although male administrators earned more than women (Weber and Ball, 1921), inadequate salaries were seen as one reason for men's lack of interest (Edsall, 1915; Walsh, 1915; Smith, 1916a; *Modern Hospital,* 1919d). The hospital administrator was called "probably the poorest paid professional man in the country" (*Modern Hospital,* 1914b: 175), with salaries inferior to those of factory or department store managers (*Modern Hospital,* 1914b). The executive secretary of the AHA expressed the need for change succinctly: "Hospital administration must be held out to young men as an attractive and remunerative career" (Warner, 1920: 176). It was acknowledged that the limited resources of small hospitals made it impossible to attract male superintendents (Babcock, Howland, and Brown, 1913; Johns, 1915; Walsh, 1915; *Modern Hospital,* 1918a, 1918c), but men were said to be "much more apt to be successful" even in this setting (Parnall, 1920: 417).

The rhetorical use of gender. We found evidence that gendered language was used to create a generic male practitioner and an image of the occupation as already largely male. For example, an editorial in the first issue of the *Modern Hospital* (1913c: 34) included a reference to a generic "Mr. Superintendent." The editors of *Trained Nurse and Hospital Review* (1913: 231) took exception to the phrase because it elevated men's contribution to the hospital field above that of women, who, they pointed out, constituted the majority of hospital superintendents and officials. Analysis of the language in use in the editorials of *Modern Hospital* suggests that this was not an isolated example. Among 1,223 references to heads of hospitals in editorials, 710 were uniquely gendered, and of these, 79 percent were to men, either by pronoun or as named individuals. Because phrases such as "he or she," and "men and women" were also used in the editorials, the disproportionate references to men were for reasons other than an accurate representation of the occupation's membership.

The same pattern occurred in the journal's editorials when they referred to named superintendents in news items or as exemplary practitioners. During the years of our study, 87 of the 102 individuals featured in this manner were men. Another example is the disproportionate weight given to men's voices in the journal's articles. The publication's stated purpose was to "bring into wider usefulness the experience and the learning of each individual to the end that these may become the common harvest of all" (*Modern Hospital*, 1913a: 32), but a closer look reveals that the voices of men were offered far more frequently than those of women. Among the fifteen volumes published between 1913 and 1920, four contained a separate listing with the names of authors of articles. Of 370 contributors, 267 could be classified by sex, and of these, 199 (75 percent) were male. An announcement that the journal would publish a series of handbooks for administrators further illustrates the emphasis on male authors: the journal stated its intent to secure as authors of the individual volumes "men eminent in the hospital field" (*Modern Hospital,* 1920f: 186). Women were similarly given a very limited role in the paper sessions at the AHA conventions. For example, they delivered only 3 of the 34 papers and committee reports at the 1916 convention (*Modern Hospital,* 1916f). Reports in the *Modern Hospital* from the convention mention that "there is the ever-existing feeling in some quarters that men superintendents discriminate against women . . . and that a few superintendents of large hospitals monopolize the discussions and 'run things'" (*Modern Hospital,* 1916f: 401). Despite reassurances in the report that this "was all held to a minimum [and] the women easily held their own in the discussions," an analysis of the proceedings shows a different picture: of 98 discussants, 85 could be classified by sex, and 75 (88 percent) of these were male (*Modern Hospital,* 1916g).

The composition of the AHA's leadership itself was consistent with a male image of the generic superintendent and of the occupation. All nine presidents who served during the years covered by our study were men, and all of them were

physicians. Of the 45 individuals who were appointed to committees by the AHA president for 1917–1918, 39 could be classified by sex. Of these, 34 were men, and only five were women (*Modern Hospital,* 1917). The discrepancy between the composition of the membership and the association's leadership did not go unnoticed. An editorial in the *American Journal of Nursing* (1919: 90) pointed out that women administer the great majority of hospitals and constitute the great majority of the audience at the convention, but that they are "markedly absent" as members of the association's committees. The AHA bylaws also signaled changing thoughts about personal characteristics of members. While membership originally had been defined as the executive heads of hospitals "without reference to sex, title or denomination" (American Hospital Association, 1905: 20), this clause had been eliminated by 1918 (American Hospital Association, 1918).

