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We need to organize that old spirit of neighborly helpfulness which still exists in our hearts, if not in our deeds, and make it do its work again by bringing it up-to-date.[1]

For charity director Richards Merry Bradley, reviving "that old spirit of neighborly helpfulness" meant restoring women's traditional role in health care to resolve the knotty problem of female poverty. In 1907, Bradley conceived the Brattleboro Mutual Aid Association (BMAA), a novel household nursing organization, as a means to supply the poor women of Brattleboro, Vermont, with charitable aid. Chief trustee and steward of the Thomas Thompson Trust, a Boston-based charity dedicated to the needs of poor "seamstresses, needle-women, and shopgirls" of Brattleboro, Bradley sought to resolve his clients' health and domestic problems and reduce the rising cost of health care in the community. In the process, he hoped to revive and reshape the benevolent impulses of the town's middle-class women as well. He urged them to recruit laboring women into a corps of trained "nurse helpers," who would provide essential care in the homes of the poor under their supervision. At a rate of only $1.25 to $1.75 a day, a nursing attendant would be far less expensive than hospital care or the services of the district nurse, who

I wish to thank the trustees of the Thomas Thompson Trust for permission to use the trust records; Kathy Peiss for her helpful suggestions on earlier forms of this research; and the anonymous readers of the *Bulletin* for their comments on earlier drafts.

1. *Brattleboro Mutual Aid Association: A Neighborhood Association for Mutual Help in Sickness, A Statement of the Purposes of the Association, and an Account of Its Work, with Financial Statement for Year ending October 1, 1908* (Brattleboro, Vt., 1909), p. 2, found in Local History Collection, Brooks Memorial Library, Brattleboro, Vt. (Hereafter cited as *BMAA Annual Report 1908*; subsequent reports cited by year.)

could command nearly three times the rate. In Bradley's view, household nursing embodied not only an efficient use of charitable funds but also the crucial role of women in restoring the family and reviving the social obligations that appeared to have waned with industrial development.[2]

The story of the BMAA, one of the earliest organizations of attendant or practical nurses, and of Bradley's promotion of household nursing reveals the connection between efforts to alleviate poverty during the Progressive Era and the genesis of two grades of nursing. In the late nineteenth century, the association of women with caring and domestic labor dictated that any woman might qualify as a nurse, but differences in education, class status, and ethnic or racial identity differentiated the ranks of potential nurses. Nursing histories have detailed the struggle for professionalization among white nurses and the exclusion of most immigrant and black women from the training process. While the latter developed separate institutions, the nursing elite promoted nurses' autonomy within established medicine and sought to upgrade the profession with training requirements, hoping to distance the work from domestic labor.[3] Trainees (or, in some areas, African Americans) served as nurse helpers, but by the 1910s an increased demand for household care for the poor and for low-cost hospital labor precipitated calls for another class of lower-paid attendant nurses. The nursing elite, who viewed the creation of two nursing grades as a threat to nurses' compensation, full employment, and identity, resisted this development and significantly retarded the acceptance of attendant nursing for several decades.[4]

2. *BMAA Annual Report 1908,* pp. 1–5. The association charged $.25 a day as a placement fee. It is unclear but highly likely that Bradley wrote the introduction to this report.

3. For grading issues from the perspective of leading practitioners, see, for example, Lavinia L. Dock and Isabel Maitland Stewart, *A Short History of Nursing: From the Earliest Times to the Present Day,* 2d ed. (New York: G. P. Putnam's Sons, 1925), pp. 362–63; Lavinia L. Dock, Sarah Elizabeth Pickett, Clara Dutton Noyes, Fannie F. Clement, Elizabeth G. Fox, and Anna R. Van Meter, *History of American Red Cross Nursing* (New York: Macmillan, 1922), pp. 269–76, 955–66, 1352–74; Mary M. Roberts, *American Nursing: History and Interpretation* (New York: Macmillan, 1954), pp. 52–59, 94. For histories that examine the gender and class aspects of professional nursing, see Susan M. Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850–1945* (New York: Cambridge University Press, 1987); Barbara Melosh, *"The Physician's Hand": Work Culture and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982); Jo Ann Ashley, *Hospitals, Paternalism, and the Role of the Nurse* (New York: Teachers' College Press, Columbia University, 1976); Jessica M. Robbins, "Class Struggles in the Tubercular World: Nurses, Patients, and Physicians, 1903–1915," *Bull. Hist. Med.,* 1997, *71:* 412–34. For racial exclusion and the development of separate black institutions, see Darlene Clark Hine, *Black Women in White: Racial Conflict and Cooperation in the Nursing Profession, 1890–1950* (Bloomington: Indiana University Press, 1989).

4. Reverby, *Ordered to Care* (n. 3), pp. 97, 140–42, 160–66, 193. For chronological histories of practical nursing, see Dorothy F. Johnston, *History and Trends of Practical Nursing*

Focusing on gender and the problems of professionalization, recent historians have largely portrayed those who promoted this deskilling as either exploiters of female labor or zealous advocates of efficiency.[5] This study shifts the focus from the results of grading to the ideological roots of attendant nursing, which were largely embedded in efforts to diminish charitable direct aid and deliver health care to poor households.

The development of professional preventive health care and the focus on urban poverty at the turn of the twentieth century reinvigorated the age-old connection between nursing, womanly duty, and charity. The gradual acceptance of germ theory, the development of new medical therapies, and the evolution of hospitals from charitable to fee-based institutions led social reformers to preventive health education for the poor and home nursing care to alleviate poverty. They believed that ill health and infant deaths could be prevented not only through new vaccines, milk purification, and the isolation of tuberculosis patients, but also through improved health practices at home.[6] The influx of immigrants, who were reluctant to accept hospital treatment, bolstered the need for home care; their use of midwives, often blamed for high infant mortality, heightened reformers' desire to educate women in prenatal and infant care. In the wake of these changes, urban charity organizations and public health departments redesigned services for the poor with the twin goals of alleviating poverty through preventive health work

(St. Louis: C. V. Mosby, 1966); Dorothy Deming, *The Practical Nurse* (New York: Commonwealth Fund, 1947; repr. New York: Garland, 1984); Karen Kreps, "Practical Nursing—Past, Present & Future," *J. Nursing Care,* 1978, *2:* 13–18; Carla Ann Nelson, "The Shepard-Gill School of Practical Nursing of Massachusetts General Hospital, 1918–1984" (Ph.D. diss., Boston College, 1987).

5. Reverby, *Ordered to Care* (n. 3), pp. 140–42, 163–66; Ashley, *Hospitals, Paternalism* (n. 3), pp. 60–63; Diane Hamilton, "The Cost of Caring: The Metropolitan Life Insurance Company's Visiting Nurse Service, 1909–1953," *Bull. Hist. Med.,* 1989, *63:* 414–34, see especially pp. 422–24.

