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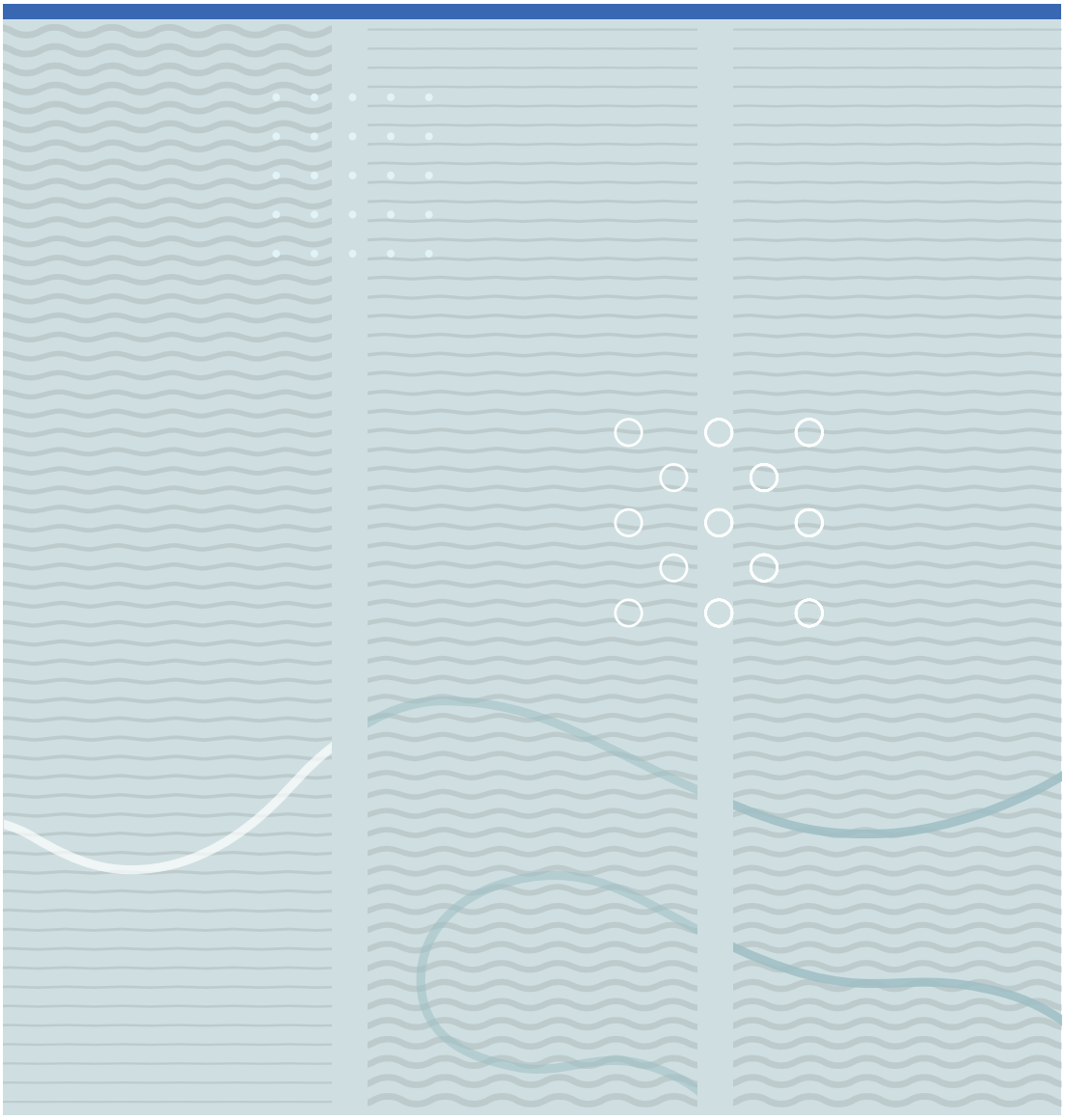
Means or meaningful? – The historical construction of the patient concept in health professions' education



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Means or meaningful? – The historical construction of the patient concept in health professions' education

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To Brynjar, Livia Josefine and Victor Martinius – for your love and support.

No human relation gives one possession in another –

every two souls are absolutely different.

In friendship or in love, the two side by side raise hands together

to find what cannot be reached alone.

Khalil Gibran, The Prophet, 1923

Dedications and acknowledgements

This journey has pushed me to my limits in many directions and in every way possible for me as a person. The support from my closest family, friends and colleagues have been unquestionable. I have learned a lot, about this exciting field of health, medicine and nursing, but also about myself, my stamina, my strengths and weaknesses. This work could never been done without the support from the persons mentioned below.

In my professional life, I would like to thank the Faculty of Health and Social Sciences, especially former Dean Heidi Kapstad who gave me the possibility to conduct a PhD when my current position at the University was no longer available for me. I am grateful that Heidi was brave enough to encourage me to pursue this project. It was not strategic work, but I grasped the opportunity when it came my way.

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A coincidence that has framed this project from the very beginning happened long before I considered taking on a PhD. This was my first meeting with my supervisor Professor Brendan McCormack, who I first met in 2012. This was also my first meeting with the Person-Centred Practice Framework and person-centredness as a conceptual framework within health and nursing. Five years and many meetings later another lucky coincidence made Brendan accept me as one of his PhD-candidates. I will forever be grateful for Brendan’s generosity in his supervision. With great knowledge, he has patiently let me find my own way through a jungle of challenges, new knowledge, frustrations and possibilities. Always supportive and cheering me on. I have been lucky to benefit from his expert understanding of nursing and health care as well as being an experienced supervisor. Brendan’s ability to guide me through reflections and discussions has been impressive and I have always felt wiser after our conversations. In addition, I need to thank Brendan for the laughter and fun we have shared through this journey and the generosity he has shown me beyond what can be expected of a supervisor. What will stay

with me from working with Brendan is the way he authentically has expressed his belief in me and made me grow as a person and as a researcher.

In my team, I have also had the pleasure of having Professor Sigrun Hvalvik as my supervisor. Sigrun came into the project at a point where I was worried about whom to include in my supervisory team. Luckily for me she did not hesitate before deciding to join my work. My discussions with Sigrun have always broadened my perspective and challenged my assumptions. With a high degree of carefulness, Sigrun has gently pushed me forward, supported by huge knowledge and academic experience. I am grateful for all the interesting discussions we have had, the patience that has been shown me and the positive feedback she has provided through the four years we have worked together. The pleasure of having a supervisor that sometimes has been more enthusiastic about the project than I must not be underestimated.

To both my supervisors I owe my sanity and getting to the finish line. I will continue to proclaim that I have had the best supervisory team ever. Thank you both of you.

As part of the PhD programme in Person-centred Health Care, regular seminars have been organized for all PhD candidates. This arena has been a place to discuss, present and test the work before finalizing, whether it has been papers, mid-term evaluation, dissertation or trial lectures. I know it takes effort to plan and conduct such seminars with the high demanding group of persons PhD candidates are. A huge thank you to Professors Kirsti Skovdahl and Line Joranger for the facilitation and creation of a safe space to develop as researchers. Not to forget, all my PhD candidate colleagues who have participated, shared, discussed, challenged, supported and cheered, both at seminars and in every-day life in our PhD bubble. I will especially highlight the writing seminars at Eidene/Tjøme, and the participants at these seminars. I hope they will continue as I regard them priceless for both progression and social support. During the autumn 2020 some of the PhD candidates at the Programme have met once a week for ‘Shut up and Write’ seminars. Thank you to those of you who facilitated and invited to these writing days. They have been most welcome during a challenging work environment due to the ongoing pandemic.

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On a more personal level, I will like to thank my family. I have a large and modern family, because family as a concept today include much more than just a couple of decades ago. This extended family has contributed to shape me into the person I am today. My parents, step-parents, former step-parents, my two sisters and three brothers, in-laws and former

in-laws, you have all contributed in my personal development. Whether you have been close or distant has meant less, you have all been family.

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My husband Brynjar deserves the greatest gratitude of everyone. Doing a PhD is a family matter. You have stood by me through endless hours of frustration, anger, tears, joy, celebrations and depressions. You have been a rock, and at the same time challenged me and pushed me forward, urging me to “hang in there.” Your inclination to never accept an assertion without sufficient argumentation has both frustrated me and taught me how to set up sufficient arguments for my position. Our discussions during my work have been most valuable. Thank you for taking on that challenging role of both being supportive and pushy when needed. In addition, you have managed family life alone in several periods, long and short, and never complained. You own a decent share of this work.

Four years in my soon to be 43 years of lifetime is not that much. Four years in my children’s life however, now fifteen and nine, are a huge amount of time. Dear Livia Josefine and Victor Martinius, thank you for patiently participating in my journey without being asked and without having a choice. Always there to remind me of the most important thing in life, my family, the two of you. Without your laughter, funny remarks, endless questions and warm hugs I would never have managed to finish this work. You truly make me a better person just by being yourself. Love you to the moon and back.

During the last year of this work, a global pandemic caused challenges the world had not faced for over a century. The COVID-19 virus spread across the globe and measures to prevent infection were introduced that have never before been seen in history. Both short and long turn effects of these measures are yet to be examined. There will be a need to analyse and understand how society and people responded to and were influenced by all the different measures that were initiated as well as by the virus itself. Historical knowledge of medicine, health, epidemic diseases, and demographic studies will be necessary, in addition to all the bio-medical approaches that are carried out in the

wake of this in order to grasp the broad understanding of COVID-19 and its effects. It seems to me that it has never been more relevant and necessary to study the history of medicine and health and contribute in a broad interdisciplinary research approach to solve future challenges in medicine and health, locally, nationally and global. I hope to be part of this in the future.

Despite all the support and guidance along the way, only one person can carry the responsibility of the results and presentation of this work. Any flaws or shortages are my responsibility, and mine alone.

Abstract

Means or meaningful? – The historical construction of the patient concept in health professions’ education.

All concepts have an origin. They shape, and are shaped by the context in which they exist. This thesis explores how the construction of the patient concept has been given meaning, changed and developed in the context of education of both doctors and nurses during the period 1880 – 1940. The overall aim was to gain insights into the historical construction of the concept of the patient as part of the education of health professionals, and to use historical knowledge to create an awareness of how the conceptual understanding of the patient has been shaped by reality. Moreover, I intend to gain an understanding of how these conceptual constructions of the patient have contributed to shaping the nature of education provision, through an analysis of the language used.

Two research questions shaped this inquiry: 1) during a period of modernization, what view of the patient is presented in nursing and medical education? 2) In what ways can historical knowledge of the patient as revealed in historical medical and nursing education inform our future healthcare education and practices?

The thesis has a historical methodological approach based on source scrutiny and hermeneutics. The analysis are based on written sources, mainly from a Norwegian context related to the education of nurses and doctors. Use of language as linguistic representations in meaning making in the construction of concepts, constitute significant theoretical perspectives for the historical analysis. The professionalization of the two professions and modernization processes in society as part of 19th and 20th century developments play important roles in this context. In addition, when placing historical knowledge into present use, theory of person-centredness will contribute to frame the discussion and analysis in the thesis.

I argue that the construction of the patient within the two professions was built on different understandings of reality and what constituted knowledge for them as part of

the modernization processes that had impact on the education. I further claim that the patient through history has been strongly connected to diseases and society’s changing response to this as knowledge and education developed. This includes an acknowledgement of the need to include social and cultural understandings in medical and health perspectives.

My findings direct us to draw historical attention to the patient as a fulcrum in medical and nursing education, emphasising the impact and power of education in the construction of patients in the professional understanding of historical reality. In this respect the patient is constructed as a phenomenon in the intersection between bio-medical, social and cultural perspectives, and is strongly connected to the tasks and objectives carried out by the different professions, and in accordance with the challenges they faced during the modernization of society.

Bringing attention to historical and linguistic awareness of the patient as a significant concept in the field of medicine and health is useful in addressing future challenges in both education and practice for healthcare professions. I argue that any person becoming a patient is in danger of losing the power to define themselves and instead can become means in a context beyond themselves. This situation amplifies the potential dehumanizing factors in medicine and health in relation to the patient both as a concept but also in treatment. The solution to this can best be achieved by emphasizing more humanizing aspects in education and in practice in the call for a renewed focus on a holistic approach to the patient. This calls for a re-emphasis on holism in future education policy in all health care professions, as well as awareness in education programs about how they include the patient as a concept and as a person in curricula and litterature.

Key words: history of medicine, history of nursing, history of health, patient, construction, health educations, concept, conceptualization, person, person-centredness, modernization processes, knowledge development, holism, reductionism, dehumanizing, humanizing,

Abstract in Norwegian

Middel eller meningsfull? – Den historiske konstruksjonen av pasient som begrep i fortidens helseprofesjonsutdanninger.

Alle begrep har en opprinnelse. Begrepene både former og blir formet av den konteksten de eksisterer innenfor og inngår i. Denne avhandlingen utforsker hvordan pasient som begrep har blitt gitt mening, utviklet og endret seg innen en utdanningskontekst både for leger og sykepleiere i perioden 1880-1940. Det overordnede målet har vært å få innsikt i den historiske konstruksjonen av begrepet pasient i fortidens helseprofesjonsutdanninger, og bruke den historiske kunnskapen til å skape bevissthet i framtidens profesjonsutdanninger om hvordan språk bidrar til å forme virkeligheten og har blitt formet gjennom ulik forståelse av virkeligheten. I tillegg har jeg ønsket å få en forståelse for hvordan de ulike konstruksjonene av begrepet pasient har bidratt til å forme legers og sykepleieres forståelse av utdanningene gjennom språklige analyser.

To spørsmål ble stilt for å bidra til å forme arbeidet: 1) Hva slags syn på pasienten ble presentert i sykepleie- og medisinutdanningen i en tid med store moderniseringsprosesser? 2) På hvilken måte kan historisk kunnskap om pasienten i medisin- og sykepleieutdanning brukes for å forbedre framtidens helseutdanninger og i praksisutvikling?

Denne avhandlingen har en historisk metodologisk tilnærming basert på kildekritikk. Analysene er basert på skriftlige historiske kilder relatert til sykepleieutdanning og medisinutdanningen i Norge i det aktuelle tidsrommet. Profesjonalisering av de to helseprofesjonene og moderniseringsprosessene som foregikk i samfunnet har vært viktige kontekstuelle rammer for arbeidet. Teori knyttet til bruk av språklige representasjoner og meningsskaping gjennom språket i konstruksjon av begreper utgjør en betydelig del av de teoretiske perspektivene som de historiske analysene knyttes opp til. Når historisk kunnskap brukes til å diskutere framtidens helseutdanninger brukes teori knyttet til personorientering som rammeverk for analysene.

Jeg argumenterer for at konstruksjon av pasient innen de to utdanningene har vært bygd på ulik forståelse av virkeligheten og hva som har utgjort kunnskapsbasen for disse to utdanningene som del av moderniseringen de var gjennom. Videre hevder jeg at historisk har pasienten som begrep vært sterkt knyttet til forståelse av sykdom og samfunnets respons på dette ettersom kunnskap og utdanningene utviklet og endret seg. Dette inkluderer en anerkjennelse av at man også innenfor medisinske og helserelaterte perspektiver må inkludere sosiale og kulturelle forståelser når man skal forstå hvordan begrep har blitt konstruert i ulike kontekster.

Funnene i avhandlingen viser at ved å fokusere på historisk bevissthet knyttet til pasienten som omdreiningspunkt i medisin- og sykepleieutdanningen, understrekes betydningen av makt i utdanningene når det kommer til konstruksjonen av pasienten som begrep i den profesjonelle forståelsen av historisk virkelighet. I forbindelse med dette må vi forstå pasienten som et begrep i skjæringspunktet mellom et biomedisinsk, sosialt og kulturelt fenomen, sterkt knyttet til de oppgavene som ble utført av de ulike profesjonene og i samsvar med de utfordringene de møtte gjennom moderniseringen av samfunnet.

Ved å sette fokus på den historiske og språklige bevisstheten av pasient som et betydningsfullt begrep in fagfeltet medisin og sykepleie, har jeg ønsket å adressere noen nåværende og framtidige utfordringer i både helseutdanninger og praksis innenfor helseprofesjonene. Jeg viser gjennom analysene at enhver person som trer inn i en pasientrolle står i fare for å miste makt til å definere seg selv og videre står i fare for å bli et middel brukt i en hensikt utenfor seg selv. Denne situasjonen forsterkes av de potensielle dehumaniserende faktorene som kan inngå i et medisin- og helseperspektiv basert på en reduksjonistisk tilnærming til pasient. Løsningen på dette kan best bli oppnådd gjennom å vektlegge mer humaniserende aspekter gjennom et fornyet fokus på en holistisk tilnærming til pasienten som begrep. Dette krever en større vektlegging av holisme i framtidens helsepolitiske utdanningsreformer innen alle helseutdanninger i tillegg til bevissthet i utdanningsprogram om hvordan de inkluderer pasient som et begrep brukt i planverk og litteratur.

Regarding translation of sources and Norwegian literature

This is a study conducted in a Norwegian context, based on Norwegian historical sources, while the thesis is written in English. Some choices have been made according to translation of historical sources and Norwegian literature used.

All translations of sources and Norwegian literature used in the thesis are my own. The sources are written originally in a language that can seem unfamiliar to the present reader, where words and linguistic structure are different from how we write today. In the translation process, I have chosen to adapt the language to a bit more modern linguistic structure without changing the content. I have chosen to include the English translation in the text, while the original reference and quote is included in footnotes in [] and has kept its original linguistic structure and use of language. Because of the flow in the text, I have chosen to explain the choices of translation here in the start of the thesis, and further references to quotes in the thesis are performed in accordance with this.

The same choice has been taken regarding the listing of sources used at the end of the thesis. The English translation comes first and the original Norwegian title is put in [].

Abbreviations

Norwegian	English	Abbreviations
Evidensbasert medisin	Evidence Based Medicine	EBM
Det internasjonale rådet for sykepleie	International Council of Nursing	ICN
New Public Management	New Public Management	NPM
Norsk magazine for lægevidenskaben	Norwegian Magazine for the Medical Science	NMfL
Tidsskriftet norsk legeforening	The Journal of the Norwegian Medical Association	TfDnl
Tidsskriftet Praktisk Medicin	The Journal of Practical Medicine	TPM
Medicinsk Revue	Medical Revue	MR
Norsk sykepleieforbund	The Norwegian Nursing Association	NSF
Personorientert rammeverk for praksis	The Person-centred Practice framework	PCP-framework
Verdens helseorganisasjon	World Health Organization	WHO

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1 Introduction

King George III: "I am the King of England"

"Physician: "No sir. You are the patient!"[1]

This short quote from the movie '*The Madness of King George'* marks the end of a dramatic scene, in which the King's therapists have restrained him in a chair. Although remote from our current experience, both the scene and this quote emphasize that in the context of medicine and health, in becoming a patient every person is at risk of losing their personhood and the power to define themselves when placed in the role of patient.

In this context, health professionals possess the knowledge and power that enable them to decide who or what a person is when placed in the role of patient. The patient as a concept can thus be seen as a linguistic construction that defines the transition from being a person in control of his or her own life, to a state in which power is taken from them. During this transition, the power between different actors in the medical and health-oriented paradigm must be seen in conjunction with knowledge, values and ideas that have evolved through time. This transition constitutes part of the relationship between the patient and the health professional, and serves towards shaping the reality in which patients understand themselves and how medical and health professionals construct the concept of a patient, and treat their patients in accordance with their construction. All concepts have an origin and are shaped by history and the context in which they appear and exist. The concept of a patient as the historical conceptual fulcrum in the context of professional health education will be explored throughout this thesis.

[1] The Madness of King George. Movie. 1994. https://www.imdb.com/title/tt0110428/

The Norwegian historian Erling Sandmo has written that almost anyone can read and understand historical research at the highest international level.[2] However, when it comes to medicine and health, the opposite must be said to be the case. Not many people can read research related to medicine, health and nursing at the highest international level without having academic training in these subjects. While history is about what is no longer in the present, most people have had personal encounters and experiences with our healthcare services and have received medical treatment and/or care of some kind during their lifetimes. In this very moment, when we enter the health care sector, even when we receive treatment by professionals at home, we become a patient subject to all the expectations and regulations that the sector entails.

In this becoming of a patient, contemporary society expects us to take active and enlightened decisions in advanced and complex areas, even though most people have neither sufficient knowledge nor the training to do so. However, the expectations we now have of patients as stakeholders in their care have changed through time, and will vary according to context. The patient as a concept is constructed as part of the social, cultural, epistemological and political context that make up the ideologies, values and virtues inherent in our society. As these perspectives change, the construction and meaning of the patient concept will also change. At the same time, historical developments contribute towards shaping present society, and we are all the bearers of history, including when it comes to the content and meaning of concepts, such as our identity and role as a patient in the healthcare sector. This awareness of what has contributed to shape the concept of the patient, and how this concept has been shaped by the context in which it exists, has been prevalent throughout history.

In this study, I have put the concept of the patient in the foreground of historical development. By focusing on the conceptual understanding of the patient, and how this contributes to a construction of reality, I lean on the hermeneutic tradition that it is

[2] Erling Sandmo, *Tid for historie. En bok om historiske spørsmål* (Oslo: Universitetsforlaget, 2015), 46.

through language that meaning and understanding occur, and that this is part of the interpretational process.[3] By focusing on the patient and bringing this concept into sharper focus, it has been necessary to bridge the gaps that exist between the different horizons, according to Gadamer. This applies both between the past and the present, and between the various stakeholders (the patient and the health professionals). In accordance with the hermeneutic understanding of different perspectives and an awareness of the horizon between the present and the past[4], I will argue for the importance of ushering the concept of the patient to the foreground in understanding of historical developments in medicine and nursing, and the professionalization of the healthcare service. This can be viewed at different levels of knowledge development by means of research and formation in education.

In research, when the patient is brought to the foreground, there is awareness of his or her status in the hermeneutic conversation with historical texts.[5] This awareness enables us to direct a specific focus on bridging the gap between perspectives held in both the past and present and the horizons between the different actors.[6] In education and practice, placing the patient in the foreground enables empowerment, holism and equity to serve as values that guide treatment and care, because a greater awareness of bridging the gaps in perspectives created by the horizon between the past and the present. This can contribute to a greater degree of understanding.

My work in linking the historical view of and knowledge about, the patient with a view to contemporary and future challenges in health education and practice has encouraged me to turn to some of the basic historical research questions so well articulated by Sandmo;

[3] Hans-Georg Gadamer, *Truth and Method*, trans. Joel Weinsheimer and Donald G. Marshall (London: Bloomsbury, 1960), 407.

[4] Ibid., 313-17.

[5] Ibid., 406-07.

[6] Ibid., 316.

"*Why is the past so important? and what contributions can be made by our knowledge of history?"*[7] I do not expect to find the ultimate answers to these questions, since I do not believe that this is possible. However, I will claim that our continuing to ask and discuss such questions will contribute to the relevance of historical knowledge, also in medicine, nursing and the healthcare sector.

1.1 Aim and research questions

Working on this project has constantly made me aware of the complexity of health care, both as a practical and academic discipline. The patient is the most vulnerable person concerning relationships within the healthcare sector. In a Norwegian healthcare service based primarily on biomedicine, Evidence Based Medicine (EBM), reductionism and New Public Management (NPM), viewing the patient as a holistic person is one of the major challenges. Allowing the patient to be the centre of focus in my analysis enables me to discuss how the construction of the patient concept has influenced and contributed to our views of the sick person throughout history, and to contribute some reflections on how this has affected our attitudes to the concept in contemporary health education and health practice. However, a further question emerges; where do healthcare workers learn and exercise their views about patients? The most obvious approach to finding an answer was to look at the education system, and the language used in education, as the place where training and knowledge foster and preserve values, ideas and virtues linked to the dominant paradigms in the different professions. The epistemological foundations underpinning the various professions are subject to continuous development and refinement as our knowledge develops through education and research. Doctors and nurses are closely linked historically in their professional development, which includes safeguarding different aspects of the tasks that constitute most of their relations with their patients. It is thus important to consider both professions when it comes to a historical analysis of the patient concept.

[7] Sandmo, 47.

Moreover, a historical focus on the patient as a stakeholder in healthcare education may contribute to obtaining more knowledge about the possible existence of a distinction between a sick person and the patient as a concept as viewed from an educational standpoint. This confers a bipartite aspect to this project in more ways than one. The first of my research questions is deeply rooted in historical research and understanding, while the other places historical understanding in an interdisciplinary perspective and tradition, with the aim of making historical knowledge relevant to present and future healthcare education, both theoretically and in practice.

I ended up with the following aim for my project:

To gain insights into the historical construction of the concept of the patient as part of the education of health professionals, and to use historical knowledge to create an awareness of how the conceptual understanding of the patient has been shaped by reality.

Moreover, I intend to gain an understanding of how these conceptual constructions of the patient have contributed to shaping the nature of education provision, through an analysis of the language used.

My overall aim has been operationalized by looking into the following essential questions derived from the aim itself:

1. During a period of modernization, what view of the patient is presented in nursing and medical education?
2. In what ways can historical knowledge of the patient as revealed in historical medical and nursing education inform our future healthcare education and practices?

The first research question has been explored tentatively and separately by making in-depth historical studies of both medical and nursing education, based on their own conditions and terms in the time of investigation. Such an exploration, with the aim of

adding knowledge within the specific context of the history of medicine and health, has an intrinsic value in itself, and will be used in discussions relating to the second question.

The second question is explored on the basis of knowledge derived from a study of the first question, and will be used in a discussion that emphasizes a broader perspective and the relevance of historical knowledge in informing our approach to future challenges in healthcare education. Together, these two research questions will help me to fulfil the aim of the study.

1.2 Relevance of the project

No man is an Island entire of itself; every man is a piece of the continent, a part of the main.

John Donne[8]

To me, this short quote from John Donne expresses an understanding that every person is an important part of society; that together we create the society we live in through the relationships that connect us; and that we are dependent on one another in a context that is beyond ourselves. This becomes even more relevant to anyone assuming the role of patient, because patients depend on help from professionals in their healing process. At the same time, without patients there would be no need for healthcare professionals.

A person who is sick and in need of care is in the most vulnerable state that he or she will experience in their lifetime. Sick persons are more dependent than others on someone to take care of them – to heal and try to cure them. Today, when receiving attention from the healthcare services, a sick person is recognised as a patient with specific needs and rights in accordance with prevailing legislation. The healthcare setting that the patient enters is already defined and organised in accordance with well-established norms. Legislation, regulations, concepts, institutions and treatments are concepts that currently

[8] John Donne. Mediation XVIII, Devotions upon Emergent Occasions, 1624

make up a huge part of the healthcare services and constitute an understanding that has developed throughout history. This development has taken different paths in different countries and within different cultures. In order to understand the contemporary view and role of the patient in the Norwegian healthcare context, we need to look into the evolution of the Norwegian narrative as it relates to medicine and health, and the place of the patient in this evolution.

Becoming a patient confers a wide range of pre-defined understandings involving fixed concepts, organizations, professions and a variety of healers, which have been shaped and developed as social and cultural phenomena and constructs both in and of the past. This study will focus on how the concept of the patient has evolved in its construction during history in different contexts and within the different healthcare professions. Hopefully, it will provide a better understanding of how important it is to pay attention to the role of patient as is imposed on every person admitted to the healthcare arena. The study will also look into how the language used contributes to the construction of the patient concept, and how this construction affects our treatment of the sick. The formative role played by education in this construction constitutes my point of departure in this work.

Historical awareness of this can thus be viewed as a contribution in support of the assertion expressed by Jerome Kagan that different sciences use different concepts to explain the same events.[9] Kagan argues that what he calls the three cultures, natural science, social science and the humanities,[10] speak three different languages. These different languages, Kagan says, impose distinct meanings on important concepts derived from their respective academic traditions, and that they compete with each other to

[9] Jerome Kagan, *The Three Cultures Natural Sciences, Social Sciences, and Humanities in the 21st Century* (USA: Cambridge University Press, 2009). p 11

[10] Kagan here builds upon the concept *"the two cultures"* introduced by C.P. Snow in 1959. C.P. Snow, *The Two Cultures* (Cambridge University Press, 2012). With this concept, Snow started a debate in academia based on what he saw as a huge gap between natural scientists and humanists.

dominate the academic paradigm.[11] Since the start of early modernization processes, concepts used within medicine and health have been dominated primarily by a reductionist view and approach, and in particular after natural science assumed dominance in this field, also linguistic. Within this tradition, concepts such as the patient, treatment, cure and care are based on a biomedical understanding. As part of this understanding, and in accordance with Kagan's argument, concepts such as *truth, coherence, validity, significance* and *statistics* contain specific meanings that derive from a specific point of view, and a specific epistemological point of departure, derived from natural science.[12]

Kagan argues that there is a need to close the gap between natural science and the humanities in order to develop an understanding of the complexity revealed in health-related issues. By employing perspectives and concepts derived from history and the humanities, this project may contribute towards broadening our understanding of how the concept of the patient was viewed and constructed in the past, using historical concepts and historical methods.[13] This approach is not intended to replace the biomedical approach employed in the health arena, since biomedicine has contributed to development of sufficient and important knowledge in the field. However, a humanist approach that focuses on history and language is intended to create an awareness that a broad perspective is needed in order to increase our understanding of a complex research area, in line with Kagan's argument, and to help us acknowledge the role of social and cultural approaches in establishing an understanding between different paradigms.

This way of thinking is not new. Professor in medicine Owsei Temkin has previously raised the idea as early as in 1946. Temkin in turn referred to several of his former colleagues

[11] Kagan, 6.

[12] Ibid., 40-42.

[13] Ibid. p 13

who had supported his view on the importance of educating medical students in the history of medicine.[14] One of these was Theodor Puschmann. When Temkin referred to Puschmann, it was to emphasize that he recognised a development in medicine whereby history was decreasing in importance as a subject, and that this was a step in the wrong direction. Temkin argued that the way in which Puschmann regarded the importance of history to those studying medicine was still relevant. Puschmann argued that history is complementary to medical students’ general education, in that it shapes the foundations on which professional knowledge rests. He also argued that the history of medicine strengthens their education and refines their character.[15] A discussion on the effect of moving away from humanities’ subjects in health care education is highly relevant, but also complex. In Chapter 8, I will introduce this discussion as part of a focus on the factors that may contribute to the humanization of the patient construction in future healthcare education.

Nursing historian Sioban Nelson has similarly argued in support of the importance of investigating the interdisciplinary possibilities between the history of nursing and the history of medicine, as well as general history, as part of nursing education.[16] Nelson argues for the role of history as an autonomous academic discipline bringing benefit to nursing and nursing education in a way beyond that which is achievable by educated nurses themselves within their theoretical framework.[17] However, in spite of these isolated voices, most research within medicine and health is closely concerned by biomedical and natural science approaches, and the humanities seem to be losing ground. I believe that there is a need to bring the relevance of such knowledge to centre

[14] O. Temkin, "An essay on the usefulness of medical history for medicine," *Bulletin of the history of medicine* 19 (1946): 34-38.

[15] Ibid., 35.

[16] Sioban Nelson, "The fork in the road: nursing history versus the history of nursing?," *Nursing history review: official journal of the American Association for the History of Nursing* 10 (2002): 182-85.

[17] Ibid., 181.

stage and to renew our focus on historical perspectives. At best, historical knowledge can help healthcare workers to reflect critically on their own history and limitations as a means of promoting the future development of the professions, as is also argued by History Professor Aina Schiøtz.[18]

Through this work, I aim towards adding knowledge of the historical understanding of the patient in the context of the education of nurses and doctors, and to renew our awareness of the importance of historical knowledge in a context that extends beyond the professions’ own understanding of theories and their epistemological base. I also believe that this project has the potential to generate new knowledge and thought-provoking ideas that are relevant to both person-centred theory and practice, contemporary research, and future developments in the health-related disciplines. Its relevance can thus be viewed both from an internal historical perspective and from an external perspective linked to medical and nursing education, and health-related research. Before exploring this further, I wish to draw attention to some of the contemporary challenges facing the patient within the modern healthcare sector. It is these challenges that have triggered my interest in focusing on the patient as a concept in my historical focus and analysis.

Contemporary challenges in being a patient

In politics and official developments in Norway and elsewhere have made the patient as stakeholder increasingly visible as a ‘partner’ in the medical and health arenas. In recent years, domestic and international policies have conferred value on virtues such as shared decision-making and empowerment.[19] Such virtues place patients in a role where they are expected to take more responsibility for the decisions made regarding own health and treatment. Initially, such an approach may be regarded as positive. However, it is also

[18] Aina Schiøtz, "Om å se seg selv i en sammenheng - medisin og historie - de to kulturer," *Tidsskrift for Den norske legeforening* 120, no. 30 (2000).

[19] Det Kongelige helse- og omsorgsdepartementet, "Nasjonal helse- og sykehusplan (Meld.St.11 2016–2019)," (Aurskog: Departementenes sikkerhets- og serviceorganisasjon, 2015).

a cause for concern and raises many challenges. In a society where basic healthcare and adequate treatments have become increasingly complex and specialized, the expectations placed on patients to take more responsibility for their own health can for many be viewed as challenging. A Danish study completed in 2019 describes a paradigm shift in how the role of the patient has been both articulated and adapted in relation to healthcare professionals. [20] In this study, the authors argue that prior to 1970 professionals were referred to as the parties possessing the expert knowledge. The patient was seen as passive, and trusting of the advice given by the professionals.[21] According to the Danish study, these perceptions have changed, and from 1979 onwards, the patient has been assigned a more active role. However, this development has not considered the gap that exists between the professional expert and the non-professional patient regarding their respective levels of knowledge, which has increased remarkably. The study points out that such active involvement by the patient is difficult to achieve within the current healthcare services.[22]

Rapid developments in medical treatment and care, as well as the introduction of New Public Management (NPM) into the health care sector are significant factors in this respect. This contribute to create a gap between the stated aims of official policies and the resources and complex knowledge that must be in place in order to achieve said aims. Part of this gap concerns what patients’ expectations should be and how they are expected to act in their encounters with healthcare professionals. Moreover, different professionals have different views on what a patient is and how they should be involved when it comes to care and treatment.