The Use of Personal Characteristics to Create an Internal Boundary

The language used in the *Modern Hospital* consistently associated female superintendents with small hospitals. As table 1 shows, 62 percent of the references in the journal's editorials to female superintendents, but only 7 percent of the references to male superintendents, associated them with the size of their hospital. Based on the number of hospitals actually run by women, the generic hospital administrator was female. If there had been a need for a subcategory, the logical choice would have been "superintendents of large hospitals." The contrary assignment of women to a subordinate category established an internal boundary that marginalized women in their own occupation and suggested the existence of a main body for the occupation that was not female.

We found other evidence that supports the creation of an internal boundary. First, the AHA's Committee to Outline a Standard Course in Hospital Administration drew different conclusions for physicians, who were predominantly men, and nurses, who were predominantly women. For physicians, the committee recommended that they acquire necessary knowledge as assistant administrator in a state hospital for the insane or in a large general hospital. For nurses, the committee recommended formal instruction in all aspects of the job, including general and business management as well as

Table 1

References to Female or Male Superintendents in Connection with Size of Hospital in *Modern Hospital* Editorials, 1913–1920

Sex of superintendent	Percentage
Female	
In connection with large hospital	0%
In connection with small hospital	62%
Without link to hospital size	38%
Male	
In connection with large hospital	6%
In connection with small hospital	1%
Without link to hospital size	93%

didactic lectures and hands-on experience in departments such as laundry, kitchen, surgical department, mechanical department, outpatient department, housekeeping, and pharmacy (Babcock, Howland, and Brown, 1913). In line with the committee's recommendations, teachers' colleges and agricultural colleges that offered courses in household economics were especially recommended for women (Johns, 1915; *Modern Hospital,* 1916h). A few large hospitals were also said to "give a good course to women" (*Modern Hospital,* 1918e: 69).

Second, the personal attributes sought for female and male superintendents differed markedly. Generic (i.e., male) hospital administrators were to share the characteristics of successful executives in the private sector, e.g., "forcefulness, clearness of mind, quick decisions, and firmness" (*Modern Hospital,* 1919d: 40) and generally "should be made of the sort of material which goes to make up the successful general or admiral" (Keppel, 1916: 305). In contrast, women were advised to exhibit "magnetism" so that they would be liked, because "a large element of success radiates from a pleasing personality" (Jordan, 1916: 20), and an editorial in the *Modern Hospital* (1918f: 110) discussed women's "ability to maintain a homelike atmosphere" in the hospital. The AHA's Committee to Outline a Standard Course in Hospital Administration urged nurses to "first carefully take an inventory of their mental assets in temperament, tactfulness, and adaptability" before embarking on hospital work and to take an inventory of their "stature, physique, and endurance" (Babcock, Howland, and Brown, 1913: 177). They were to be

> between twenty-four and forty years of age. They should be single, in good physical health, and be definitely committed to a future of hospital work. . . . [O]ther qualifications being equal, the woman with a commanding presence, whose stature surmounts five feet five inches, and whose activity gives promise of much potential energy generally, proves the most successful in hospital work. (Babcock, Howland, and Brown, 1913: 177)

Third, internal segregation occurred at the AHA conventions. Representatives from small and large hospitals used to attend paper sessions jointly, but in 1913 some separate sessions were introduced. As the pros and cons of this policy were debated (*Modern Hospital,* 1913e, 1914a), the striking argument was made that the segregation was for the benefit of the segregated:

> The fact is that the thinking members of the association have known for a long time that the superintendents of small hospitals have seemed disinclined to enter into the discussions, and backward about expressing themselves on their feet in the meetings. It was felt that if some meetings could be held in a section definitely designated as of the "small hospitals," the members would overcome this diffidence. (*Modern Hospital,* 1914a: 297)

At the Boston meeting, fewer than 20 participants attended the session on large hospitals, while the session on small hospitals drew 300 participants (*Modern Hospital,* 1914a). Separating superintendents of large and small hospitals was called a "tactful piece of work" (*Modern Hospital,* 1914a: 297), but it is unclear whether women were really disinclined

to enter into discussions or whether they felt silenced. Women had complained about the refusal to let them debate topics of great interest to them at the 1913 convention (Aikens, 1913), and an editor of the *Modern Hospital* who attended a meeting of the American Nurses Association expressed his admiration for the vigorous debates he witnessed there (Hornsby, 1914).