6. See Karen Buhler-Wilkerson, "Public Health Nursing: In Sickness or in Health?" *Amer. J. Pub. Health,* 1985, *75:* 1155–61, see especially pp. 1155–57; Richard A. Meckel, *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850–1929* (Baltimore: Johns Hopkins University Press, 1990), pp. 92–123; George Rosen, *Preventive Medicine in the United States, 1900–1975: Trends and Interpretations* (New York: Science History Publications, 1975), pp. 25–29; Michael E. Teller, *The Tuberculosis Movement: A Public Health Campaign in the Progressive Era* (New York: Greenwood, 1988); Nancy Tomes, "The Private Side of Public Health: Sanitary Science, Domestic Hygiene, and the Germ Theory, 1870–1900," *Bull. Hist. Med.,* 1990, *64:* 509–39. For an overview of changes in medicine and hospitals, see Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982); Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987).

and limiting the mounting cost of health care by employing trained women to deliver home and neighborhood services.[7]

For many progressive reformers, home nursing represented a key solution to disease prevention and the uplifting of poor homes. Beginning in the 1880s, women philanthropists had begun replacing the friendly visitors of voluntary charitable associations with visiting nurses, who provided both bedside care and health education. By the 1910s, these functions had begun to separate: visiting nurses specialized in maternity and infant care, and public health nurses, who rose to elite status within the profession, served as health educators and inspectors for municipal health departments.[8] Whether privately or publicly funded, these nurses also addressed fundamental concerns about the breakdown of the family, often highlighted by female reformers. Just as infectious disease and high rates of infant mortality provided the rationale to improve the health of the poor, so too rising levels of divorce, desertion, juvenile delinquency, and child abuse fueled the desire to intervene in poor households. Social reformers' efforts to replace the dole with efficient programs and meet the health needs of the poor represented not only a wise investment in poverty prevention but also a way to bolster the family and re-create a sense of community responsibility in urban neighborhoods.[9] Visiting nurses could help remove the stigma associated with charity by transforming the helping hand into that of a health-care professional with womanly instincts to restore the home. As spreaders of a "gospel of health," public health nurses linked the scientific knowledge

7. Kathleen D. McCarthy, *Noblesse Oblige: Charity and Cultural Philanthropy in Chicago, 1849–1929* (Chicago: University of Chicago Press, 1982), pp. 132–36; Meckel, *Save the Babies* (n. 6), pp. 79–80.

8. Karen Buhler-Wilkerson, *False Dawn: The Rise and Decline of Public Health Nursing, 1900–1930* (New York: Garland, 1989), pp. 1–30, 87–115; McCarthy, *Noblesse Oblige* (n. 7), pp. 125–36; Mary Sewall Gardner, *Public Health Nursing* (New York: Macmillan, 1916; 3d ed., 1936), pp. 27–40; Harriet Fulmer, "History of Visiting Nurse Work in America," *Amer. J. Nursing,* 1902, *2:* 411–25. For a southern example, see Karen Buhler-Wilkerson, "Caring in Its 'Proper Place': Race and Benevolence in Charleston, SC, 1813–1930," *Nursing Res.,* 1992, *41:* 14–20.

9. See, for example, Robyn Muncy, *Creating a Female Dominion in American Reform, 1890–1935* (New York: Oxford University Press, 1991), chap. 2; Theda Skocpol, *Protecting Soldiers and Mothers: The Political Origins of Social Policy in the United States* (Cambridge: Harvard University Press, 1992), pt. 3; Molly Ladd-Taylor, *Mother-Work: Women, Child Welfare, and the State, 1890–1930* (Urbana: University of Illinois Press, 1994); Linda Gordon, *Heroes of Their Own Lives: The Politics and History of Family Violence, Boston 1880–1960* (New York: Viking, 1988), chaps. 3–5; Linda Gordon, *Pitied But Not Entitled: Single Mothers and the History of Welfare, 1890-1935* (New York: Free Press, 1994), chaps. 3–4. For the desire to re-create community, see Paul Boyer, *Urban Masses and Moral Order in America, 1820–1920* (Cambridge: Harvard University Press, 1978); Nathan Irvin Huggins, *Protestants against Poverty:*

of medicine and middle-class health practices with the lives of the poor, instilling their concepts of family life and motherhood along the way.[10]

It was this perception—that a nurse could alleviate the effects of ill health on family life among the poor—that led to the organization of the BMAA. Frustrated by a lack of adequate home care for poor women and local physicians' monopoly over nursing services, Bradley devised a cost-effective system to address his clients' health needs without creating dependence. He envisioned working-class and poor women serving each other with bedside care and household help. Using the BMAA as a case study, I will detail the gender and class dimensions of this effort to reform charity and the way in which two grades of nursing developed in Brattleboro. I will then show how this model subsequently influenced the national conflict over standardized training. The use of attendant nurses represented not only a response to changes in health care but also a new vision of poverty prevention.

Neighborhood Health Care

In the small, commercial town of Brattleboro, Vermont, whose largest factory produced finely crafted organs, the demand for nursing expanded at the turn of the century. Civic leaders and local physicians sought to develop hospital care for a burgeoning population, and the onset of a charitable trust to serve poor women in 1901 set the stage for a local nursing organization. The Thomas Thompson Trust, the million-dollar legacy of Boston philanthropist Thomas Thompson, was designed to provide temporary assistance for the "seamstresses, needle-women, and shopgirls" of Brattleboro and Rhinebeck, New York.[11] From its inception until his death in 1943, trustee Richards Merry Bradley, a wealthy Boston real estate developer with family roots in Brattleboro,

Boston's Charities, 1870–1900 (Westport, Conn.: Greenwood, 1971), pp. 111–35; Kenneth L. Kusmer, "The Functions of Organized Charity in the Progressive Era: Chicago as a Case Study," *J. Amer. Hist.,* 1973, *60:* 659–71.

10. Melosh, *"Physician's Hand"* (n. 3), pp. 113–42; Meckel, *Save the Babies* (n. 6), pp. 79–80, 92–129. Lillian Wald of the Henry Street Settlement in New York City was perhaps the best-known social reformer who championed the role that visiting nurses could play in resolving urban problems. See Karen Buhler-Wilkerson, "Bringing Care to the People: Lillian Wald's Legacy to Public Health Nursing," *Amer. J. Public Health,* 1993, *83:* 1778–86; Lillian D. Wald, *The House on Henry Street* (New York: Henry Holt, 1915), pp. 26–65.

11. With no children, Thompson left his estate to his wife, and after her death to the poor seamstresses of these two towns where the couple had vacationed. Two-thirds of the legacy went to Brattleboro, where the population of 6,640 in 1900 was twice that of Rhinebeck; by 1920 Brattleboro's population was 8,332. The annual allocation for the town

controlled the allocation of funds. Throughout his long tenure, Bradley continually sought to use funds efficiently and to avoid creating dependence through direct aid. As his experience with the problems of poor women mounted, he increasingly attributed their poverty to illness and turned to medical care as a solution. In 1902 he hired Brattleboro's first visiting or district nurse from Waltham Training School in Massachusetts to run an infirmary and provide visiting nurse services. Three years later the trust funded the conversion of the infirmary into a community hospital with free treatment for Thompson Trust clients, but the hospital proved more expensive than Bradley had anticipated. Seeking an alternative solution for those clients who appeared physically ill-equipped to support themselves, in 1907 he set out to develop an efficient nursing organization to provide care for sick women and employment for poor women.[12]

Bradley's contact with physician Alfred Worcester, founder and director of Waltham Training School, enhanced his belief in the moral value of nursing and its connection to womanly duty and a revitalized community. Following the Nightingale ideal, Worcester had begun training nurses through apprenticeships in home care in 1885, and he continued to promote the art of nursing, not only as women's natural calling, but also because he believed it could provide the kind of caring for the helpless that underlay a just society. In his view, physicians had lost their humanitarian impulse as science increasingly dictated medical treatment, and a market-driven hospital had replaced the home as the site of curing. Bemoaning the increasingly professional attitude that hospital nurses exhibited, Worcester charged the profession with preserving the ethic of care through household training.[13] His system was not unique, for some hospital schools, particularly black training schools, apprenticed

averaged $36,000 between 1901 and 1920. See *Thomas Thompson Trust: Expenditures by the Trustees under the Will of Thomas Thompson in Brattleboro, Vermont, from January 1, 1901, to August 1, 1903* (Boston: Joseph Dooley, 1904); Lucile Eaves and Associates, *A Legacy to Wage-Earning Women: A Survey of Gainfully Employed Women of Brattleboro, Vermont, and of Relief Which They Have Received from the Thomas Thompson Trust* (Boston: Women's Educational and Industrial Union, 1925), pp. 12–27. For local history, see Mary Rogers Cabot, *Annals of Brattleboro, 1681–1895,* 2 vols. (Brattleboro, Vt.: Hildreth, 1921–22).