[20] Louise Solholt and Kirsten Frederiksen, "The construction of the active, involved patient," *Nordisk sygeplejeforskning* 9, no. 4 (2019): 257.

[21] Ibid.

[22] Ibid.

Ole T. Kleiven, Lars Kyte, and Kari Kvigne, "Sykepleieverdier under press?," ibid.6, no. 04 (2016).

NPM was introduced as a means of gaining control of increasing costs in every part of healthcare sector and its institutions by setting targets for performance management and efficiency. Recently, increasing volumes of research have been produced in support of the assumption held by many health practitioners that the patient has no place as a contributor to decision-making under the NPM framework.[23] Despite this, the NPM has for some decades exerted a tight hold on health care and medical practice. Professionals within the sector have tried to find a balance between putting the patient first and achieving their efficiency and cost control targets. In order to succeed within the macro-level external frameworks issued by politicians and the treasury, doctors and nurses have to adapt to the patient needs within stipulated target frameworks. An extensively held belief among health care professions is that the adoption of NPM has diverted focus towards efficiency and financial performance to the detriment of time devoted to consultations and patient-related care.[24] My assumptions is that the language used in NPM policies has, possibly unconsciously, further contributed to a new construct of what the patient is. This assumption will be reflected on later in the thesis, in chapter eight.

In spite of this, official policies insist on the value of both NPM as an efficient framework, and of the individual patient as a co-creator of future healthcare models of provision.[25] The patient is not only the focus of treatment and care, but is considered as an equal ‘partner’ (or at least a co-participant) in addressing his or her own health challenges. Professional healthcare workers are obliged to work together with the patient in deciding the best care and treatments, with the patient adopting the role of ‘expert’ on his/her own physical and mental health, being thus enabled to participate fully in decision-making processes.[26] However, we must recognize that there is an inequality in both

[23] Noralv Veggeland, "Fastlegeordningen og reformer," *Tidsskrift for velferdsforskning* 21, no. 1 (2018).

[24] Liv-Ellen Vangsnes, "Hospital cornerstones are crumbling," *Tidsskrift den Norske Legeforening* 136, no. 3 (2016).

[25] Det Kongelige helse- og omsorgsdepartementet, 9-11.

[26] Ibid., 55-62.

expertise and power in relation to decision-making that must not be underestimated in the relationship between the professional and the patient.

Within the crossing between NPM as a framework that values efficiency and productivity over a holistic approach that facilitates shared decision-making, patient involvement and professional integrity, doctors and nurses encounter a major dilemma in trying to include the patient in the healing process.[27] For many doctors this is expressed in terms of continuously seeking a balance between meeting the demands of their role as gatekeeper based on efficiency and societal resources, and patients’ benefits.[28] At the same time, most modern doctors are educated and expected primarily to refer to biomedical science and EBM. They will exercise EBM principals to search for the best and most effective treatment for as many of their patients as possible.[29] Within this epistemological approach, there seems to be little or no place for the needs of the individual or for involving the patient in decision-making based on a holistic approach. Their training in these subjects, as provided by their medical education, appears to be minimal.

As for nurses, recent research has shown that they find it hard to fulfil the traditional ideals and values embedded in their education and professional work. Providing high quality holistic care in institutions and a health service that operate according to the principles of NPM has proven to be challenging if not impossible.[30] Both nurses and doctors regard this development as a threat to their professionalism and the safety of their patients. As a counter balance to this threat, a wide variety of theories and

[27] Benedicte Carlsen and Julie Riise, "Fastlegenes dilemma: Pasientvelferd eller kostnadshensyn?," *Nytt Norsk Tidsskrift* 30, no. 4 (2013).

[28] Ibid., 355-56.

[29] Hilde Bondevik and Eivind Engebretsen, "Innføring av "kunnskapsbasert medisin" i norsk medisinsk diskurs," in *Sann opplysning? Naturvitenskap i nordiske offentligheter gjennom fire århundrer*, ed. Merethe Roos and Johan L. Tønnesson (Oslo: Cappelen Damm Akademisk, 2017), 446.

[30] Kleiven, Kyte, and Kvigne.

frameworks has emerged, placing the patient as a holistic person in centre. This focus has received renewed attention in both research and practice development in some health care professions in recent decades.[31]

Both NPM, EBM and the frameworks that promote the holistic nature of the patient contribute through their language to a construct of what a patient is and how the patient should be treated. If the patient is viewed primarily from a biomedical standpoint, this would not only impact on how health professionals deal with patients, but would also promote an understanding of the expectations that becoming a patient entail. Within such a construct, the greater good of society as a whole overshadows consideration of the patient as an individual. In the language of the NPM, the patient is often reduced to a product associated with costs and about whom the use of terms such as “assembly lines” and “packages” reflect the attitude that everyone responds to and handles their illnesses and diseases in the same way. However, from a holistic patient care perspective, other perceptions of treatment and care emerge. Within a holistic care framework, the individual is put in the foreground, and generalizations are less important in describing the needs and experiences of the individual. My main point here is to emphasize that the content of the patient construct will vary according to the approach adopted, and that this will have implications beyond the intentions of those who employ macro frameworks to determine how we approach our future healthcare challenges. This study will also show that language influences the continuous evolution we observe in the ways we understand concepts and their content.

[31] WHO World Health Organization, "WHO Global Strategy on People-centred and Integrated health Services. Interim Report," (2015).

Brendan McCormack and Tanya (editors) McCance, *Person-Centred Practice in Nursing and Health Care Theory and Practice*, second ed. (Chichester: Wiley Blackwell, 2017).

Brendan McCormack et al., *Person-Centred Healthcare Research*, 1st ed. (Hoboken, N.J United Kingdom: Wiley-Blackwell, 2017).

In light of these contemporary challenges, I have chosen to explore our existing perceptions of what a patient is, and was in history, and to understand these perceptions in different contexts within a historical perspective. The importance of understanding how the concept of the patient has changed and developed in the context of societal changes and knowledge development will be discussed.

1.3 A guide to the reader

It has not been possible to write this dissertation without some repetitions of some points. Some findings, analysis and theoretical perspectives have been relevant to more than one chapter, and hence need to find its place on more than one occasion. However, by providing a guide to the reader on how the work has been structured and written, it is my intention to create an understanding that makes it possible to follow my way of thinking through the work that has been conducted.

To combine the different parts together as a whole, I have chosen to present small pieces of a narrative that has been present to me through my journey. Some of the conversations I have had with my now 9-year old son, his wondering and questions to me regarding my work have been a part of this journey. I have used part of these dialogues to frame some of the different aspects in some chapter showing and emphasizing how we as researchers always come with a story and assumptions ourselves, which we bring into the work. These experiences are not solemnly based on our professional life, but are made up by all our experiences as a person.

In the first chapter I have placed the work in the present and argued for the relevance both for historical knowledge as well as for the health care service and educational development. I have drawn attention to how I view some of the contemporary challenges in being a patient today as a background to why I chose to look into the historical construction of patient as a concept.

In addition, in the first chapter I have presented the aim and the research questions that have guided my work.

Chapter 2 will place the study in accordance with the research area both nationally and internationally. A historiographic approach is used to describe earlier research within the history of medicine and health and how this subfield within academic history has developed. In this chapter, I have also raised a discussion regarding for whom this research and knowledge is relevant and the limitations I have found in earlier research in light of a Norwegian context.

In chapter three, I will narrow the timeline and perspectives of this project and clarify central concepts. I will argue for the choices that have been necessary to take in order to frame the project into a manageable size geographically, according to time and focus of this study. In addition, chapter three contain a presentation of the theoretical basis of this study.

In chapter four, I will draw attention to the work with the historical empirics for this study. Here the different historical sources will be presented together with an introduction to the scrutiny that have worked as a base for the selection, relevance and use. I further use this chapter to position myself as a researcher in this work, focusing on the reflexivity that happens in the process between myself and my understanding of history, the sources and the knowledge that develops. I view this in relation to a discussion of how to understand reality historically.

Chapter 5 will consist of an analysis of how the patient is constructed through the education in medicine. Here the focus will be to show how the development in medicine and medical knowledge triggered a discussion regarding the medical education that had significance for the view of the patient. The analysis consideres how different parts of the medical society had different views in what to highlight in education and the consequences this had for the construction and view of the patient based on arguments and language used to emphasize the different views. Societal changes that occurred and contributed to contextual understanding in the modernization processes in the period are considered.

In chapter six, the focus changes to nursing education. How nurses related to the patient in their education and training and professional development has been analyzed. The same way as in the previous chapter regarding medical education, social and cultural developments are seen as crucial to the formation of and development of nursing education and how that affected their view of the patient, as this has come forward through language used in historical sources.

Chapter 7 is used to broaden the perspectives and discuss what aspects that can be viewed as significant when it comes to differences and similarities in the two educations, and what contributed to these divisions when it comes to linguistic representation of what a patient is. This chapter will focus on what can be considered the humanizing and dehumanizing factors in the construction of patient as a concept and use this to explore the use of a person-centred practice framework in future health care education and practice.

This thesis finishes with an epilogue consisting of some final reflections regarding my work and my PhD journey placed within the frame of a contemporary context. Some dialogues between my children and me is brought forward in order to bring together the narrative of this journey, and the knowledge developed during this PhD project and see this in connection to future challenges.

2 Earlier research – a historiographic approach to the field

"Mum, is being a patient the same now as before?"

"Yes and no. From what I know I will say that it was much worse before than now. But being a patient means that you need to have doctors and nurses to take care of you. That is the same now as before."

In this chapter, I will provide an overview of a selection of historical research studies in the history of medicine and health using a historiographic[32] approach. My understanding of the field is closely linked to previous approaches, and I believe this underpin the need for this study to be conducted, focusing on the patient. Since the patient constitutes the focus of this study, I will start by looking into earlier research conducted on the patient throughout history. However, before embarking on this, I intend to present a summary of the development of *"history of medicine and health"* as a delineation of general history as a subject, and the place of history of medicine and health within medicine and nursing as professions.

Both history of medicine and history of nursing holds a history of themselves, written by and mainly for the professions.[33] Within this early tradition documentation of progressive developments in knowledge, inventions, methods and professionalization within the professions that led to positive development through time had focus.[34] This is in line with

[32] Historiography is here understood as the history of history, and points to how historians have written about historical events and how these have been reinterpreted by different historians through time.

[33] Aina Schiøtz, *Viljen til liv* (Oslo: Samlaget, 2017), 13-15.

[34] Within history, this kind of history is referred to as "whigism" or "whigish history" which incline that history are understood as linear development based on progression, knowledge development that would lead to a better society. The present are always seen as better and more developed than the past. Within this understanding, history is often written from the "victors" point of view.

the dominant paradigm within history during the 19th century and Leopold von Ranke's conception of how history should be written. Currently, this field exhibits a broad scope, allowing several narratives to run side by side. From the mid-20th century, the impact from various social sciences, as well as social and cultural history existed as natural perspectives, to include in writing academic history.[35] Within medicine and health as a sub-field of history, a new approach was introduced when scholars of history made their entry into the field, unlike before when this field was mostly conducted by researchers within the professions. From 1960 to 1970, as historians expanded their interest in the history of medicine and health, a broader approach was introduced to research, encompassing a cultural and social focus that conferred a more diverse perspective on the field than was previously the case.[36] Nevertheless, what remains for us as historians is to grasp part of this huge canvas of historical events and bring forward different perspectives and approaches to the field.

"The historical record is like the night sky:

We see a few stars and group them in mythic constellations.

But what is chiefly visible is the darkness."

Roy Porter, 1997. [37]

Ludmilla Jordanova, *History in practice* (London: Hodder Education, 2006), 230.

Edward Hallett Carr, *What is history?*, ed. Richard J. Evans, 2nd ed., repr. with new introd. ed. (Basingstoke: Palgrave, 2001), 18-19, 37-38.

[35] George Iggers, *Historiography in the twentieth century. From Scientific Objectivity to the Postmodern Challenge*, 2 vols., vol. 2 (Middletown, Conn Wesleyan University Press, 2005 (1997)), 99-100, 20, 50-60.

[36] Andrew Wear, *Problems and Methods in the History of Medicine*, ed. Roy Porter, 1 ed., vol. 12 (New York: Routledge, 1987), 1-3.

[37] Roy Porter, *The Greatest Benefit to Mankind. A Medical History of Humanity from Antiquity to the Present* (London: Fontana Press, 1997), 13.

The history of medicine and health

What is currently referred to as the ‘history of medicine and health,’ has traditionally focused on medicine as a subject and the great achievements accomplished by doctors. This sub-field of history went under the name ‘history of medicine’ and was taught in medical schools in most countries when medicine became established as an academic subject. This also applies to the School of Medicine at the Royal Frederik’s University in Oslo, which opened in 1813.[38] History has today mostly disappeared as a subject being taught in medical schools, and also as a field of research from the medical profession. One can argue that it is primarily historians who are preoccupied with the history of medicine and health as a field of research today. However, even in the history departments of most universities, the history of medicine and health is little taught, and account for only a small part of historical research globally. This has resulted in a discussion about the relevance of such history for doctors, and if the language used and the approaches taken have moved so far from their origins that the teaching of history has become irrelevant to the profession itself.[39] Within nursing too, a discussion has emerged concerning the relevance of the history of nursing, and to whom such knowledge and research are useful.[40] This will be discussed later in this chapter (page 33 and forward).

Today, the term ‘history of medicine and health’ has replaced the former ‘history of medicine’ and is used to cover a broad field that adopts a social and cultural just as much as a biomedical approach. The ‘history of medicine and health’ as a subject also encompasses the histories of the various healthcare professionals.[41] In this study, I have chosen to adopt a broad approach to the ‘history of medicine and health’ and to

[38] Aina Schiøtz, "Medisinhistorie eller medisinsk historie," *Tidsskrift den Norske Legeforening* 12 (2011).

[39] Magne Nylenna, "De "to kulturer" i medisinen," *Tidsskrift for Den norske legeforening* 120, no. 30 (2000).

[40] Nelson.

[41] Schiøtz, "Medisinhistorie eller medisinsk historie."

emphasise developments observed since the 1990s. My understanding is that both patients and patients’ experiences can be included within the scope of the term ‘history of medicine and health’. Aina Schiøtz has argued similarly when explaining the historical development of the linguistic changes that have taken place when moving from the ‘history of medicine’ to ‘medical history’.[42] Nevertheless, as this historiographic review will reveal, the ways in which the subject has been understood and written about are just as closely linked to contemporary settings and prevailing scientific and historical paradigms as they are to the focus directed by the professions on their own understanding of the field. However, the professions in medicine and health have to be understood as part of their relationship towards the sick person despite their various understanding of the field both regarding knowledge, research and in practice.

2.1 The patient in historical research

In 1985, the medical historian Roy Porter encouraged historians to change their perspectives within the subject ‘history of medicine and health’ and adopt a more patient-oriented focus. In his article ‘*The Patients View. Doing Medical History from Below’*[43] , he puts the patient firmly on the agenda and proposes how such research could be carried out. Although it may be argued that patient-oriented research within history has increased in recent decades, there are still only very few historians who are exploring this perspective in the way highlighted by Porter in 1985.[44] Both internationally and in Norway, few researchers have explored the ‘history of medicine and health’ with a

[42] Ibid.

[43] Roy Porter, "The patient's view. Doing Medical History from Below," *Renewal and Critique in Social Theory* 14, no. 2 (1985).

[44] A recent exception from this is a great study in German and Swiz. Martin Dinges et al., *Medical practice, 1600-1900: physicians and their patients*, vol. volume 96, Clio medica (Amsterdam, Netherlands); (The Netherlands: Brill Rodopi, 2016).

patient-oriented focus. This is partly due to the relative lack of and difficult available historical sources within this field.[45]

In my view, it is possible to argue that early historical accounts most commonly characterise the patient in a supporting role in the historical development of diseases, the health institutions, and of health care professionals. This is very much in line with the early traditions of historical writing emerging from Europe during the 19th century. Historians wrote primarily about the history of wars and great men. In the field of medicine, the great men were the doctors. It was only when the social sciences, social and cultural history, and other academic subjects became integrated into historical research, that the door was opened to the inclusion of the lives and experiences of ordinary men and women. Within the history of medicine and health, this also enabled historians to focus on the patient.[46]

It was only in 1985, when Roy Porter focused attention on a patient-oriented perspective, that the patient was raised to the status of an independent actor playing an important role in the history of medicine and health. Porter has integrated the patient in much of his work, and in several publications. A good example of this is his exploration of the doctor-patient relationship in 18th century England.[47] Further, in the *Companion Encyclopedia of the History of Medicine,* which Porter edited together with William Bynum, some chapters are included that focus on the patient-doctor relationship throughout history.[48] The same is the case of a study that was conducted by a team from

[45] Schiøtz, *Viljen til liv*, 398-99.

[46] Peter Burke, *New Perspectives on historical writing* (Cambridge: Polity Press, 2001), 2-6, 15.

[47] Roy Porter and Dorothy Porter, *Patient's Progress. Doctors and Doctoring in Eighteenth-century England* (England: Polity press, 1989).

[48] Edward Shorter, "The history of the doctor-patient relationship," in *Companion Encyclopedia of the History of Medicine*, ed. Roy Porter and W.F. Bynum (London: Routledge, 1993).

the Netherlands in 2016,[49] especially the chapter concerning doctors and their patients during the period from the 17th to the 19th century.[50]

All these studies show that there has been an increase in focus on patient-oriented perspectives within this field. Most of these studies address the relationship between doctors and their patients. A discussion thus emerges as to whether simply including the patient in historical texts is really the same as adopting a patient-oriented focus, or whether in fact a focus on the patient-doctor relationship still places the doctor in the centre of the narrative. Few of these studies have actually drawn attention to this point of view, but an investigation of several of them reveals that most of their sources are based on the doctor’s point of view. In such studies, the patient is viewed and articulated using the language of the expert doctor, with the voices of patients only very rarely being considered. Using Aina Schiøtz’s argument, we can conclude that this is exploration of the patient from an outside perspective, even though the patient acts as an important premise provider and the studies put the patient in the foreground.[51] Again, we can assume that the reason for this approach to exploring the patient-doctor relationship has to do with access to sources coming from the patients themselves, who from this time in history is rare and hard to come by.

Viewing the patient from an outside perspective, based on sources that express primarily the points of view of doctors or nurses, has been used as an approach by several researchers both nationally and internationally. This is also an approach that I have used in this project. This has raised many concerns in terms of my attempts to hold up the patient as the focus of my research, as will be demonstrated in my analysis. It has not been possible for me to escape the fact that the construction and view of the patient

[49] Dinges et al., volume 96.

[50] Marion Baschin, Elisabeth Dietrich-Daum, and Iriz Ritzmann, "Doctors and Their Patients in the Seventeenth to Nineteenth Centuries," in *Medical Practice, 1600 - 1900. Physicians and Their Patients*, ed. Martin Dinges, et al. (The Netherlands: Brill Rodopi, 2016).

[51] Schiøtz, *Viljen til liv*, 410-12. Gadamer, 316.

concept are linked inextricably to other developments in society, and are not based on the patients’ view of themselves. Access to such an understanding is derived primarily from those who are able to participate and engage formally in such developments, such as academic professors, doctors, educated nurses and other officials.

In historical terms, my belief is that the adoption of an outside perspective on the patient in the history of medicine and health is based on two important premises. The first addresses access to relevant sources. The voices of patients throughout history are difficult to access because, if they ever existed at all, they are either lost or not preserved. Secondly, early historical narratives focusing on the stories of great men and their achievements always constituted the dominant expression of society’s elite. The voice and experiences of ordinary men and women was not a focus in research, but neither was it a focus of people’s life when they lived it. Although some work has been conducted the last decade, little work has been conducted addressing the inclusion of patients in studies of the period affected by modernization processes. My assumption is that modernization processes have been viewed in the light of long-term development trends rather than as clear breaks. Because historians commonly search for either breaks or continuum in history, greater focus has been directed on the period leading up to modernization than on the changes that have occurred as a result of these long term processes.

If modernization in medicine and health in relation to the patient is viewed as a gradual development from earlier periods rather than a clear break, this may provide an explanation as to why this aspect was much less emphasized in earlier research. Thomas Dahl has conducted a study in a Norwegian context that supports this notion. In his study of medical practice and medical interpretation regimes in 1840[52], Dahl looked into how doctors used both traditional and modern approaches in their diagnoses and treatments of patients in the mid-19th century. Dahl emphasises that during the modernization

[52] Thomas Dahl, "Den rene diagnosen og den gamle terapien – medisinsk praksis og medisinske fortolkningsregimer anno 1840," *Historisk tidsskrift* 83, no. 04 (2004).

processes and the scientific revolution that gained a hold during the 19th century, two contrasting epistemological views on the patient and medical knowledge existed side by side. In recognising this, it becomes more difficult to identify a clear break between the old and the new. Historians need to look for other explanations or understandings of how patients under the complexities created by the co-existence of different epistemological paradigms in science and practice, as is also the case at a time when the modernization of society had started to constrain and influence the healthcare sector. This is one of the reasons why I have chosen to explore the construction of the patient concept from an educational standpoint.

Formal education contributes to the development and modification of discourses in knowledge and practice paradigms that in turn influence how professionals view and treat their patients, and how they use language to support these developments. By linking education in medicine to historical knowledge, in which the patient is included as an important stakeholder, the picture becomes somewhat more diverse than within other areas in the field.

Prior to Porter’s arguments for a renewed focus on the patient, Edmund Pellegrino, who is also preoccupied with linking education in medicine to historical knowledge in relation to both patients and diseases, published a paper on the same topic as early as in 1974.[53] During the last decade, John Harley Warner has adopted the tradition established by Pellegrino, George Canby Robinson and William Osler in emphasizing a holistic approach to the patient, and bringing to the foreground a view that supports humanist subjects in medical education as a means of preventing the disciplines from becoming inhumane.[54] Linking these researchers to the dominant paradigm within historical research traditions, we can see that the follow in the wake of the same development as other fields and sub-

[53] Edmund D. Pellegrino, "Educating The Humanist Physician: An Ancient Ideal Reconsidered," *JAMA* 227, no. 11 (1974).

[54] John Harley Warner, "The Art of Medicine in an Age of Science: Reductionism, Holism, and the Doctor-Patient Relationship in the United States, 1890–1960," *National Museum of Ethnology Repository* 120 (2014): 68-69.

fields within history. We go from a positivistic approach focusing on the grand narratives, emphasising objectivity where the patient is left out, to include social and cultural approaches, involving ordinary men and women in research on the patient-doctor relationship.

An increase in focus on social and cultural history has produced honourable exceptions to traditional narratives, including patient-focused research in the fields of mental health and psychiatry, specialized occupational groups such as soldiers and sailors, and in relation to specific diseases such as leprosy and venereal disease. Some examples from Norway are included here in order to highlight how a patient-oriented perspective have been applied in medical and health research the last decades. In such cases, historians, literary scholars and others have utilised sources such as literature and fiction, as well as other records of historical events.[55] In recent years, a project has been completed at the Norwegian University of Science and Technology (NTNU) looking into criminals suffering from mental health conditions. A number of doctorate thesis have been completed as part of this project, putting the patient/ the criminal person in centre of attention.[56] In addition, a study has been conducted at the University of Bergen addressing the psychiatric patient as a conceptual study throughout history.[57] In this study, the focus was to understand how the psychiatric patient as a concept had changed in relation to both history and policy. Social and cultural history, and microhistory[58], have opened the

[55] Petter Aaslestad, *Pasienten som tekst. Fortellerrollen i psykiatriske journaler Gaustad 1890-1990* (Aschehoug, 1997). Schiøtz, *Viljen til liv*, 397-424.

[56] Eivind Myhre, "Farlige menn. Mannlighet, seksualforbrytelser og sinnssykdom 1895–1940" (Norges teknisk. naturvitenskaplige universitet (NTNU), 2016).

Hilde Dahl, "Institusjonaliseringen av farlighet, sinnssykdom og samfunnsvern i Norge: En studie av farlige kriminelle sinnssyke pasienter i Kriminalasylet og Reitgjerdet asyl, 1895-1940," ed. Øyvind Thomassen and Sverre Flaatten (NTNU, 2018).

[57] Anne Madeleine Botslangen, "Den psykiatriske pasient: En begrepshistorisk studie" (Universitetet i Bergen, 2015).

[58] Giovanni Levi, "On microhistory," in *New Perspectives on historical writing*, ed. Peter Burke (Cambridge: Polity Press, 2001), 97, 99-101.

door to innovative approaches to shaping and rethinking how we explore the past. In the field of the history of medicine and health, such opportunities represent only the first stages of future progress. For this reason, in this present study, I have focused on adding knowledge by viewing the healthcare sector as a social and cultural arena in which language, power structures and relationships all play a significant part in understanding the conceptual construction of the patient in a historical context. Since the patient is only one of the actors in the health sector, I also take research focused on doctors and nurses into account. Previous research addressing the professional development of doctors and nurses by means of education is thus also presented as part of this work.

As part of my presentation of early research into the professionalization of doctors and nurses, I will draw attention specifically to work carried out in Norwegian contexts and according to Norwegian traditions, and will then discuss this research comparatively in the light of international research within the same field. Attention will be given to a conceptualization of how history has been exploited strategically in order to construct specific narratives of the medical and nursing professions, referred to here as ‘*preferred narratives.’* [59] This exploitive approach to history has often been linked to narratives related to the history of different organizations and companies, although not in terms of conceptualization as preferred narratives, which is the concept used in this thesis.[60] Within nursing, a similar understanding of ‘preferred narratives’ can be derived from

[59] Preferred narrative(s) [foretrukne historier] is a concept I came across during a presentation at a seminar for Norwegian historians in 2019. Lars Fredrik Øksendal participated in a project concerning the history of the Norwegian Stock, and presented the concept as part of that project, to emphasize some of the challenges they met concerning what narrative should come forward in the history of this institution. This concept filled a gap I had been missing in my work with the history of health professions. When I heard Lars Fredrik’s use of the concept, I felt he was able to catch some of the thinking I had done concerning this, and was eager to find out more. Through several e-mails we explored and discussed how we both put meaning into such a concept and how that could contribute to an understanding of a fixed historical knowledge historians meet in their work with the history connected to specific professions, institutions, businesses and such. Moreover, we discussed how historians should relate to and work with such preferred narratives in our meeting with these. I am grateful for Lars Fredrik’s willingness to let me use a concept I found valuable to use in my understanding of former research within the history of medicine and health.

[60] Mike Zundel, Robin Holt, and Andrew Popp, "Using history in the creation of organizational identity," *Management & Organizational History: Re-visiting the Historic Turn 10 years later: Current Debates in Management and Organizational History* 11, no. 2 (2016).

what Sioban Nelson argues when referring to ‘the professional project,’[61] in order to rethink nursing history to an audience outside own profession.

2.2 The history of medicine and medical education - a history by and for doctors?

The history of medicine was once regarded as an important part of the professionalization of doctors and medical practice. The subject was taught as part of medical education ever since medicine was introduced to the European universities during the 18th century.[62] The idea was that most existing knowledge was rooted in the achievements of the past, and that these should thus be valued and learned from.[63] Theodor Puschmann expressed this clearly in 1889, and the idea has continued to re-emerge in subsequent years. One example of this is the paper ‘*An essay on the usefulness of medical history for medicine*[64] by Owsei Temkin. Temkin’s view on learning from history was in line with Roman ancient history, in which it is argued that it is important to learn from history, both people, events and developments.[65] Since that time, the history of medicine has disappeared not only as an important subject in medical education, but also as a legitimate object of professional focus. In contrast, the subject has become a source of interest for an increasing number of historians, who have adopted a wide range of perspectives and approaches.[66] In a paper written in 2018, the Norwegian professor Magne Nylenna describes how the history of medicine can now be regarded as an autonomous part of history, and how the field has become uniquely distinct from other

[61] Nelson, 175, 79-82.

[62] Magne Nylenna, "Medisinens immaterielle historie," 3/18 (2018): 246-47.

[63] Ibid., 247.

[64] Temkin.

[65] Sandmo, 41.

[66] Both Puschmann and Temkin were educated doctors specializing in the history of medicine

disciplines, including those related to medicine and other health-related subjects.[67] Some doctors, including Nylenna himself, still value historical narratives and continue to contribute important perspectives to the history of medicine and health, making it relevant to the profession and the wider field of medical and health-related research.

Research in the field of medical education focuses mostly on educational perspectives and the professionalization of the modern doctor. Even the major narrative of Theodor Puschmann’s book published in 1923 addressing the history of medical education up until that date, is mostly preoccupied with these issues.[68] It was only a decade later, in 1936, that the three doctors Ingjald Reichborn-Kjennnerud, Fredrik Grøn and Isak Kobro, wrote a comprehensive overview of medical history in Norway.[69] Their work includes a thorough review of most aspects of the evolution of medicine in Norway, covering the period from prior to the Viking era to the 1930s. Although the work does not adopt a specific educational approach, a chapter is included about the only University in Norway at that time, mostly focusing on the subjects taught and the position of warfare medicine in a learning context.[70] In line with most historical writing of the time, the authors’ main focus is directed towards the achievements of great men after the model of Leopold von Ranke, who emphasized an objective and rigorous exploration of historical events.[71]

What emerges from these two essential overviews is that both Norwegian and international research within this field prior to the early 20th century focused primarily on topics such as the structural development of education, in line with the dominant paradigm in historical research of the time it was written. Moreover, the main emphasis

[67] Nylenna, "Medisinens immaterielle historie," 247-50.

[68] Theodor Puschmann and Evan H. Hare, *A history of medical education from the most remote to the most recent times* (Nabu Press, 1923).

[69] I. Reichborn-Kjennerud, *Medisinens historie i Norge*, ed. Fredrik Grøn and I. Kobro (Oslo: Kildeforlaget, 1985).

[70] Ibid., 213-40.

[71] Iggers, 2, 25.

was to highlight a grand narrative within medicine, focusing on the development of institutions such as hospitals and universities, advances within theoretical and practical medicine, and an understanding of knowledge about the various sicknesses and diseases for dissemination in medical schools.[72] These early works on the history of medicine were dominated by the scientific achievements in science performed by professors and practitioners, with the aim of imparting these to new students.

This exploitation of history with the aim of constructing and focusing on preferred narratives has constituted an important aspect of the medical professions, including those in medicine, and is reflected in the ways in which such narratives were used to acquire power and position in society. As pointed out by Aina Schiøtz, we observe a journey in knowledge, power and influence that follows developments in education, and which has been exploited by doctors to achieve executive administrative positions and high-level status beyond the confines of the healthcare arena.[73] Such observations are also supported by early research conducted in this field. One can argue that such narratives were written primarily by and for doctors. An inherent danger here is that such ‘heroic’ narratives leave little opportunity for criticism of the more problematic aspects of historical developments within the profession. There is no place in such narratives for ordinary persons, or of any discussion of problematic issues that might overshadow the preferred narratives describing the grand historical construction designed to be placed in the foreground of attention. However, this way of writing history both in general as within history of medicine and health have changed. Starting in the 1960s, a more diverse

[72] Roy Porter, *The Cambridge History of Medicine* (New York: Cambridge University Press, 2006), 110-35.

Puschmann and Hare.

Øivind Larsen, *The Shaping of a Profession. Physicians in Norway, Past and present* (United States of America: Science History Publictions, 1996).

Jon Røyne Kyllingstad, "Universitetet og legevitenskapen," in *1870-1911: Vitenskapenes universitet. Bind 2 i J.P. Collett (hovedred).* ed. Jon Røyne Kyllingstad, Thor Inge Rørvik, and John Peter Collett (Oslo: 2011).

[73] Aina Schiøtz, *Folkets helse - landets styrke 1850 - 2003*, vol. 2, Det Offentlige helsevesen i Norge 1603-2003 (Oslo: Universitetsforlaget, 2003), 153.

approach has emerged in the writing of the history of medicine and health, reflecting changes in social and cultural history, as pointed out above.

In a Norwegian context, Øivind Larsen has written several books and papers on the history of medicine and health.[74] He has completed a wide range of studies in the field of medical education that are preoccupied primarily with the establishment and development of the School of Medicine at the first University in Norway, the professionalization of medicine within a university framework, and the few but important professors that taught at the School during its first 100 years. His approach has much in common with international research in this field. In his own way, Larsen has contributed to the creation of a typically Norwegian narrative addressing developments in medicine that uphold the traditional approach adopted in this field. However, Larsen has also helped to expand our perspectives on the history of medicine and health, especially with different approaches the last decade.

A Norwegian Professor in history that have included social and cultural aspects of the history of medicine and health in all her research is Aina Schiøtz. Her interest in focusing on the broad approach to understanding medical developments is visible both in choice of research areas and in her diverse books and papers published in the field.[75] Schiøtz

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[74] Larsen.