Small hospitals were deemed "in great need of the experience and counsel" of the large hospitals, which were able to give "proper direction to new and empirical practice in various directions" (*Modern Hospital,* 1914a: 297). Not only did nurses voice disagreement about this one-directional flow of learning (Jordan, 1915; *Trained Nurse and Hospital Review,* 1920), the separate sessions at the convention may have limited the educational benefit for women. For example, one of the papers presented at the 1913 meeting was on standardization of hospitals. The minutes of the meeting referred to standardization as "perhaps the most important issue before the hospitals of this country at this time" (*Modern Hospital* 1913d: 121), yet the topic was slated for the meeting of the large hospitals (*Modern Hospital*, 1913f). An editorial in the *American Journal of Nursing* (1919: 90) pointed to women's absence from the convention program and noted that "the meetings were dominated absolutely by a small group of men who are the superintendents of the few very large hospitals."

DISCUSSION

During the years covered by our study, none of the influences that have been demonstrated to change an occupation's sex composition existed. Most employers did not express a desire for superintendents of the opposite sex; women who dominated the occupation were not leaving it; men were not interested in a career in hospital administration; and there were no larger social, economic, technological, or political forces that drove men into the occupation despite their lack of interest. The boundary work of establishing a jurisdiction, adopting a body of knowledge, and denoting educational requirements conceptualized the occupation along professional lines before individuals skilled in applying the new body of knowledge to hospitals actually existed. As well, a conceptual male sex label was created for the occupation while it was still female-dominated and before men had entered it in significant numbers. This echoes Abbott's (1995: 860) argument that "boundaries come first, then entities." In hospital administration, the boundary work paved the way for the subsequent masculinization of the occupation.

First, the association of hospitals with firms in the private sector implicitly made men the appropriate heads of hospitals. The functions that were carved out and elaborated as superintendents' jurisdiction and the position envisioned for them in the hospital hierarchy echoed those of men in private industry. The institutional logic of business was captured in the AHA's own mission, which at that time was the "promotion of economy and efficiency in hospital management" (Smith, 1916b: 268). Under the business logic, women who headed the great majority of hospitals no longer fit the image

of the manager, because there is "no ideal business image for women to conform to, no way to be a woman manager" (Kilduff, 2001: 605).

Second, prescriptions for male practitioners and for characteristics and behaviors were made that gave the desired practitioners an aura that Acker (1990: 146) referred to as "forceful masculinity." Additionally, rhetorical use of gender created an image of the generic superintendent and of the occupation as male, and an internal boundary segregated female practitioners within the occupation. All of these actions combined to give the occupation a conceptual male sex boundary, disassociating it from gender essentialism. As women were effectively barred from being managers in the private sector at that time, the successful importation of the business logic into the hospital field might have been sufficient to create a male sex boundary for the occupation, associating it with gender primacy. Several explanations are possible for why the boundary work of the professional leadership went even further.

It may have been the deliberate policy of the AHA to drive women out of the occupation, starting with a "segregationist" strategy (Witz, 1992: 30) that demarcated the occupation by gender, assigning women to a subcategory, followed by a strategy of "exclusion" (Witz, 1992: 30) that limited the occupation to men. We did find some outright prescriptions for male practitioners, opposition to women giving orders to men, and an express desire to recruit more men into the occupation, but our data do not reveal the existence of an official policy to expel women.

More likely explanations of the findings draw on subtler ways in which gender may have shaped and reflected assumptions and behaviors of the AHA leadership, which was largely male, and of the AHA's membership body, which was largely female. First, the AHA's boundary work may reflect an attempt to raise the status of the occupation by creating a new social identity for it. The men who headed the few large hospitals were embedded in a female-dominated occupation intimately linked to nursing, and with superintendents engaged in many of the hospital's caring tasks. In this context, one can interpret the boundary work as creating a "connotative dimension" to the occupation that separated it from the female practitioners who did "denotatively similar work" (Van Maanen and Barley, 1984: 296). References in the *Modern Hospital* to the inadequate administrator of the past and the contrasting modern hospital superintendent are consistent with this interpretation, as are comments that the occupation was at a crossroads. Most members of the AHA leadership were not only hospital superintendents but also physicians, and attaching the "valued identities" (Van Maanen and Barley, 1984: 298) they enjoyed in their occupational role as physicians to their role as hospital superintendents would enhance their self-image in the latter. The prescriptions for male administrators, combined with the creation of a generic male superintendent and an image of the occupation as male created a social identity that was consistent with the experience of male superintendents, even as it made women an "out-group" (Ashforth and Mael, 1989: 25) within the occupa-