12. For a fuller description of Bradley's relationships with the community and charity clients, see Marilyn Schultz Blackwell, "Entitled to Relief: Poor Women, Charity, and Medicine, 1900–1920" (Ph.D. diss., University of Massachusetts Amherst, 1996), pp. 68–75, 89–139.

13. Alfred Worcester, *Nurses for Our Neighbors* (Boston: Houghton Mifflin, 1914); Annette Fiske, *The First Fifty Years of the Waltham Training School for Nurses* (Boston: Harvard Medical Alumni Bulletin, 1949; repr. New York: Garland, 1985), pp.3–10.

students in the homes of the "sick poor" as well. But Worcester's belief in women's moral responsibility for care went beyond the use of female health-care workers. He urged Bradley to install elite women on Brattleboro's hospital board and to help them develop a visiting nursing association that would supply district nurses and "nurse watchers." The "women of Brattleboro by assuming their rightful privileges and obligations of neighborliness," Worcester noted, "would grow in grace."[14]

Worcester's insistence upon the value of home nursing nourished Bradley's appetite for a morally worthy solution to poverty at a time when nurse professionals endeavored to upgrade nursing by disassociating training from home care. In Bradley's view, the respectability of nursing, considered an ideal occupation for rural, native-born, single women, held the potential to resurrect charity clients from dependence while they earned a living. "No other occupation," Worcester advised, "excepting that of making a home for her own family, can better bring out all that is best in womanhood."[15] Yet household nurse training clearly countered the trend toward hospital training, which had begun in the 1870s, and the educational goals of leading nurse professionals. It threatened to confuse the trained nurse with the untrained woman, thereby reinforcing the connection between nursing and women's domestic work. Graduate nurses were gradually replacing traditional nurses who cared for family members and infants at home, but clients were slow to recognize the need for a higher-paid trained nurse in the home. Despite nursing leaders' efforts to promote schools of nursing education, reduce apprenticeship training, and eliminate the untrained from the "nurse" label, nursing remained linked historically to female duty. Moreover, many graduates working in homes as private-duty nurses adhered closely to this ideal, feared educational reform, and resisted leaders' admonitions to further upgrade training.[16] Worcester's school and his promotion of household training only aggravated these divisions among nurses, as leaders sought to standardize nurse training in professional schools and hospitals.[17]

14. Alfred Worcester to Richards Merry Bradley, 29 October 1906, Thomas Thompson Trust Records, Sophia Smith Collection, Smith College, Northampton, Mass. (hereafter TTTR). For black hospital schools and training in homes, see Hine, *Black Women in White* (n. 3), pp. 53–61.

15. Alfred Worcester, *Training Schools for Nurses in Small Cities* (Boston: Massachusetts Board of Managers, World's Fair, George H. Ellis, 1893), p. 838, quoted in Reverby, *Ordered to Care* (n. 3), p. 48.

16. Reverby, *Ordered to Care* (n. 3), pp. 95–142; Melosh, *"Physician's Hand"* (n. 3), pp. 22–35.

17. For a discussion of the contradiction posed by nursing as paid, professional work, see Melosh, *"Physician's Hand"* (n. 3), pp. 26–27.

With his central focus on the rescue of poor households from illness, at first Bradley paid little attention to the question of training. Believing that any woman could nurse, he anticipated simply hiring women with little to no training to work under the supervision of the district nurse. The town's first visiting nurse alerted Bradley to the need: "What a blessing it would be to the mothers too ill to care for their homes and children," she suggested in her yearly report, "to have some competent person they could call to relieve them of their responsibility and also give the mothers general care."[18] Recognizing that most families could not afford $3 a day for a private-duty nurse, and rationalizing that much of the help needed did not require her skills anyway, Bradley envisioned a "Household Rescue League."[19] He proposed a system of professional "household help" to support a family of moderate means when the "household machine is broken down by sickness." "Is it a nurse that is always needed?" he asked; "By no means. It is often household help—cooking, washing, chores, care of children, and the numerous other things that have to be done to keep the ordinary household going." With a central telephone office to "bring the needs in touch with the helps" by receiving calls and dispersing both helpers and equipment, the organization could provide the "household assistance" that would enable convalescents to regain their health. "Our mothers, wives, sisters, and daughters," he insisted, "do not want to shirk their duties but want our help in finding out . . . how to make their patients comfortable." Anticipating that he could replace female "customs of mutual helpfulness" with systematized, paid work, Bradley also expected to stem the destruction of the home by providing poor and working-class women more appropriate home employment as a substitute for factory labor.[20]

This plan for neighborhood care was both a response to and an extension of the professionalization of health care. In Bradley's view, hospitals and the "richer families" were monopolizing "the best nursing ability," which "now demands higher pay than the average family can afford"; these services had "killed, or weakened, [the] custom of neighborly help without filling the gap."[21] He envisioned improving the efficiency of the health-care system by not "wasting the powers of the trained nurse on things that others can do, nor using the unskilled women to do work that demands the nurse's training, education and pay"; he specifically

18. *BMAA Annual Report 1932,* p. 9.

19. Richards Merry Bradley to Amy Aldis Bradley, 14 November 1906, box 19, fl. 376, Bradley Family Papers, Schlesinger Library, Radcliffe College, Cambridge, Mass.

20. *BMAA Annual Report 1908,* pp. 2–3.

21. Ibid., pp. 1–2.

labeled these workers "helpers, not nurses, to distinguish them from the graduate nurses."[22] In Bradley's estimation, the BMAA would simply organize domestic labor to meet medical emergencies, not downgrade nurses, whom he valued highly. Ironically, this proposed level of female care stemmed partly from nursing leaders' success in distancing the profession from housework, even as it rejuvenated the link between nursing and female duty.

To ensure community support and circumvent physicians' control over the organization, Bradley enlisted benevolent women in Brattleboro to organize the service. At odds with local physicians whose fees appeared to drain the Thompson fund, Bradley believed that middle-class women, many of whom were already assisting poor families with in-kind aid, could establish appropriate care. Delighted with the plan, they envisioned the future association as the "center of a wide field of helpfulness."[23] Organized in March 1907, the BMAA board of approximately twenty-seven women represented the town's various Protestant denominations and the Irish Catholic church.[24] Leaders Mary Cabot, who also led the local Daughters of the American Revolution, and widow Florence Tyler, who began operating the referral service using the telephone in her home, spearheaded the association until 1920. Other board members included wives or widows of Brattleboro's professional and business leaders as well as the kindergarten teacher, visiting nurse, and superintendent of the hospital.[25] Cabot and Tyler worked closely with Bradley, the local Thompson Trust agent Augusta Wells, and trained nurses to set standards for the association and identify clients and helpers, while a volunteer social service committee oversaw the extended needs of poor families.[26] This coalition of elite, middle-class, and professional women provided a solid base of support for developing a community service association.