"Doktorskole og medisinstudium ; Det medisinske fakultet ved Universitetet i Oslo gjennom 200 år (1814-2014) : noen trekk fra utviklingen og noen tanker om den," *Michael. Supplement* 11 (2014).

Legestudent i hovedstaden (Oslo: Gyldendal, 2002).

"Legestudent Sverre Sørsdals brev til sin mor 1919-27 [Medical student Sverre Sørsdal’s letters to his mother 1919 -27]," *Michael* 10 (2013).

[75] Aina Schiøtz, *Doktoren. Distriktslegens historie 1900-1984* (Oslo: Pax Forlag A/S, 2003).

Folkets helse - landets styrke 1850 - 2003, 2.

"Mellom legekunst og vitenskap - Tidsskriftet 1906-56," *Tidsskrift for Den norske legeforening* 126, no. 24 (2006).

"Helsetjenester og rettferdighet - tre blikk på norsk helsehistorie," *Michael* 5, no. 3 (2008).

contributed to place the different actors in centre stage of her research, doctors, nurses, patients and women’s, and was occupied with showing how different social and cultural backgrounds and understandings played an important role in both understanding and explaining historical events and developments within the health care arena as part of the medical framing. This point of view in her historical approach made her research relevant and innovative within the field seen from a national point of view.

During my investigations of the research carried out into the history of medicine and health in Norway over the last three decades, I have found a number of doctoral theses, produced by both history and medical departments that have adopted a broad perspective and approach.[76] Moreover, several medical journals currently accept papers on the history of medicine and health on a regular basis. However, and in spite of this, few researchers within the field are, or have been, greatly concerned with addressing the challenges imposed by medical education on society and individuals in the wake of the modernization processes that took place in the 19th and 20th centuries, or the development of the modern doctor within an educational frame. In order to make historical knowledge relevant for future medical education, we need to re-establish a focus on the importance of seeing medical education as part of a broader relation to both patients, other stakeholders and society.

2.3 The history of nursing and nursing education – a history by and for nurses?

During the last two or three decades, research into the history of nursing has developed internationally into a broad and diverse field. A broad range of studies is being carried out within this field, and the subject has also stimulated the interest of professional

Viljen til liv.

"Omsorgens røtter – et historisk blikk," *Tidsskrift for omsorgsforskning* 5, no. 01 (2019).

[76] At the University of Oslo, the department of Community Medicine and Global Health has delivered several doctoral thesis within the history of medicine and health.

historians, as well as researchers within the profession itself. In Norway, research into the history of nursing education appears to be progressing along two paths. The first focuses on the religious nursing tradition, originating in the monasteries[77], and the deaconess tradition inherited from the German city of Kaiserwerth.[78] The second path addresses the more secular nursing tradition, originating in the School of Nursing at St. Thomas’s Hospital in London, founded and developed by Florence Nightingale.[79] These two paths combine to create a divided perspective that views nurses either as obedient and self-sacrificial assistants to the doctors, or as autonomous professionals who challenged the absolute professional power held by doctors in the healthcare arena during the 18th and 19th centuries.[80] Both of these perspectives are frequently studied in the contexts of gender, power, social class and professionalization. It can also be discussed if nurses of today still find themselves in a position where these two competing perspectives make up the primary frame to hold within nursing, the assistant to the doctor or the autonomous nurse. This will be explored during the analysis in the two final chapters.

Internationally, Anne Marie Rafferty (2014) wrote about what has preoccupied most researchers in the history of nursing during recent decades. Rafferty points out that she has observed a tendency towards the emergence of three ‘macro themes’ – religion, war and politics.[81] This conforms well to the two paths and the different perspectives previously described in a Norwegian context, in which the religious aspect constitutes a key perspective within the deaconess tradition, and where gender and power are

[77] Sioban Nelson, *Say little, do much: nursing, nuns, and hospitals in the nineteenth century* (Philadelphia: University of Pennsylvania Press, 2003).

[78] Sigrun Hvalvik and Ole Georg Moseng, "Kristen tro og innflytelsen på profesjonsdannelse - sykepleien, faget og kallet," in *Politikk, profesjon og vekkelse : kvinner i Norge på 1800- og 1900-tallet* ed. Knut Dørum (Bergen: Fagbokforlaget, 2014).

[79] Schiøtz, *Viljen til liv*, 327.

[80] Ibid., 329-30.

[81] Anne Marie Rafferty, "Tiptoeing Towards a History of Nursing in Europe," *Nursing history review : official journal of the American Association for the History of Nursing* 22 (2014).

important factors in the political aspects of nursing. Nursing has also played a significant role in warfare, as is illustrated by Florence Nightingale and her care of soldiers during the Crimean War, and brought professional nursing to the front when it came to care of the soldiers. Here, nurses from both the religious and secular traditions worked side by side. However, as will be pointed out later in this thesis, this situation caused tension in the wake of World War I, both in Norway and internationally.[82]

In a Norwegian context, the history of nursing has recently started to emerge as a significant field of research, and professional historians have generated some interesting work on this subject from a national perspective.[83] However, while international researchers in the history of nursing have payed attention to topics that I see as extending the narratives beyond the construct of preserving an autonomous profession,[84] relatively little attention has been paid to similar topics in Norway. The history of nursing and the history of medicine have a common destiny, and share many of the same challenges. One who point to some of these similarities is Helen Sweet in a paper from 2002.[85] Despite that Sweet argues from a British perspective, many of her arguments reasons with the

[82] The discussion regarding the training courses for Samaritans [samarittene] in Norway played a significant part in the demand by the nurses for a three-year education, and came in the wake of the First World War and the need for nurses at the front. This discussion will play a significant part of the analysis and approaches in chapter six, page 176-179

[83] Ole Georg Moseng, *Framvekst og profesjonalisering. Norsk sykepleieforbund gjennom 100 år (1912-2012)*, Bind 1 (Oslo: Akribe, 2012).

Kari Melby, *Kall og kamp: Norsk sykepleierforbunds historie* (Oslo: Norsk sykepleierforbund og J. W. Cappelens Forlag, 1990).

Åshild Fause, *Glimt fra sykepleiefagets historie* (Bergen: Fagbokforl., 2017).

[84] Nelson, "The fork in the road: nursing history versus the history of nursing?."

"Reading nursing history," *Nursing Inquiry* 4, no. 4 (1997).

Kylie M. Smith, "Facing history for the future of nursing," (Journal of Clinical Nursing, 2019).

Jenny Carryer, "Letting go of our past to claim our future," *Journal of clinical nursing* (2019).

[85] Helen Sweet, "Establishing Connections, Restoring Relationships: Exploring the Historiography of Nursing in Britain," *Gender & history* 19, no. 3 (2007).

same historical development in a Norwegian context. Most historical narratives have been written by and for nurses in order to relate preferred and trustworthy narratives with the aim of securing for the profession a significant status in society, primarily focusing on the time from Nightingale and onwards.

In Norway, Ingrid Wyller has been an important voice in setting the research agenda when it comes to the history of nursing.[86] For many years, Wyller's book constituted the only general text on the history of nursing in Norway, and as such, her narrative was the only source of knowledge and historical perspectives for many generations of Norwegian nurses. Although Wyller wrote in the aftermath of the adoption of social, cultural and linguistic perspectives in the field of historical research, her aim was to present a descriptive history of nursing in a Norwegian context. In so doing, her work can be said to follow in the traditions of Ranke and the classical historicism of the 19th and early 20th centuries.[87] However, the work of both Wyller and others has been of great value, while remaining very much products of their time. It is important to value these early works and regard them as important contributions to professionalization of health care during the modernization processes, when nursing had to find its place both in society and within the healthcare sector. Nevertheless, it is important that we continue to progress, and not simply preserve these early narratives as eternal truths.

Despite the urge to portray nursing historically as a profession in which self-sacrifice in the care of others is seen as the primary task beyond anything else, little research has been conducted to discuss the role of the patient in nursing education. However, this topic has been the subject of much greater interest in nursing theory, nursing philosophy

[86] Both nationally and internationally, Wyller has written and played a significant role in promoting the Norwegian history of nursing and nursing development. Ingrid Wyller, *Sykepleiens historie i Norge*, 2. utg. ed. (Oslo: Gyldendal, 1990).

Norsk Sykepleierforbund 1912-1962, ed. sykepleierforbund Norsk (Oslo: Norsk Sykepleierforbund, 1962).

Sykepleiens verdenshistorie, 2. oppl. ed. (Oslo: Fabritius, 1978).

[87] Iggers, 2, 34-35.

and caring science.[88] There may be many reasons for this. My assumption is that the inclusion of the patient in nursing theory and nursing philosophy is seen both as relevant and as having direct implications for nursing practice. Moreover, the discipline of caring science can be said to have evolved directly from the idea of caring for a person, and the patient represents an essential part of the development of professional care and caring as an autonomous science. This contrasts with the view of the patient as told in accordance with nursing history, which introduces elements with the potential to reveal flaws in the grand narrative of nursing as a profession that developed with the aim of safeguarding the sick and vulnerable. This point of view has been well expressed by Kylie M. Smith in a recent editorial in the Journal of Clinical Nursing.[89] In the following, Smith calls for more history within nursing in order to see that:

"Modern health systems and the biomedical model are an effect and function of white supremacy, colonialism and neoliberalism and nursing is not separate from this. To understand how this has come to be, we need more history not less."[90]

By introducing the patient as a stakeholder in the history of nursing and nursing education, I will argue that a history of the profession is relevant to an audience beyond the profession itself, but at the same time that this approach must be regarded as crucial to future nursing education and practice. In the same way as for the history of medicine, a history dealing with nursing and nurses needs to be more widely recognised by professional historians in Norway than has previously been the case. Only then, will the history of nursing assume a status that extends beyond a narrative by and for nurses

[88] Jean Watson, *Nursing. The Philosophy And Science Of Caring*, vol. 2 (Colorado: Colorado Associated University Press, 1985), 10-11.

Kari Martinsen, "Filosofi og fortellinger om sårbarhet," *Klinisk Sygepleje* 26, no. 2 (2012).

[89] Smith.

[90] Ibid., 1.

alone, and become relevant to a broader part of society, which will also apply to future nursing education as part of society.

2.4 Summary of earlier research

Based on this historiographic review, I will argue that most early research into the history of medicine and health was conducted within the professions themselves. This served two purposes. The first of these was to establish and develop knowledge, and the second to construct historical narratives that could be exploited with the aim of gaining respect for an autonomous profession in an age of modernization. This approach to writing history must be understood in the context of the times during which the narratives were written, when the dominant paradigm was to construct a grand narrative, and to highlight the positive aspects of historical development, in line with most historical research. This paradigm continued to dominate the field up until prior to the Second World War II, fulfilling the purpose of constructing a successful narrative concerning professional development, referred to as preferable narratives.

During the 1970s, 1980s and 1990s, scholarly historians and other academics entered the field and broadened its scope in terms of epistemology, methodology, methods and perspectives. Currently, the field is being researched as part of several academic disciplines, resulting in the emergence of a wide range of relevant and complementary topics. However, research into the histories of both medical and nursing education has most commonly limited itself to addressing issues of structure, disease, cure and care, with less focus on the role of the patient as a stakeholder, or on educational developments that include the concept of the patient either as an individual or as a group. Within the Norwegian nursing tradition in particular, narratives of the history of the profession have had difficulties in demonstrating relevance and in raising questions beyond those that serve the established narrative.

In general terms, the topic of research into the history of patients only came to light when, in 1985, Roy Porter argued for a shift in focus in the field of the history of medicine. Prior to this, the history of patients was the subject of only occasional and fragmented

studies. Since then, the topic has been somewhat more explored. In the case of the history of psychiatry, more attention has been paid to the patient than has been done than within somatic diseases. However, it is correct to say that little interest has been shown in the combination of patient and educational history, although such interest may be boosted by exploration into the integration of person-centred health care. The development of an understanding of the patient as a person in healthcare settings, and how the language we use gives meaning to this concept, and of the consequences of the ways in which we treat persons assuming the role of patient, will provide important knowledge for the future.

3 Delimitation, conceptual clarifications and theoretical perspectives

This chapter will be used to delimit the present work in time and space, and to clarify the concepts that I regard as necessary in order to highlight and explore the aim of this study and the research questions. In addition, I will draw attention to the theoretical perspectives necessary to shape the methodological framing of the study and associated research activities. As will be revealed through this chapter, the theoretical approaches that I employ in this work will serve mostly to place myself within a historical tradition involving the active use of language and conceptual history in my understanding of history, rather than referring to specific theorists. This makes my approach more pluralistic than purist in terms of my choice of theories, thus drawing on several historians working within the same tradition. This may be seen as an extension of an inductive process, employing a descriptive, explanatory and interpretative approach to my sources.

The specific focus chosen for my work centres on the conceptual construction of ‘the patient’ as this is presented in the educational context of doctors and nurses. Part of this must be viewed as an extension of an emerging professionalization and the impact that this had on attitudes to the sick person in the context of a professionalized health care sector. Within this context, several discourses and relationships can be viewed as having an impact on how the patient as a concept acquired meaning, and on its subsequent development and that of the relationships between professional healthcare and unskilled workers, and between the healthcare professions. The relationship between patients and professionals will be highly relevant in these contexts. In addition, the healthcare sector was influenced by the prevailing societal contexts and knowledge paradigm at the time, and these also played a significant role in the construction of the patient concept. In the following, I will first argue for the decision to investigate the period between 1880 and 1940, and will then present some conceptual clarifications before discussing the theories applied and used in this work.

3.1 Narrowing the timelines

Some key choices had to be made in delineating the scope of this project in order to make it manageable. One important delineation was in defining the period for investigation (1880 to 1940). One of the research questions used to operationalize the aim of this study draws on the term ‘*modernization’.* This was selected after careful consideration, and its choice has contributed to the time period selected. . A more in-depth clarification of my understanding of the term modernization will be provided below. Although modernization is closely linked to my period delimitation, I first want to draw attention to other factors that have had a crucial influence in my choice of historical period. In all historical studies, such delimitations and choices should be closely connected to the focus and approaches employed in the study. In the following, I will argue why I regard the period between 1880 and 1940 as relevant and useful to the aim of the study, in spite of the fact that other historians have chosen different delineations for the investigation of their work.

In an overview of the Norwegian history of medicine and health, *Det offentlige helsevesen i Norge 1603-2003,* the authors chose a different period to my own.[91] Two periods are considered in the second book of this huge work, *Folkets helse – landets styrke, 1850-2003,* (Schiøtz 2003) the first spanning from 1850 to 1912, and the second from 1913 to 1945. In acknowledgement of these divisions, my thesis will range over two periods, but will end in 1940. In the following, I will argue why I view 1940 as a clear break in the history of medicine and health. When Schiøtz argues for the period adopted in the overview, there is a strong connection between the narrative and the focus of her book. For Schiøtz, the central focus is state engagement in medicine and health, and her time delimitation has been selected in accordance with the background and progression of

[91] Ole Georg Moseng, *Ansvaret for undersåttenes helse 1603 - 1850*, 2 vols., vol. 1, Det offentlige helsevesen i Norge 1603 - 2003 (Oslo: Universitetsforlaget, 2003).

Schiøtz, *Folkets helse - landets styrke 1850 - 2003*, 2.

state involvement, and its evolution through time.[92] In my work, the patient and education are chosen as the core elements of the study, and other framing thus serves as more sufficient in accordance with the aim of the study.

Given that the concepts of the *'patient'* and the *'education'* of healthcare workers, in this case doctors and nurses, are those chosen as key elements of this project, a time period had to be selected during which we recognise that both patients and education were essential concepts. These concepts will get a thoroughly discussion later in this chapter, for the present, I would like to reaffirm that it is crucial to frame the concept of the patient both geographically and in space. Moreover, the concept of education indicates that a professionalization of healthcare workers had found its place, because the formal education of professionals is associated with such an understanding, in contrast to that of unskilled workers. Since this project encompass on both the processual and relational interactions between different groups and individuals, as part of the conceptual construction, the overall timeframe was set to the period between 1880 and 1940. However, respective focus on the two sets of education studied will differ slightly. The geographical focus will be on developments in Norway, although some international developments will be referred to since these may shed some light on, and help to contextualize, national developments.

Towards a professional health care sector

During the 19th century, there was a shift from a privatized to a more professional and institutionalized approach to healthcare.[93] During this shift, the health care professions had to reaffirm their existence, and develop trust within society. An important aspect of this process was the construction of a narrative that enabled the professions to succeed in their professionalization process, which included safeguarding their status as the

[92] *Folkets helse - landets styrke 1850 - 2003*, 2, 18-21.

[93]Moseng, *Ansvaret for undersåttenes helse 1603 - 1850*, 1.

Schiøtz, *Folkets helse - landets styrke 1850 - 2003*, 2.

keepers and developers of important knowledge. A key premise in this narrative was the establishment of an understanding that educated doctors and nurses possessed unique skills that separated them from non-professionals and unskilled workers in the healthcare arena.[94] In this arena, the focus was on advancement in science, medicine and hospitals, and on fighting the great epidemics that raged across the nations of the world, including Norway. In historical terms, this period is associated with late modernity, and I will discuss this concept and its delineation later in this chapter together with the discussion of modernization.

Towards the end of the 19th century, developments in medicine had moved from bedside-medicine, through hospital medicine and were now progressing towards the start of what has been referred to as 'laboratory medicine', a classical division derived from Erwin Ackerknecht, later used by N.D. Jewson and others to distinguish between the different epistemological approaches to the patient by doctors.[95] This shift was observed all across Europe and in North America, and seen as a result of the scientific revolution that contributed to the further development of the medical profession.

Although education in medicine and the professionalization of doctors superseded similar developments and discussions within nursing and nursing education, both must be seen in relation to each other. Several researchers who have studied the development of these professions have pointed out that a system of professions exists by which all have evolved in a state of mutual dependence and independence.[96] The period I have

[94] An example of how fragile the position of the professional health care worker was during the 19th century was the "quack regulation" from 1794. There was a constant struggle to get this repealed by the representatives from the districts at the Parliament, and get it strengthened by the doctors and the establishment coming from the capital in Norway. Not until 1935 was a restrictive legislation on this matter in place. *Folkets helse - landets styrke 1850 - 2003*, 2, 148.

[95] N. D. Jewson, "The disappearance of the sick-man from medical cosmology, 1770-1870," *International journal of epidemiology* 38, no. 3 (2009).

[96] Andrew Abbott, *The system of professions: an essay on the division of expert labor* (Chicago: University of Chicago Press, 1988), 9-20. Abbot here present a brief historical overview of different ways to understand the concept professionalization.

chosen for this project is selected with the aim of covering both of these formative periods in medical and nursing education. The starting point is 1880, shortly before medical education became the subject of debate concerning future curricula and development, and shortly before the founding of the Norwegian Medical Association in 1886.[97] In the years that followed, also nursing education found its place and continued its development. The Norwegian Nursing Association (NSF) was established in 1912[98], and in the same way as the Medical Association, exerted a major influence on nursing education in the professional healthcare sector.

The selected year for the end of my timeline is 1940. At first sight, this date may not be regarded as a natural point at which to conclude my study. Norwegian healthcare continued along the same path during the Second World War. However, I wish to argue that it is both possible and even desirable, to regard the years of German occupation (1940-45) as a separate and exceptional period. In 1945, a new era started with the reconstruction of post-war society. The so-called ‘Evang period’ in Norwegian health care was initiated with the employment of Karl Evang[99] as Director at the Directorate of Health in 1938. This period represents both a break and a continuum in the history of healthcare in Norway,[100] and the focus of this study will be limited to the period leading up to that.

Another delimiting factor that has contributed to the framing of this study is the role of the healthcare system as part of wider society. However, my focus on education within

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Vibeke Erichsen, *Profesjonsmakt: på sporet av en norsk helsepolitisk tradisjon*, LOS-senterets utgivelsesserie på Tano Aschehoug (Oslo: Tano Aschehoug, 1996). Vibeke Erichsen present the same overview put in a Norwegian context in this book from 1996.

[97] Schiøtz, *Folkets helse - landets styrke 1850 - 2003*, 2, 18.

[98] Ibid.

[99] Karl Evang is considered a giant in public health, and stood for the building of the Norwegian welfare system in public health from 1938 to 1972, when he retired. Ringen Knut, "Karl Evang: A Giant in Public Health," *J Public Health Policy* 11, no. 3 (1990).

[100] Aina Schiøtz, "Fagstyrets vekst og fall - fra helseadministrasjonens historie 1800-1983," *Michael* 4, no. 2 (2007): 82-84.

the healthcare system constitutes only a minor aspect in terms of our understanding of health within society. Health is included in many aspects of people's life, and must be understood in accordance with the culture and social frame of the life people live. The health care system is through this thesis considered to be a social and cultural arena of health provision.

The health care system – a social and cultural model

I have chosen to view the healthcare system as a social and cultural arena. This view draws on a model developed by Arthur Kleinman.[101] Kleinman exploited his background in anthropological research to explain how the healthcare system, similarly to other cultural systems, has to be understood by its participants in terms of its objectives and activities, and that these are dependent on a variety of institutions, agents, interrelationships, and economic and political factors.[102] Although Kleinman developed his model and understandings as a result of his anthropological studies, carried out mostly in China and Taiwan, his model has been described to be relevant as a universal and interdisciplinary model for the understanding of healthcare systems, and which is, and has been, applicable in a variety of cultures and social settings throughout history.[103]

Kleinman emphasized the importance of viewing the healthcare system in a context, and that this involves implementing a continuous shift in focus and perspectives based on knowledge, religion, experiences, concepts, rules and relationships. Such a view leads us to a holistic approach to the understanding of any healthcare system.[104] The model allows us to recognise the different roles of the various sectors involved, and to

[101] Arthur Kleinman, *Patients and healers in the context of culture: an exploration of the borderland between anthropology, medicine, and psychiatry*, Comparative studies of health systems and medical care (Berkeley: University of California Press, 1980), 24ff.

[102] Ibid., 26-27.

[103] Bente Gullveig Alver, *Vitenskap og varme hender: den medisinske markedsplassen i Norge fra 1800 til i dag*, ed. Tove Ingebjørg Fjell and Teemu Ryymin (Oslo: Scandinavian Academic Press, 2013), 25-26.

[104] Kleinman, 34.

understand their impact on sickness, illness, power, gender, and how the various relevant roles and relationships are played out and understood. The various sectors involved will also exhibit a variety of internal cultures that change over time as the sizes and relationship between them will vary.

Kleinman’s model is made up of three sectors; 1) the professional sector, 2) the folk sector and 3) the popular sector.[105] According to Kleinman, the last of these is the largest, consisting of non-professional and unskilled persons, such as families, social networks, local communities, and individual persons living with illness or sickness.[106] This sector contains a variety of persons with a diversity of understandings as to what health and sickness mean, how these persons influence others within the sector, and how serious an individual regards his or her own condition. More importantly, it is within this sector decisions are made about who to seek for help, care and cure, and what sector to enter next, the professional or the folk sector.

The folk sector consists of a variety of actors that provide medical treatment and care outside the professional sector. It includes persons providing treatment primarily as a supplement to the provision offered by professionals, but also as alternatives to science and EBM, which currently accounts for most medical care offered in the western world. Other concepts used about this sector would in the western world include the concepts of ‘alternative’ and ‘complementary’ medicine. Historically, the distinction between the folk sector and the professional sector has been much smaller than is the case today. In this regard it must be added that during the period under study, a struggle between the healthcare professions and unskilled healthcare workers affected ordinary people’s life in the way that none of these two sectors had monopoly on treatment and care. People could choose to seek help from both sectors; dependent on what they felt gave most

[105] Ibid., 50.

[106] Ibid., 50-53.

sufficient and trustworthy effect on their illness.[107] The sizes of these two sectors were not fixed during this period, and the extent to which the public at large sought them out for help varied according to ease of access and the trust engendered by professionals in terms of the treatment and care they were offering. Other historians have pointed to that the professional sector did not always win out in terms of the healthcare choices made by most common people.[108]

Traditionally, and at least since the second half of the 19th century, the professional sector has emerged as the most dominant, at least in Western societies.[109] It certifies healthcare professionals with a formal education to work and practice within a set of rules that apply to their profession and the relationship between them. This sector is the home of science- and evidence-based medicine and healthcare, and within which the reductionist approach must be regarded as the dominant paradigm today. These elements are what give this sector the power and legitimacy to define and prioritise what sickness is and how it should be treated. Later, I will discuss how this power is exploited to define the dominant paradigm within which we view the patient and how this evolved and extended over time, not just within the professional healthcare sector, but also in other sectors both within and outside healthcare. I will argue that Andrew Abbot's[110] understanding of a system of professions and their associations with the tasks they perform, and the objectives they aspire to, harmonize well with how professional development is played out according to Kleinman's model and of the definition of what a profession is. Together these two theories on health care sectors and the system of professions will contribute to frame the analysis of the historical sources.

[107] Alver, 49, 60-66, 68-72.

[108] Ibid.

[109] Ibid., 49, 82.

[110] Abbott.

It is within the professional sector that the education of both doctors and nurses belong. The nature of education of both professions supports and reproduce the dominant paradigm that has existed since the scientific revolution of the 19th century. I base my assumptions on the patient as a social construct embedded in the professional health care sector, and further that the education of the professions is embedded in Kleinman’s professional sector of healthcare development. On this basis, I will argue that it is possible to understand the different views of the concept of patient in accordance with the development within the professional healthcare sector, in spite of other constructions can have emerged outside this sector. Formal education opens many doors, but it also lay the premise for hierarchic struggles, exercise of power through access to professional knowledge, which give the professional the role of an expert. Within such practice, experts can assume a variety of roles rooted in different images conferred on them by society and the profession itself. Within these varieties of roles, different constructions of the patient concept may appear and develop as part of educational knowledge development and applied images on the professional. Before exploring this more thoroughly some clarifications of concepts are necessary.

In the following, I will present my arguments for some conceptual clarifications that are relevant to the time period of my study, and the healthcare system within its definition as a professional sector. These clarifications must be regarded as my means of emphasizing how the various concepts are viewed within the context of the period under investigation, and the social and cultural factors that inform my analysis.

3.2 Conceptual clarifications

In order to enable me the application of the central concepts included in my analysis, I will clarify my understanding of, and discuss, some of these concepts in relation to pervious research in the fields of both history and health.

Modernization and modernization processes

Several historians have argued that a ‘break’ in the continuum can be identified at the transition to our ‘modern’ health service. However, a debate is continuing among

historians as to exactly when this transition can be said to have taken place.[111] Ole Moseng has argued that the modern Norwegian health service emerged in the 18th century in conjunction with the establishment of the '*Radesykehusene*'. Moseng argues that these hospitals were established to treat and cure person's sick with 'radesyke.'[112] Moseng bases his argument on society seeking a cure for this disease in a hospital setting, and supports this by referring to a 'break' in comparison with the previous use of hospitals, focusing on retention and caring.[113]

Moseng is not the only historian to identify the wider development of hospitals as a break in historical development. Michel Foucault has in his book *The Birth of the Clinic* advocated that the hospitals were the institutions in which such a break in the development of medicine and medical knowledge was played out.[114] In his work, Foucault has demonstrated how the hospital served as an institution where the clinical gaze changed and, in doing so, served as an example of a clear break in history, not only in medicine but also in relation to our view of the patient. Further, Foucault claim, this must also be viewed in terms of its effect on society in general, and the development of a knowledge gap between the expert and the layman. Foucault argues that this break in the clinical gaze contribute to transforming the hospital into a modern institution, in

[111] See discussion about this by Anne Kveim Lie. Anne Kveim Lie, "Radesykens tilblivelse: Historien om en sykdom," (2008), 227-29.

[112] 'Radesyken' was a national disease that during 18th century accounted for the biggest health challenge in Norway. What this disease actually was is not accounted for, although Anne Kveim Lie explore different possibilities thoroughly in her doctoral dissertation from 2007/2008. What we do know is that this disease was a chronic disease that caused leprosy-like wounds in the flesh, primarily in the nose and swallow area, combined with rash and pain in the joints. Ibid., 217-18.

There has been conducted two PhD projects in Norway on this disease. The first was by Frederik Holst in 1817. The other by Anne Helene Kveim Lie in 2007/2008. Frederik Holst, *Hva er sykdommen som kalles Radesyge, og på hvilken måte kan den utryddes fra Skandinavia (Morbus, quem Radesyge vocant, quinam sit, quanamque ratione e Scandinavia tollendus?) doktoravhandling 1817* (Oslo: Michael, 2005).

Lie.

[113] Moseng, *Ansvaret for undersåttenes helse 1603 - 1850*, 1, 235ff.

[114] Michel Foucault, *Klinikkens fødsel*, Naissance de la clinique (København: Hans Reitzel, 2000).

which power and freedom must be regarded as developments that derive from this.[115] Although both Moseng and Foucault use the hospital and its ability to cure as an argument for entering into a modern understanding of health, there are some important differences between them. One historian that has problematized this approach to understanding the break and subsequent transition in a Norwegian context in the history of medicine and health is Morten Hammerborg, in his doctoral thesis completed in 2009.[116]

Although Moseng argues convincingly for his points of view, there are several aspects regarding his understanding that I find problematic in relation to my own work. Firstly, in its broadest sense, the traditional concept of modernity has been understood as being synonymous with industrialization, capitalism and other specific characteristics that typify western society, and which are untypical of other, less well-developed societies. However, I consider it problematic to think of Norway as an industrialized society with a well-developed capitalist system during the 18th century. Neither the industrial nor the economic growth that came in the wake of this development reached Norway until the 19th century.[117] Moreover, to claim that Norway possessed modern hospitals in the 18th century becomes problematic in the context of modernity as we define it in contemporary society. People in general, including academics, refer to our existing healthcare service and its modern hospitals as the product of a modern society. If we compare this with the conditions that existed in the 18th century, we can hardly call the latter modern. This consideration brings us neatly to what we mean by the concepts of *‘modern’* and *‘modernity’*, and serves to generate a broader discussion on how these concepts apply in relation to health.

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[115] Ibid., 96-97, 98, .

Morten Hammerborg, "Spedalskhet, galeanstalter og laboratoriemedisin - endringsprosesser i medisin på 1800- tallet i Bergen" (Universitetet i Bergen, 2009), 19-44.

[117] Gro Hagemann, *Det moderne gjennombrudd: 1870-1905*, vol. B. 9 (Oslo: Aschehoug, 2005), 187.

Modernity is hence a concept that changes depending on the relational context, and also on what one views as 'unmodern' or 'not modern'. This approach of viewing modernity was promoted by Bruno Latour in his 1933 book '*We have never been more modern'*. Latour claimed that the idea of a modern society is impossible because it will always stand in the contradiction between a naturalistic and positivistic understanding of what a modern society is, and the subjective construct created by different societies as to how they understand modernity.[118] Returning to Moseng, and his argument that the modern health service in Norway started with the development of curative hospitals, I want to argue that this represents a simplification of our understanding of modernity. Firstly because I find it hard to separate the understanding of a modern health service sector from other parts of society. Secondly, because it is problematic in our consideration of other societies, both past and present, to link an understanding of modernity to single institutions such as hospitals. In acknowledging Latour, I prefer to treat modernization as a process, and to understand modernity as part of a continuous change towards something. When the terms modernity and modernization are understood as relating to a continuous process, we can examine specific developments that contribute to this process and the relationships between them.

The modernization process, and the transition towards a modern healthcare system, must be seen in close relation to society in general. Most historians will agree that the scientific revolution in the natural sciences influenced the developmental and modernization process in medicine and the professional healthcare sector, although there is less agreement as to exactly when this revolution began.[119] In my opinion, the

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[118] Bruno Latour, *We have never been modern*, ed. Catherine Porter, Nous n'avons jamais été modernes (New York: Harvester Wheatsheaf, 1993), 10,13,46-48.

[119] Moseng, *Ansvaret for undersåttenes helse 1603 - 1850*, 1.

Anne-Lise Seip, *Sosialhjelpstaten blir til: norsk sosialpolitikk 1740-1920*, 2. ed. (Oslo: Gyldendal, 1994).

Schiøtz, *Folkets helse - landets styrke 1850 - 2003*, 2.

Lie.

precise timing is not crucial. What is crucial, however, is to establish that during the period covered by this thesis, continuous development progressed as part of the modernization processes both within society and the professional healthcare sector. The way I understand the contextual impact, these developments have influenced the construction of the patient concept as part of a meaning-making process, highly in relation to modernization as a continuous process.

The opportunity to achieve an effective means of protecting people from diseases by applying hygienic methods and exploring the possibilities of cures constituted the basis for the scientific revolution within medicine. The optimism within medicine that derived from the Enlightenment also extended into government.[120] A belief that medical advances could promote a healthy population constituted an important basis for the development of a modern society driven by economic growth. For the state, this meant getting more involved in the establishment of new hospitals, combined with securing access to educated and professional doctors who would be available to the entire population. Both of these contributions to the health arena represented a sound investment from the state perspective.[121] The state also contributed by enacting regulations to reduce the severity and decelerate the spread of epidemic disease. Public health as a concept evolved in the wake of opportunities created by the scientific revolution and modernization processes in medicine and health, and doctors constituted a profession that could contribute to fulfil government objectives on these matters.[122]

The scientific revolution occurred at the same time as two other important revolutions in society – the industrial revolution and the democratic revolution.[123] The overall effect

[120] 227.

[121] Schiøtz.

[122] *Folkets helse - landets styrke 1850 - 2003*, 2, 43, 138-41, 52-54.