tion and "impinged" (Jenkins, 1996: 23) on their identity and experience. If this boundary work could attract more men to the field, the occupation's masculinization could proceed even without a link to the business logic.

Second, the actions of the AHA leadership may reflect assumptions about gender essentialism and gender primacy that manifested themselves in the rhetorical use of gender and imagery we found. Once hospital administration was conceptualized as business management, it may have become impossible to think of it as anything but a male occupation, and the iconic male practitioner would replace the nurse as the representative head of the hospital. This becomes even clearer when we look at the large social role that was envisioned for hospitals. It contained the prospect for hospital executives to assume a place as important as that of the captain of industry, a role that would have been inconceivable for women at that time. The disassociation from nursing again is salient, because it separated hospital administration from gender essentialism. The separation of women into a subcategory as superintendents of small hospitals is also consistent with this explanation because it echoed the separate spheres that were created at the time for women and men through job structures in the private sector (Bradley, 1989; Kwolek-Folland, 1994). This explanation makes a conceptual link to the business logic but does not depend on its diffusion. Regardless of the actual implementation of business practices in hospitals, hospital administration would have a conceptual male sex boundary as long as it was linked rhetorically to management in the private sector.

Third, the AHA leadership's actions may reflect Davies' (1995: 30) argument that men "schooled in masculinity reproduce their worlds in ways that are gendered masculine." In the early 1900s there were few male superintendents, but they exerted a disproportionate influence in the occupation. As physicians, they belonged to an occupation with a male sex boundary and the cultural authority to shape social reality in its domain. Thus a relatively small group of men who shared education, work experience, and professional affiliations controlled developments in hospital administration. They imported into the female-dominated occupation the "hegemonic masculinity" (Kilduff, 2001: 599) from other areas of their life and reconceptualized hospital administration as a male occupation. This is consistent with the argument that physicians had a right to monopolize hospital administration. It also made it natural to focus on exemplary practitioners who were men, to give more importance to men's voices at the convention and in the journal, to use the male pronoun for the generic practitioner, and to assume that male superintendents would be appropriate to run any type of hospital, large or small. It again placed women outside the occupation's redefined mainstream and made it natural to account for their presence by assigning them to a subordinate category. This explanation depends neither on a conceptual link to the business logic nor on its diffusion because it is associated with the composition of the AHA leadership.

As for the female practitioners, our data suggest that they had some awareness that they were being marginalized. We

found several instances in which women contested the diminution of nursing in the scope of administrative work, the presentation of men as the representative superintendents, the exclusion of women from the AHA's leadership structure, and their silencing at the annual conventions, but women did not seem to offer a strong countervailing force. Ashley (1975) suggested that nurses may not have recognized the strength of the forces facing them in the AHA as they tried to professionalize nursing. Our findings suggest that female superintendents similarly may not have fully comprehended what was happening to their occupation. Women had no reason to object to improvements in the work or status of hospital superintendents: they may even have welcomed men in the occupation because it usually signals an elevation in status and economic benefits. They may also have felt safe in their assigned niche as superintendents of small hospitals, not anticipating that over time men would claim them as well. Lastly, in the early 1900s, women lived and worked in a context that accepted the general superiority of men in society and in organizations and the cultural authority of physicians to define social reality in their work setting. In that context, female superintendents may not have felt empowered to contest the actions of their male leadership. They did not, at any rate, have access to the resources and positions within the AHA's structure that would have been needed to shape the organization differently, had they wanted to do so.