22. Ibid., pp. 4–5.

23. Brattleboro Mutual Aid Association Minute Book, March 1907–December 1910, entry for 24 May 1907, TTTR.

24. *The Brattleboro Mutual Aid Association, 1907–1982: The First Seventy-Five Years of Community Service* [Brattleboro, Vt.: The Association, 1982], p. 9.

25. For Tyler and Cabot, see Cabot, *Annals of Brattleboro,* vol. 2 (n. 11), pp. 925, 940. The breakdown of members in 1920, excluding Cabot and Tyler, was as follows: wives of professionals, 8; manufacturers, 3; storeowners/managers, 3; clerks, 5; female professionals, 6. See *BMAA Annual Report 1920*; *Brattleboro Directory Including Dummerston, Guilford, Marlboro, Newfane, Putney and Vernon, Vt., and Hinsdale, N.H. 1914* (Springfield, Mass.: H. A. Manning, 1914); ibid, 1920. Physicians' wives were conspicuously absent, perhaps because tension developed between the BMAA and physicians over nurse practice.

26. BMAA Minute Book, 1907–10 (n. 23); *BMAA Annual Report,* 1909–20.

Initially a poverty program, the BMAA addressed a perceived breakdown in household management due to women's ill health. By substituting supervised care for direct aid, the organization supplied what was largely domestic service for the poor in the guise of professional nursing care. The association's purpose, to provide "a medium of exchange between those who need help and those who can give help in sickness or in household emergency," coupled a charitable goal with a response that associated illness with the failure of women to fulfill their domestic responsibilities.[27] Fixing the problem involved providing care for both a woman and her home, the kind of care on which many middle-class women prided themselves. Neither Bradley nor the BMAA board members believed that much training was necessary as long as the district nurse provided supervision. Indeed, the BMAA helpers delivered bed linen and food, coupled with cleanliness and orderliness. In a typical case, "One mother was found in bed, with her seven- and nine-year-old girls taking care of her. One attendant bathed the mother, and made her comfortable with clean linen, while one washed the pile of accumulated dishes, and the other swept the floors, and prepared food for the family and for the patient."[28] For members of the BMAA, the transformation of this domestic work into nursing care could potentially upgrade the domestic practices of nurse helpers and patients alike. As one consultant suggested, helpers should set "high standards of efficiency" and do their work "in the best manner, so that in the poorly managed households, they will be able to leave an ideal behind them."[29]

Paralleling other Progressive Era reforms, the BMAA embodied both a nostalgia for the past and an updated system for addressing social problems emerging from a mobile, industrializing society. The goals of the association coupled a moral vision of community cohesiveness, featuring women at its center, with the progressive impulse toward efficiency and centralization. Bradley denied that the association was a substitute for traditional family care or a free service for the community. "We are merely a machine for doing the work and those who wish to have the work done will furnish the fuel to run the machine," BMAA leaders announced; the community would pay for this female "machine," they rationalized, because it also represented "a human expression . . . of the spirit that underlies true neighborly helpfulness."[30] By putting household care "at the disposal of everybody for what he or she can pay" and serving

27. "Constitution and By-Laws," in *BMAA Annual Report 1908,* p. 16.
28. *BMAA Annual Report 1920,* p. 11.
29. BMAA Minute Book, 24 May 1907 (n. 23).
30. *BMAA Annual Report 1909,* pp. 4–5.

as a community resource for other helping institutions in the town, the association could reform local social provision; organizing properly and treating the problem of sickness in a "business way" was Bradley's solution to the paucity of local nursing and its potential high cost.[31] It allowed him to maximize the effectiveness of charitable funds with a health program for everyone, minimize the need for direct aid, and shift the burden of charity onto local people.

From Nurse Helpers to Attendants

Even though the association of all women with care of the sick underlay its mission, the BMAA clearly expressed local class divisions between women who organized the work and those who performed the labor of caring. From the beginning, these differences shaped the development of the BMAA. Despite their proclamations that the service offered a "career of unequaled honor and usefulness," BMAA board members had difficulty finding and keeping nurse helpers.[32] Few of the applicants possessed the domestic skills and virtuous reputations that BMAA leaders required for the work, and the wages were too low and irregular to attract a sufficient pool of workers. As members struggled to define the role and wages of nurse helpers and maintain a standard of service that would meet their household norms, they slowly recognized that applicants needed education for home nursing, which would also clarify their status in the community.

Prospective applicants were screened carefully for good habits in much the same manner that agent Wells scrutinized charity clients, but they often failed to meet BMAA standards. Both in their late twenties with one child each to support, widow Ada Hall worked 268 days and Elsie Paige worked 144 days in 1908; they were more successful than the twenty other helpers who averaged only 29 days each. At $1 a day for normal service and $1.50 for maternity cases, wages barely competed with the more regular pay of approximately $8 weekly at the local garment factory. Graduate nurses, by comparison, could earn as much as $21 a week. Inspired to improve her situation, Hall requested some nurse training that would qualify her for better rates; she subsequently planned to take a short training course at a small hospital.[33] Meanwhile, BMAA

31. *BMAA Annual Report 1908,* p. 5.

32. Ibid., p. 12.

33. BMAA Minute Book, 1907–8 (n. 23); BMAA Secretary's Book, 1907–9, TTTR. Attendants' names and terms of employment are available only for two years. Ada Hall worked 74 days, and Elsie Paige worked 199 days in 1909. For nursing salaries in the northeast, see Reverby, *Ordered to Care* (n. 3), p. 98.

members voiced their concerns about the need for "competent women," the limited resources of potential patients, and the association's reputation. In one maternity case, for example, they criticized the helper who had "fed the mother turnips and other improper food, and fed the baby bananas."[34] As early as February 1908, they considered asking the town's ministers to help solicit the services of "a better class of woman," who presumably could provide the kind of care they sought without training.[35]

The BMAA members' dilemma resulted from the historical undervaluation of women's work and the persistent confusion between household service and nursing. The low value placed on domestic work prevented the organization from training or paying women for bedside care and domestic help without substantial charitable support. If more training were provided, BMAA members reasoned, attendants would "demand more pay"; despite a consensus that they needed to pay more for helpers because "they will be worth it, and we shall have to give it," the BMAA board members were unable to act.[36] If they raised the price of the service, it would cost as much as the hospital ward ($10 a week) or the services of a second-year nurse-in-training, and would defeat their goal of serving low-income households.[37] Other charitable organizations resolved the dilemma by using student nurses, or—for example, in Charleston, South Carolina—black nurses.[38] But in Brattleboro student nurses from the hospital were under the control of local physicians who referred them to patients.