[123] The industrial revolution occurred during a range of different phases from 1840/50’s stretching into the 20th century. The democratic revolution occurred during the same period, including constitutional rights to

was that the growth in knowledge, employment opportunities and economic development, combined with individuals' increasing demands for equality and a better quality of life, placed demands on the state to find solutions adapted to a new era.

This demonstrates that we must adopt a broad approach in our consideration of modernization, because it comprises several processes taking place within society in general, and within health and medicine in particular. The processes continued in a multitude of fields related to power, gender, economics, welfare and governmental affairs. In order to illustrate the complexity of these processes and, simultaneously, to establish a dynamic, rather than a fixed, understanding of the concepts of modern and modernity, I wish to argue that modernization processes are relevant for use in this project. As I have argued in the foregoing, the patient as a concept constitutes an important premise, both for discussions about modernization processes, and my delimitation of the period covered by this thesis.

The patient

Etymologically, the word *patient* is derived from the Latin *patiens,* which means suffering or enduring. The French concept of *pacient* picks up on *pati/pathos* from Greek, meaning *to suffer.* Previous research has argued that it is important to raise awareness of the etymological meaning of the word in order to focus on the patient as an important stakeholder in research into the history of medicine and health. In his paper, '*The patients view. Doing Medical History from Below',* Roy Porter argued that the concept *'patient'* first comes into use when put in a professional medical context.[124] Part of Porter's argumentation rests on Foucault's argument that I presented earlier; when hospitals changed to adopt a curative focus, the appearance of the patient as a concept was

a larger group during the first decades of the 20th century than in 1880's when democracy was established in Norway.

Hagemann, B. 9, 187-92,250-59.

[124] Porter, "The patient's view. Doing Medical History from Below," 181-82.

established. However, Porter also argues that by putting the patient on centre stage, we are telling the history of a ‘*sufferer’* or *‘the sick person’,* regardless of what concept we use. In Chapter 7, I will challenge aspects of these arguments, and discuss the distinction between focusing on the patient versus focusing on the person or other newly included concepts into the health care arena, as part of broaden perspectives on contemporary and future challenges within health education and practice.

When Porter presented his arguments in 1985, his intention was to draw attention to his view that research done on in the field of ‘the history of medicine’ had contributed to diminishing focus on the patient. Porter goes further by claiming that the patient’s role had been ignored systematically by researchers.[125] Porter uses this paper to point out how both historians and others can transform this history of neglect by trying to return the patient back into centre of attention. However, distinguishing between the patient and the sufferer as concepts are not the main focus of Porter’s paper. He is simply using this point to emphasise that the patient as a concept is heavily based on the healthcare professional’s understanding of medicine and health. However, if we examine the work of other researchers, we can find arguments supporting that even as early as the 15th century, the English word patient was well established – referring to a person receiving medical treatment or care of some kind, although not exclusively by educated doctors.[126] Although Porter was reluctant to use the concept of patient in contexts prior to the professionalization of medicine, such an understanding harmonizes well with his argument that a sufferer or sick person usually attended to their sicknesses themselves or sought help among a circle of care providers that were known to them. Prior to the beginning of the 20th century, seeking help from a doctor was only one of many options available in the search for medical assistance.[127]

[125] Ibid., 176.

[126] Botslangen, 59-60.

[127] Porter, "The patient's view. Doing Medical History from Below," 182.

As I will explore in the following, the concept of patient has always been constructed and understood in relation to the professional healthcare arena. This argument is important as a basis for understanding some of the changes that took place when people began to be treated and cured in *the professional health sector,* as defined by Kleinman, rather than in the popular or folk sectors.[128]

Today, the concept of the patient encompasses a broader meaning than someone who is simply suffering or in pain. However, the concept is closely linked to the professional healthcare sector. In Norwegian legislation relating to patients' rights, a patient is defined either as a person who requests treatment or care from the healthcare services, or a person who is given treatment or care by said services.[129] Thus, in Norwegian law, a person does not have to be sick in order to be defined as a patient. Similarly, being sick without requesting treatment does not make a person a patient. In order to come under the legal definition of being a patient, a person has to be in contact with the professional healthcare services.

We encounter another definition in the Norwegian Medical Encyclopedia. Here, a patient is defined as a person who is sick and receiving treatment either in an institution or from a healthcare service. The sick person assumes a specific role, and accepts the norms and regulations that apply to sick persons in this specific setting.[130] These norms and regulations also refer to specific rights and duties established in Norwegian society. These contemporary understandings of the concept of patient, including norms and regulations, is explored in the book 'The modern patient' (2008) written by different Norwegian researchers from different academic subjects.[131] In this book, the modern understanding of the concept patient is explored and illustrates how the patient is

[128] Kleinman, 53.

[129] https://lovdata.no/dokument/NL/lov/1999-07-02-63

[130] https://sml.snl.no/pasient

[131] Aksel Hagen Tjora, *Den moderne pasienten* (Oslo: Gyldendal akademisk, 2008).

positioned in relation to the healthcare services, and how he or she assumes a variety of roles on encountering these services. The authors emphasise the complexity inherent in this concept and demonstrate the variety of different categories within which such a concept may be operationalised. They also provide specific meanings as they relate to specific contexts. The aim of the authors is to emphasize how the patient, on encountering professional healthcare workers, constructs specific sets of premises to enable him or her to receive the necessary treatment, and how different social, cultural, political and economic agencies influence this construction.[132] The authors conclude that in todays health care sector, the patient exists and relates to the expert professional in the intersection between the paternalistic frame, developed as part of modernization and the individualistic choices of being a customer of health provisions, understood as part of the post-modern society.[133]

These different ways of viewing the patient as a concept serve to emphasize that patient is a social construct that is heavily dependent on the context in which it appears and develops. Similar to what Porter argues in his paper, all definitions view patient as part of a process of professional treatment and care provided to a person, and in relation to others. There is no mention of a patient being part of a context involving traditional private or folk/alternative/complementary treatment and care. Emphasis is entirely focused on the patient in relation to the professional health care sector.[134] In the context of alternative or complementary care, we also speak today of ‘sick persons’, or of persons with specific challenges, but rarely as ‘patients’. From this we can derive that what separates the professional from the folk and popular sectors is that people being treated and cared for in the latter are not strictly defined as patients and nor are they treated or cared for by professionals, in a strict meaning. However, this does not mean they are

[132] Ibid., 11, 16-18.

[133] Ibid., 29.

[134] Arthur Kleinman, "Concepts and a Model for the Comparison of Medical Systems as Cultural Systems," *Social Science and Medicine* 12, no. 2B (1978).

unable to receive adequate treatment. It is not my intention to pursue this discussion in this thesis. My work has led me to an understanding that the definition of a patient between 1880 and 1940 must be seen in relation to the care needs of a person who is sick in the context of the professionalization of the medicine and health sector.

Professionalization and education of the professions

As I intend to use the term 'profession' as part of my analysis, the concept requires clarification. Firstly, it is important to state that during the period of history selected for my analysis, doctors and nurses would not have viewed themselves as professionals in the way in which we understand the term today. The term profession as a concept developed after the period covered by my analysis. However, I have identified some similarities in the way in which I perceive our current understanding of the concept, and have examined the development of the education of doctors and nurses during the late 19th and early 20th centuries based on the definition provided by the sociologist Vilhelm Aubert. I will not enter into a protracted discussion on the sociological aspects surrounding this concept, but will present two elements that I have found useful in my work.

Aubert states that the term profession can be applied to specific types of professionals educated to a certain academic level. By definition, they hold a monopoly to exercise and practice certain tasks, and exert a high degree of power and control over the ethical and professional regulations that apply to their respective professions.[135] This definition has been challenged over several decades within a variety of scientific disciplines. However, a similar definition, provided by the Norwegian political scientist Ulf Torgersen, supports that proposed by Aubert. Torgersen argues that a profession is defined by persons with formal educations of certain lengths leading to specific occupations that, according to

[135] The definition is picked up from the book "The history of professions." Jan Messel and Rune Slagstad, *Profesjonshistorier* (Oslo: Pax, 2014), 11.

social norms, cannot be conducted by persons without the relevant educations.[136] Although my thesis is not concerned with a discussion of the various understandings or the development of the concept profession, it is important to understand how such a definition can be used to support and challenge the hierarchical struggle that has taken place between the different professions within the healthcare sector, and the impact of this struggle. As early as in the 19th century, both doctors and nurses are seen to conform to these two aforementioned definitions. Although very different, both had formal educations of a certain length. Both doctors and nurses held occupations that, during the period of history covered by my thesis, could not be held by others who had not completed the respective educations. It is also true that parts of their educations were designed to ensure that they upheld social norms derived from ethical standards and regulations, defined as part of the education. Finally, both professions obtained power as a result of their educations, although this power was expressed in different ways and in different arenas.

Vibeke Erichsen has identified three different perspectives in the development of a theory of the healthcare professions in a Norwegian context, and we can consider these as part of our attempt to understand developments and the tensions that have arisen between the professions. The three perspectives are as follows: (1) the classical doctor-oriented perspective, (2) the power perspective and (3) the historical-sociological perspective.[137] It is possible to view the development of healthcare professions using all of these perspectives. Within the historical-sociological perspective, Erichsen illustrates how a variety of theorists have emphasised the use of comparative approaches in the shaping of the different professions.[138] One of these is Andrew Abbot, who linked the comparative perspective to everyday work in his book '*The System of Profession'.*

[136] This definition is picked up from Øivind Larsen. Larsen, *Legestudent i hovedstaden*, 58.

[137] Erichsen, 24-28.

[138] Ibid., 26.

Abbot argues that a profession must be understood in accordance with the tasks that the professionals perform. We approach this by examining the production of the essential services as provided by professional healthcare workers, and the establishment of inter-relational patterns. The tasks can be viewed in terms of who has the power to decide how we define or construct reality within the healthcare institutions. In this way, the connection between the profession and its tasks constitutes the backbone of the profession in question, defined by Abbot as ‘jurisdiction’.[139] For Abbot, the link between the profession and its tasks is determined not only by social structures but also by the history of the profession itself.[140] This perspective has proven to be fruitful in my work in terms of understanding the evolution of the relationships between doctors and nurses and their respective views of the patient. I have used Abbot’s theory to understand how education in medicine and nursing has influenced an arena in which different patient-related tasks have contributed towards shaping the construction of the concept and view of the patient, based on different understandings of reality in relation to the designed tasks. This historically recessed view can be regarded as a contributor to the tension that has arisen between the two professions, which is still visible in our contemporary healthcare arena, and that also influences the view of the patient.[141]

Power as a relational factor in healthcare

Vibeke Erichsen highlights power as one of the three perspectives within which to study the various health professions and the relationships between them. Erichsen specifically refers to education as one of the main bastions of power that must be explored if we are to understand how doctors through time have characterized developments in healthcare.[142] This understanding can be seen as an extension of what Michel Foucault

[139] Abbott, 20.

[140] Ibid.

[141] Heidi Haukelien, "Omsorgsyrker, hierarki og kjønn: Historiske linjer," *Norsk antropologisk tidsskrift* 24, no. 03-04 (2013).

[142] Erichsen, 25.

defines as the concept of relational power, which is reliant unavoidably on the development of knowledge. Foucault was preoccupied with demonstrating how power had changed from something that a person possessed, to the idea that being in power is a relational concept wherein knowledge is regarded as a prerequisite for exercising this power.[143]

Within the health care arena power can be studied both in terms of the relationship between the various professions, and also, as pointed out by Foucault in his book ‘*The Birth of the Clinic’,* as a development in the professionalization of health and medicine, by which the professions evolve as the experts and the patient as a ‘layman’.[144] Part of this development is linked to the knowledge that enables the doctor to assume expert status, and the impact this knowledge has on changing the balance of power. The process results in benefits to the professional doctor, who is in possession of the knowledge, while the patient, as a non-professional layman, becomes the exposed object of the power exercised by the doctor.

In the light of Foucault and his extensive discussions of our various understandings of power based on historical investigations within the fields of health and other authoritarian social systems, it is almost impossible to ignore the perspective that regards power as a major factor in the relationships between the different healthcare professions, and those between the professionals and their patients. In my thesis, the construction of a concept such as the patient is explored in terms of education, during which knowledge is developed and which forms the basis for both objectives and hierarchic structures. Based on this I intend to emphasise my understanding of power as

[143] Michel Foucault, *Overvåkning og straff: det moderne fengsels historie*, ed. Dag Østerberg, 3. utg. ed., Fakkel (Oslo: Gyldendal, 1999).

Galskapens historie i opplysningens tidsalder, ed. Erling Sandmo, Fredrik Engelstad, and Erik Falkum, Bokklubbens kulturbibliotek (Oslo: Bokklubben dagens bøker, 2000).

[144] *Klinikkens fødsel*.

a relational concept, exercised in the context of the different levels of knowledge possessed by the actors involved.

3.3 Theories of language in historical analysis

My epistemological point of view as a social constructivist emphasises an approach to knowledge that constitutes consistently an interpretation based on experience, history, culture and language. In adopting this approach, I place myself in the historical tradition eloquently expressed by Paul Veyne: *"History does not make progress, but widens, which means that it does not lose backward the terrain that it conquers forward."*[145]

Meaning making through language is essential to the construction of a concept. A fundamental understanding within a social constructivist approach is that reality is shaped by the way we use language to conceptualize different phenomena, events, concepts and suchlike. This means that the way in which we use language will also be an expression of the ideas, values and virtues that constitute the representation of how we relate to reality. This constitutes the connection between social and conceptual history, an approach to understanding of history explored and argued by Reinhart Koselleck (2002).[146] The weakness of this approach is that reality may differ in practice, and be understood differently, from the discussions that emerge through the texts. The ways in which we speak and write about specific topics do not always determine the ways in which we act. On the other hand, most people seldom behave contrary to the ways in which they speak and write about a topic, although nuances in their approach may emerge depending on how they adapt to given situations. It is important for me to clarify here that practice and practice development, and the relationship between the patient and healthcare workers as experienced in healthcare settings are not the focus of this study. Instead, my analysis focuses on linguistic representations as set out in documents

[145] Paul Veyne, *Writing History. Essay on epistemology* (Middletown, Connecticut: Wesleyan University Press, 1984), 228.

[146] Reinhart Koselleck, *The Practice of Conceptual History. Timing History, Spacing Concepts* (Stanford, California: Stanford University Press, 2002), Chapter 2, 20-37.

from which I interpret and understand history. A focus on language in historical research implies a dualistic recognition of a challenge articulated by the same Koselleck in a paper from 1989:

“The linguistic conception neither takes in what happens or what was actually the case, nor does something occur that is not already altered through its linguistic shaping.”[147]

As I understand Koselleck, he emphasizes that the linguistic turn focuses on language and meaning as something that are not fixed, but created and understood by human beings in different contexts at different times in history – a view that is not unfamiliar in historical research.[148] In historical research, the linguistic turn has been linked primarily to a break from the traditional focus on the political- and state-oriented approach to history, more than a methodological break. [149] One can argue that in historical research, an understanding of language as meaning making harmonizes both with a hermeneutic[150] as well as with a constructivist approach. Such an understanding acknowledges that concepts will change and be understood differently at different times and in different cultures, depending on the representational system that is used to construct meaning.

By applying the theory of language in this way, I place myself in a tradition that not only distances itself from the claim that it is possible to achieve an objective representation of history, but that also acknowledges the place of the researcher in shaping the analysis. In line with Koselleck, who not only connects social and cultural history to conceptual history, but also emphasizes the synchronous and diachronic meaning of language[151], I have found this approach especially relevant in my analysis of the construction of patient

[147] "Social history and conceptual history," *International journal of politics, culture, and society* 2, no. 3 (1989).

[148] Iggers, 2, 118-33.

[149] Leidulf Melve, "Ein «reflektert historiefagleg identitet»?," *Historisk tidsskrift* 81, no. 4 (2007).

[150] Gadamer, 401-13, 15.

[151] Koselleck, "Social history and conceptual history," 317-18.

as a historical concept. In this lies the interpretational challenges and opportunities in situations where language uttered synchronically also becomes diachronic.

Within medicine and healthcare, where interpersonal relationships constitute the grand narrative in terms of our understanding of development in time, space, and across cultures, text was produced in an in-depth context that has now disappeared. This distance between the text and the researcher is what I try to grasp by use of the fusion of horizons based on hermeneutics. This emphasise the significance of context where language is produced, not as a means of obtaining knowledge of social realty, but as a guide to this knowledge based on the discourse and society in which the concepts appear.[152]

As said by George Iggers;

"…it means that science, especially "historical science," which is so closely tied to human values and intentions must be seen in the sociocultural and political framework in which it is practiced."[153]

As argued in the foregoing, the construction and development of concepts through language have played a significant part in my work. I have chosen to focus on the healthcare system as a cultural and social system.[154] The historical data comprises the starting point of an inductive approach. However, the historical sources have been investigated with the aim of showing how a given concept in the healthcare arena can both frame, and is also framed by, the meaning assigned to it in a given context, in line with the way in which language is connected to the linguistic theory of concepts. Social and cultural influences both have an impact on the meaning assigned to concepts in the field of medicine and health. By using Kosellech as a starting point, I will argue that within

[152] Iggers, 2, 126-28.

[153] Ibid., 18.

[154] Schiøtz, *Folkets helse - landets styrke 1850 - 2003*, 2, 15.

such an understanding, concepts and knowledge develop and must be understood according to the values, ideas and attitudes prevailing at the time at which they appear.[155] In so doing, I will also include a discussion on how the different professions relate to each other and to the society of which they are a part, and how this contributes to the priorities and focus exercised within and between the professions, as expressed by their representatives in a number of different sources.

Peter Burke is another historian who has emphasized this approach to history. Burke has stated that the philosophical foundation for this type of history, which he refers to as ‘the new history’, is: *“the idea that reality is socially and culturally constructed”.*[156] Burke goes on arguing that it is impossible not to view history from a point of view in which cultural, social and historical understanding and tradition also apply to the writing of history itself.[157] Furthermore, he argues that the key concepts used in both social and cultural history, such as gender, class, social status, power, ideas and the various understandings of the roles acted out in both the civil and public spheres all play an important part in analysis conducted within this framework.[158] In my work I have been curious as to how these concepts, drawn from a social and cultural understanding, must be seen in relation to concepts drawn from the biomedical and natural sciences in healthcare and medicine, and how they have influenced the way in which language was used to construct the patient concept within the different paradigms. Between these two traditions lies a tension that can be exploited to broaden the understanding of medicine and health within a cultural and social perspective, but where natural science also plays a significant part.

[155] Reinhart Koselleck, Futures past: on the semantics of historical time, (New York: Columbia University Press, 2004).

[156] Burke, 3.

[157] Ibid., 6.

[158] Peter Burke, *History and social theory*, 2nd ed. ed. (Cambridge: Polity, 2005), 47-54, 60-64, 79-82.

3.4 The framing of images and different objectives

In society in general, but especially within the healthcare sector, we have a clear idea of what the different professions should be like, and what tasks or objectives they should conduct as part of their work. This vision of different images we apply to doctors have been used by Øivind Larsen to develop a framework within which to understand how such specific images appeared and changed in emphasis through time.[159] Within this framework, I will examine how both the ways in which doctors view themselves, and the ways in which society views them, are woven into our collective image and expressed through the conceptualization of these images. In addition, Larsen has connected the different images of the doctors’ to the most important tasks and objectives they perform within these images.[160] The objectives are thus closely connected to the images.

In this project, I have used Larsen’s framework as a basis for understanding the images and objectives of the doctor, and of how medical education developed and adapted to enable doctors to fulfil the images that they themselves and society regarded as most important. I have also adapted this framework to nurses and nursing education in order to achieve a similar understanding of this profession. For example, what image was applied to nurses by themselves and society, and how did their education develop to meet these expectations? Finally, I will extend these understandings of images and objectives among the professions to obtain an understanding of how the construction and view of the patient concept was expressed as an extension of these images. This framework, developed by Larsen, will for me be treated in accordance with and seen as an extension of the theory by Abbot concerning the system of professions.[161]

In terms of the framework of images related to doctors, there are mainly four Larsen speaks of, the doctor as life saviour, the doctor as caring supporter, the doctor as

[159] Larsen, "Doktorskole og medisinstudium," 103-04.

[160] Ibid., 105-06.

[161] Abbott.

gatekeeper and the doctor as researcher. I acknowledge that it is possible to consider other images that also apply to our understanding of the role of the doctor in society, but for the most part, I will restrict my discussion to the four images listed above.

While it must be said that the first two roles must be regarded as the most prominent leading up to second half of the 19th century, the latter two have subsequently assumed more dominance from mid-19th century and onwards.[162] It is worthy of notice within this framework that Larsen subdivides the objectives linked to the image of the doctor as a caring supporter into ‘*serve the sick’* objectives and ‘*serve the society’* objectives*.* In the first objective, the individual patient is considered the prominent focus of attention, thus associating this objective with the role of the doctor as a life saviour. However, the objective ‘serve the society’ must be understood in terms of regarding patients as a group within the population that makes up society.[163] Within this objective, although it too relates to the doctor as a life saviour, the individual patient is not considered important. The logical argument for this position incorporates the methods and structures that promote the best health among the majority of the population, sometimes at the cost of the individual.

As regards objectives linked to the image of the doctor as gatekeeper, Larsen argues that this role requires the existence of something that has to be managed or governed. During the late 19th century, what needed to be governed was primarily the medical knowledge and professional education that separated doctors from unskilled healers and laymen. This way of thinking can easily be transferred to nurses and their education, since the nursing profession also recognised a need to keep professional development separate from uneducated orderlies and other unskilled workers. In the mid-19th century, not many issues were managed by doctors. However, as their power and status in society increased, the stakes became higher, and the image of gatekeeper continued to develop

[162] Larsen, "Doktorskole og medisinstudium," 106-09.

[163] Ibid., 105-06.

to where it is today. In a Norwegian context, the doctor acts as a gatekeeper in most of the healthcare services.

What we can draw from this is that the various images of both doctors and nurses apply to specific objectives. These objectives are crucial in our understanding of the construction of the patient concept. The different objectives, will in varying degree focus on the patient as an individual, or as an extension of the disease they suffer from on a group level. I will try to argue during my analysis that the different objectives caused for varying view of the patient; as means towards something else, a healthy population, or as valuable in themselves. It is this understanding that explains the way in which healthcare professionals use language when they relate to reality, this being highly dependent on the tasks and objectives they understand as their priorities in their roles as professionals within the healthcare sector.

My recognition that the different objectives held among professionals within the healthcare sector have consequences for how the patient is viewed was fully brought to my attention through the Person-Centred Practice (PCP) framework. This framework has been developed during recent decades, and is now regarded globally as the favoured approach to care and health by the World Health Organization (WHO).[164] The PCP framework was developed in a nursing context, and is now being introduced to nursing education.[165] In the final chapter of my thesis, I have used the concept of person-centredness and the PCP framework as the basis for extending the historical knowledge obtained through my work into a broader understanding of contemporary and future challenges. Thus, a short theoretical approach to this framework is considered necessary.

[164] World Health Organization.

[165] Deirde O'Donnell, Neil Cook, and Pauline Black, "Person-centred nursng education," in *Person-Centred Practice in Nursing and Health Care. Theory and Practice*, ed. B. McCormack and T. V. McCance (John Wiley & Sons Ltd., 2017).

Andrew Miles, Jonathan Elliott Asbridge, and Fernando Caballero, "Towards a person-centered medical education: challenges and imperatives (I)," *Educación Médica* 16, no. 1 (2015).

3.5 Person-centredness and the Person- Centred Practice framework in education

An important premise of my research in connection with this thesis has been to demonstrate the relevance of historical knowledge as a basis for my presentation of frameworks as applied in healthcare research, health education and practice. I have deliberately focused on how historical knowledge can contribute to an understanding of why we act and do the things we do today, and how we can trace our knowledge, and the meanings we attach to concepts, back in history. In doing so, it has been my intention to add knowledge and promote a broader understanding to person-centredness as a theoretical framework for the future, but also to show how health challenges can be met by the application of a broader field of knowledge.

I see this work as an opportunity to add knowledge to a framework developed to change current practice in the professional healthcare sector from a science and EBM-based approach to a person- centred approach as is embedded in the *‘people-centred health services’* focus promoted by the WHO.[166] In an interim report published in 2015, the WHO recognized that professional healthcare should be organized with the person, and not diseases, as the centre of focus. It also recognized a need to empower people to participate in decisions regarding their own health and treatment. I will argue that there is a need to focus on what make people feel humanized in their meeting with professional healthcare sector of the future, and bring to the front the educational responsibility in emphasizing such an approach. To achieve this level of knowledge we must first explore how factors in education have contributed to the prevailing reductionist construction of persons in their roles as patients, which can be assumed as dehumanizing factors.

[166] World Health Organization, 10-11.

«…we shall explore the momentous, but by no means inevitable, step of becoming a patient, the moment when a sick person puts himself under a doctor."[167]

The quote above is taken from Dorothy and Roy Porter (1989) and captures the very essence of the later developed framework in person-centredness. It encapsulates the idea that there is a significant difference between being a person and becoming a patient. The quote also amplifies the understanding discussed above, in which the construction of the patient concept is connected to the professional health system, here exemplified by the doctor. What is even more interesting is that the quote not only states that there is a difference between being a person and becoming a patient, but also carries an implied sense of the difference in power that exists when a person becomes a patient and 'puts himself under a doctor'." I cannot be sure that either Dorothy or Roy Porter were aware of the implication that I am now currently assuming as part of my thesis. However, I wish to argue, based on their research and awareness of the unequal balance of power between the sick person and the professional, that it is reasonable to assume that this approach to understanding the relationship between the doctor and the patient in a changing paradigm deserves more thorough examination. Through the work with this thesis, I wish to explore this by focusing on education and formal training.

Discussions of what a person is, and what distinguishes persons from non-persons, form the core of person-centredness and personhood.[168] The literature demonstrates how problematic the concepts of both patient and person have become for scientists and therapists, as Carl Rogers does in his article from 1955.[169] Philosophically the distinction between body and soul, and what makes a person a person, can be traced to the ancient philosophers. The moral perspective was amongst others discussed by Kant in the 18th

[167] Porter and Porter, 12.

[168] Brendan McCormack and Tanya McCance, "Underpinning principles of person-centred practice," in *Person Centred Practice in Nursing and Health Care: Theory and Practice*, ed. Brendan McCormack and Tanya (editors) McCance (UK: Wiley Blackwell, 2017). p 13 ibid

[169] Carl A Rogers, "Persons or Science? A philosophical Question," *The American Psychologist* (1955).

century. All of these thinkers question the significance of what makes a person a person, and discussion of how to retain personhood on becoming a patient has been explored further by researchers and philosophers of the late 20th and 21st century.[170] Such reflections and philosophical underpinnings are relevant if you accept the assertion that every patient is first and foremost a person. However, within this framework, we must also reflect on what personal attributes besides being sick changes when a person becomes a patient. This reflection can return us to an understanding that lies beyond purely philosophical thinking, and direct us onwards to a variety of views of the person’s role as a patient through history. What are the costs to the sick person on becoming a patient in a professional healthcare system in an era characterised by early modernization processes and constant development?

In order to understand the significant difference between being a person and becoming a patient we can look to the PCP framework developed by Brendan McCormack and Tanya McCance.[171] The philosophical perspectives underpinning this framework are derived from ideas that can be traced back to Ancient Greece. Both Plato and Aristotle were concerned with the state of the human being in relation to and separated from nature, and what virtues and values a human being should have in order to be a moral

[170] McCormack and McCance.

Martin Buber, *I and Thou* (Edinbourgh: T&T Clark, 1923).

Rogers.

Tanya McCance, Brendan McCormack, and Jan Dewing, "An Exploration of Person-Centredness in Practice," *Online Journal of Issues in Nursing* 16, no. 2 (2011).

[171] Brendan McCormack and Tanya McCance, *Person-centred nursing: theory and practice* (Chichester: Wiley-Blackwell, 2010).

person.[172] These perspectives have recently been revitalised by several authors engaged in the development of the PCP framework within nursing and nursing research.[173]

What was important to me was to see how these philosophical perspectives interacted with specific medical and health-related issues as viewed by the ancients, placing Aristotle in the legacy from Hippocratic tradition and as an inspiration for Galeanus in his development and understanding of the concept of the sick person.[174] The common thread that emerges from Hippocrates and Galeanus, and which continues into today’s PCP framework, is that the person, and not the disease, is the focus of attention. Both Hippocrates and Galeanus adopted a holistic approach to the sick person and used observation as a means of understanding how to care for and help the person.[175] Both these perspectives, emphasise key building blocks subsequently applied in the PCP framework developed by McCormack and McCance.

However, in between the holistic medicine of the ancient philosophers and the later theories of Rogers, and McCormack and McCance, a more mechanical, reductionist approach to the person intervened. This approach was initiated by Descartes during the 17th century[176] with his dualistic division of the body into two separate substances; ‘*res extensa*’ (the body) and ‘*res cogitans’* (the soul). However, this idea failed to gain any traction until the mid-19th century, when a more mechanical approach to the human body was adopted and achieved dominance in the wake of huge advances in medicine. This mechanical approach constitutes the dominant view in reductionism and laboratory

[172] Jan Dewing, Tom Eide, and Brendan McCormack, "Philosophical Perspectives on Person-Centredness for Healthcare Research," in *Person-Centred Healthcare Research*, ed. Brendan McCormack, et al. (Wiley Blackwell, 2017).

[173] Ibid., 22.

[174] Schiøtz, *Viljen til liv*, 32-33.

[175] The Hippocratic thinkers lay the foundation for *prognostic* as a method within medicine, basing their theory on what they observed in order to care and cure. Ibid., 32.

[176] Aina Schiøtz, "Kroppens bilder - de sykes hus," in *Blod og bein. Lidelse, lindring og behandling i norsk medisinhistorie*, ed. Nasjonalbiblioteket (Oslo: 2019), 13.

medicine and retained its preeminent position right up until the present day, despite encountering a number of challenges in the mid-20th century.

The argument held high by both Rogers and McCormack/McCance maintained that there was a need to put the person back in the centre of attention, when assuming the role of patient.[177]

3.6 Summary of delimitations, conceptual clarifications and theoretical perspectives

In this chapter, I have argued for the relevance of narrowing the time period of my study, and for why modernization can be understood to be a continuous process rather than considering modernity or a modern healthcare service as static and fixed in relation to the development of hospitals. Key concepts such as the patient and professions have been linked to the professionalization of, and the changing paradigm within, medicine and health. Elements of this clarification have been based on Arthur Kleinman’s model of the different sectors within health and Øivind Larsen’s framework on the different images and objectives that can be associated with doctors, which I believe can also be applied to nurses. I have discussed the professionalization of the professions and the modernization processes in relation to the three revolutions that occurred in society during my chosen period – the scientific, industrial and democratic revolutions.

I have given an account of the epistemological foundation that forms the basis for my theoretical understanding of historical research, involving the use of language and conceptual history as a means of treating the healthcare sector as a social and cultural system. I have rejected the notion that history represents an objective reconstruction of the past, and have placed myself in a tradition in which historical and social reality are

[177] Brendan McCormack and Tanya McCance, "Development of a Framework for Person-Centred Nursing," *Journal of Advanced Nursing* 56, no. 5 (2006).

guided by the use of language and discourse. Historians such as Reinhart Koselleck, Peter Burke and others, who have shaped my understanding of produced texts as part of historical research, have influenced me in the construction of my theoretical framework. In so doing, I have positioned myself as a pluralist in terms of the theoretical tradition by which I am influenced in my historical analysis.

Last, but not least, I have presented the theory of person-centredness and the PCP framework as the trigger for my initial interest in exploring the concept of becoming a patient while remaining a person. I have also argued for how a framework such as the PCP can make use of historical knowledge and be of relevance to the future education of health professionals.

In the next chapter, I will build on these clarifications and theoretical perspectives as part of an exploration of my various sources, and explain why I consider them to be relevant to addressing my research questions.

4 Method and sources – selection, relevance and use

«Mum, how can you possible know anything about the past?”

“Do you think we can?”

“No, I think you are just making up and guessing, like a story”

“Well, to some degree you are right. I am not making up, but I am sometimes guessing. But it is guessing based on what people of the past has left behind.”

“Have people left things behind?”

“Yes, both things and stories, newspapers, letters, books and others stuff that we can use when we guess.”

This dialogue with my son is reflective of one of many discussions often repeated about the nature of history we study as an academic subject. It also raises a number of questions. Is it possible to extract a true reality from the past? What kind of truth can we identify, and what gives validity to the truth we promote? In this chapter, I will account for my position on these issues and present arguments for my methodological approach to my treatment of sources as I endeavour to obtain historical knowledge. I will also explain how this relates to an understanding of reality, both historically and in the present.

Discussions concerning truth, reality and meaning in history have continued since Leopold von Ranke’s positivistic view on historical research was challenged by the turn of modernism and post-modernism during the 20th century.[178] I place myself in the

[178] Erling Sandmo, "«Hvordan det egentlig var»," *Nytt Norsk Tidsskrift* 27, no. 01-02 (2010): 11-12.

Iggers, 2, 25-26.

tradition of Edward Hallet Carr[179] and those who came after him, which maintains that language and the reflexive researcher are an integral part of the interpretational analysis of historical sources, by which a definitive and objective understanding of history can never be obtained. My position does not however lead me to a purely relativistic understanding of access to historical knowledge. This is important, because, as is pointed out by a number of historians engaged in discussions regarding truth and meaning within history, such an understanding can easily mislead us into a denial of historical events that we may find problematic.[180]

"No theoretically sufficient verification of any past fact can ever be hoped for."