The early professionalization of the occupation and other boundary work may have been overshadowed subsequently as other factors influenced the masculinizing of the occupation. Over time, the number of small hospitals declined, and as the niche grew smaller, the number of women declined as a matter of course. Men, however, took over the small institutions as well. We know that in Massachusetts, for example, 81 percent of the small institutions were headed by men in 1964 (*Hospitals,* 1965a). The process of masculinizing hospital administration may have been enhanced by institutional pressures. For example, the emphasis on the few large organizations that were almost exclusively headed by men as the exemplary organizations may have created mimetic pressures on hospitals of all sizes to employ male administrators. The occupation's ongoing professionalization may have created normative pressures on hospitals to hire male administrators. The far greater number of men who graduated from programs in hospital administration that were founded in the ensuing decades (*Hospitals*, 1965b, 1967, 1972) may have played a role as well. Such imbalance could have represented universities' admission policies but also could indicate a voluntary withdrawal of women from the occupation if they no longer saw themselves as appropriate for the work. Either possibility would have limited the number of female candidates for hospitals that were looking for a formally trained executive. All of these foregoing explanations, however, presuppose that hospital administration had become a legitimate occupation for men. The early boundary work we described laid the foundation for that assumption.

Implications for Theory and Research

Theories on changes in sex boundaries address how male occupations feminize. They draw on interactions among employer or worker preferences, changes in work content, and institutional forces (Strober, 1984; Reskin and Roos, 1990; Charles and Grusky, 2004). There is less theoretical development about the masculinization of female occupations because of its rarity, but it has been hypothesized that it would occur "only in very special circumstances" (Bradley, 1993: 16), defined as times of social, economic, technological, or political change (Abbott, 1969; Clark, 1968; Bradley, 1993). The empirical findings of our study add occupational boundary work as another circumstance.

First, concepts of boundary work to masculinize a female occupation must now recognize the role of internal forces. Given that an occupation's general membership body would not demand its own ouster, the internal stimulus must come from a subset of members who are not representative of the membership overall and have the resources needed to reconceptualize the occupation. The leadership of a professional association would constitute such a subset. It is in a position to shape the image of the occupation, has the legitimacy to command an audience for its views, and has control over the occupation's means of communication. In the case of a male-dominated professional association in a female occupation, it is men who have the power and legitimacy to create both a social reality in which the occupation is male and a new sex boundary. Further, the concept of boundary work by professional associations must extend beyond maintaining and enforcing exclusionary occupational barriers to delegitimizing the existing membership body and paving the way for people with different personal characteristics to enter the occupation in large numbers.

Second, the conundrum between gender primacy and gender essentialism in the masculinization of a female occupation is reconciled when external forces, such as social or economic upheavals, drive men into an occupation and make it socially acceptable for them to be in it. Such legitimization in the form of societal approbation does not exist, however, when the change to masculinize a female occupation originates internally. In that case, the reconciliation of the two tenets has to originate internally as well. What we observed was the extraction and elaboration of aspects of the existing occupation that were consistent with assumptions about appropriate work and hierarchical position for men and the sloughing off of aspects of the occupation that were associated with gender essentialism. This boundary work reconceptualized the occupation and enhanced its legitimacy by linking it to other occupations that were consistent with gender primacy.

This process may explain why female occupations masculinize so rarely. Because they concentrate on service, nurturing, and social interaction, they likely lack a sufficient number of tasks consistent with gender primacy that can be extracted and elaborated and then used to reconceptualize the entire occupation as male. The process also makes it clear that masculinization and feminization of occupations are not sym-

metrical: the latter is unlikely to occur as a result of a small number of women who have gained entry into a male occupation. They are unlikely to have the authority, legitimacy, or control over communication channels to engender change. Further, women themselves may be loath to associate the whole occupation with women's work because of the attendant lower pay, status, and opportunities (Reskin and Roos, 1990; Bradley, 1993; Jacobs, 1993). Lastly, while men who set in motion an internal process of changing a female occupation's sex boundary have the burden of reconciling gender primacy and gender essentialism as part of the process, this issue does not arise for women. In light of the diminished economic benefit and status that result from the feminization of a male occupation, they would have no interest in setting in motion such a process internally, nor would they have the means to do so. Once women have gained entry into a male occupation, it is usually employers or the diminished interest of male workers in the occupation that lead to its feminization.