Indeed, by defining their service as nursing care, the women of the BMAA had challenged local physicians' control over health care in the community. Suspicious of the level of care available from BMAA nurse helpers, some physicians complained about the "reputations" of the helpers, assumed they were ignorant because they came from poor families, and rarely referred patients to the association. Moreover, physicians monopolized the services of the district nurse who also operated out of the hospital, leaving the BMAA short of a trained nurse supervisor. These complaints and the lack of referrals from physicians led BMAA members to consider hiring their own district nurse, but they feared the organization was "not strong enough to conflict with the hospital and the Drs."[39]

34. BMAA Minute Book (n. 23), 8 February 1909.
35. Ibid., 2 February 1908.
36. Ibid., 9 March 1908.
37. For nurses' rates, see *BMAA Annual Report 1908,* p. 18.
38. Buhler-Wilkerson, "Caring in Its 'Proper Place'" (n. 8), p. 16.
39. BMAA Minute Book (n. 23), 12 April 1909; quotation on 12 October 1908.

Rather than succumbing to local physicians' control over nursing, Bradley instituted a training requirement to upgrade the nursing service. In this way, he transformed helpers into trained attendants and began his efforts to establish a second grade of professional nurses. Using Thompson funds, in 1909 he hired nurse Charlotte MacLeod, who had worked closely with Alfred Worcester and served as superintendent of Waltham Training School, to supervise and train a "corps of Nurses, Assistants [attendants], and Helpers," in Brattleboro.[40] The association purchased a headquarters and employed five full-time attendants, who received three months of in-home training before permanent employment. Benefits included housing at $4 to $5.50 a month, a two-week vacation, and salaries progressing from $5 to $12 a week.[41] Part-time helpers remained "women who will go out to wash and clean up"; carefully excluded from critically ill cases, attendants learned household and maternity skills, and "to follow the doctor's orders."[42] Physicians retained a pool of student nurses at the small Brattleboro Memorial Hospital but relinquished control over nursing service outside the hospital in 1911. The following year the BMAA's finances improved as it began providing a district nurse for Metropolitan Life Insurance policyholders, largely working-class families.[43] The number of attendants increased gradually; in 1912 the supervisor reported that "the attendant is better established in her rightful sphere" than ever before, while insisting that she was "not an imitation nurse, and only as we can free her from sham can we add to her position the dignity to which it is entitled."[44] Attrition remained a constant problem, however, largely because a little training still qualified women to enter private-duty nursing. In October 1919 there were sixteen attendants on staff or in training; in the ensuing year, eight left for private nursing.[45]

The difficulty of separating attendants' labor from that of trained nurses and distinguishing it from domestic service persisted because the

40. Quotation from BMAA Minute Book (n. 23), 15 May 1909; see also *BMAA Annual Report 1909,* p. 3; for Macleod, see "Charlotte Macleod," in *American Nursing: A Biographical Dictionary,* vol. 2, ed. Vern L. Bullough, Lilli Sentz, and Alice P. Stein (New York: Garland, 1992), pp. 208–9; Fiske, *First Fifty Years* (n. 13), pp. 71–73.

41. *BMAA Annual Report 1909,* p. 12.

42. BMAA Minute Book (n. 23), 15 May 1909.

43. BMAA Minute Book (n. 23), 13 February 1911; *BMAA Annual Report 1912,* p. 4. Metropolitan Life Insurance began paying for nurse visits in an effort to reduce mortality rates. The plan originated from social reformers Lillian Wald and Lee Frankel, formerly head of United Jewish Charities, whom Metropolitan hired to manage the service. See Hamilton, "Cost of Caring" (n. 5), pp. 420–22.

44. *BMAA Annual Report 1912,* p. 6.

45. *BMAA Annual Report 1920,* p. 7.

connection between sickness and disorderly households formed the foundation of the BMAA. District nurses who supervised attendants maintained a vision of nursing that encompassed household reconstruction—from simply making patients comfortable, "putting the house in order," and cleaning up the children, to demonstrating proper food preparation, locating baby carriages, and finding appropriate work for family members.[46] Attendant nurses provided much of the actual work of caring. Ten attendants worked 1,692 days in 1911, representing 80 percent of BMAA employment.[47] Instructed in "more hygienic ways of living," they were expected to labor "faithfully in the home, leaving it in much better condition than [they] found it."[48] The Household Nursing Association (HNA) of Boston, which Bradley helped organize in 1912, replicated this model, often recruiting poor white women from the countryside in a pattern mirroring the influx of domestic servants into the city. In 1918 the HNA adopted a telling motto appropriate for both associations: "For the care of sickness in the home; for the care of the home in sickness."[49]

Nonetheless, for women who were often just a step away from charity themselves, the BMAA provided specialized training essential for participation in the new marketplace for medical services. In effect, the organization assigned monetary value to traditional female care. In one maternity case, for example, the association provided a district nurse for the confinement, an attendant for three weeks, and a helper for housework for another four weeks, for a total charge of $62.50.[50] This professionalization of women's caring meant that volunteer family and neighborhood assistance, subsidized with charitable funds, became part of the local service economy.[51] For some attendants, the work was clearly a substitute for seeking charity. Attendant Anne Greene, for example, faced a dilemma when her sister fell ill and needed nursing: "I wondered if you could furnish a nurse for my sister, for a little time, til she is better," she wrote the charity agent; "in that way, I could be the one to care for

46. BMAA Minute Book (n. 23), 11 April 1910.

47. *BMAA Annual Report 1911,* p. 13.

48. *BMAA Annual Report 1912,* p. 6; *BMAA Annual Report 1909,* p. 7.

49. Nelson, "Shepard-Gill School" (n. 4), p. 19. For emphasis on domestic skills at the HNA, see ibid., pp. 31, 53–55, 78.

50. *BMAA Annual Report 1909,* p. 6.

51. From 1910 to 1920 the Thompson Trust covered approximately 40 percent of the BMAA's annual expenses, including the salary of the district nurse, housing, and care for Thompson beneficiaries. See Eaves, *Legacy* (n. 11), p. 57; *BMAA Annual Report,* 1910–20. Charitable support for Boston's HNA is described in Nelson, "Shepard-Gill School" (n. 4), pp. 11–24.

her, and also, by so doing—avoid asking for aid for my-self."[52] By paying Greene, the trust supported her living expenses and the operation of the BMAA while providing the care her sister needed; Bradley was willing to pay for this family service, even for Irish Catholics whose lifestyles he often scorned, whereas he was reluctant to support direct aid for either woman. Aid in the form of nursing care for poor women reinstalled the mutual obligations that Bradley valued, not only among family members but also between the charity and its clients, and supported the female economy as well.

As the BMAA served an increasing number of maternity cases, attendants' work became more specialized and to some degree more highly regarded. Between 1912 and 1920 nurse attendants increasingly replaced the informal nurse watchers who assisted local women during childbearing. Reflecting the national trend to medicalize childbirth and to regulate or eliminate midwives, local physicians recommended that new mothers needed "a graduate visiting nurse, especially trained for maternity work"; BMAA members agreed, adding that a helper should "come at the time of the confinement and remain in the house."[53] With the counsel of physicians, BMAA leaders warned that "great dangers are run from unskilled work" and advised calling a nurse "in every maternity case" to avoid "needless risk."[54] Bradley expanded his focus to maternity care as well on the advice of his friend Elizabeth Lowell Putnam, who chaired the Milk and Infant Social Services Committee of the Women's Municipal League of Boston.[55] Subsequently, visiting nurses from the Boston area, who specialized in maternity services for poor families as part of the preventive health movement, trained Brattleboro attendants in the needs of expectant mothers and the care of babies.[56]

This specialization helped classify attendants as nurses providing health care, rather than as adjunct social workers in poor homes. BMAA maternity cases grew steadily from 21% of calls in 1910 to 61% in 1920,

52. Anne Greene to Sophia Stedman, #1927, Case Records, TTTR. (I have used pseudonyms for charity cases.)

53. *BMAA Annual Report 1909,* p. 6.