C.I. Lewis.[181]

The quote from Lewis emphasise the historical tradition amongst most academic historians today. However, such an understanding has come through discussions concerning what history is and how it relates to reality. History comes from Greek *historia* and means scrutiny, investigation or account of, if looking to the etymological definition of the word.[182] For as long as humans have existed, history has enabled them to provide themselves with rational and consistent narratives. Before I enter on a more thorough explanation of my position, I wish to assert three important reasons for why I find historical research important and interesting. In the first place, there is a past – a past that existed in a way that was very real to the people living in historical times. Secondly, history is different from the present, and this difference must be respected if we are to

[179] Carr.

[180] The most used examples in these matters are related to revisionists and Holocaust deniers. A pure relativistic approach to history would lead us away from an understanding that some historical facts can be claimed as universal.

Knut Kjeldstadli, "I hvilken forstand kan vi snakke om sannhet i historie?," *Historisk tidsskrift (Oslo: trykt utg.).* 78:1999:3 (1999).

[181] The quote from Lewis is taken from David Lowenthal, *The Past is a foreing Country* (Cambridge1985), 187.

[182] https://snl.no/historie

make history relevant today. Thirdly, in the same way as the present, history has been understood and interpreted differently by different people. No single understanding of reality ever existed in the past, as no single understanding of reality exist today. What historians do is to try to grasp these different understandings and meanings using a variety of approaches to obtaining historical knowledge.

Historian Professor Knut Kjeldstadli has pointed to three different ways of approaching true knowledge of history by using concepts from philosophy of science. (1) truth as compliance or correspondence to reality, (2) truth as coherence to other known knowledge or/and as part of an inner logic within the empirical material and (3) truth as a conversation or consensus about what is understood as right.[183] All these three different positions within historical research will have strength and weaknesses. I will place myself within the second approach, and treat historical sources and historical knowledge in accordance with finding an understanding of historical reality as part of coherence to other knowledge and as an inner logic within the sources used. At the same time, both seeing truth as compliance to reality and as a conversation to what one understand as being right are not left behind in my understanding, but have been put more in the back of attention.

4.1 The researcher in the researching process; reflexivity in historical research and my position

Based on my background and academic training, the perspectives I adopt and the analysis and results from this work, represent nothing other than an '*outside'* perspective in terms of medicine, nursing and health.[184] Historians who conduct research into the history of

[183] Kjeldstadli, 378.

[184] The concept outside perspective is understood in accordance with how the concept is used by Aina Schiøtz (2017) where she uses the concept to explain how patients in history can be understood from an outside or an inside perspective. The outside perspective is here understood as when conditions and experiences in a field is interpreted and explained through external sources. In my case, I use this concept because of my outside perspective on health and medicine, having no training or experiences from this field myself. Schiøtz, *Viljen til liv*, 410-11.

medicine and health are required to show how their methodological approach and methods can serve to generate new knowledge that adds to that already provided by those with an ‘*inside perspective’.*[185] What historians can bring to research in medicine and health is a strong emphasis on scrutiny and an ability to regard different phenomena and developments in context. This also implies an ability critically to analyse the interaction between various agents, systems, individuals, societal challenges, norms and ideas involved. In this way, the outside perspective may serve as a possibility, when found useful to researchers in an interdisciplinary research environment.[186] However, as has been pointed out by a number of researchers working in interdisciplinary research societies, merging the traditions of historians and ‘bench-scientists’ [187] can be a challenging task.[188]

Throughout this thesis, the starting point will be to persist with a historical method and perspective that acknowledges historical reality as different from the present. This approach enables us to grasp various historical understandings from the sources, and allows the language used in the sources to enable us to access part of what has been regarded as real. In this thesis, I will advocate an understanding that language as a tool

[185] Vibeke N. Nyborg, Sigrun Hvalvik, and Brendan McCormack, "Understanding care in the past to develop caring science of the future: a historical methodological approach," *Scandinavian journal of caring sciences* (2018).

John Harley Warner, "The humanising power of medical history: responses to biomedicine in the 20th century United States," *Medical Humanities* 37, no. 2 (2011).

Julie Fairman and Patricia D'Antonio, "History counts: How history can shape our understanding of health policy," *Nursing Outlook* 61, no. 5 (2013).

[186] Schiøtz, *Viljen til liv*, 13-15.

[187] I have picked up the concept “bench-scientist” from Bruce S. Fetter (2002) and I understand this as theoretically oriented researchers within medicine, health and science.

[188] Jan Groven Grande, "Veien, sannheten og livet: norske medisineres vitenskapelige moderniseringsarbeid ca 1840-1880," (Trondheim: Senter for teknologi og samfunn, Institutt for tverrfaglige kulturstudier, NTNU, 2004).

Bruce S. Fetter, "History and Health Science: Medical Advances across the Disciplines," (2002).

for meaning making is strongly related to the social and cultural aspects of the society in which it emerges and develops. The theory behind this position is thoroughly accounted for in chapter 3. However, this position raises some difficulties. As part of this understanding, we must acknowledge that language and constructs encompass only part of the reality we are attempting to grasp. What actually happened as a historical event is not possible to reveal. An additional challenge is provided by the fact that in the space between the researcher and history, we cannot avoid bringing our own language and meaning making to the sources through the lens of contemporary understandings and perspectives in our attempts to establish a connection to history. Herein lies a danger that our meanings may be based on false premises. It is hence crucial to be aware of such challenges to historical accounts and understanding of historical reality.

The challenge of such an approach is to place ourselves, our biases, assumptions and prejudices clearly within the analytical process. The importance of letting the sources ‘speak’ is an acknowledgement that they do not appear in an ambiguous form, but that they are treated in accordance with reliability criteria that are valid for historical research. One aspect of this is to focus on understanding the difference between the synchronic understanding of the text, and the diachronic interpretation, of the text.[189] The in-depth context in which the language was produced, and its given meaning at the time, are lost. This may constitute part of the synchronic dimension of the text. As historians, we can add a diachronic dimension to our analysis by looking into the development of a concept and language that reveals repeatable structures that stretches beyond the specific concept or event.[190] This way we can use the diachronic understanding to make meaning of the synchronic dimension that before seem lost to us. If we apply this to the arena of medicine and health, with the patient in focus, we can argue that for as long as diseases have existed, there have also existed structures in society by which a person who is suffering from a disease is in a relationship with a person in the role of healer or caregiver.

[189] Koselleck, "Social history and conceptual history," 318, 23.

[190] Ibid.

To look at the historical development of these structures and relationships, is what constitutes the diachronic dimension of my analysis, which gives meaning to the synchronic to the text as uttered in a specific context in past records.

Historical knowledge can never provide us with factual proof of how anything in the past really ‘*was’.* All we can hope to know will be based on the traces left behind and the historians’ interpretation of these traces. At the same time, history has showed that what we consider to be relevant knowledge and being true will always evolve as our knowledge and understanding increase and change.[191] If we extrapolate this fully, we can lean on the French historian Paul Veyne, who said that history is a descriptive discipline without a specific method, and as such there can be no progress in historical synthesis.[192] I am doubtful of this polemic assertion, and even Veyne himself seemed to retract this view somewhat when he later emphasized that history also expands in the sense that the old also exists side by side with the new.[193] However, in Veyne’s opinion, this clearly must not be understood as progress in terms of historical synthesis, but that old and new knowledge can exist simultaneously to reflect different realities in history.

This approach to history serves to emphasize that we cannot achieve a single objective truth, and that in conducting historical research, a descriptive approach is the primary basis for writing. This will be evident to the reader in this thesis, in which a descriptive approach goes hand in hand with the analysis, and constitutes the basis for all my discussions. In embracing this approach to our understanding of history and historical research, one opens up to a wide range of methodological and theoretical opportunities

[191] Erling Sandmo, "Mer og mindre sannhet," *Historisk tidsskrift (Oslo : trykt utg.).* 78:1999:3 (1999): 396.

[192] Veyne, 228.

[193] Ibid.

in historical research and writing that have been made available to us during recent decades, and which I have made use of during the writing of this thesis.[194]

The interpretation of sources based on an inductive approach to historical events has always occupied a unique position in historical research. From the linguistic turn within the science of philosophy, it has long been recognised that language contributes to the meaning-making process as we search for historical understanding. As I pointed out earlier in my discussion of the synchronic and diachronic dimensions of the text, language is not objective, but is used by both authors and interpreters as a means of giving meaning. In the same way as Koselleck, Paul Ricoeur also tends to be drawn to this way of approaching historical sources when he states that in our interpretations we give the historical texts a meaning that extends beyond that which was actually intended by the people who wrote them.[195] Based on this, one may argue that although objects and materials exists without us contextualizing them, they only become interesting and meaningful when we perceive them, and locate them in time and place, through language.[196]

My approach to working with historical sources harmonizes with this approach, and emphasizes that in my search for historical knowledge, I recognise that multiple truths can exist simultaneously without becoming purely relativistic in my search for historical knowledge. I maintain that we can obtain an understanding of reality by looking for coherence within the sources, and then either linking this coherence, or placing it in opposition, to previously existing knowledge.

[194] Leidulf Melve, "Kilder, kildekritikk og historieskrivingens vitenskapelighet - noen historiske eksempler," in *Historikerens arbeidsmåter*, ed. Leidulf Melve and Teemu Ryymin (Oslo: Universitetsforlaget, 2018), 210-14.

[195] Paul Ricoeur and John B. Thompson, *Hermeneutics and the human sciences: essays on language, action and interpretation* (Cambridge: Cambridge University Press, 1981), 140-42.

[196] Sandmo, *Tid for historie. En bok om historiske spørsmål* 184.

The functional use of sources and the reflexive researcher

The development of a functional use of historical sources is rooted in the criticism of the strict approach of using historical sources based on Ranke’s requirements for objectivity.[197] Such criticism developed as part of the linguistic turn where reflexivity also within historical research was emphasized,[198] but also encouraged historians to expand their areas of investigation. In utilising this approach to their sources, historians recognize that remains only become evidence or reveal a narrative about the past when questions are asked, and when the researcher becomes part of the interpretation.[199] Through this work, I have scrutinized my sources but have also emphasized the role of language as part of a meaning-making process in the construction of specific concepts. Herein lies an understanding that the text can contain meaning that extend beyond the intention of the author, although it must be understood also in close connection to history as something different from the present.[200] This understanding of the sources is in line with what Narve Fulsås’ argues in terms of what ‘unfolds in front of the text’ by the merging of the different horizons in the past and the present.[201] Fulsås here is in line with both Ricoeur and Koselleck in their approach to working with history, focusing on the text both as a representation of past reality but in addition as an expression of ideas, values and virtues that is revealed by placing the text in context.

[197] Peter Edelberg and Dorthe Gert Simonsen, "Changing the Subject: Epistemologies of Scandinavian source criticism," *Scandinavian Journal of History* 40, no. 2 (2015).

[198] Carr, 18-22.

[199] Edelberg and Simonsen, 223.

[200] Narve Fulsås, "Kva er gale med det historiske kjeldeomgrepet? ein kritikk av kjeldekritikken," *Historisk tidsskrift* 80, no. 2 (2001): 245-46.

[201] Ibid., 244-45.

In the analysis, I adopt a descriptive, explanatory and interpretative approach, as emphasized by Kjeldstadli as the basis for historical research.[202] Moreover, by focusing on the context in which the patient as a concept is given meaning, I have looked for an understanding beyond that which can be found in the actual text. I have achieved this by adopting a hermeneutic approach to the sources by lifting the gaze from the text and into the context in which it appeared and by which it was influenced before going back to the text again for new understanding and meaning of how it can be understood. In this way, this analysis can be seen as a representation of meaning that has been played out and viewed as important in construction of the patient as a concept.[203] Representation’ here must be understood in accordance with letting certain voices to come forward to represent wider society. In my work, these voices have consisted of professors at the School of Medicine, doctors that were actively engaged in educational issues within both medicine and nursing, and nurses that have exerted the same degree of influence within nursing and nursing education.

The concept of *‘patient’* constitutes the core of my analysis and I have explored this concept through the language used in sources as representations of ideas, values and virtues framed by the context in which it appeared. This is not a conceptual analysis in the sense that the concept itself is constantly in the forefront. The sources are used to understand how conceptualization and construction of ‘patient’ has emerged as part of developments in education. Sometimes this understanding is emphasized by the absence of the concept patient in the sources just as much as by the way it is used in specific settings. I believe that my outside perspective on healthcare settings has helped me to maintain a distance between myself and contemporary views on how the patient concept was constructed, as guided by professional perspectives based on the histories of, and dominant paradigms within, the professions. At the same time, I have recognised the in

[202] Knut Kjeldstadli, *Fortida er ikke hva den en gang var: en innføring i historiefaget* (Oslo: Universitetsforl., 1992), sett inn sidetal.

[203] Astri Andresen, Ryymin Rosland, and Atle Skålevåg, *Å gripe fortida: innføring i historisk forståing og metode*, Samlagets bøker for høgare utdanning (Oslo: Samlaget, 2012), 110-14.

danger of excluding important premises from my analysis that may have arisen because of the disconnect that my outside perspective may create in relation to any personal experience of working with patients.

The prejudices focus primarily on two concerns. The first relates to my own experience in the healthcare sector in being a patient or being the next of kin to a patient, and secondly of working in a research community characterised by education traditions in nursing and their influence on attitudes to the patient and other health care professionals approach to patient. The latter has made me aware of the lack of methodological knowledge that exists within various academic fields. For my part, this has been an awakening experience and has raised challenges that have influenced me and framed my approach to this thesis. In order to bridge methodological understanding between historical and healthcare research, I have chosen, as I pointed out in my introduction, to refer to Jerome Kagan, who emphasized that different sciences use different epistemological and methodological languages and perspectives to explore the same events. My outside perspective has allowed me to treat both professions and their developments equally, since I have no special relationship to either other than my curiosity about their development and their approach to the patient through history. My prejudices have been challenged as my knowledge has increased, constantly forcing me to be aware of them through the process of analysing the sources. This process has in turn aided my dialogue with the historical sources during my analysis.

4.2 Selection of sources and source scrutiny

As stated above, empirical sources have constituted the starting point for my analytical and research approach. I have selected the historical sources in accordance with a functional approach corresponding to the questions asked and the chosen approaches.[204] In adopting a functional use of sources, it is not the implicit characteristics of a source that makes it trustworthy, but rather the way in which the historian, use the source to

[204] Leidulf Melve and Teemu Ryymin, *Historikerens arbeidsmåter* (Oslo: Universitetsforl., 2018), 43.

argue for functionality in terms of answering the research question(s).[205] Moreover, as part of a functional approach, scrutiny is required in order to identify relevant sources. Here, I conform to the tradition that most historians apply, regardless of their philosophical or ontological point of view.

Through scrutiny, some sources have been excluded despite the fact that they contain elements pertaining to educational issues in medicine and nursing, but are not considered to be relevant to the aim of this study. Actual practical training, and how such training was carried out, has not been the focus of this study. To the extent that such training and the encounter with the patient have been regarded as relevant, it is the way in which these encounters have been discussed as part of the development of education, and the place of the patient in this development. This serves to emphasize my focus on highlighting that language as a meaning-maker confers content on the construction of a concept.

The most important and shared characteristic of my selected sources is that they are written mainly as commentaries on highly debated contemporary challenges in society. They occur in the form of the personal experiences and views of professors, professional doctors and nurses working in medicine, nursing and education. In my view, the issues debated are very different from the challenges that face our current healthcare system, and the views on the patient that emerge from these challenges. However, as objects, these linguistic representations are symbolic of an insight into the thoughts and views on issues that some people regarded as important and responded to in specific contexts. In order to grasp these representations they must serve as the expressions of individuals, and as such must not be regarded as generalisations of how contemporary society understood reality. In situations where I use the sources to generalize and broaden my scope, the context of earlier historical research has played a significant role in the analysis. This supports the diachronic dimension of the concept, and my position that

[205] Ibid., 41.

historical reality can be grasped by inner structure in the empirical material and coherence in relation to other knowledge.

All sources are representative of views and experiences that require contextualization. Thus, a major aspect of working with the sources has involved making myself familiar with the authors of the texts that I have used. Relevant questions about who they were, the positions they held, and what values and virtues can be said to have guided their professional work and how these contributed to influencing their voice in public debate, have been conducted in accordance with the hermeneutic circle of approach emphasising the relationship between the whole text and partial expressions within the text. Another important part of the work has been the contextualization of my sources in relation to societal development and, more specifically, to the development of the medical and nursing professions.

The modernization processes that occurred within society, combined with the struggles for power and debates concerning gender-related issues among the professions, all play an important part of understanding the contemporary contexts of the sources. This constitutes the synchronic dimension of the text that is lost to us, as it actually was, but which is visible through the work of others. By paying attention to the distance between history and the present through language and context, the sources have been used to evoke a historical construction. In doing so, lies an implicit understanding that my prejudices are being considered. This is entirely in line with Gadamer’s notion that historical consciousness is made up of the horizons that enable us to look into history on its own terms.[206] The understanding that sources can contribute to a construction of different realities based on the questions asked, the historical awareness of the researcher, and an ability to work with prejudices, forms the basis of my approach to working with history.

[206] Gadamer, 310, 13, 15-16.

Sources concerning the construction of the patient in medical education

When it comes to the exploration of the construction of the patient concept in the context of medical education, several different sources have been used. Approved regulations and subsequently approved curricula that prevailed at the School of Medicine at the Royal Frederik’s University, was the point of departure for my engagement with the sources. Other sources have included records of discussions regarding medical education that took place in various medical societies, newspapers, journals and pamphlets. Records of developments and governmental proposals for statutory Acts and regulations have, in combination with historical literature, served to support my analytical work. In contrast to nursing education, medical education was carried out at the only Norwegian university during the period covered by this thesis. This is a crucial difference, and I will discuss its impact in the discussion below and as part of my interpretation in chapters 5, 6 and 7.

Regulations dating from 1877 governing education in medicine constitute the initial source used in this thesis. Subsequent to this, the School did not approve new regulations or a curriculum before 1914. However, in the intervening period, two committees were convened to prepare proposals for new regulations and curricula. The results were documented, and have been used as sources. The first was produced in 1887, ‘Suggestion for a Curriculum for Medical Education by the Royal Frederik’s University Kristiania’. The work was conducted and encouraged by the Norwegian Association of Medicine, founded in 1886, and it was the Association that appointed the committee members.[207] In 1899, the second committee was appointed by the School of Medicine at the university and produced the document ‘Suggestion for a Curriculum for Medical Education and the Examination’. Both documents give us an insight into prevailing knowledge developments in medicine, not only in Norway, but also internationally.

[207] The committee had the following members: Doctor Klaus Hansen, Professor H. Heiberg, Professor J. Hjort, superior doctor E. Kaurin and military surgeon W. Mohn.

Between 1886 and 1914, a continuous and somewhat tense debate arose between the professors at the university and doctors practicing medicine in hospitals and in rural areas.[208] Some of their discussions took place in meetings of the Norwegian Medical Society[209] and are recorded in the protocols of their meetings.[210] Other discussions concerning medical education were featured in a variety of contemporary medical journals.[211] Protocols of the journals have been reviewed in order to find relevant records addressing the education debate. The main register for the different journals were examined for key words such as education, teaching, curriculum, education regulations, School of Medicine, medical development, patient, care of patient and view of patient. Initially, I read all items that contained these words with the aim of deciding whether or not they were relevant to an understanding of the construction of the patient concept in relation to developments in education. Those that directly or indirectly addressed the topic of education, and which referred to the patient or a sick person, were included in the study.

An interesting publication that emerged from these discussions, and which was mentioned in both the Medical Association's minutes and in those of Board meetings of the School of Medicine, was a pamphlet written and published in 1899 by a young doctor called Johan Scharffenberg.[212] Scharffenberg was engaged in medical education and

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[208] Kyllingstad, 220-22.

[209] Det Norske Medicinske Selskab [The Norwegian Medical Society]

[210] Protocols from the National Archive after the Norwegian Medical Society. RA/PA-1301/D/Dd/L0004/0006.

[211] The following Journals existed: Medicinsk Revue [Medical Revue] (1884), Tidsskrift for Praktisk Medicin [Journal of Practical Medicine] (1881) which changed name to Tidsskrift den norske Lægeforening [Journal of the Norwegian Medical Association] in (1890), and Norsk Magazin for Lægevidenskaben [Norwegian Magazine for Medical Science] (1840).

[212] Johan Scharffenberg, *Reform af den medicinske undervisning [Reformation of the medical education. Our teachers, especially Professor Doctor J. Nicolaysen]* (Kristiania: Forfatterens forlag, 1899).

This pamphlet caused a lot of attention as it made its way all the way to the Ministry. However, after many considerations it was decided not to take the case to trial.

spoke forcefully for reforms to what he felt was a vague and random examination of medical students. He was critical of several of the professors at the School of Medicine, and had tried to change both the curriculum and regulations over a period of several years while he was still a student.[213] In this pamphlet, Scharffenberg highlights aspects that he found problematic in the relationship he experienced between the professors and students on the issue of the treatment of patients. Since this represents the view of one individual drawing on his own experiences, I have included the pamphlet as a relevant source, mainly because of Scharffenberg’s prolonged battle to introduce improvements to medical education. His views are also supported and underpinned by other sources.[214]

Amongst many publications and important research, a significant work has been done concerning the letters of the Norwegian medical student, Sverre Sørsdal. Sørsdal wrote letters to his mother throughout his time as a medical student, and Larsen and others have made these available for further research.[215] The letters provide a unique insight into the life of a medical student in the early 1920s, and I have used these to provide context and because this source seem to underpin and support findings I have revealed from other sources.

These records of discussions and minutes, taken together with Sharffenberg’s pamphlet and Sørsdal’s letters,[216] all relate personal reflections on how various stakeholders

[213] Scharffenberg himself was occupied with stating that he was not after personal revenge, but had the best intentions, to protect future students in medicine from attack from the Professors, especially professor Nickolaysen. Ibid., 81-82.

[214] Larsen, "Doktorskole og medisinstudium," 196.

[215] Larsen gives a thorough review on the choices that have been made concerning the rendering of these letters, as they were never meant to be published by the author and contains issues of privacy. The rendering gives an insight into Sørsdal’s life as a student and some contextual features relevant to this.

[216] Øivind Larsen has part of the publication of the letters done a thoroughly review of the choices made in conjunction with transcription and publication of this source.

Larsen, "Legestudent Sverre Sørsdals brev til sin mor 1919-27 [Medical student Sverre Sørsdal’s letters to his mother 1919 -27]," 368-72.

viewed and evaluated contemporary medical education and the place of the patient in it. The diversity and intensity of some of these records provide a heterogeneous picture of contemporary preoccupations and views held on medicine as a subject, on its development in practice, on patients, and on future developments in medical education. These are however only personal thoughts, reflections, and considerations, and any conclusions we may draw from them must not be thought of automatically as generally representative of the views of the wider community of doctors and professors. My task has been to look for trends that can be discussed in a specific context and time.

Sources concerning construction of the patient in nursing education

In nursing, there was no sets of universal regulations to which we can refer. Nursing education was much more diverse and fragmented than was the case for medical education. The first nursing education was founded in 1868 by the deaconesses and towards 1900, a range of both religious- and secular nursing education systems emerged all across the country.[217] When The Norwegian Nursing Association (NSF) was founded in 1912, work was started to develop a common curriculum for all nursing schools. This curriculum did not have the same status as the regulations that applied to medical education, since it was not the subject of either Royal or Ministerial decree. However, the curriculum approved by the NSF had a huge impact on the development of Norwegian nursing, and laid the foundation for most nursing education systems that emerged after 1917. In the absence of any regulatory system, three textbooks in nursing were produced, covering the period for this analysis. As being the only produced text for nursing education the first formative period for Norwegian nursing, I consider them to be highly significant for understanding the place of the patient in nursing education these years. I have also included as sources the records of discussions on nursing education as published in journals, newspapers and in the minutes of NSF meetings, with the aim of

[217] An overview of all established nursing schools in Norway were published in the Journal *'Sykepleien'* in 1912 together with an account for all nurses being educated at these schools from 1868 to 1911, which constituted for approximately 1000 nurses all together. *Sykepleien.* 1912. Årgang 1 nr 2, page 12

obtaining a broad perspective in my exploration of the views of the profession on the patient.

The Deaconess Ulrikke Eleonore Nissen wrote the first nursing textbook in 1877. In her doctoral thesis, Kari Martinsen (1984) conducted a thorough review of the use and impact of Nissen's book.[218] The book is divided into several sections, of which the first is dedicated to describing what it means to be a professional nurse, and the attributes and values Nissen considered were required by a nurse. This section places clear emphasis on the religious calling, which Nissen saw as the primary force for becoming a nurse.[219] Subsequent sections in the book are dedicated to practical nursing skills, and guidance on how to care for patients with different infirmities, maternal care and other patient needs, as well as how to provide assistance during surgery. Nissen continues with a short description of specific diseases, accompanied by some basic knowledge about the human body and finally, a short section about writing reports and preparing medicines.

The second textbook was written by Doctor Hans Riddervold Waage in 1901. We know that Waage's textbook was used in several nursing schools because it has been referred to on several occasions in discussions recorded between nurses and doctors.[220] We also know that it was published in five separate editions. The first chapters describe the duties and specific attributes required by a nurse.[221] These are followed by an updated knowledge of anatomy and physiology, before focusing on aspects of practical nursing. Waage also included a section on diseases and how to treat patients with a variety of symptoms. The final chapter is concerned with acute care.

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[218] Kari Martinsen, *Freidige og uforsagte diakonisser: et omsorgsyrke vokser fram, 1860-1905* (Oslo: Aschehoug/Tanum-Norli, 1984), 137-40.

[219] Rikke Nissen and Kari Martinsen, *Lærebog i Sygepleie for Diakonisser [Textbook in Nursing for Deaconesses]* (Oslo: Gyldendal akademisk, 2000), 19-25.

[220] Ibid., 291. Waages book is among many other places referred used in *Sykepleien* [The Norwegian Journal for Nursing, *Sykepleien]* Årgang 1 nr. 10 August 1913

[221] H.R. Waage, *Lærebog i Sygepleie [Textbook in Nursing]* (Kristiania: Aschehoug & co, 1901), 1-6.

The third textbook (1921), with a second edition in 1926 (used in this thesis) was written by doctors Kr. Grøn and Sofus Wiederøe. [222] Superintendent Nurse Andrea Artnzen wrote an introduction to the book, as well as a chapter on the essential attributes and duties of a nurse. Mrs. Aagot Lie was given the honour of writing a chapter on general nursing practice. In addition, several doctors contributed with their medical expertise in various fields.[223] The teachers at one of the hospitals in Christiania wrote the book in response to demands from nurses who said that they '*lacked access to a textbook that focused on the principals of modern nursing.'*[224] Together with the aforementioned texts, this book highlighted a number of contemporary challenges in medicine that also reflected those being encountered in wider society. An entire chapter of the book is dedicated to hygiene, including both personal and institutional hygiene.[225] Here we discover that health challenges has stretched into other areas of society, including schools, housing and the water supply. Another chapter was dedicated to tuberculosis, which was severely epidemic at the time, and the care and treatment of this specific group of patients.[226] The recently developed use of x-rays as part of health was also allocated a chapter that included specific theoretical knowledge on the nature of x-rays, as well as details on the function of x-ray machines and how to use them in providing treatment.[227] All chapters accounting for this being a textbook built on modern nursing principles.

[222] Already in 1918 there was a notice about this book in "Sykepleien." Here the book is presented as being built on modern principals and used as a base for the methodical and practical theoretical teaching at nursing schools. Further, it is argued in the book that the authors stress to invite in experts on the different chapter to enhance the knowledge needed. *Sykepleien.* Årgang 6 nr 1. Januar 1918.

[223] Kr Grøn and Sofus Widerøe, *Lærebok i sykepleien [Textbook in Nursing]*, 3. forøk. ed. (Oslo: Aschehoug, 1932), overview of content.

[224] Ibid., introduction.

[225] Ibid., 183-204.

[226] Ibid., 221-51.

[227] Ibid., 306-32.

In addition to these textbooks, a couple of additional sources must be mentioned briefly. A small guide to nursing that was written specifically for nurses in 1879 by Doctor Edvard Kaurin.[228] This was not however an official textbook used in nursing education, as we know it, although it did come to be used as a guide in the everyday life of many nurses after it was published.[229] Secondly, I have also referred to a curriculum developed by NSF in 1917.[230] This text serves to emphasize the fact that the greater part of nursing education consisted of practical training in hospitals. Theoretical knowledge constituted a much smaller part than is the case today, estimated to be about 240 hours over a three-year period,[231] although this still must have seemed to be quite significant when the curriculum was published in 1917.[232]

I have also made use of discussions on nursing education that were published in the journal *Sykepleien* during the period 1912-1938. These serve to support and broaden contemporary views and perspectives on the patient that appear in the other sources. The main register in the Journal has been examined for key words such as education, teaching, curriculum, nursing textbooks, nursing schools, nursing development, patient, care of patient and view of patient. All posts containing these words were read initially with the aim to investigate whether or not they were relevant to my understanding of the construction of the patient concept in relation to developments in education. Those

[228] Edv Kaurin, *Sygepleiersken: kortfattet Veiledning i Sygepleien for Sygepleiersker i By og Bygd [The nurse. A short guide to nursing for nurses in cities and villages]* (Kristiania: Cammermeyer, 1879).

[229] Martinsen, *Freidige og uforsagte diakonisser: et omsorgsyrke vokser fram, 1860-1905*, 140.

[230] Moseng, *Framvekst og profesjonalisering*, 181-83. *Sykepleien.* Årgang 5 nr 4. April 1917

[231] *Sykepleien.* Årgang 5 nr 4 April 1917

[232] It is the theoretical part of the nursing education that is in focus of this study. It is however crucial to stress how significant practice must have been in influencing the value of nurses when it comes to their meeting with patients, constituting the largest part of the education. Seeing textbooks as a way to implement standard in practical nursing has been explored by Ann Bradshaw in a British context, and has served as a possible assumption to emphasise also within this thesis. Ann Bradshaw, "Competence and British nursing: a view from history," *J Clin Nurs* 9, no. 3 (2000).

that either directly or indirectly referred to nursing education, and which also referred to the patient or sick person, were included in the study.

Neither in the discussion regarding medical education or nursing education can a specific social constructions of the patient concept be drawn directly from the sources. For the most part they are restricted to patient-related topics that serve to demonstrate the complexities of developments in knowledge and within the professions, professional struggles, overseas influences and other national developments. All of these discussions exerted an influence on how patients could or should be treated and as such enabled a variety of representations to come forward through the language used. Thus, as we give the language meaning, investigate in depth, and contextualize both in relation to our synchronic understanding and in line with a diachronic perspective, the patient gradually emerges as a specific construct. Legislation, combined with the processes leading up to the enactment of legal Acts, has proved to be a valuable source in terms of context drivers in understanding how language can be used to promote a specific construct and views on the patient as part of the approach to education. By including legislation as a source, I have to a greater extent been able to emphasize and understand the structures that enable us to recognise how a concept is both shaped by, and contributes to, shape various understandings of reality through the use of language.

Other sources

As additional sources, I have combined actual legislation related to health and medicine with the records of the negotiations leading up to the enactment and further endorsement of three specific legislative Acts. These are the Norwegian Health Care Act of 1860 (*Sunnhetsloven*),[233] the Leprosy Act of 1877 (*Lepraloven)*[234] and the Tuberculosis

[233] https://www.stortinget.no/no/Saker-og-publikasjoner/Stortingsforhandlinger/Saksside/?pid=1814-1870&mtid=39&vt=a&did=DIVL90790

[234] https://www.stortinget.no/no/Saker-og-publikasjoner/Stortingsforhandlinger/Saksside/?pid=1871-1891&mtid=34&vt=a&did=DIVL95913

Act of 1900 (*Tuberkuloseloven).*[235] All of these, together with the records of negotiations, were found in the Norwegian Parliament’s digital historical archive. These sources serve to offer a broader approach to my investigation of the view of the patient than can be found within the educational framework. They have been included because, towards the end of the period covered by this thesis, professors, clinical doctors and nurses all expressed their opinions in relation to patients in connection with these Acts. Further, as argued above they have proved to be a valuable in terms of understanding how language can be used to promote a specific construct and views on the patient. As such, they serve as useful contextual primary sources in my attempts to answer the research questions.

The need to understand how diseases and social stigma contributed towards framing the view and construction of the patient concept during the end of the 19th and beginning of the 20th centuries has played a significant part in my contextualization. This need has been emphasized by the ways in which society, by means of legislation and regulation, has attempted to confront the challenge of disease and how this may have influenced focus in education and, at the same time, distracted attention from the patient as an individual. When working with the sources, it has been important for me to view education as part of societal development. This will be addressed later in the thesis as part of my clarification of concepts, professionalization and education of the professions in chapter three.

Historical literature as sources

As part of my analysis, I have also referred to earlier research conducted within the field of the history of medicine and health, chiefly with the aim of establishing depth and contextualization, and to achieve understanding. In line with my epistemological position that calls for an investigation of coherence both within the sources and the extension of previous knowledge, I have leaned on work carried out by both Norwegian researchers

[235] https://www.stortinget.no/no/Saker-og-publikasjoner/Stortingsforhandlinger/Saksside/?pid=1892-1900&mtid=55&vt=a&did=DIVL65262

into the history of medical and nursing education in Norway, and International researchers working within the relevant period of history and within the same field. I have also referred to research carried out into the healthcare professions by the broader research community. A broader perspective on society drawing on research carried out in relation to the scientific, industrial and democratic revolutions (discussed on page 51-53), which in my opinion exerted a major influence on societal developments and which I believe cannot be overlooked in terms of health-related issues and the development of the healthcare services, have been emphasized from earlier research.