Third, boundary work to masculinize an occupation extends beyond reconceptualizing an occupation. It includes the rhetorical use of gender to define the occupation as male and the creation of an internal boundary that marginalizes women within the occupation even as they constitute the majority of practitioners. This sheds additional light on the reconciliation of gender primacy and essentialism as men work toward the masculinization of a female occupation. The rhetorical use of gender reinforces gender primacy: the occupation has been recast as appropriate for men, and a generic male practitioner reflects the appropriate representative. Creating an internal boundary that marginalizes women reinforces gender essentialism: they are recast as occupying an occupational niche that draws on their "ability to maintain a homelike atmosphere" (*Modern Hospital,* 1918f: 110). Again, a small number of women in a male occupation would not have the power, legitimacy, or control over communication channels to engage in rhetorical use of gender to create the image of a generic female practitioner for the occupation, let alone marginalize the majority of workers—men in this case—because they will hold the positions of authority.

The rhetorical use of gender also suggests that the emergence of an occupation's initial sex boundary and a subsequent change, a distinction made in the literature on occupational sex segregation, may occur simultaneously. The rhetorical use of gender creates an artificial distinction between an existing occupation, with its actual functions and female practitioners, and a "virtual" occupation, with idealized practices and a conceptual male practitioner. This virtual occupation obscures the existing one and can be held out to men as a "new" occupation.

Few female occupations have masculinized, but there are specialty areas, or "micro-occupations," within female-dominated occupations that see concentrations of men. For example, male nurses concentrate in the emergency room, intensive care units, or anesthesia (Egeland and Brown, 1989; Charles and Grusky, 2004). It has been suggested that nursing work in the emergency room or intensive care unit is

"more congruent" with the male sex role (Egeland and Brown, 1989: 693) or that men are nurse-anesthetists because it is a "technical specialty" (Charles and Grusky, 2004: 316). Both of these explanations hint at boundary work conducted by men within the female occupation. In view of our finding that boundary work to masculinize an occupation can occur from within, the question arises whether the professional association or groups of powerful men play a role in creating micro-occupations suitable for male practitioners within a larger female-dominated occupation.

The observed extraction and elaboration of work consistent with gender primacy and the sloughing off of work associated with gender essentialism provide a basis for studying micro-occupations with concentrations of male practitioners. What functions were extracted from the work and how were they elaborated and reconceptualized so that the specialty area could be cast as appropriate for men? Was the legitimacy of the micro-occupation enhanced by linking it to other activities consistent with gender primacy? Similarly, micro-occupations (or entire female occupations) that contain sufficient tasks consistent with gender primacy to reconceptualize them as male work could be identified and studied longitudinally. The rhetorical use of gender and the marginalization of women were also important aspects of boundary work in our research. In micro-occupations with a concentration of men, is there a rhetorical use of gender to create an image of the representative practitioner and of the micro-occupation itself as male, and are the remaining women marginalized?

The rhetorical use of language may also be extended to the boundary work in other occupations, including micro-occupations, in which attributes or qualifications have changed over time. For example, while the role of professional associations in establishing educational requirements for practitioners is well documented, our findings suggest that additional processes in boundary work take place before the new credential has become widely agreed upon among the membership. Is rhetorical language used to present the first practitioners who have the new credential as the norm? Are the majority of practitioners who are without the credential marginalized through an internal boundary?

Our research indicates that the time period covered by a research project may influence the interpretation of how change in an occupation's sex boundary occurs. Extant work has attributed change to social, economic, technological, and political forces, or to the preferences of employers and workers. If boundary work toward a change in the sex label originates within the occupation itself, it may set in motion changes in work content, demands from employers, or workers' preferences. These changes subsequently may be interpreted as drivers of the change, but that interpretation would constitute a retrospective rationalization of events resulting from boundary work that began much earlier. It would be fruitful to reconsider the examples of occupations that have masculinized by studying boundary work within the occupation that occurred not just contemporaneously with external

changes but before external changes manifested themselves.