54. Ibid.

55. For Bradley's relationship with Putnam, see Richards Merry Bradley to Elizabeth Lowell Putnam, 3 and 16 December 1909, box 5, fl. 71, Elizabeth Lowell Putnam Papers, Schlesinger Library, Radcliffe College, Cambridge, Mass. For Putnam's work in Boston, see Sonya Michel and Robyn Rosen, "The Paradox of Maternalism: Elizabeth Lowell Putnam and the American Welfare State," *Gender Hist.,* 1992, *4:* 364–86.

56. BMAA Minute Book (n. 23), 15 May 1909. For maternity nurses, see, for example, Meckel, *Save the Babies* (n. 6), chaps. 4–6; Alisa Klaus, *Every Child a Lion: The Origins of Maternal and Infant Health Policy in the United States and France, 1890–1920* (Ithaca: Cornell University Press, 1993), pp. 70–78; Buhler-Wilkerson, *False Dawn* (n. 8), pp. 103–10.

representing 78% of the town's births; meanwhile, "emergency housework" decreased from 25% of 737 calls in 1912 to 2% of calls in 1920.[57] With a similar maternity focus, Boston's HNA offered comprehensive maternity care at $30 per case. In this way, trained attendant nurses helped maintain childbirth in the home for a brief time, even as specialization in the medical profession, hospital expansion, and efforts to reduce infant and maternal death rates slowly discredited the practice of home birthing and the use of midwives. In 1924 the BMAA opened a small maternity care facility for childbearing women, which became an interim step on the pathway to hospital births.[58]

By that time the shift to maternity care had garnered support for the BMAA from a broad sector of the community, including its physicians. Serving many more families than the poor as defined by charitable tradition, the BMAA helped erode the stigma of charity for its clients, in Bradley's estimation. For the organization's leaders, supplying nursing care that would improve the health of women and babies provided a pathway to community service and a means of elevating the importance of domestic skills and maternal values as a source of civic improvement. The trained nurses and attendants who provided this help and education not only gained specialized employment, but also fulfilled a role supported by community leaders and enhanced by contemporary gender norms. As for the wary physicians, Bradley kept them at bay by not challenging their local leadership in the hospital, separating the BMAA function from physicians' practice, and championing the role and status of the fully trained nurse who supervised treatment. Originating partly to counter local physicians' control over nursing in the community, the BMAA eventually enhanced physicians' status. They welcomed the supervisor's instructions that nurses, attendants, and patients "follow the doctor's orders." Indeed, as attendant nursing evolved, physicians generally championed the development as a means to reduce the cost of nursing care.[59]

57. *BMAA Annual Report,* 1910–20.

58. *Brattleboro Mutual Aid Association, 1907–1982* (n. 24), pp. 13–14. For the HNA, see Nelson, "Shepard-Gill School" (n. 4), p. 12. For the transition from home birth to the hospital and the attempt to discredit midwives, see Judith Walzer Leavitt, *Brought to Bed: Childbearing in America, 1750 to 1950* (New York: Oxford University Press, 1986), pp. 171–95; Meckel, *Save the Babies* (n. 6), pp. 172–77; Frances E. Kobrin, "The American Midwife Controversy: A Crisis of Professionalization," in *Women and Health in America: Historical Readings,* ed. Judith Walzer Leavitt (Madison: University of Wisconsin Press, 1984), pp. 318–26.

59. Quotation from BMAA Minute Book (n. 23), 15 May 1909. For physicians' attitudes, see Reverby, *Ordered to Care* (n. 3), pp. 130–31, 163.

To say that the BMAA gained local support is not to imply that the organization adequately addressed the needs of poor women, whom it was originally designed to serve. The association increasingly drained funds from the Thompson Trust that might otherwise assist poor women directly and placed them under the direction of middle-class women. Although the service was available both to welfare cases (subsidized by the trust) and to those who could afford to pay, by the end of the decade the latter appeared to take more advantage of it. As one seamstress complained in 1919, "the Mutual Aid Society really helps the wealthy to get help."[60] A number of wage-earning women continued to prefer relatives for help during illness. Even as it capitalized on illness as a means of gaining middle-class support and unifying the community, the association clearly differentiated those who distributed knowledge about good health practices from those who needed help in household management. Coupling domesticity and science, BMAA members widened their social distance from poor patients, who solicited help from a rational, structured system with hired experts rather than an individual friend, fellow church member, or patron. Although unintended, Bradley's organization of female helpfulness had fallen short of its goals and reinforced the divisions between the town's poor and middle-class women.

Moreover, the development of a grade of nursing attendants created a new category of low-paid female work that would eventually divide the profession along class lines. BMAA board members discovered that helpers needed training, but they could not afford to educate them to the level of graduate nurses and still provide care for poor clients. Meanwhile, attendants' participation in training and the specialization of nursing did not increase the value of their work sufficiently. Earning between $7 and $12 weekly, attendants barely commanded a living wage and occupied the lowest level of the medical hierarchy under the graduate nurse.[61] Tension between highly educated supervising nurses and working-class attendants surfaced periodically. In 1913, for example, the supervisor expressed frustration at the rate of attrition and illness among attendants: "A large percent of these women come to us after the habits of life are formed, and it is not always easy for them to adjust themselves

60. *Boston Daily Globe,* 9 August 1919, Thompson Trust Scrapbook, Local History Collection, Brooks Memorial Library, Brattleboro, Vt. For nursing care of working women, see Eaves, *Legacy* (n. 11), pp. 104–7. In 1920, calls for the district nurse, which represented about a third of BMAA service, were largely covered by paying patients (54 percent) and Metropolitan policyholders (32 percent); nonpaying clients represented only 10 percent of her patients. Attendants' service for paying versus nonpaying patients is unclear. See *BMAA Annual Report 1920,* pp. 8–9.

61. BMAA Minute Book (n. 23), 14 June 1909; *BMAA Annual Report 1909,* pp. 12, 22.

to new methods and new environment," she noted.[62] The low pay and minimal training of attendants limited their self-sufficiency even as they threatened the precarious status of the fully trained nurse. A year earlier, the BMAA superintendent had been more sanguine about the future of "our attendants," whom she noted were "not displacing the graduate nurses" but finding their "proper place in the community."[63] Her defense of the new grade only camouflaged her underlying concern as attendant nursing created dissension in the profession.

The Attendant Nurse and Standardized Training

Among national nursing leaders, the apparent success of the BMAA model of organization represented a danger to the campaign to elevate nursing both as an art and as a profession. To those who sought to limit the profession to graduates of qualified training schools, the specter of a two-tiered system among visiting nurses, particularly those trained in the household, opened the door to the registration of lower-class, poorly trained women; it would dilute their efforts to upgrade the word "nurse," flood the market, and fill hospitals with cheap labor. In the ensuing confrontation between leading nurse professionals and advocates of grading, the battle over who would control hospital labor often overshadowed the needs of the sick poor in their homes, despite Bradley's efforts to highlight this concern.