The most important research carried out within these fields has been thoroughly accounted for in chapter two, concerning Norwegian and international research (see page 19-39).

4.3 Summary of the selection, use and relevance of sources

Throughout this chapter, I have placed myself in a position from the historical tradition that draws on the opinions of E.H. Carr, Koselleck, Ricouer and other social and cultural historians, who view language and reflexivity as part of the interpretational process. I have stated my position with the aim of emphasizing my views firstly that the past is something different from the present, and secondly on how knowledge can be obtained and how we should relate to reality. This has greatly influenced my approach to the historical sources as well as my methodological approach to understanding and interpreting the historical sources used.

I have reviewed what sources that have been considered relevant to the questions that I have set out to answer. I have argued that the sources have been treated according to a functional approach, and why certain sources were included following the scrutiny process. In my review, I have drawn on both a hermeneutic and social constructivist approach to the role of language in meaning making processes. Scrutiny and relevance of sources has constituted a major part of the work. I have been trying to grasp the horizon between history and the present by relating to the synchronic and diachronic content of the language and the context in which it appears.

5 The construction of the patient concept through medical education

“Mum, why do you have to write about the sick people. I hate being sick.”

“But what do you feel about the doctors who try to help you?”

“I like the ones that are being nice to me and the ones that make me better. But not the ones that decide that I need to take a blood test, or go to sleep [i.e. into narcosis].”

From the patient’s point of view, it is the doctor who has the power to decide what treatment is considered necessary and the responsibility for initiating it. The image of the doctor as a gatekeeper is brought forward by his/her ability and responsibilities within the professional healthcare sector. However, before becoming a patient, a person decide whether to enter the professional healthcare sector. This transition must be valued and understood as something more than simply an acceptance of treatment in accordance with the biomedical diagnosis reflected in the disease. The transition also reflects a transfer of power from the self to an expert. The way in which different objectives are connected to different images by the doctor and society are significant factors that must be investigated if we are to understand how they relate to the patient and power as reflected through the different objectives. The images will also differ in terms of the ways in which doctors use language to emphasize their relationships towards the patients, and the ways in which the patient as a concept is constructed in accordance with the linguistic representations of these images and objectives.

In this chapter, I will explore the ways in which the patient is presented in the regulations and discussions that arose during the historical development of medical education, and how these contributed to a specific construction of the patient. I regard the developments in medicine and the professionalization of doctors as a profession as

important contextual premises in the analysis, based on the different images and objectives linked to these developments and the ways in which these have been expressed in terms of historical societal challenges and evolution.

Before embarking on a discussion of how the patient as a concept was constructed and framed by the medical education and the professors teaching at the School of Medicine at the Royal Frederik's University, we need to obtain a greater understanding of the close context in which this construction appeared. In this case, the close context refers mainly to the way in which medicine and medical education developed. However, as I have argued previously, medical education cannot be regarded as detached from society and the societal challenges of the time. The conceptualization of the patient acquired its content and meaning through linguistic construction within both a close and a broader context.

5.1 A national monopoly on medical education and emerging health challenges

In 1813, the School of Medicine at the Royal Frederik's University commenced its educational activity. Initially, only three professors were employed and there were only a few students.[236] From 1813 to 1880, when the debate concerning medical education took hold, extraordinary developments occurred in society and in education, and within the medical profession. Medical education evolved from being the smallest to becoming the second largest of the University's academic studies by the turn of the century. By 1900, about 30% of all the students at the University were studying medicine.[237] Moreover, during these decades, medicine as a subject had transformed from 18th century based medicine[238] into a modern, natural science-based, subject field achieving

[236] Jan Eivind Myhre, *Kunnskapsbærerne 1811-2011 : akademikere mellom universitet og samfunn*, vol. Bok 8, Universitetet i Oslo 1811-2011 (Oslo: Unipub, 2011). The tables 2.3 and 5.3

[237] Kyllingstad, 187-88.

[238] The 18th century medicine was built up on two separate approaches, one coming from surgery, based on handicraft and guild, the other coming from medicine, based primarily on humanistic understanding

major breakthroughs and exerting great influence. We can affirm that when it comes to the medical education, the University and its professors had entered the age of laboratory medicine. This can be explained in part by the development of professionalization enabled by an increasingly standardized educational system, but further as part of a broader development in society in the aftermath of the Enlightenment. Scientific methods, technical advances, and the industrial revolution were all key factors in driving improvements in medicine, in parallel with temporary developments in wider society.

From its establishment in 1813, and until the founding of a new university in Bergen in 1946, the School of Medicine at the Royal Frederik’s University enjoyed a national monopoly on the education of doctors. Although there were only few professors working at the School, they played a significant role in the development and contribution of the profession, while at the same time responding to the health challenges faced by wider society. What is also important, but less widely disseminated, is that from its establishment, the School of Medicine educated both doctors and surgeons. The relevance of this is that medical education in Norway evolved as a hybrid between the academic medical education informed by the European universities and the more practical training of surgeons, in the tradition of artisans’ guild.[239] This meant that a combination of theoretical and practical skills were offered and emphasized as part of a doctor’s education, enabling those educated at the University to attend to both external injuries and internal diseases. This combination of and balance between theory and practice contributed to the discussions concerning both organization and content, and reinforced the professors’ need to safeguard both of these perspectives. It is further possible to argue that this merging between two very different approaches to the body and its treatment may have had an influence on attitudes towards not only deciding

and philosophically logic based on previous experience. In addition, a huge part of medicine came from folk medicine and myths concerning diagnosis and healing.

[239] Grande, 29.

which patients should be treated as part of education, but also the expectations that educated doctors should have of their patients. From the beginning of the 19th century, this combination was unique within a European tradition.[240]

During the modernization processes of the 19th century, doctors as a profession progressed from being a small group of officials who were afforded little consideration, to a highly regarded profession that held significant power within the fields of academic and clinical medicine. This power also extended into the arenas of politics and bureaucracy.[241] The professors taught the students, worked in the laboratories, practiced medicine at the teaching hospital,[242] and contributed to a variety of associations. They established some of the first medical journals,[243] and frequently contributed with original articles and in discussions concerning developments in medicine and scientific research carried out by themselves and others. Their views on medicine extended into wider society, in particular in the fields of hygiene and improvements in public health.[244] This also meant that their views on reality in terms of prioritizing the measures needed to promote a healthy population had an impact outside their own medical community. Primarily we can argue that they had an impact on political decisions and health legislation during a period when it may have been harder to convince the population at large on these issues.[245]

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[240] John Peter Collett, *1811-1870: universitetet i nasjonen*, vol. Bok 1 (Oslo: Unipub, 2011), 303-04.

[241] Schiøtz, 18-19, 24-27, 29-30.

[242] The teaching hospital, Rikshospitalet, opened in 1826 to support the education in medicine with access to practical training and a variety of diseases.

[243] Øivind Larsen and Magne Nylenna, "Medisineren Frederik Holst - mer fagets enn folkets lærer," in *Sann opplysning? Naturvitenskap i nordiske ofentligheter gjennom fire århundrer*, ed. Merethe Roos and Johan L. Tønnesson (Oslo: Cappelen Damm Akademisk, 2017), 154, 58.

[244] Within medicine, the subject «hygiene» was the closest to what we in today’s education would find in community-based medicine, where the relation between medical knowledge and a broader part of society is addressed. Ibid., 151.

[245] Schiøtz, *Folkets helse - landets styrke 1850 - 2003*, 2, 79-95.

Based on earlier research and what can be drawn from several sources,[246] is that the professors adopted a relatively conservative stance in their approach to societal development. This occurred in spite of the fact that they were quite liberal in their approach to the development of medicine as an academic subject and the application of new scientific methods. This conservatism is particularly visible in the areas of gender and class, such as on issues related to women’s access to medical education and their right to birth control.[247] The professors also received criticism by some of their contemporary colleagues for their conservative values regarding changes in medical education.[248] Their conservative attitudes were also soon to become visible in their dealings with the content and duration of nursing education, a debate which occurred as part of the professor’s and doctor’s wish to construct a nursing education in line with own view and needs.[249]

In order to establish links between the development of the School of Medicine and the professors’ views on societal challenges and the construction of the patient concept, I will proceed along two paths, firstly by addressing the scientific revolution and secondly, the democratic revolution. Both of these revolutions, and their impacts on wider society,

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[246] Cecilie Arentz-Hansen, *"Kvinder med begavelse for lægevirksomhed" : Norges første kvinnelige leger, og tiden de virket i* (Oslo: Cappelen Damm, 2018), 14, 17-18, 22, .

Schiøtz, *Folkets helse - landets styrke 1850 - 2003*, 2, 145, 69-71.

The Journal of Norwegian Medical Association. [*Tidsskrift den Norske Lægeforening*.] 1900. 774. Post by Doctor Hennum regarding the suggested curriculum for the medical education. Emphasize the conservative attitude of the committee (1897) in their work with a new curriculum, which was ready in 1899.

[247] Arentz-Hansen, 16-26, 126.

The Professors held a conservative approach to midwives access to use birth rod, a debate that went on for several years. The viewpoint of the School and specific Professors emerges in Norwegian Magazine for Medical Science. [*Norsk Magazin for Lægevidenskaben.*] 1879.1058-1066.

[248] The Journal of Norwegian Medical Association. [*Tidsskrift for den Norske Lægeforening.*]1900.774. A critique of the suggestion to new curriculum that came from the committee sat down by the School of Medicine, where district doctor I.O. Hennum clearly express he feels the committee have been too conservative in their suggestion to change the curriculum.

[249] Ole Georg Moseng, ""En forstaaelsesfuld sykepleierske at arbeide sammen med"; legen som regissør av sykepleierens rolle," *Michael* 5, no. 3 (2008).

have been described in general terms on page 52-53. While one can link the influence of these revolutions to a period prior to that covered in this thesis, they continued to influence wider society and the field of medicine and health as it progressed as part of the a professional health-care sector.

The Impact of the scientific revolution in constructing the patient concept

Through the lens of the scientific revolution, we can identify some important factors that enable us to frame an understanding of the focus and content of medical education and the construction of the patient concept as part of this development. Part of this involves an understanding of the transition from bedside medicine to laboratory medicine. While bedside medicine is based on the close relationship between the sick person and the doctor, carried out at the bedside, laboratory medicine is linked primarily to a focus on diseases, as part of which microbes and cells are viewed as biological entities examined in laboratories, with less emphasis on the sick individual.[250] During the period leading up to 1880, which is the starting point of my study, the University and its educational activity, including medicine, underwent a period of consolidation. From 1840, Norwegian doctors had contributed to major advances and had established a significant professional community of doctors, based entirely on the education system established at the only available institution in the country.[251]

One relevant factor that played a role from 1880 onwards is the professors' understanding of the main purpose of a medical education. The contemporary debates indicate a growing disagreement between the professors on the one hand and the wider community of doctors on the other. The scientific revolution had created new opportunities in the fields of medicine and scientific development, but there was still a

[250] The terms bedside medicine and laboratory medicine was together with hospital medicine used by Erwin Ackerknecht in *Medicine at the Paris Hospital, 1794-1848.* The concepts are used by Jewson in an article where he tries to show how the patient loses power in the relationship with the doctor as knowledge develop and the doctor's focus move away from the patient and to the microbiological structures in the human body. Jewson.

[251] Grande.

long way to go towards identifying the etiology of the different diseases and sufficient cures for most of them. For example, should education focus on theory combined with scientific experiments, or should the emphasis be on practical skills and patient care? As I will demonstrate and discuss throughout this chapter, this disagreement made a significant contribution towards framing the meanings conferred on a variety of different medical concepts, including that of the patient.

One approach towards understanding the differences in attitudes to medical education that emerged during the last decades of the 19th century is to link the tension that occurred between the professors and others to the different images of the doctor that were applied both by society and by the doctors themselves (discussed during chapter three, pages 65-67). Such an approach enables us to use this framework to emphasize the various objectives that apply to the different images. This provides us with a tool to reflect on the complexities in the arguments played out in connection with medical education, and how these affected the wider community of doctors and society in general, here represented by the sick person.[252] However, it must be emphasized that the medical community of doctors did not adopt a uniform approach to these matters, as will illustrated and discussed later in this chapter.

In accordance with the various images and objectives connected to these images, developed by Øivind Larsen,[253] we can recognise that the ‘serve the science objectives’ underpin the image of the doctor as a scientist. Inherent in this is the doctor as a knowledge developer and gatekeeper, of this knowledge. As part of this objective, one can identify a dichotomy surrounding the object of knowledge development – namely, who plays the role of end-user or recipient of the knowledge produced? If we consider the patient as being the one benefiting from this objective, we can view the doctors’ role as more altruistic than if they produced the knowledge simply to enhance their own

[252] The framework used is developed by Øivind Larsen, and accounted for in general terms in chapter three. Larsen, "Doktorskole og medisinstudium," 103-09.

[253] Ibid., 105-06.

interest in the theoretical basis of medicine. The Norwegian professors were not consistent in their approach here, and later in this chapter (on page 137-138), I will cite the case of Gerhard Armauer Hansen as an example. Science was regarded by some doctors as a means of helping the sick, but by others clearly as a primary motivation for extending their fascination and curiosity in relation to solving the mysteries surrounding the various diseases.[254] In addition, the image of the doctor as a scientist underpinned and emphasized the professional objective of 'serve the society,' in the sense that knowledge can be used both strategically and systematically to improve the health of the general population. This must often have said to set the holistic approach aside and emphasizing a more reductionist approach, applied by scientific methods. Larsen has pointed out that, with the exception of the professors, doctors were scarcely visible as scientists during the first half of the 19th century:

"the image of the doctor as a scientist must said to be minimum prominent during the first half of the 19th century, an exception is the few eager and curious teachers at the University and some of their colleagues, that both did interesting observations themselves and encouraged colleagues to do the same…"[255]

As time went by, it is not likely that the professors' preoccupation with their image and responsibilities as scientists diminished in any way. However, this image contrasted with the view that most doctors held concerning their primary task and objectives. This applied in particular to those working outside the hospitals and in rural areas, who would primarily image themselves as 'life saviours' and 'caring supporters.' For most doctors, the dominant objectives during this period were to 'serve the sick,' which can contribute to explain why these doctors seem to hold on to a more holistic approach despite the professors taking a different stance during the period of this study. For the professors a

[254] Grande.

[255] [Legerollen som *vitenskapsmann* må sees som svært lite framtredende i første del av det nittende århundret, når vi da unntar de ivrige og faglig nysgjerrige universitetslærerne og en del av deres kollegaer som både gjorde interessante observasjoner selv, oppfordret sine kollegaer til å gjøre det samme, (…)]Larsen, "Doktorskole og medisinstudium," 109.

'serve the society' approach became more dominant. Norway had few doctors per capita[256], and by involving doctors in public health issues, the state could implement effective health-related measures with relatively little resources. The image of the doctor as life-saviour and caring supporter was embedded in the minds of most people, and we must assume that this image conformed to majority expectations during this period, especially since the professional health care sector eventually developed as the population got more trust in this sector of health. Through the framework of images and objectives, and the correlation of the various images and objectives with the sources, we can see the contours of a dichotomy developing between the image highlighted by the professors and that voiced and promoted by practicing doctors, best exemplified by serve the science objectives. These objectives, as far as wider society was concerned, was emphasized by the image of the doctor as a life-saviour, the more lives saved, the better it was for both the individual and society. However, it is the image of knowledge-developer and gatekeeper that develop and enable the objectives to be achieved by emphasizing method and knowledge as the key areas of focus. Based on this understanding, there is no place for a holistic approach because each patient serves simply as an objectified means of extracting knowledge for the benefit of the many.

As part of the expectations linked to these different images, wider society also exerted pressure in the form of the political and state involvement in health-related issues that had started some decades prior to 1880, as part of the modernization processes. One must bear in mind that as well as holding a monopoly on medical education, the University was also financed and controlled by the public in the form of legislative funding.[257] In the construction of the patient as a concept within these social and cultural perspectives, the image applied on the doctors by themselves and others will be discussed in accordance with what the professors regarded as being the most important

[256] Statistics concerning this is picked up from Aina Schiøtz in her book from 2003, appendices 3 and 4, table 1 and 2. Schiøtz, 455-56.

[257] Grande, 29.

aim of medical education. When the professors expressed their opinions on issues regarding the focus of medical education, and how to implement scientific and natural based methods in education and practice based on international developments, they gave meaning and content to the concept of the patient. This meaning-making process was played out in the contemporary discussions concerning education in medicine. It is possible to follow a transition in the focus of medical education from bedside practice to laboratory medicine, which introduced a shift in emphasis from a holistic to a reductionist view of the patient.

The impact of the democratic revolution in constructing the patient concept

The second path addressed is informed by the democratic revolution, where gender and class play a significant role, and where both diseases and people can be viewed in relation to power and prestige in terms of how these concepts were treated and constructed. Within this setting, conservative ideas and values of the professors must be discussed and viewed in relation to contemporary ideas and humanistic values that characterized society during that time.

In terms of the democratic revolution, also other health professionals developed and found their place in society, within health mainly nurses, midwives and pharmacists. These developments can be explained in part by the industrial revolution and a transition in the population from rural areas to the cities.[258] This transition of people and the development of a significant working class, exerted both positive and negative effects on the democratic development of society. New social challenges arose that had not existed before, and society demanded change. We now enter what historian Anne Lise Seip has called the early phase of the Norwegian “*social welfare state.”* [259]

[258] Hagemann, B. 9, 96-104.

[259] Seip, 11-15.

The development of the welfare state came about as a result of health-related challenges, and our view of events must be seen in contrast to how these challenges had been addressed previously. Seip argues that new developments must be understood in contrast to how, leading up to 1870, health issues and dealing with sickness were primarily individual matters, attended to by family and next of kin. Later, as part of the modernization processes, the state became more heavily involved, as is reflected in the introduction and nature of insurance schemes and legislation relating to health, poverty and work.[260] Linking this to Kleinman's three-sector model of healthcare, we can argue that Norway experienced a transition, fuelled by modernization, from the public and folk sector to the professional sector, and that this transition created tension between the various healthcare professions, as well as between the professions and the population at large.

Part of this tension may be viewed in the light of contrasting traditional values relating to gender, class and power. These traditional values had not progressed the same way as might be indicated by parallel economic and political developments. When looking to other aspects of the structural evolution of society, we observe a divergence between traditional values and modern developments. A division that will be explored thoroughly in my discussions of nursing education in Chapter 6. Thus, if we are to understand how the professors at the School of Medicine constructed and advocated their particular views on the patient during this period, we must give due consideration to the prevailing social and cultural setting. As I have emphasized previously, I have aimed towards understanding the sources in the context in which they were written as a means of understanding the contemporary frame within which the professors and doctors viewed their own reality. My task is to view events in same way as they did.

Cecilie Arentz-Hansen (2019) has in a book concerning the first women doctors in Norway and their professional life as doctors, described that in order to understand their story,

[260] Ibid., 87-90, 95-102.

the desperation in society needs to be added to the narrative. We must also understand that the work of women doctors was woven into the fabric of contemporary social and medical challenges to such an extent that it is crucial to contextualize this with the life and sicknesses faced by the population as part of their ordinary lives.[261] I wish to argue that while Arentz-Hansen highlights an important issue, her arguments are not restricted only to the lives and work of the first female doctors. Such recognition is also crucial to our understanding of the divergence that arose between the professors and the broader community of doctors. More importantly, it will assist our understanding of how it was possible that the patient as a concept could be viewed differently in separate parts of the medical community, depending on the currently held images and objectives pertaining to the doctors. It is more obvious to us today to recognise how social factors such as gender and class, combined with cultural factors such as our understanding of how we react to different diseases and the role religion and beliefs, have played a part in these matters. However, viewing this historically give us different challenges from a present perspective. I will elaborate on this below, and argue why these issues greatly influenced the construction of the patient concept during the period covered by this thesis.

Most doctors educated during the 19th century came from upper class backgrounds.[262] As their educations progressed, they became 'carriers of knowledge', moulded by the professors. Their background and education served to maintain and preserve the values, virtues and perceptions of a reality that in fact were shared by only a small part of the population. The contrast between the realities held by the doctors, based on their own experiences and backgrounds, and those held by the majority of the population, has been thoroughly accounted for by Aina Schiøtz.[263] Schiøtz emphasizes that the doctors were

[261] Arentz-Hansen, 119-20.

[262] Table 3.2 in Jan Eivind Myhre, *Kunnskapsbærerne 1811-2011: akademikere mellom universitet og samfunn*, vol. Bok 8 (Oslo: Unipub, 2011), 82.

[263] Schiøtz, 272-78.

Folkets helse - landets styrke 1850 - 2003, 2, 79-81, 92-95.

carriers of a level of knowledge and a social and cultural capital that far exceeded that held by the population at large, and to an extent that is difficult to comprehend today. From the doctors’ point of view, they had to relate to a population that they were not only tasked to cure, but also to civilise and raise to a higher standard of living – rescuing them from their underdeveloped culture.[264] When we understand that this standpoint frames the view of the patient held by the majority of the medical community, we can more easily relate to the language that was used by doctors to describe the patient during this period. On the basis of this historical view, I will argue that for many doctors, and especially from the professors points of view, patients had hardly any meaning or value as individuals. It was for the population at large most doctors believed that they could make a difference. At the same time, the majority of these people were remote from their own world – poor, dirty and uncultivated. The social and cultural distance between the two groups was far greater than we can imagine today. Furthermore, the various revolutions and modernization processes only served to widen this gap, both in the short and long term.

These two paths and different revolutions had impact on the development of medical education, and the professors continued to be highly involved in discussions relating to medicine and health. Since the School of Medicine remained the only education in medicine in the country, the increased influence of graduate doctors made them one of the most important contributors to the development of the health sector at all levels of society. The social and medical challenges faced by society challenged the role of the individual sick person becoming a patient at a time characterised by a changing medical paradigm in the wake of rapid industrial development and scientific advancement. This was compounded by the necessity of encountering doctors from different social and cultural backgrounds to their own. In their role as professors at the School of Medicine, a small group of men had huge impact on what view contemporary society should view, and construct the concept of, the patient, and on the meaning that formed the basis for

[264] Op.cit

becoming a patient. The extent of the professors' impact was very significant, but also highly disproportionate in relation to their numbers.[265]

However, the professors were not entirely separated from the wider community of professional doctors. They acted both within, and as an extension of, the Norwegian Medical Association, which was and remains the most influential association of doctors in Norway since it was established in 1886.[266] In spite of the fact that differences arose between the School of Medicine and the wider community of doctors concerning education, they remained in broad agreement on key issues such as salaries, positions and authorization, and on public health issues, although the professors' views on matters generally received the greatest attention. As a result, some doctors recognised the importance of supressing the tension created during discussions on education and on what issues should be prioritized.[267] However, the power acquired by the professors by virtue of their position must not be underestimated.

5.2 "A medical profession, has the Faculty it deserves"

This is a quote from a discussion in the Norwegian Medical Society in 1902, during which representatives from the clinical profession criticised the professors at the School of Medicine. At times, the tension generated between the professors and the practitioners was surprisingly high. After listening to criticism delivered by the young liberal doctor Scharffenberg, Professor Axel Holst, who in 1902 was also Dean at the Faculty of

[265] Myhre, *Kunnskapsbærerne 1811-2011: akademikere mellom universitet og samfunn*, Bok 8, 243.

[266] Still today the association on their website refers to that 97% of all doctors in Norway are a member of the association, which accounts for 31 000 members, making them one of the most influential labour organization in Norway. https://www.legeforeningen.no/om-oss/for-pressen/#/

[267] Medical Revue. [*Medicinsk Revue*.] 1887. 124. by doctor W. Mohn

Medicine, responded with the following: *"it is with a Faculty, as it is said about governments, in fact: that a medical profession, has the Faculty it deserves."*[268]

What Doctor Holst meant in this striking statement amounts to a rebuttal to Scharffenberg and other critics of the faculty. Their exchanges illustrate that these two men, Professor Holst and doctor Scharffenberg, can be viewed as representatives of the tension that had existed between the professors at the University and the practicing doctors since early 1880. As will be discussed in this chapter, they also exemplify contrasting views on what the most important objectives of a doctor should be, and how the view of the patient was expressed as an extension of this in the prevailing discussions of the time.

Initially, the professors were not eager to involve doctors outside the School of Medicine in matters concerning educational development. However, as was pointed out by the editors of the medical Journal *Medicinsk Revue* in 1885, there was no one better suited than the clinical doctor to voice the existence of gap and lack of medical formation in medical education. The demand for improvement and changes was just as much a matter for the profession as it was for the School of Medicine.[269] When given the opportunity, Professor Holst stated quite clearly that if the critics were dissatisfied with the professors and the medical education on offer, it was because the doctors themselves had not succeeded in meeting their own expectations.

When the wider community of doctors entered the debate on the development of medical education, criticism followed a number of different paths. One of these addressed where the emphasis should lie between theoretical and practical training. The professors wanted to reinforce the students' theoretical knowledge, focusing on

[268] Protocols from the National Archive after the Norwegian Medical Society. RA/PA-1301/D/Dd/L0004/0006. [det forholder sig med et fakultet, som det er sagt om en regjering, nemlig: at en lægestand, den har det fakultet, som den fortjener]

[269] Medical Review. [*Medicinsk Revue*.] 1885, 367. The editors of this journal were at the time E. Bøckmann, G.A. Hansen and K. Hanssen

scientific methods and basic biology and pathology. The doctors, arguing that their most important work was with the patient, argued that more practical training aimed directly at patient care was more relevant. At the core of this argument lies a wide range of social and cultural understandings linked to the scientific and democratic revolutions discussed in the foregoing, and in the various images that accompanied the objectives of both the professors and the clinical doctors. The social mission of the School of Medicine and the professors was clear – to educate medical experts for the benefit of society. Relating to images and objectives, it becomes natural to view the School of Medicine as an important professional premise provider, and as will be illustrated and discussed later, the professors seemed to support this well-defined image. They recognised themselves as important developers and guardians of knowledge who served to give meaning to the terms disease, the patient and treatment; terms, which constituted key elements in their understanding of reality and the context within which, they framed their own role.

When we examine the curriculum that formed the foundation of medical education in Norway in 1880, there is no doubt that its approach was centred on pathology. Subjects such as pathologic anatomy, medical pathology, surgical pathology, skin diseases, syphilis, leprosy and the diseases of women and children dominated large parts of the curriculum.[270] This curriculum did not differ from most other medical educations in Europe, although the influence from Copenhagen was significant as Norway had former been part of the Danish Kingdom.[271] Both surgical and medical approaches were incorporated in the education from the beginning. Theoretical knowledge and practical skills were considered to be equally important. Some researchers have interpreted this emphasis on pathology as an abandonment of the focus on the sick person as an individual,[272] with the majority view highlighting a shift towards diagnoses based on

[270] Regulations for the medical exam by 1877, approved by Royal decree 20th of January 1877, § 1a-c. Rendered in The Journal Norwegian Magazine for the Science of Medicine.

[271] Larsen, "Doktorskole og medisinstudium," 48-49.

[272] Kyllingstad, 204-07.

pathological examinations, and thus an objectification of the patient.[273] This has frequently been explained by the evolution of medicine towards natural science, a reductionist approach, and the professionalization of doctors.[274] However, I will to some degree challenge this understanding.

On examining the discussions regarding the demand for more practical training in education, coming both from the professors and the Norwegian Medical Association's committees set up to put forward new curriculum proposals, I find it difficult to argue that the sick person was being abandoned from an educational standpoint. In my investigations of discussions on the development of the education system, one can find that practical training and the encounter with patients constituted a repeated focus of attention. What we need to examine is not whether the sick person was abandoned or removed from centre stage, but the meaning conferred on the sick person by the professors. Were the sick person may be regarded as a means towards something that was beyond themselves or as meaningful individuals in themselves? This can be viewed in terms of how practical skills where discussed among the professors and within the medical community.

Medical students were obliged to obtain documentation from the superior doctor at the teaching hospital[275] confirming that they had completed a *'satisfactory practical training.'*[276] However, my review of the regulations has failed to reveal precisely the content of the term "satisfactory practical training". Instead, they state that students were required to be in possession of documentary evidence of having being present on

Jewson.

[273] Schiøtz, *Viljen til liv*, 52.

[274] Porter and Porter, 14.

[275] Rikshospitalet as a training hospital for the medical students became just as important as the university during the 19th century as a place to develop and increase medical knowledge. Kyllingstad, 189.

[276] Regulations for the medical exam by 1877, approved by Royal decree 20th of January 1877, § 1c.

different wards at the teaching hospital.[277] There is no mention of either the level of skills or performance required in order to demonstrate that their practical training was adequate, other than the number of months they were required to spend in each ward. For this reason, it is difficult to regard the students' education as qualitative patient-oriented practice. Instead, it must be understood more in terms of the achievement of quantitative targets in terms of treating various diseases and the completion of a given level of diagnostic training, aimed of developing their clinical gaze relevant for deciding the correct diagnosis. In any event, and based on my interpretation of the regulations, I consider it a harsh judgement to interpret a wholesale abandonment of the patient, in spite of the pathology-oriented focus in the education system. This must rather be understood as an extension of the focus of attention in any medical education at the given time, and in line with the scientific development and an understanding of reality for doctors regarding their primary task and objectives.

The focus on practical training was further addressed by the work in two different committees. The first committee was convened by the Norwegian Medical Association in 1887, and the second by the Faculty of Medicine at the University in 1897.[278] The work of both committees directed an executive focus on pathological training. My findings here are is in line with other historical sources and previous research into the history of medicine. [279] However, practical training was emerging in these discussions as

[277] Regulations for the medical exam by 1877, approved by Royal decree 20th of January 1877, § 1c, the following wards are mentioned; one semester at the different medical wards, one semester at the different surgical wards, one semester at the birth and children's ward and a half semester at the ward of different skin diseases. In addition, documentation of performing one section in pathological anatomy.

[278] Suggestion for Curriculum of the medical education by the Royal Frederiks University, Kristiania 1887, and Suggestion for Curriculum of the medical education and examination compiled by the appointed committee of the Faculty of Medicine in 1899.

[279] Kyllingstad, 192-98.

Dahl.

increasingly relevant for medical education.[280] Although practical training involved patients, little is found concerning within what frame it was acceptable to treat the sick person. Once again, it was doctor Scharffenberg[281] who spoke most freely on this topic, having clearly experienced that attitudes towards the treatment of patients held by the professors and other doctors were unacceptable. In his pamphlet, Scharffenberg uses terms such as 'impetuously', 'brutal', 'angry' and 'cross' in his descriptions of attitudes towards the patient. Furthermore, Scharffenberg is quite clear in his opinions on what should be ideal behaviour among professors and doctors teaching students at the hospital. Two quotes in particular are illustrative of his views:

"If it is always a big mistake, if a doctor should be impetuously, angry, brutal or cross, grumpy, crooked towards the sick, such a behaviour is a mortal sin by a clinical teacher."[282]

"*The clinical teacher must be the ideal doctor; otherwise he is not good enough"*[283]

Scharffenberg's opinions raised little or no criticism, and we may interpret this to mean that such statements were regarded as unremarkable. However, without drawing any conclusions, we may assume that this have been related to a common understanding that during this period, that patients during this period could not expect the same degree

[280] Suggestion for Curriculum of the medical education by the Royal Frederiks University, Kristiania 1887, 14, 21

Suggestion for Curriculum of the medical education and examination compiled by the appointed committee of the Faculty of Medicine in 1899, 10-13, 24-25, 31-32

[281] Scharffenberg, 118-20.

[282] As most of the clinical teachers during this time was either professors or doctors connected to the University and School of Medicine, we must assume that Scharffenberg here referred to any doctor taking on a teaching role at the hospital, representing the University.

[283] Scharffenberg, 119. [Er det altid en stor feil, om en læge viser sig opfarende, hidsig, brutal eller sur, grinet, vrang mot de syge, saa er slig optræden dødssynd for en klinisk lærer.]

[Den kliniske lærer skal være den ideale læge, ellers duer han ikke]

of respect we will anticipate from a doctor today in their encounter with patients. As pointed out above, the existence of diseases and sickness was commonly linked to poverty and people of dubious morality practicing poor hygiene. One of the doctors' objectives was to civilise and cultivate these common people. In this respect, being 'angry' and 'cross' with the population at large conformed entirely to their perceived mission to ensure that their patients should change their way of life and adopt more cultivated ways of living after they had been discharged from hospital.[284]

Two Norwegian historians, Stavheim and Djupedal, have described how concepts such as health and disease were constructed and understood differently by doctors and the inhabitants of rural Norway during the late 19th century.[285] As is the case for the concept of the patient, both cultural and social conditions exert a significant influence when different people confer meaning on such concepts. It is crucial here to recognise who has the power to assert a concept and to act in accordance with this affirmation, and to understand how such an affirmation influenced the development of both the concept and society as time passed. On this basis, we may assume that given the limited amount of attention given to Scharffenberg's criticism regarding the behaviour of the professors towards patients at the teaching hospital, such attitudes constituted the dominant paradigm concerning patient treatment during this period. Scharffenberg's stance challenges this dominant paradigm, and by emphasizing this, we introduce the notion of Scharffenberg portraying what he identifies as the desired characteristics of the ideal doctor and professor.