This research reclaims a part of hospital administration's history that was all but lost. The occupation's professionalization in the years following our study has been discussed and recorded (Wilensky, 1962; Neuhauser, 1995), but the gender implications have been overlooked. When women are recalled, it is not as executive heads of complex organizations, reflecting the totality of their responsibilities, but as heads of a "household" (Spence, 1994: 240; Applebaum, 1975), focusing only on the tasks that had been associated with gender essentialism. Nothing was known until now about the early boundary work that reconceptualized the female occupation as male. The neglected history of women in hospital administration makes us wonder whether this is a rare case or whether there are other micro-occupations or entire occupations that were once female and have been lost to history.

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1916c "Curtailing the abuse of hospital privileges." Vol. 6: 310.
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APPENDIX A: Examples of Service in the Leadership of the American Hospital Association by the First Editors of the *Modern Hospital**

Henry M. Hurd
AHA president, 1911–1912
Committee on the inspection, classification, and standardization of hospitals
Committee on bureau of hospital information
Committee on necrology
Committee on training of nurses
Committee on constitution and bylaws

Frederic A. Washburn
AHA vice president, 1910–1911
AHA president, 1912–1913
Committee on the inspection, classification, and standardization of hospitals
Executive committee
Committee on war preparedness
Committee on education and training of nurse assistants for the care of people with limited means in their homes
Committee on standard nomenclature
Committee on standardization of hospitals
Committee on training of nurses
Committee on bureau of hospital information

Winford H. Smith
AHA president, 1915–1916
AHA trustee, 1916–1918
Committee on hospital efficiency, hospital finances, and economics of administration
Auditing committee
Committee on the development of the association
Committee on bureau of hospital information
Committee to memorialize Congress to place hospital instruments on the free lists
Committee on state subsidy for hospitals
Committee to consider the grading and classification of nurses
Committee on standardization of hospitals
Committee on war preparedness
Committee on standard nomenclature
Nominating committee

S. S. Goldwater
AHA president, 1907–1908
Committee on bureau of hospital information
Committee on constitution and bylaws and committee for the development of the association
Executive committee
Committee on health insurance
Committee on war preparedness
Committee to cooperate with the military service
War service committee
Membership committee
Representative to medical section of Council of National Defense
Committee for the national study of hospital social service

W. L. Babcock
AHA secretary, 1908–1910
AHA president, 1910–1911
Committee to outline a standard course in hospital administration
Committee to memorialize Congress to place hospital instruments on the free list
Committee to study the character, cost, and value of direct and indirect work for the prevention of diseases
Nominating committee
Executive committee
Committee on standardization of hospitals
Publication committee
Committee on training of nurses

John A. Hornsby (left editorial board in 1919)
Committee to study the character, cost, and value of direct and indirect work for the prevention of diseases
Committee on the inspection, classification, and standardization of hospitals
Nominating committee
AHA delegate to American Medical Association Council on Health and Public Instruction
Committee on the development of the association

H. E. Webster (joined editorial board in 1919)
First vice president, 1913–1914, 1919–1920
AHA trustee, 1920
Committee on publications
Committee on legislation
Committee on hospital construction
Membership committee
Committee on constitution and bylaws

R. G. Brodrick (joined editorial board in 1919)
Second vice president, 1919–1920
Executive committee
Legislative committee
Auditing committee

***** Source: *International Hospital Record* (1908–1912) and the *Modern Hospital* (1913–1920)

APPENDIX B: Topics Pertaining to Hospital Management Covered in the *Modern Hospital*

Access to care
Accounts receivable, patients' accounts, free care
Auxiliary
Board and board relations
Business values and practices
Compensation for superintendents
Construction
Cost of hospital care
Cost accounting and internal control systems
Dietary services
Dispensaries and outpatient services
Economy of hospital work
Education, training, and qualifications of superintendents
Efficiency of hospital work
Ethics
Fund raising
Health insurance
History of hospital administration
Human resources management
Large vs. small hospitals
Legal matters
Medical records
Medical staff and medical staff relations
Miscellaneous services (e.g., social service, housekeeping, laundry)
Nursing services
Organization of hospital
Patient care (including quality)
Public relations

Purchasing
Queries and hints to superintendents
Reimbursement
Role of hospitals
Role and functions of superintendent
Standardization and classification of hospitals
Technology and innovation
Women and men in hospital administration