In 1910 the BMAA caught the attention of the American Hospital Association (AHA), probably because its vice president, Charlotte Aikens, sought solutions for standardizing nursing while also accommodating hospitals' needs for inexpensive labor. As founder and promoter of a model nursing organization employing a lower grade of nurses, Bradley was invited to participate in Aikens's effort to examine training schools and to classify nurses according to training and skill levels.[64] Between 1909 and 1916, the association issued a series of reports recommending a clear classification system that would recognize the level of nursing care that Bradley had initiated in Brattleboro, and that also appeared in other locations under the auspices of the YWCA and other voluntary health institutions. The AHA recommended that large hospitals and their affiliates continue to train nurses in a two-year program, and that smaller, unaffiliated hospitals train attendants in a shorter program. Leaders in

62. *BMAA Annual Report 1913,* p. 6.

63. *BMAA Annual Report 1912,* p. 4. For the grading problem, see Reverby, *Ordered to Care* (n. 3), pp. 98, 109–10, chap 7.

64. *BMAA Annual Report 1910,* pp. 26–28.

the American Nursing Association viewed these reports as a threat to their own strategy to improve the profession.[65] They were particularly dismayed in 1912 when former charity leader Lee Frankel, then head of the widely used Metropolitan Life Insurance nursing service, suggested employing attendant nurses for the company's chronic cases as a means to make the service more efficient.

Frankel's proposal for two nursing grades challenged the status and wages of visiting nurses, who were particularly vulnerable to the demand for a less-well-trained and lower-paid nurse to serve poor urban populations. Edna Foley (superintendent of the Chicago Visiting Nurse Association) and others attacked the idea in the pages of the *American Journal of Nursing*, claiming that "women, unskilled and but little trained, [would] usurp the nurses' duties in the homes of the chronically ill"[66]; bemoaning that "the poor are at the mercy of too many half-trained and counterfeit workers as it is," Foley exhorted the visiting nurse associations to "maintain the integrity of our calling by offering their best alike to the acute and the chronic sick."[67] Others argued that training attendants represented a commercial rip-off perpetrated by upstart schools, and that most visiting nurses who used attendants were unhappy with their service.[68] Yet, some nurses committed to the social service aspect of nursing supported the plan because of the enormous need among urban populations relative to the number of nurses in the public health field.[69] In the wake of this controversy, a group of visiting nurses organized the National Organization of Public Health Nurses (NOPHN) to protect their professional status. Frankel eventually abandoned his proposal, but the controversy simmered unresolved for several years. The AHA's final report circumvented the grading issue by excluding any woman without hospital training from the profession.[70]

For such charity leaders as Bradley, the issue of nurse grading shrank in importance next to the need for care and disease prevention for the poor. This concern continued to fuel the demand for attendant nurses

65. Reverby, *Ordered to Care* (n. 3), pp. 140–42.

66. Edna L. Foley, "Concerning the Employing of Practical Nurses by Visiting Nurse Associations," *Amer. J. Nursing,* 1912, *12:* 328–30, quotation on p. 329. See also Hamilton, "Cost of Caring" (n. 5), p. 424; Buhler-Wilkerson, *False Dawn* (n. 8), pp. 68–70, 134.

67. Foley, "Concerning the Employing of Practical Nurses" (n. 66), p. 330.

68. Grace E. Allison, "Shall Attendants Be Trained and Registered?" *Amer. J. Nursing,* 1912, *12:* 928–34.

69. Anna M. McGee, "The Opportunities and Need of Nurses Trained for Social Service in Small Cities," *Amer. J. Nursing,* 1912, *12:* 295–300.

70. Buhler-Wilkerson, *False Dawn* (n. 8), p. 134–48; Reverby, *Ordered to Care* (n. 3), p. 141.

before World War I. Driven by a belief in civic improvement, the fear of infectious disease, and a desire to eliminate dependence on charity, Bradley became, according to Dorothy Deming, the "great proponent" and "irrepressible protagonist for practical nurses."[71] In 1912 he launched a new phase of his program to systematize home nursing on a national basis, and this time he found allies among a group of socially concerned physicians. In cooperation with Frederic Washburn, who had served on the American Hospital Committee on grading, and Richard C. Cabot, both of Massachusetts General Hospital, Bradley proposed a Bureau for Organizing Home Care for the Sick in the United States and Canada. These physicians were largely concerned about the lack of adequate care for families of "moderate means" who could no longer afford a nurse but who resisted the stigma associated with custodial care in the hospital ward. Members of the Women's Municipal League of Boston—who included Bradley's wife, Amy Aldis, and his close friend Elizabeth Lowell Putnam—assumed leadership locally and organized the Household Nursing Association of Boston based on the BMAA model.[72] The following year, Bradley used Thompson money to fund a demonstration project to train and house attendants for the Detroit Visiting Nurse Association; in 1915 the Cleveland Visiting Nurse Association adopted a similar model.[73]

Bradley bolstered his case for affordable home nursing by appealing both to women's role in restoring households and to the importance of family life. Against the protests of nursing leaders, in 1915 he argued that there were "vital needs" not served by the hospital or visiting nurse.[74] As a product of the hospital, the trained nurse, he insisted, was too specialized and often ignored "the household and family side of the patient's problem"[75]; "no true woman," he explained, "could be made comfortable if her household were going to pieces."[76] With moralistic overtones, he explained that providing affordable care for families of moderate means would elevate women's self-respect and help rid them of dependence upon charity. "The work that keeps the family together," he insisted, "is

71. Deming, *Practical Nurse* (n. 4), p. 48.

72. Nelson, "Shepard-Gill School" (n. 4), pp. 4–10. For Putnam's conflicted association with progressive reform, see Michel and Rosen, "Paradox of Maternalism" (n. 55), pp. 366–82.

73. Leona B. Stroup, "Home Nursing Aides: A Community Project in Detroit, Michigan, for the Training, Placing and Supervision of Subsidiary Workers in Homes," *Amer. J. Nursing,* 1940, *40:* 255–60; Blanche Swainhardt, "Organized Neighborhood Nursing," *Pub. Health Nursing Quart.,* 1917, *9:* 8–18.

74. Richards Merry Bradley, "Household Nursing in Relation to Other Similar Work," *Amer. J. Nursing,* 1915, *15:* 968–75; quotation on p. 970.