If we refer to the writings of a medical student some decades later, we find that attitudes towards patients had changed minimal. Medical student Sverre Sørsdal's writing to his mother in March 1924, says that he is enjoying his practical training at the *Rikshospitalet*,

[284] Schiøtz, *Folkets helse - landets styrke 1850 - 2003*, 2, 92-95.

[285] Ibid., 94.

but that he has obviously some concerns about how one of the professors was treating patients admitted to the hospital.

"All patients at Rikshospitalet (the teaching hospital) are being treated without cost, and Professor Bruusgaard expedites them with a certain speed, and not always very polite.[] One day a young mother came in with her child of 6 months on her arm. The child had a small mole on the forehead, which the mother wished to remove. When Professors Bruusgaard looked at the child he said; "Oh my God what a gruesome snout it was on that kid".[286]

Such statements serve to illustrate that despite attracting a certain amount of concern from students such as Scharffenberg and Sørsdal, the issue of the treatment of patients did not stimulate much attention and was not discussed widely in the same way as other topics related to medical education. It certainly received much less focus than subjects such as the diseases encountered among patients admitted to the hospital. This assertion is supported by the fact that I have found no sources addressing the criticisms raised by Scharffenberg and Sørsdal despite the fact both are documented in writing, albeit in Sørsdal's case in a letter to his mother.

What I draw from this is that patients as a group were regarded primarily as utilitarian objects exploited by the medical doctors, students and professors in order to understand the pathology and etiology of the diseases from which the patients suffered. This situation enhanced the power and status of the professors and doctors within society, and has been conceptualized by the sociologist Paul Starr as the establishment of *cultural authority.*[287] In this way, the professors, in particular, and the doctors working at the

[286] Larsen, "Legestudent Sverre Sørsdals brev til sin mor 1919-27 [Medical student Sverre Sørsdal's letters to his mother 1919 -27]," 410. [Alle pat. Paa Rigshospitalet blir behandlet frit, og prof. Bruusgaard ekspederer dem da som oftest med en viss fart og ikke altid særllig høflig.[] [En dag kom der en ung mor med et barn paa ca. ½ aar paa armen. Barnet hadde en liten føflekk paa panden som moren ville ha fjernet. Da prof.Buusgaard saa ungen sa han; «Men gubbevare mig vel for et fært tryne den ungen har da.»]

[287] Paul Starr, *The social transformation of American medicine* (New York: Basic Books, 1982), 3-30.

teaching hospital had the power to demonstrate what they believed should be defined as diseases and health. They were also enabled to establish the image of their role as gatekeeper by deciding which patients obtained access to treatment at the hospital, based entirely on what diseases they considered to be most worthy of investigation. According to this understanding, a sick person assuming the role of patient is recognised, by means of actions and language, as a means towards achieving a greater good for wider society rather than an individual with meaning in themselves.

These attitudes reflected the values that the doctors brought with them from their backgrounds in the upper echelons of society, and which were reinforced by their education.[288] Starr argues that in doing so, the doctors and professors not only held the power to construct reality within the field of medicine, but also used their cultural authority to influence arenas outside medicine such as economics, politics and morality. Here we can see an example of how a concept such as the patient can contribute, by means of social and cultural factors, towards the construction of a reality that fits not only into a society that makes up the epistemological base for the construction, but which is also exploited to reaffirm societal status and power. It is also interesting here to consider the time that passed between the statements made by Scharffenberg and Sørsdal, which reflects the very slow development of the paradigm concerning construction of the patient concept. Weather this can be understood as an adoption by the modernization processes of a conservative leaning, or as a process exploited by the medical community to preserve its influence in society can only serve as assumptions. However, I will reflect on some perspectives drawn from these statements.

Almost 30 years passed between the statements made by Scharffenberg and Sørsdal. From this we may argue that very little had changed in terms of the ways in which patients were viewed and treated at the hospital. This may imply that despite the ongoing discussions regarding changes to formal aspects of medical education, the cultural values

[288] Schiøtz, 21-22.

and virtues inherited from previous generations were difficult to change, and contributed to manifest certain images of the doctor. When these values and virtues were reinforced by an increasing focus on biology and pathology, medical education adopted a more reductionist approach, leaving the patient as little more than an object awaiting diagnosis and treatment in accordance with the results obtained from application of the correct scientific method.

In terms of medical education as reflected in examination regulations and curricula, it is striking how little the patient as a concept is referred to. However, this should not be interpreted as a developmental change in the curricula towards a biomedical focus. In an educational context, as represented by the regulations, curricula and examination plans the patient had never occupied centre stage. This view may be said to have been afforded greater relevance within medical education in recent years.[289] However, the entire idea of medicine and medical development is rooted in an urge to help the sick person, and even when we consider the professionalization of doctors in the context of formal education; it is not to question their fundamental desire to cure the sick.

Developments in medicine have not taken place in a vacuum removed from wider society. As argued earlier, both cultural and social background played significant roles in creating the distance that developed between the doctor and the patient in history. The professionalization of doctors and the establishment of the doctor as an expert emphasized this distancing. In the wake of the establishment of this distinction between the doctor as a professional expert and the patient as a non-expert layman, combined with the tendency to recognise medicine and medical treatment as the solution to every challenge in health (and life), the term ‘medicalization’ has been used to encompass the impact caused by the distancing process.[290] Although the term medicalization can hardly

[289] See attachment with an overview of the Norwegian Medical Education from 1813 to 1914, and in 2002 in Larsen, *Legestudent i hovedstaden*, 126-27, 30-37.

[290] Foucault, *Galskapens historie i opplysningens tidsalder*.

Ivan Illich, "The medicalization of life," *Journal of Medical Ethics* 1, no. 2 (1975).

be said to have been used in the 19th and early 20th centuries, I want to explain why I have chosen to draw attention to its relevance as part of this study. First a summary of how I understand the term.

The concept of medicalization implies that medicine or medical concepts and interventions exist to address not only health-related problems, but also issues that stretches beyond what may be considered as health-related. In his book ‘*Limits to Medicine: Medical Nemesis: The Expropriation of life,* Ivan Illich points out that when medicine is understood in this way, we should regard it as more of a threat to the public and public health than as an approach to caring.[291] By extending Illich’s arguments, we can say that medicalization represents the conceptualization of a society attempting to meet all challenges in life by the application of medicine and, more specifically, by objectifying people and using statistically significant methods to develop drugs that make people feel better. In this visualisation, the doctor embodies the image of a cultural hero who enables the entire scope of possibilities open to medicine.[292] According to Michel Foucault, this development was promoted by the clinical gaze and professionalization of medicine that evolved during the 19th century. In his studies of various phenomena within the field of health, Foucault sought to emphasize not only how truth changes, but also the place of language in the construction of different truths, and how both language and truth are connected to power and the power structures that develop within society.[293]

Thus, both Foucault and Illich can be regarded as advocates for the argument that doctors, by adopting a more purist biomedical view of medicine, have exerted a negative

[291] *Limits to Medicine: Medical Nemesis: The Expropriation of Health* (United Kingdom: Marion Boyars, 1976).

[292] "The medicalization of life," 73-74.

[293] Erling Sandmo, "Sannhetens historie," *Prosa*, no. 4 (1999): 21.

influence on society.[294] In this study, I will employ two premises on which to argue for the relevance of this understanding. Firstly, within this understanding, the doctors and professors are those wielding the power inherent in the dominant medical paradigm, and thus serve as active agents in the implementation and preservation of their power and its extension into wider society. By using the medicalization of society as a point of departure in my understanding, the professors, via the School of Medicine and its education system, have contributed towards the construction of a view of the patient that conformed to their approach to natural science and the reductionist methods that extended beyond the University. They have used their medical knowledge to develop society, and a previous definition of what a profession is emphasizes just this point; *“to hold a monopoly on the exercise and practice of certain tasks and to have a high degree of power and control of the ethical and professional regulations that apply to the profession.”*[295] In order to safeguard such a view, the language used concerning the patient had to develop in line with the professors’ understanding of reality in terms of what they considered important in the curriculum and training offered at the School of Medicine. Thus, we can see that the construction of the patient concept must be regarded both as a way of preserving reality in terms of the way in which it was understood, and at the same time as a way of building an understanding of that reality. Secondly, the entry by the professors and doctors into political and legislative debates served to enhance the movement of medicine and medical solutions outside the bounds of the strictly medical arena.

The view that people were a resource that needed to be kept healthy constituted the premise for a sense of national responsibility for public health that also found its way into education. With state-supported forces mobilised in favour of the individual, the public had to be protected from infectious diseases, and the population provided with care.[296]

[294] Illich, "The medicalization of life."

[295] Quote taken from page 57 in this thesis.

[296] Larsen, *Legestudent i hovedstaden*, 73.

It is a matter of debate whether medicalization or mercantilism constituted the primary motivation for the interaction between the Norwegian state and professors at the School of Medicine. However, from what can be found in the sources, I believe that the prevailing biomedical paradigm had a more dominant role in driving the development of the patient as a construct than any consideration of the individual sick person.

In a Norwegian context, there was a clear expectation that it was by means of medical expertise exercised mainly by the doctors that society would secure the breakthroughs that gave protection and secured a healthy population.[297] In attempting to achieve this, the professors must have felt an enormous responsibility. Both to keep themselves updated on the latest developments in medicine, and to teach their students the necessary skills they would need, not only to practice as doctors, but also to contribute to the advances in knowledge development that would help them diagnose and cure the most infectious diseases. Even since the early stages of the professionalization of medicine through education, it had been the wish of the professors that a Norwegian healthcare service would be administered primarily based on the doctor and his knowledge.[298] With the enactment of the Health Care Act of 1860, the work of the health commissions was incorporated into law, which vindicated the doctors’ influence on societal developments in the fields of medicine and science, but also beyond.[299] By the second half of the 19th century, the professors’ vision of holding influence and administrative responsibility for healthcare in Norway at all levels had been achieved. Therefore, despite the introduction of a new concept, we can assume that the medicalization of society was well in hand.

This mercantilist approach to health came primarily from Vienna during the late 18th century. "Doktorskole og medisinstudium," 44-46.

[297] Schiøtz, *Folkets helse - landets styrke 1850 - 2003*, 2, 42-43.

[298] John Peter Collett, *1811-1870 : universitetet i nasjonen*, vol. Bok 1 (Oslo: Unipub, 2011), 314.

[299] Schiøtz, *Folkets helse - landets styrke 1850 - 2003*, 2, 44-46.

Nevertheless, it remained the primary task of the professors to develop medical education into a modern and high-quality system that met the demands of society and from the profession itself. This situation created a tension that becomes clearly visible in empirical sources that directly address the challenges involved in educating doctors to safeguard their dual image of knowledge developer and caring supporter and life-saviour.[300] The professors' approach to promoting these various roles was to emphasize the scientific method and its application in medicine. In order to exercise their social responsibility to society, the professors argued for a focus on education in pathology, biology and the scientific method in order to *"fix the medical education in such a way that it seeks to provide the students that enter life to skilful and practical doctors*."[301]

As the tasks assigned to doctors became increasingly more complex, and procedures more invasive, it is easy to argue that the government expected a focus on the scientific approach in medical education. The professors took their social responsibility seriously, arguing that natural science constituted the core of their teaching approach designed to equip the students with the best possible means of focusing their practice as doctors.[302] This view is supported by the fact that most professors, in addition to their posts at the University, also held positions at the training hospital, where they and their students could test new methods to practice. A consequence of this was that the patient came to be viewed as no different from any other natural science-based phenomenon. The following can serve as an example;

"A specific method is to be followed when doing a natural science based examination, it is the same method more or less modified that must be followed when doing an

[300] Larsen, "Doktorskole og medisinstudium," 103-09.

[301] Suggestion for Curriculum of the medical education and examination compiled by the appointed committee of the Faculty of Medicine in 1899, page 10. [Komiteen finder at det er universitetets opgave først og fremst at ordne den medicinske undervisning saaledes at den søger at gjøre elevene, der gaar ud i livet til dygtige praktiske læger.]

[302] Negotiations in the Norwegian Medical Society in 1886, printed in the Journal of the Norwegian Medical Association, 1886, 911

examination of the sick, and one must hence from the very first moment bring the observation and thinking of the student in a specific direction."[303]

From the perspective of our modern and humanistic construction of the term, it can be argued that the patient was being objectified. Curiously, this objectification somewhat contradicted the liberal ideas concerning individual rights and humanistic values that were influencing society as part of the modernization processes which in turn were being fuelled by the democratic revolution that was about to influence society in a number of different ways.[304]

On the other hand, this way of viewing the patient was in line with what was expected, and indeed encouraged by the dominant contemporary medical paradigm. Naturally, this view was also cemented by the cultural dominance of the doctors and professors. To borrow the arguments of Foucault concerning truth, I suggest that this represented the reality in terms of how patients were viewed in the present. If the professors were to enable doctors to fulfil their social mandate successfully, training in scientific methods were essential, regardless of the nature of who or what was exposed to this training. In spite of the liberal ideas and values that were exerting an increasing influence all across Europe, it remained the fact that when it came to health, the 'common people' were regarded as a potential threat to society because of their frivolous lifestyles. Furthermore, as the industrial revolution led to demographic transition from the country to the towns and cities, greater population densities caused by people living in confined accommodation represented an increased risk of infection. This can be illustrated by the

[303] Negotiations in the Norwegian Medical Society in 1886, printed in the Journal of the Norwegian Medical Association, 1886, 911. [Der følges en bestemt Metode ved de naturvidenskabelige Undersøgelser, men det er den samme Metode, som mere og mindre modificeret maa gjennemføres ved Sygeundersøgelsen, og det gjælder derfor allerede fra første Stund af at bringe den Studerendes Iagttagelsesevne og Tænkemaade ind i en bestemt Retning]

[304] Hagemann, B. 9, 250-52, 71-72.

following, taken from among the discussions of the committee that worked to prepare the Health Care Act;

"One has realized, that the increasing population by its companions: relatively bigger constriction of individuals in small rooms and in bigger clusters, extended Industry and factory operation, poverty and misery in addition to excessive pleasure, make the demands of Science strong in order to counteract such conditions often harmful influence on the health of most people."[305]

Motivated by the scientific revolution emanating from Europe, the Norwegian state and its legislative bodies became increasingly reliant on the doctor to practice his skills actively in the best interests of society. From this perspective, it is difficult to find support for the notion that the sick person was viewed as anything other than an objectified means towards a greater good. Here, the 'greater good' can be characterized in terms of promoting a healthy population, and that this could only be achieved through the development of medical knowledge and the control of infectious diseases, combined with economic and moral growth. However, it is a matter of debate whether this can be understood as an early medicalization of society in the sense described by Foucault and Illich. We cannot ignore medicine and the role of the doctors in the development of a modern society, and nor were the professors alone in advocating such a view. Throughout the 19th century, most doctors repeated these arguments in their search for

[305] [O.No.34 Regarding gracious Proposition to the Norwegian Constitutional Body concerning the preparation of an Act concerning Health Care Commissions and on measures on the occasion of epidemic and infectious Diseases. Report and draft, issued by Royal Decree of 6th February 1858 gracious arranged Committee, dated 30th December 1859.] page 2.

"O.No.34 Angaaende naadigst Proposition til Norges Riges Storthing betræffende Udfærdigelse af en Lov om Sundhetscommissioner og om Foranstaltninger i Anledning af epidemiske og smitsomme Sygdomme. Betænkning og Udkast, afgivet af den kongelige Resolution af 6te Februar 1858 naadigst anordnede Commission, datert 30te december 1859," (1859), 2.

[*Man har indseet, at den stigende Civilisation ved dens Ledsagere: forholdsvis større Sammentrængen af Individerne paa mindre Rum og I støre klynger, utvidet Industrie og Fabrikdrift, Fattigdom og Elendighed ved Siden af overdriven Livsnydelse, gjør stærke Krav paa Videnskaben for at modvirke hine Forholds ofte skadelige Inflydelse paa Sundhedstilstanden]*

diagnosis and cure. We find them in particular in the discussions concerning new legislation, such as the Leprosy Act in 1885.[306] When Professor Axel Holst claimed that a profession 'gets the Faculty it deserves', the contemporary doctors who argued for a different approach by the professors and most of their colleagues, spoke against the contemporary dominant medical paradigm. These criticisms also challenged what the professors viewed as their legitimate power to influence society through the development of scientific and, more specifically, medical knowledge development. However, these critics were largely ignored, and Holst became a spokesman for actively rebutting the criticism of those doctors who opposed the contemporary paradigm.

Is it possible that we can interpret Professor Holst and his outburst concerning the medical profession and the Faculty as a direct expression of the few acting in opposition to the dominant view on medical education? As will be discussed more thoroughly in the following, we know that doctor Scharffenberg exercised a strong and critical voice. In fact, it was Scharffenberg and his criticisms that triggered Professor Holst's statement. It is possible that what we find by examining the contrasting views on medical education and the patient as expressed by Scharffenberg and Holst may shed some light on the conceptualization of the patient that was about to develop.

5.3 The construction of the patient as part of a reductionist focused education and varying images of the doctor

Johan Scharffenberg was one of the doctors who, in the late 19th century, raised his voice against what was about to be vindicated as the dominant paradigm in medical education. In order to understand the motivation behind his arguments, we need to take a closer look at this young doctor and his liberal ideas. Scharffenberg brought to the surface a different voice to the medical education debate that contrasted with the views of most

[306] Georg Armeuer Hansen argued that the most humane in terms of leprosy was to protect the well from the sick by isolating and force infected people into institutions. Journal of Norwegian medical Association, [*Tidsskrift Norske legeforening.*] 1885.391

other doctors. He completed his medical education (1897), and from his many publications and engagement in societal challenges of his time, we know that he was familiar with the liberal ideologies of his time, coming from and being part of the upper class in society. It is clear that he believed that the education system was in great need of reform. Based on his own experiences as a student at the School of Medicine,[307] Scharffenberg forcefully advocated reform within medical education. His primary concern was to promote the idea of the doctor as a practitioner, and he spoke up for a professional and clinical approach to practice by which the doctor worked fastidiously with his patients to achieve high-quality care. In this regard, he argued, the Professors and the School were unsuccessful. Not only did he promote the role of the clinical doctor, he also made it clear that in his view, the education of medical scientists should not be the primary task of the Faculty.[308]

As the discussion concerning medical education continued, an impatient Scharffenberg published a pamphlet containing his views on reform.[309] Much can be said about this pamphlet and Scharffenberg’s attack on the various professors. His criticism of both the School of Medicine and of individual professors was so forceful that the Ministry of Health[310] was moved to sue him for injurious defamation.[311] However, this issue has been discussed thoroughly in previous research,[312] and is not the focus in my study. What is

[307] Scharffenberg was especially occupied with what he regarded as a poorly planned study and random systematic teaching from the Professors. Scharffenberg, 16-18.

[308] Protocols from the National Archive after the Norwegian Medical Society. RA/PA-1301/D/Dd/L0004/0006.

[309] During 150 pages, Scharffenberg presents clear critique of both the medical education and also specific Professors at the School of Medicine, especially Professor Julius Nicolaysen. Scharffenberg.

[310] At the time of this study, the official name of the Ministry of Health was *‘Indredepartementet,’* meaning the Ministry of Interior Affairs, and included all national affairs.

[311] Kyllingstad, 220-22.

[312] Frode Tarjei Selman, ""Thi jo mindre der fordres, des mindre vindes": Johan Scharffenberg og striden om den medisinske undervisningen ved Det kongelige Frederiks universitet i Kristiania" (Universitetet i Oslo, 2002).

critical here is that Scharffenberg gave voice to an alternative way of looking at both medical education and the primary aim of the University. He was a spokesperson for the argument that patients deserved to be treated with dignity, and that the primary task of the doctor was to care for the patient. This view continued to make up the basis for his patient approach through his entire professional career. [313] With this in mind, Scharffenberg argued, the School had a key responsibility to exercise the role of educating doctors to serve patients all across wider society.[314] In his opinion, the School of Medicine was failing in this role. Scharffenberg must be regarded as an advocate of the preferred image of the doctor as a caring supporter and, as prior to any other image. As I have pointed out above, he put forward sufficient arguments to why the image as knowledge developer and scientist was outside the tasks of the School.[315]

Although Scharffenberg exercised a strong contemporary voice, he was nevertheless speaking out against the dominant paradigm that had developed in medicine during the 19th century. That he believed that medical education should encourage a patient-focused role for the doctor was one thing. However, to argue against the role of the doctor as a scientist was quite another, and most of his colleagues found this difficult to

[313] Olav Sundet, *Johan Scharffenberg: (1869-1965): samfunnslege og stridsmann* (Oslo: Tanum, 1977), 119-23.

[314] Scharffenberg, 119-20. and Protocols from the National Archive after the Norwegian Medical Society. RA/PA-1301/D/Dd/L0004/0006.

[315] «This consideration of the welfare of the sick is in my eyes more important than the consideration of science, of the students, even of the convenience of the Professors… our medical task is to educate skilled doctors for the country (doctors, whom one calmly dare see as the only doctor in villages shut out from the rest of society.) The task is not to educate scientific specialists.

[«Dete hensyn til de syges tarv er I mine øyne endog viktigere end hensynet til videnskaben, til studenterne, endside til professorernes bekvemmelighed…vor medicinske undervisningsopgave er at uddanne flinke landslæger (læger, hvem man rolig tør se som enelæger I afstængte bygder.) Oppgaven er ikke at uddanne videnskapelige specialister.»]

Protocols from the National Archive after the Norwegian Medical Society. RA/PA-1301/d/Dd/L0004/0006

accept.[316] At a time when most of the professors advocated the scientific approach, it was easy to ignore a single voice of opposition. However, if we examine some of the views expressed outside Norway, we find that Scharffenberg was not the only person speaking out about the possible disadvantages to patients of the new paradigm.

The American Professor J. H. Warner has pointed out that it was not unusual, within a number of academic institutions in Europe and North America, to hear voices warning of the dehumanization of the patient as a result of the prevailing reductionist approach to medicine.[317] These voices had an impact on contemporary society because they were calling for a ‘rehumanization’ in medicine, not at the expense of the scientific approach, but as an important supplement to it.[318] Men such as Theodor Puschmann, William Osler and John Shaw Billings advocated an approach to medical education that involved introducing the ‘art of medicine,’ which would be implemented by teaching of the history of medicine to their students. [319] By adopting a more pragmatic approach than Scharffenberg, they presented a view that succeeded in resonating with a movement arguing for a holistic and humanistic approach that endured well into the 20th century, despite the fact that medicine and medical education was evolving in another direction. [320] What we may assume from these contemporary advocates of rehumanization of the patient is a recognition that such an approach had disappeared from the consciousness of the majority of professors and practicing doctors due to the medical paradigm that had gained dominance during the 19th century.

[316] Negotiations in the Norwegian Medical Society in 1902, printed in the Journal of the Norwegian Medical Association in 1902, 1011-1012.

[317] Warner, "The humanising power of medical history: responses to biomedicine in the 20th century United States," 92.

[318] Ibid.

[319] Warner, "The Art of Medicine in an Age of Science: Reductionism, Holism, and the Doctor-Patient Relationship in the United States, 1890–1960," 61-63.

[320] Ibid., 63.

The image of the doctor practicing bedside medicine working as a caring supporter had been replaced by the doctor as a scientist and knowledge developer, where the image as a life saviour make up an extended part of the scientific approach that focused on public health and keeping society free of epidemics. As discussed above, it is difficult here to find any support for the argument that the dominant view of the patient was any other than reductionist, framed as it was by the prevailing biomedical paradigm.

In Norway, it was easy to ignore the voice of Scharffenberg because of his combative and agitating behaviour. However, it was much more difficult to ignore the voices of other practitioners arguing for the inclusion of more practical training in medical education. Using this reasoning, it is possible to recognise the same concerns about medical education as expressed by Scharffenberg, as well as those views on what should be the primary image and objectives of doctors and their roles in terms of everyday practice. Critics were claiming that a theoretical focus, combined with excessive laboratory and dissection work, had been assigned far too high a priority.

“It is such that a man with his exam in his pocket can go straight from the examination to practical work without having any guaranty that he actually have performed any practical training. [] There should be required a 6 months period of internship in a common hospital before awarding licentia practicandi.”[321]

In spite of the reluctance of the professors, these discussions gradually resulted in changes. As part of its preparation of the curriculum to be proposed by the School in 1899, the committee included a session, the minutes of which demonstrate that the critics were beginning to exert an influence.[322] The committee acknowledges that the

[321] Statement from Dr. Yngvar Ustvedt in a short memo in the Journal of the Norwegian Medical Association in 1900. *Journal of the Norwegian Medical Association,* 1900, 981 [Det er nemlig den ting, at nu kan en mand med sit testimonium i lommen, gaa lige fra eksamensbordet ind I praksis, uden at man har nogensomhelst garanti for, at han har praktisk øvelse; [] Der burde forlanges 6 maaneders kadnidattjenestenved et almindelig sygehus før meddelelsen af licentia practicandi.]

[322] Laache et al., "Forslag til plan for den medicinske undervisning og examen udarbeidet af en af det medicinske fakultet nedsatt komité [Suggestion for a Curriculum for Medical Education and the

University’s primary task is to educate skilled and practically trained doctors. However, the committee also inserted a sentence in support of its view that the only way in which this aim could be achieved was to provide the students with sufficient training implemented according to the principles and methods of natural science. Using their strategic rhetoric, the professors succeeded in accommodating the views of their harshest critics, while at the same time remaining firm on their stance on the theoretical and methodological approach to medical education. It was another 15 years before real changes were made to the curriculum and the organization of medical education.[323]

The faculty’s views on this issue were largely in step with those expressed in most other European countries at the time. The Norwegian medical profession, especially the professors, were well aware of and familiar with developments taking place in Europe. The proposed curriculum prepared by the committee established by the Norwegian Medical Association in 1887 includes a long introduction that recognises the developments in medical education taking place in Sweden, Denmark, Finland, Germany, Holland, Belgium, France, England and America.[324] It was more common than not for Norwegian doctors to travel and practice in a European country after graduating from the University. The German model, which focused on scientific principles and laboratory training, was highly favoured. As the Flexner report reveals, this model became the gold standard for medical education in America and Canada at the beginning of the new century. Flexner spent much time investigating, and was greatly inspired by, the medical educational literature from Europe, and from Germany in particular.[325] The German

Examination compiled by the appointed committee of the School of Medicine in 1899]," (Kristiania: Det kgl. Frederiks Universitet, 1899), 10.

[323] New regulations and curriculum for the degree of medical exam, printed in Journal of Norwegian Medical Association 1914, 845-853, 910-920.

[324] K Hanssen et al., "Forslag til Plan for den medicinske undervisning ved det Kgl. Frederiks universitet i Kristiania," (Kristiania: den norske lægeforening, 1887).

[325] Thomas P. Duffy, "The Flexner Report - 100 years later," *The Yale journal of biology and medicine* 84, no. 3 (2011): 271.

model was integrated into American and Canadian medical education, incorporating a scientific approach based on laboratory training and an eagerness to develop new knowledge for the benefit of wider society.[326] It is also within this frame that William Osler and some of his colleagues based their criticism of the dehumanization of medicine and medical education, arguing for a counterbalance to the German model, and advocating the teaching of history, philosophy and the ‘Art of Medicine’. However, what was this medical educational model that had evolved which caused Scharffenberg, Osler and others to be so critical?

The German model that was implemented according to the Flexner system, and which provided important inspiration to Norwegian medical education, was built on the principle that medicine was first and foremost a biological discipline in which the scientific method and clinical and laboratory experiments were its most important components.[327] Medical education should be based on testing hypotheses, and the students were best served by learning by doing. Within this context, that primary meant testing hypothesis of diagnosis and new treatments on patients, based on results from laboratory experiments. In addition, Flexner promoted research as a core activity. Some researchers have argued that the Flexner report and his system of medical education were previously misinterpreted. [328] Kenneth Ludmerer pointed out that Flexner never meant for a dehumanization of the patient or to devalue the doctor-patient relationship, and that in his later years, Flexner himself became frustrated that his name had become synonymous with a system that promoted such an approach. [329] This may be so, but modern

[326] Ibid.

[327] M. Kenneth Ludmerer, "Commentary: Understanding the Flexner Report," *Academic Medicine* 85, no. 2 (2010): 194.

[328] Ibid., 195.

[329] Ibid., 196.

researchers are largely in agreement that implementation of the Flexner model greatly encouraged the objectification and dehumanization of patients.

However, we cannot ignore that both Osler and some of his contemporary colleagues identified this tendency as the major shortcoming of the Flexner model. In Norway, Scharffenberg expressed the same sentiments. An educational system that promoted science and the testing of hypotheses on patients may have had the best intentions, and in solving some of the greatest challenges in medicine of that time, it must be regarded a success. However, as was argued by both Scharffenberg in the late 19th and the student Sørsdal in the early 20th centuries, patients at the teaching hospitals were not treated in accordance with humanistic values.[330] In this regard, one may argue that the image of the doctor was on the verge of radical change, and that the doctors’ objectives fuelled changes designed to fit this image. For many years, the professors had argued for and worked strategically to promote the image of the doctor as a scientist. However, it is a matter of debate as to whether they fully understood the consequences of the way in which the image was developed. As stated above, the doctor’s primary task of caring for and treating the sick should not be questioned as such. However, what objectives that were prioritized and the image that attained primacy have both contributed to the construction of a number of concepts at the intersection between professionalism, values, culture and social power. The issue as to whether the doctor saw himself primarily as a scientist or as a caring supporter has influenced this view, and the language used when referring to patient-related perspectives reflected the reality inherent in the predominant challenges of the time.

[330] Scharffenberg, 120. Larsen, "Legestudent Sverre Sørsdals brev til sin mor 1919-27 [Medical student Sverre Sørsdal’s letters to his mother 1919 -27]," 410.

5.4 The construction of the patient in a broader educational context

In the introduction, I suggested that ‘patient’ is a concept constructed in relation to the context in which the sick person appears on entering the professional healthcare sector, and that the construction is based on social and cultural factors just as much as it is on biomedical influences. Up until now, the professional health sector that I have referred to in my approach has been represented by medical education.

At the turn of the 20th century, the biomedical model constituted the dominant paradigm in medical education and, in a Norwegian context, this contributed towards justifying the introduction of the modernization process with the aim of promoting a healthy population. In retrospect, this paradigm has largely been viewed as a success. To a much greater extent than before, progress in medical science ensured that infectious diseases and epidemics were brought under control. More people remained healthy and more survived their diseases. The revolutions in medicine and medical thinking changed the ways in which wider society related to and lived with sickness and disease.[331] It is easy to acknowledge that a greater good was being achieved, and far-fetched to underestimate the significance of these developments. Medical education contributed in support of the notion of the greater good by maintaining and consolidating developments that extended beyond the field of medicine. History was on the verge of the emergence of a paradigm that applied scientific method in education at the expense of patient-oriented training. Previous research has seen this as a consequence of the transition from bedside to laboratory medicine[332], and a key premise for the construction of the patient concept was about emerge – a discourse that enabled the objectification of the sick person.

[331] Schiøtz, *Folkets helse - landets styrke 1850 - 2003*, 2, 51.

[332] Jewson.

Charles Rosenberg has said that in order to study the history of medicine, one has to start with diseases. The concept of sick people, he argues, is constructed as part of their illness, and that this also applies to doctors.[333] Part of these constructs incorporate the values, status and virtues derived from the wider society of which they are a part, Rosenberg argues further. Based on Rosenberg’s arguments, I intend to argue that during the last decades of the 19th and into the 20th century, the patient as a concept was constructed at the intersection between epidemic diseases, a reductionist medical paradigm, and prevailing conservative values and mercantilist attitudes towards the population, all played out as part of the development in the medical education.

Such a discourse leaves little room for the individual. The darker side of this tendency was the cost incurred by individual patients, even though these costs were known to contemporary politicians and public officials.[334] In order to succeed in this, it became necessary to develop a language that not only emphasized the construction of the patient in the service of medicine and societal development, but that also preserved a construction of the patient that served to maintain the balance of power. As has been pointed out in earlier studies of the influence on medicine of the German model, the development of advanced knowledge was to supersede all other considerations, including the patient.[335] In a Norwegian context, Professor Aina Schiøtz has concluded that in the cause of combating epidemic and infectious diseases for the greater good of society, all methods were acceptable, regardless of the price paid by the sick.[336] When Schiøtz makes such an argument, this must be seen in accordance the context of the liberal and mercantilist ideologies of the time, and in the light of the contemporary

[333] Charles E. Rosenberg, "Introduction. Framing disease: Illness, Society and History," in *Framing Disease. Studies in Cultural History*, ed. Charles E. and Janet Golden Rosenberg (New Brunswick, New Jersey: Rutgers University Press, 1997), introduction, xiii-xiv.

[334] Schiøtz, *Folkets helse - landets styrke 1850 - 2003*, 2, 44-48.

[335] Duffy, 273.

[336] Schiøtz, *Folkets helse - landets styrke 1850 - 2003*, 2, 77.

paradigm in medicine. At the same time, we must also question whether stating that the price paid by individual sick people due to advancements in medicine is the same as saying that the individual patient disappeared from the medical arena, which was an argument put forward by N.D. Jewson in a paper published in 2009.[337]

Schiøtz's arguments are in line with an ideological approach in which a reductionist view in medicine is not in conflict with the overall mercantilist aim of safeguarding society from disease. Within this perspective, every sick person is viewed as a threat to the notion that regards people as a utilitarian resource used to fuel the development of a modern society. This threat had to be met with knowledge and appropriate measures – the only way being the scientific method and experiments derived from observing how diseases presented themselves in the sick person. On becoming a patient, the sick person also became an instrument in the search for knowledge as a part of the mission to solve the problems facing wider society. The primary aim was to eradicate epidemic diseases using the force of sufficient knowledge.