75. Ibid., p. 971.

76. Ibid., p. 970.

worth far more than that which tried to do something for the broken fragments when they are reduced to seek charitable aid."[77] Despite his inability to grasp the nursing leaders' point of view, to his credit, Bradley closed with a prophetic warning: "I ask that you open your minds and hearts to the practical nurse and to her problem which is also your problem."[78]

By 1917 nursing leaders would recognize that Bradley was right. Increased demand for nurses during World War I, and the patriotism of women who volunteered to nurse for the war effort, drove a spike into their best-laid plans for protecting the professional nurse. Two issues were at stake: how to recruit enough nurses without employing untrained women, and how to provide for civilian care when local nurses went overseas. Fearing that the BMAA would fail during the shortage, Bradley immediately became involved in recruitment as a member of the Massachusetts Committee on Nurse Assistants—a subcommittee of Massachusetts Public Safety, which handled shortages during the war. In this capacity, he persistently lobbied Jane Delano (head of Red Cross nursing) and other officials to recruit nurse assistants and allow local Red Cross units to serve the working population during the nurse shortage. Delano, who recognized the need for more nurses but also hoped to control and manage their training, frustrated Bradley with noncommittal responses until she eventually argued for recruiting volunteer aides. Nursing leaders temporarily stalled this program until the postwar flu epidemic of 1918.[79] Threatening national Red Cross officials to "get hold of sufficient women to take care of the sick" in this crisis, Bradley warned that it was their "last chance to make good for the civic population."[80] As the shortage of nurses became acute, the AHA recommended the recruitment of "hospital helpers" to ease the crisis.[81]

The vital need for nurses during the war and the flu epidemic bolstered the outlook for practical-nurse training nationwide. In 1917 Bradley established the Thompson School for Nurse Attendants in Brattleboro, and another in Lynn, Massachusetts; the HNA of Boston opened its school of attendant nursing in April 1918. Although the Lynn school was

77. Ibid., p. 973.

78. Ibid., p. 975.

79. Richards Merry Bradley, "The Shortage of Nurses," 1 May 1918; Bradley to Jane Delano, 8 May 1918; Bradley to Mr. Jackson, 22 June 1918, all in TTTR. Delano also resisted pressure from African-American nurses who sought entry into the Red Cross and war service: see Hine, *Black Women in White* (n. 3), pp. 102–4.

80. Bradley to Elizabeth G. Fox, Dept. of Nursing, American Red Cross, 27 November 1919, TTTR.

81. Reverby, *Ordered to Care* (n. 3), pp. 160–64, quotation on p. 161.

short-lived, the HNA persisted until the mid-1980s; the Brattleboro school, which formalized a three-part, six-month training, operates today. After the war, the international experience resulted in diverse schemes to train "hospital helpers," "sub-nurses," and college women.[82] To accommodate these proposals, the NOPHN endorsed the training of attendants. By 1923 the acclaimed Goldmark Report provided substantial support for "a subsidiary grade of nursing service," despite the objections of nursing leader Adelaide Nutting.[83] Written by the social reformer Josephine Goldmark for the Rockefeller Foundation, the report recognized the "practical nurse" or "trained attendant" as "an existing fact"; recommended a defined training course of eight to nine months; and, much to Bradley's satisfaction, confirmed the quality of training at the Thompson School. Careful to separate the grades of nursing based on patient needs rather than economics, Goldmark insisted that the "partially trained worker" attend only mild and chronic illness and convalescence.[84] Despite this clear support and growing numbers of employed attendants, the grading issue remained unresolved among nurses.

The persistence of the BMAA and HNA and their respective training schools did not herald the acceptance of practical nursing within the profession. Nursing leaders continued to debate the issue of standardized training and certification of nursing schools during the 1920s and 1930s. By that time the oversupply of highly trained nurses, the growth of hospital care, and the effects of the Depression, which heightened the demand for low-cost female workers, shaped the enduring debate over nursing grades. The BMAA and a nursing insurance plan in Brattleboro continued to provide a model of preventive community health care for reformers. Nonetheless, in 1932 the Committee on the Cost of Medical Care sounded a note of warning about the Brattleboro service: fearing that attendants would overstep their roles as caregivers for cases "beyond [their] capacity or training" and charge too much, the committee recommended strict supervision and licensing as a means to control the practice.[85] Four years later, the national nursing associations finally acquiesced to

82. Ibid., pp. 161, 163.

83. Ibid., p. 165. For the NOPHN, see Buhler-Wilkerson, *False Dawn* (n. 8), pp. 168–69.

84. Committee for the Study of Nursing Education, *Nursing and Nursing Education in the United States* (New York: Macmillan, 1923; repr. New York: Garland, 1984), p. 15. See also Reverby, *Ordered to Care* (n. 3), pp. 165–66.

85. Allon Peebles and Valeria D. McDermott, *Nursing Services and Insurance for Medical Care in Brattleboro, Vermont: A Study of the Activities of the Thomas Thompson Trust, with an Evaluation of the Nursing Program* (Chicago: University of Chicago Press, 1932), quotation on p. 42; see also pp. 41–45, 63–65. Bradley initiated the Thompson Benefit Association for Nursing Service in Brattleboro in 1926.

licensing as well, largely as a means to fulfill hospital staffing demands without compromising the education of student nurses.[86]

Conclusion

The story of the BMAA adds another dimension to the professionalization of nursing by revealing the influence of charity reformers on its evolution. They identified ill health as a social problem and lesser-trained nursing women as a solution to the need for low-cost care for the poor. Despite Bradley's attention to ill health and his respect for the value of nursing, his continued desire to reduce direct aid and channel low-income women into nursing care proved less than satisfactory for charity clients. More important, class differences between Brattleboro's benevolent women and nurse helpers dictated the need for training of the latter in acceptable health and domestic practices, but without elevating them to the status of graduate nurses whom their patients could not afford. This minimal training may have been even more necessary to differentiate nurses in this nearly all-white community where race was not a salient factor in defining nursing status.[87] The work appeared attractive to potential attendants because there were few other options in small towns like Brattleboro, and it allowed them to utilize female values and skills. Despite this appeal and the benevolent intentions of its founders, the BMAA also replicated the prevailing gender and class division of labor, helping to initiate another grade of low-wage female work.

Ironically, both Bradley and the nursing leaders who contested the two-tiered system retained a belief in the moral underpinnings of nursing as a female occupation even as they promoted rationalization of the profession in different directions. The status of the attendant nurse became a battleground between those who sought to transform charity and those who sought to elevate professional nursing standards. To some extent, it was the leadership's success in achieving professional status for the trained nurse by the 1910s that precluded the possibility of using untrained women for any sort of health care. But nursing leaders were unable to present an affordable alternative to the use of either student nurses or attendants for care in poor homes. Separate training for attendants emerged in Brattleboro partly because Bradley lacked access to the student nurses used elsewhere for similar work. For Bradley and

86. Licensing, which had already begun in some states, was only a step in the direction of full recognition, which took another decade. See Reverby, *Ordered to Care* (n. 3), pp. 168–79, 191–98.

87. For a southern example where race defined nursing status, see Buhler-Wilkerson, "Caring in Its 'Proper Place'" (n. 8).

his allies, it was thoroughly reasonable to train and employ relatively poor women to serve other women in need. Family breakdown and public health concerns loomed larger than inadequate female employment. Those physicians who agreed with him envisioned attendant nurses under private medical supervision; attendants could provide low-cost home care without the threat posed by public health nurses, who appeared to represent the expansion of state medicine, or midwives, who were untrained and therefore dangerous in the eyes of many physicians.[88] Despite nursing leaders' admirable goals for nursing education and independence, their priorities and class bias inhibited their ability to sympathize with poor and working-class women who needed work.[89] Few could see the grading issue from the perspective of the attendant nurse, who remained poorly paid and even more mired in domestic duty than her fully trained nursing supervisor.

88. For the relationship between physicians and public health nurses, see Melosh, *"Physician's Hand"* (n. 3), pp. 127–32. For public health reformers and midwives, see Kobrin, "American Midwife Controversy" (n. 58), p. 320.

89. Even leaders who supported the grading of attendants, like Katherine Shepard of the HNA of Boston, demonstrated a patronizing attitude with respect to student attendants. See Nelson, "Shepard-Gill School" (n. 4), pp. 30–31, 43.