Jewson, on the other hand, targets his criticism at the biomedical paradigm and regards this as inconsistent with a humanistic construction of the patient. Jewson highlights what he sees as an objectification of the sick person in the transition from bedside medicine to laboratory medicine by which the individual is eradicated from the medical discourse.[338] Jewson himself points out that his analysis does not take into account other cultural and social factors. Nor does he consider how medical modes of production influence policy, economics or other practices. Jewson argues, in fact, that the focus of his paper is the changing appearance of the sick person within pathological theory.[339] Based on my examination of the historical sources, I cannot claim that the professors, or most of the doctors, succeeded in eradicating the patient from medical discourse. However, as both

[337] Jewson.

[338] Ibid., 629.

[339] Ibid., 630.

Jewson and Schiøtz have pointed out, and which is further supported by the language used in the sources, we are left with an objectification of the patient, and the clear impression that this was supported both within the medical paradigm and by society at large, although perspectives vary as to why this was necessary.

The advances in medical knowledge development that emerged in the wake of the change from bedside to laboratory medicine both supported, and were supported by, state involvement in taking responsibility for public health issues. The need to control epidemics and keep the population healthy extended into developments in medical education, and contemporary advances in medicine made the exercise of these responsibilities in the form of public health policy possible. The modernization processes in wider society depended on doctors that were at the front of scientific development. Moreover, the state relied on the doctors to apply their knowledge and exploit their recently achieved status in order to pave the way for processes supporting social initiatives at population level, including regulations, health legislation, hospital building and the development of the healthcare professions. As I have argued previously, there was no place for the patient as an individual person in this process. The social construction of the patient emerged within the frame of the dominant prevailing discourse of medicine and medical education of the time. Within this frame, we must understand the patient as a construct developed primarily in relation to science and the image of the doctor as a knowledge developer.

The objectification of the patient can be viewed as problematic in relation to the image of the doctor as a caring supporter, and of the relationship between doctor and patient in terms of the former providing individual treatment. As I have pointed out above, the professors saw it as their main aim to equip the students with sufficient skills and methodologies to enable them develop more knowledge and clothe themselves in the image life saviour as they tackled the huge challenges coming from society. Within this frame, one may assume that the objectification of the patient was simply in line with the dominant paradigm and the expectations of the state. In spite of this, those that criticized the dominant paradigm by stating that modern medicine and teaching lacked humanistic

values and contributed to a dehumanization in patient care, continued to advocate an alternative approach and included the ‘Art of Medicine’ as an approach in their teaching.[340]

The objectification of the patient was a view that was on the verge of manifesting itself in the wider medical community, and was at the same time an object of criticism from other areas of society. In a Norwegian context, external critique can be drawn from an example concerning Doctor Gerhard Armauer Hansen. In 1880, Hansen was brought to trial after testing his scientific methods on a patient. Hansen worked as a superior doctor at the leprosy hospital, St. Jørgen’s hospital in Bergen, and carried out research at the same time. In his eagerness to prove the causal link between bacteria and leprosy, he deliberately applied a specific leprosy bacterium to one of his patients’ eyes after she had specifically refused to give her consent.[341] In his view, Hansen was conducting his experiment in order to develop knowledge for the greater good of society. The patient, a female and of a lower class, was simply a means to an end in his grand scheme. Nevertheless, Hansen was charged and convicted of assault against a defenceless person and exploitation of his position at the hospital, leading to the loss of his position at St. Jørgen hospital as a consequence.[342]

This was a historic verdict because it was the first time that a doctor had been convicted of performing experiments on a human who was also one of his own patients. This may serve as an example of how the more liberal ideas held in society concerning individuals rights, as represented by the legislature, differed from the dominant contemporary

[340] Warner, "The Art of Medicine in an Age of Science: Reductionism, Holism, and the Doctor-Patient Relationship in the United States, 1890–1960," 80-81.

[341] Schiøtz, *Viljen til liv*, 438-39.

[342] Michael F. Marmor, "The Ophthalmic Trials of G. H. A. Hansen," *Survey of Ophthalmology* 47, no. 3 (2002): 281-84.

For a short presentation of the case and its ethical consequences in a Norwegian context, see this text from University of Bergen https://www.uib.no/ka/50966/overgrep-i-vitenskapens-navn

paradigm in medicine, which had been fuelling the growth in power enjoyed by the doctors.[343] However, because Hansen's defence was based on his use of scientific methods and experiments as a means to an end in the context of medical education, his case obviously had very little effect on the professors. The professors supported him unconditionally during the trial, based primarily on arguments maintaining the arguments of setting aside individual concerns in preserving the benefit for the grater good. While Hansen lost his position at the hospital, he retained his post as a researcher in leprosy, as well as the prestigious Norwegian title of Chief Medical Officer for Leprosy for the rest of his life.[344]

This example serves to emphasize that it was not only the dominant medical paradigm within medical education that influenced the frame within which the patient as a concept was constructed. The values and virtues prevalent in society were not something that the doctors and professors could easily ignore, and this became clearer after Hansen's trial. However, the judges can only adopt ruling according to Acts already approved. The new Leprosy Act was under discussion in 1885, and was advocated strongly by Dr. Hansen, although it is now viewed as controversial in terms of its intrusion on individual freedoms. The perceived need to isolate family members suffering from leprosy generated heated discussions among doctors, and this coincided with discussions concerning medical education. Dr. Hansen was very clear in his views:

"We must weigh the disadvantages against the advantages which the community may derive from the isolation. I believe that I am a full-blooded friend of liberty who wishes to place the individual's freedom high, yet at the same time I am a member of the community and, as a citizen, often find that this conflicts with my individual instinct for liberty."[345]

[343] Schiøtz, *Viljen til liv*, 440.

[344] Marmor, 284.

[345] The English quote is taken from ibid., 285. The Norwegian quote is found as a response by Hansen to dr. Wulfsberg as part of a discussion regarding the new Act on Leprosy, written in *The Journal of Norwegian Medical Association.* 1885.391 [Vi må alltid veie ulæmpene mot fordelene samfunnet kan oppnaa ved

Reflecting on the conviction of Hansen, and the successful introduction of the Art of Medicine ideology by Osler and his colleagues in America, we can say that the professors' dominant paradigm regarding their view of the patient became the subject of some degree of criticism. Challenges came both from outside the University, as in the case of Hansen, and from within the profession. Doctors such as Johan Scharffenberg and William Osler revealed themselves as important voices contradicting the paradigm of the search for objective knowledge based exclusively on scientific methods. A new curriculum for medical education in Norway was approved in 1914, with the view on the patient amended somewhat:

"…express our unconditional support to the Faculty to have taken the steps to finally complete also in our country a structure with the medical student's clinical training that will be in accordance with the demands of the time – and indicate a significant improvement both for the students and non the less for the hospitals and their patients."[346]

Whether this could be understood as a change most professors at the university supported is uncertain. however small the change may seem, it paved a way for a more nuanced construction of the patient in the context of medical education. If we examine medical education today, we still recognise the biomedical view as the dominant paradigm.[347] The view of the patient remains a subject of critical discourse, and the debate has resulted in the introduction of subjects such as humanistic medicine in some

isolation. Jeg mener jeg er en fullblods forkæmper for frihed og plasserer menneskets frihed høyt, på samme tid er jeg et medlem af samfundet og som borger finner jeg ofte at dette er i konflikt med min individuelle instinkt for frihed]

[346] Editor in Medical Revue [*Medicinsk Revue,*] 1914, 816. [uttrykke vor ubetingede tilsutning til fakultetet fordi det har tatt skridt til endelig at faa gjennemført ogsaa i vort land en ordning med de medicinske studenters kliniske opøvelse som vil være mere i overensstemmelse med tidens krav – og betegne væsentlig forbedring baade for studentene, og intet mindre, for de større sykehus og deres patienter.]

[347] Carl-Magnus Stolt, "Vad är humanistisk medicin?," *Tidsskrift for Den norske legeforening* 120, no. 30 (2000).

contemporary curricula.[348] I have attempted to demonstrate here is that within the professionalization of medical education, a dominant discourse emerged that justified a social construction of the patient as a means to an end in achieving the greater good of society, in accordance with the contemporary paradigm. Moreover, this construction was in line with official policy and concurrent state involvement in the development of an effective healthcare service, enabled by modernization processes. In spite of this, there existed at the same time contemporary voices who advocated a humanistic and holistic understanding of the patient and who challenged the reductionist paradigm and the scientific approach to the sick person.

How do we attempt to understand these contrasting voices within a biomedical paradigm that advocates a reductionist approach? A paradigm that views patients only as the means towards achieving the greater good of society implies an objectification of the sick person, which in turn constitutes the foundation for constructing the patient concept. The sources investigated support an assumption that the biomedical paradigm advocated by the professors contributed towards giving meaning to a concept that was to some extent acknowledged by most members of the profession. However, at the same time we can find that some medical students felt that the ways in which patients were being treated by both the doctors and professors at the teaching hospitals were problematic. We can thus argue that the specific view held by the professors helped to reinforce what we might consider to be an unintended effect of medical advances.

In this way, the construction and perception of the patient can be used to illuminate the understanding of the two cultures in medicine[349] – the scientific and the humanistic, represented respectively by the images of the doctor as a scientist and as a caring supporter. The power of the professors and doctors in the field of medicine thus

[348] Ibid.

[349] Nylenna, ""to kulturer"."

developed by embracing both of these images, and became a significant feature of the professional healthcare sector and society at large.

5.5 The power to construct meaning – consequences for the patient

In the past, the power to control the healthcare sector resided first and foremost in the hands of the professors at the School of Medicine. Many professors worked as doctors at the teaching hospital and thus had the power to decide which patients were accepted for treatment. This can be understood in accordance with dividing people into sick and healthy depended on what was important issues to study in relation to medical developments. This argument is derived and developed from Foucualt’s theoretical stance, and emphasize power as relational in conjunction with the modernization of health care and medicine. As part of their professional development, nurses could not take this kind of approach to the patient. The nurses were themselves subject to how the professors and doctors tried to construct their education in accordance with their power and professional work. Based on this, the nurses had to choose a different strategy. This will be discussed more fully in the next chapter. This distinction between the two professions and their educational strategies underpins how conceptualization through language influences the construction of concepts, and how the concepts in turn contribute to constructing our understanding of reality.

The power and hierarchic structure that developed in the wake of medical advances in gradually more successful treatments and cures served to reinforce the construction of the contemporary concept of the patient. This was supported by statistics and collectivist attitudes, combined with the reductionist approach to the human body, and has dominated the healthcare sector since the late 19th century. Such a construction supports the ideas of Michel Foucault, as illustrated by his ideas concerning ‘biopower’,

'population' and 'force relations', which are used to create security.[350] Foucault argues that power must be seen as an extension of these force relations. Although they are unequal, such relations can be viewed as stable and are thus considered 'safe' both by the dominant and the dominated parties in the relationship. In the professional healthcare sector, such relations are recognized for example between a patient and a professional healthcare worker, within which an implemented power exists. Foucault argues that in order to create security, one exploit different sets of regulations to control the population. In medicine, the need to control the body and its diseases by means of applying discipline and care must be seen as crucial to the construction of the patient as a person whose care must be governed by control and the exercise of authority.[351] In retrospect, we may recognise that this harmonizes well with the contemporary mission to civilise the common people, and with the way in which an expert doctor uses language to exercise his authority over the patient, both inside and outside healthcare settings. For many of the patients this could cause a sense of security, despite that they were treated poorly and was to some extent dominated by the expert doctor in these encounters. In line with Foucault, we can argue that force relations based on the difference in knowledge and power was about to be manifested in the professional health care sector.

Care and control can thus be viewed as key elements within the context of the evolution of medical education, control being heavily related to relational power based on professional knowledge, modernization of society and an increasing difference between the expert and the nonprofessional. The modernization processes that occurred during this period supported a construction of the patient at population level, which was necessary if the Norwegian state was to succeed in its mission to develop a healthy population that could contribute to the building of society. In this way, the mercantilist

[350] Michel Foucault, *Security, territory, population: lectures at the Collège de France, 1977-78*, ed. Michel Senellart, François Ewald, and Alessandro Fontana, Michel Foucault: lectures at the Collège de France (Basingstoke: Palgrave Macmillan, 2007), 2, 11, 367-69.

[351] A. Davidson, M. Foucault, and Graham Burchell, *Psychiatric power: lectures at the College de France, 1973-74*, Michel Foucault, Lectures at the College de France (Palgrave Macmillan, 2006), 40-42, 146-49, 233-47.

ideals favoured by the state can also be seen as contributing to the reductionist paradigm and the exercise of power by the professors and doctors, which constructed the patient as a means towards achieving the greater good. Returning to Abbot's theory on the system of professions, and Larsen's framework of images and objectives of doctors, and their links to the tasks they perform as a means of forming relationships, we immediately recognise a connection to the various images of the doctors, and can relate these to the objectives of both doctors and nurses. The tasks of the professors were to educate professionals who would guarantee achievement of the government's desire for a healthy population. Medical knowledge, obtained via advances in scientific methods, represented the means of fulfilling this desire. The image of the professors and doctors as knowledge developers gave them the power to construct a reality within the professional healthcare sector. The various tasks and objectives that in the past were valued as important to the profession evolved into the governing forces that are now central in our contemporary discussions concerning the healthcare sector.

The dehumanizing factors that enabled the construction of the patient as a means to an end is still prevalent today, and is first and foremost linked to the demands of objectivity that emanated from the scientific revolution. It promoted a reductionist and mechanical approach to the human body by advocating the scientific method as the key pathway to knowledge. This now extends into Evidence-Based Medicine (EBM) methods that also focus on standardization and objectivity, further reinforcing the reductionist approach to medical knowledge and the patient.[352] The extent to which this approach has now become problematic and dehumanizing is illustrated in a chapter of a book published in 2017. Here, the introduction of EBM to Norway is reviewed using as sources papers published in the Journal of the Norwegian Medical Association in the years 1991 to 2017.[353] One of the book's findings is that the discussions relating to EBM established that, from a medical viewpoint, biomedicine and pathology will always dominate over the

[352] Bondevik and Engebretsen, 448-49.

[353] Ibid.

more holistic approaches to the patient, and that more humanistic-leaning and social science-related approaches is defined outside the predominant scientific paradigm and knowledge-based approach.[354] This development happened as part of the modernization processes, fuelled by the scientific revolution and contributed to construct the patient within the dominant views relating to this.

During the 19th and 20th centuries, as pointed out previously, the view of the patient was subject to constant change as the reductionist approach to medicine gained ground in the wake of the success of the natural science and laboratory-based paradigm. The professors had a responsibility to introduce new knowledge and methodologies to their students, and they were eager to climb the social ladder. As Doctor Espen Schønberg said in his "Overview of the Norwegian Medical Literature in the 19th century;"

"By the mid-century, was as mentioned before a new direction had broken forth within the medical science. Also within this area, it can be said that realism had started to penetrate at the cost of the former romantic period. New examination procedures was introduced. One improved one's knowledge on diseases based on more tangible basis, provided by the stethoscope, by the new chemistry and by that the knowledge of the chemical composition of human body"[355]

As Schønberg states in the above, it was already becoming clear during the 1850s that science-based medicine was altering the doctors' approach to the human body and transforming their understanding from the romantic to the realist. This was reinforced in the medical education system and influenced the approach adopted by both the

[354] Ibid., 461-62.

[355] Espen Schønberg, *Oversigt over den norske medicinske litteratur i det 19. aarhundre [Overview of the Norwegian Medical Literature in the 19th century]* (Kristiania: Bigler, 1897), 25-26. [Ved aarhundredts midte var som før nævnt en ny retning brudt frem i lægevidenskaben idethele. Ogsaa paa dette omraade kan det siges at realismen var begynt at trænge sig frem efter den foregaaende tids romantik. Nye undersøkelsesmethoder var indført. Man fordrede sit kjendskab til sygdommene bygget paa et mere haandgribeligt materielt grundlag, som ydedes af stethoskopet, af den nyere chemi og deigjennem kundskaben om det menneskelige legemes chemismus.]

professors and the doctors. Two decades later, Schønberg points to the continuing emphasize on how the medical profession was embracing the science of bacteriology and the use of biological and physiological research to further understanding of the organic processes taking place in the human body.[356] Leaning on Rosenberg’s theory, I wish to argue that this movement towards the reductionist, natural science-based, paradigm within medicine not only brought new status to the doctor-patient relationship, drawing primarily on biomedicine, but also contributed to the objectification and dehumanization of patient as a concept by means of formal medical education. The professors had the knowledge and secured the power to promote this change in status, and used a specific language to impose the reductionist scientific paradigm on the patient.

In retrospect, it is easy for us to be harsh in our judgements of some of the actions performed, and language used, by the professors and doctors in the past, especially in relation to their attitudes to and their constructed reality of the nature of patients and how they should be treated. However, this is not the purpose of history. The objective here is to highlight the connections between the various constructions of the patient that evolved as part of the development of the medical and nursing professions, and to shed some light on aspects of the context within which such developments occurred.

Historical reality must be viewed by looking the same way as the professors and doctors of their own time. Reality must thence understood by us in relation to the context in which it existed. This means to acknowledge the biomedical paradigm by which patients were regarded largely as a means towards achieving a greater good. A different reality applied in the case of nurses, which caused different approaches and different connections, as will be explored in the next chapter.

[356] Ibid., 74.

5.6 Summary

Within the medical discourse that established the dominant paradigm in Norwegian and international medicine and medical education during the early modernization processes, the image of the doctor as caring supporter changed to that of a knowledge developer and gatekeeper. The huge health-related challenges in society, combined with state involvement in public health issues, encouraged the doctors and professors to pursue the new images at all costs.

As shown using the discussions on developments within medical education, the patient was constructed as a means towards the achievement of the greater good of society at large. Consideration of patients as individuals was suppressed. They were not considered as important in themselves, but rather as ‘case studies’ that served as interesting objects of investigation in the professors’ search for new knowledge. This attitude was encouraged by the prevailing reductionist biomedical ideology that constituted the contemporary medical paradigm, and was forcefully illustrated by the trial of Armauer Hansen. In spite of this, and in an attempt to prevent medical education from becoming dehumanized, some professionals raised their voices in criticism of the paradigm, and the treatment of patients in a clinical setting. Although some of these voices were important in helping to establish a more nuanced understanding of the patient, they were not sufficient to change the established construction of either the nature of the patient or how he or she should be treated. Thus, the professors at the University, in combination with a powerful medical organization backed by international research, were able to ensure that the biomedical paradigm continued to exert a dominant influence on future medical education. The views and values derived from this must be seen in relation to both cultural and social aspects of society and the place of power between experts and laymen as part of developing a professional health care sector to the advantage of a more modern society.

In the following chapter, I will further explore and expand these arguments in relation to nursing education.

6 The construction of the patient concept through nursing education

"It must be clear, that a nurse can be of extraordinary use for the doctor and thereby also for the patient by the fact that she at all times can give the doctor truthful information concerning all the things he need to know with regard to the patient's person and the course of the disease"[357]

The quote above is taken from Doctor Waage's textbook for nurses, describing not only the relationship as he saw it between nurses and doctors, but also between the patient and professional healthcare workers at the beginning of the 20th century.

In this chapter, I will explore how the patient is presented in different textbooks that were written to support nursing education and in discussions that arose as part of the professionalization of nursing and the autonomous nurse. I will further explore how this contributed to a specific construction of the patient as an extension of this process. The professionalization of healthcare and the tensions that existed between traditional and modern nursing values are regarded as important contextual premises in the analysis.

The first system of nursing education in Norway was established at the Deaconess' House (*Diakonissehuset*) in 1868, based on the Kaiserwerth model.[358] Up until 1895, when a Red Cross Nursing School was established in the capital, Christiania, the deaconess' amounted for the only education for nurses in Norway. However, by the turn of the century, several nursing educations had emerged, and between 1868 and 1911 almost

[357] Waage, 7. [Det er derfor klart, at Sygepleiersken kan være til overordentlig stor Nytte for Lægen of derved ogsaa for Patienten derigjennem, at hun til enhver Tid kan give Lægen sandfærdige Oplysninger om alle saadanne Ting, som han har Brug for at kjende til med Hensyn til den syges Person og Sygdommens Gang.]

[358] Martinsen, *Freidige og uforsagte diakonisser: et omsorgsyrke vokser fram, 1860-1905*, 28-32.

1000 nurses had completed a formal training to become a nurse at six different education systems and schools.[359]

Despite the development of many nursing schools, they were diverse when it came to what knowledge and practice they demanded from their students. No national regulations existed to govern nursing skills requirements. Nor was there an established national syllabus or curriculum containing a consistent system of education until the founding of the NSF 1912, when the issue was brought to the fore. A decision regarding national regulations took however decades to become a reality.[360] The struggle to put in place a three-year nursing education with state authorization started by the NSF in 1914 and was not concluded until after the Second World War.[361]

The development of nursing as a profession is closely linked to both developments in medicine and the modernization processes that characterized the 19th century and succeeding decades. The idea of caring for people can be traced back to as far as people have lived together. Medicine itself has its roots in Antiquity, but historians of nursing characterize modern nursing as a construct that is most closely linked to the 19th and 20th centuries.[362] In chapter three, I discussed some of the challenges faced by the concept of ‘modern’ in this context. I argued for how I understand modern to be a continuing process, based on Latour’s understanding of the concept (see page 51). Within such a context, the term modern nursing cannot be understood in the same way as we think of it today. However, there is no doubt that during the late 19th century, a

[359] Overview by doctor Bentzen. The Journal *‘Sykepleien. Organ for norsk sykepleierske-forbund.’ (Tilægsblad til Medicinsk Revue, desember 1912).* The Journal *Sykepleien.* Årgang 1 nr.2.12

[360] Sigrun Hvalvik, "Bergljot Larsson og den moderne sykepleien," (Oslo: Akribe, 2005), 70, 128-32. Moseng, *Framvekst og profesjonalisering*, 181-83.

[361] *Framvekst og profesjonalisering*, 227-28.

[362] Christopher Maggs, "A history of nursing: a history of caring?," *Journal of Advanced Nursing* 23, no. 3 (1996): 635.

Ole Georg Moseng, "Sykepleierne," in *Profesjonshistorier*, ed. Rune Slagstad and Jan Messel (Pax, 2014), 604-06.

breakthrough occurred that changed the ways in which nursing was viewed and practiced compared to the decades and centuries before. With the aim of understanding this transition, historians have highlighted specific prerequisites that influenced a shift towards a more professional and modern approach to nursing.[363]

One of these prerequisites was the introduction of formal education and training. Nurses that had completed training at a teaching hospital or other organization were considered better skilled and qualified to safeguard and care for the sick than the unskilled orderlies [gangkoner/vaagekoner]. Up until the mid-19th century, the orderlies had amounted for the only assistant the doctors had at the hospitals.[364] This is also regarded as a key factor in an international nursing historical context, since the same educational reforms in nursing were taking place in London,[365] as in most other European countries during the second half of the 19th century. [366] Another break that is often linked to the professionalization of modern nursing is the trend towards caring for people outside the household or within the community. A characteristic of the thinking of modern nursing as a 19th century construct has often been connected to a universal and holistic concept of care for everyone in need, regardless of their origins. When such an understanding is viewed as a fundamental premise, nursing as a profession can truly be said to have entered the professional healthcare sector and must thus be regarded as a profession beyond the popular and folk sector in which care was traditionally carried out.[367] Based on such a premise one can also argue for the close connection between the professional nurse and the patient as a concept, linked to the development of a professional health

[363] Moseng points to developments of hospital, education and civil, religious philanthropy as three specific prerequisites that must be considered as part of the break from earlier nursing tradition. "Sykepleierne," 606-13.

[364] *Framvekst og profesjonalisering*, 46-52.

[365] Carol Helmstadter, "Early Nursing Reform in Nineteenth-Century London: A Doctor-Driven Phenomenon," *Medical History* 46, no. 3 (2002): 349.

[366] Wyller, *Sykepleiens verdenshistorie*, 246-54.

[367] Kleinman, *Patients and healers in the context of culture*, 50-60.

care sector. One can further argue that by bringing nursing towards the state of an autonomous profession, part of the modernization processes were closely linked to the professionalization of care. As professional care developed, training in the sense of a formal education became a precondition for becoming a nurse, and the patient thus also became part of the professional sector, entering into a “professional” patient role with professional care.

Behind this thinking lies an understanding that not everyone was qualified to give adequate care. Care in this sense became a specialist task for a highly competent woman with formal training based on sound medical knowledge and practical nursing skills. When care was professionalized, a sick person was no longer someone you had a relationship to, but a patient that needed to be cared for professionally. However, professional care had to develop in relationship to something and, from this point of view, the patient must be regarded as a crucial stakeholder. Two factors stand out as key premises in our consideration of the position of the patient in nursing education. The first involves our attitude to the patient in relation to traditional values and compassion towards the sick, as is presented in the nursing education textbooks. The second addresses how we see the patient in connection with the professionalization and modernization of nursing education. The latter must also be viewed as an extension of the developments taking place in medicine and society in general, and is reflected in the discussions that took place in the public arena regarding nursing education and nursing as a profession.

6.1 The construction of the patient and nursing values

When looking into early nursing education through the textbooks and discussions related to nursing education developments, two constructs of the patient stands out. The first is linked to the traditional and Christian values of compassion towards the sick. Within this understanding, the sick person in the role of patient is developed primarily in the context of being cared for by a woman who has inherited her abilities through generations of women, and in which the basic values linked to providing care are seen as an extension of being a woman. Within this understanding, the patient is constructed as a person in

need of relief from suffering, and the education should only be viewed as supportive to the natural calling for care within a religious frame. The deaconesses and the religious foundation helped to construct the patient as the most important beneficiary of nursing and nursing values during the early stages of professionalization. This is emphasized in the introduction to the textbook written by Rikke Nissen:

"A nurses task is as far as possible to relief the suffering of the sick, perform doctor's orders, and give the doctor notion of the condition of the sick."[368]

An interesting aspect here is that in this early part of modern nursing, the use of the patient as a concept seem to be absent from the text analysed. The construction of the patient concept is hence worth discussing in this early stage of professional development in nursing. In chapter three, as part of the conceptual clarifications, I argued that patient, as a concept must be seen in relation to the professionalization of both medicine and nursing. Patient as a concept is not referred to at all in Nissen's book. This cannot be because the concept was unknown to the deaconesses at the time, because we find that the concept was much in use in earlier medical sources, and was certainly a concept used by Florence Nightingale in her *'Notes on Nursing,'* [369] and Nissen has specifically mentioned Nightingale as one of the inspirations for her textbook.

An assumption may be that the concept was unfamiliar in relation to professional care because, in Norway, it was still linked primarily to the religious calling and being a woman, where care for the sick person was still the primary understanding of any care given in any context. In England, the 'Nightingale tradition' had advanced nursing further as part of the modernization processes in education and healthcare reforms. The patient as a concept had thus already been implemented in an English nursing context, but had not achieved the same degree of professional status in a nursing context in Norway. In spite

[368] Nissen and Martinsen, 19. [En Sygepleierses Opgave er saavidt muligt at lindre den Syges Lidelser, at udføre Lægens Anordninger og at give Lægen Beretning om den Syges Tilstand.]

[369] Florence Nightingale, *Notes on Nursing. What it is, and What it is not*, 2017 ed. (Boston: Squid Ink Classics, 1898), 9-13, and so on through the book.

of this, Nissen uses the concept of 'the sick' or 'the sick person', and as such her textbook is of value because it refers to a basic concern for people as a starting point for the professional care of any sick person in need of care.

However, by the time that Waage's book came into use in 1901, we find that the concept of the patient seems to be well established, also in nursing textbooks.[370] Waage's book is distinct from Nissen's in that the approach to the idea of 'care' has now become part of professional nursing and is closely linked to the patient. While Nissen used the expression '*relief the suffering of the sick*,' Waage use '*care for the patient.'*[371] By the turn of the century, the two concepts of 'care' and 'patient' seem to have become closely linked within the framework of nursing education, and this serves to emphasize the assumption that not only was the patient constructed within the professionalization process of modern nursing, but it was also connected to the prevailing understanding of professional care. An important premise for our understanding of the construction of patient in relation to nursing values seems to be a link to care that is something more than simply the relief of pain and an adherence to the doctor's instructions. This supports my previous assertion that the patient as a construct developed differently within medicine and nursing. At the same time, the concept is clearly connected to the modernization processes that were taking place within both professions.

If we now move on to Grøn and Widerøe's textbook, published in 1921, we find that the objectives of the nurse had advanced somewhat further. While Nissen was preoccupied with the relief of pain and suffering, an idea developed further by Waage into the concept of caring for the patient, Grøn, Widerøe also focused on nursing as an essential part of preventive healthcare, carried out before disease, and sickness occurred.[372] This development leads us to an understanding that the conceptualization of what a patient

[370] Waage, 1-14, and so on through the book.

[371] Ibid., 1.

[372] Grøn and Widerøe, 2, 186, 245-50.

is was about to be challenged. Another interesting point in this context is the evolution of a nurse's duties, as described by the nurse Andrea Arntzen in this textbook from Grøn and Widerøe. Nissen and Waage are clear that the nurse has two main duties; 1) to care for the patient/the sick, and 2) to inform the doctor of the condition of the patient/the sick. Arntzen, however, introduces two additional duties. Firstly, the nurse's duty towards her colleagues and, secondly, towards herself.[373] In this context, caring must be viewed as something that not only extended beyond simply relating to suffering patients, but also into the realms of a value that encompassed colleagues in a nursing community, each looking after their own health and well-being. We observe here a development by which professional care abandons its close ties to the patient and disease, and starts to advance as an autonomous subject in which the patient is viewed as just one of many stakeholders.

What I draw from this is that in the context of nursing education, the development of the profession was influenced jointly by traditional values and the modernization processes taking place within medicine and society in general. The image of the nurse as a caring supporter is closely linked to this professionalization, and professionalized care developed as part of the same process. In this context, the patient is viewed and constructed in the extension of Christian and humanist values, based on a holistic approach. A further development occurred when nurses started arguing for professional autonomy and an adequate knowledge-based education in order to separate themselves both from the unskilled orderlies and the doctors. This reveals itself in arguments presented by nurses during public debates, in which they promoted the view that patients were not important in themselves, but were a means to securing an autonomous nursing profession with greater levels of status and power within the professional healthcare system. These arguments drew on an acceptance that professional care was strongly linked to developments in medicine, accompanied by an eagerness on the part of nurses not to be regarded simply as assistants to the doctors. This line of argument

[373] Ibid., 4.

contains an implied criticism of the Christian nursing education system that had developed during the previous decades, which some nurses felt had not advanced since the establishment of the deaconess' mother-house that solemnly built on the Kaiserwerth ideology.[374] This critique was strongly visible for the public during a discussion between Nurse Elise Furuholmen and Reverent Wisløf regarding nursing education and knowledge development in the best interest of the patient. Nurse Elise Furuholmen pointed out that it is *"pointless and inhuman to expose young nurses with such miserable knowledge in responsible positions."*[375] Furuholmen was referring here to the short 18-month nursing education offered by the Christian Congregation Home (*Menighetssøsterhjemmet)*, an education developed after the model of the first Deaconesses' House.

In such a context, we can argue that also nursing developed into different images stretching beyond the image of 'caring-supporter.' Furuholmen through this discussion portray the image of the nurse as a gatekeeper, acting to safeguard the nursing profession. This framework of images has been found useful in my analysis to understand the arguments promoting the patient not only as someone who needed care, but also as someone that needed a strong nurse holding a strong position. I understand this in line with a need to protect and safeguard the population from sickness and disease. This understanding of reality, that the population at large must be protected from the sick, was, as argued before, promoted by the State and by the Professors at the School of Medicine, and many of the doctors working at different hospitals. Such responsibility could no longer be trusted to unskilled nurses or nurses with a brief and inadequate education.

The view of the professional nurse was about to develop beyond being simply a caring supporter of the sick and suffering. With organized support, nursing education paved the

[374] *Sykepleien.* 1917.no 2, 11-15.

[375] *Sykepleien.* 1917.no 2, 13 [Det er meningsløst og inhumant at sætte unge sykepleiersker med saa elendige forkundskaper paa ansvarsfulde poster.]

way not only for professionalized care, but also the power to construct and conceptualize patients in the nurses’ own interests, based on both a social and cultural understanding.

6.2 Early nursing education and nursing values as a premise for understanding the patient

The religious calling and ideal of care can be traced back to early Christianity regardless of seeing care as part of medicine or nursing.[376] Care practices that developed in the monasteries, and which constituted the foundation of the Deaconess tradition in protestant countries was based on female characteristics and womanly values. However, during the modernization processes of the 19th and early 20th centuries, some of these traditional values came under threat. In nursing, this threat must be seen primarily in connection with advances in medical science and technology.[377] Nursing as a profession developed and was shaped in the wake of progress towards a modern society, and at the intersection of the scientific and democratic revolutions, where both caring tradition and traditional gender roles were being challenged, as well as liberal ideas concerning the individual person as part of society. As part of this process, the construction of the patient in a nursing education context was also being challenged.

An attempt to unite traditional and modern values is essential if we are to understand developments in nursing and how nurses related to and put these values into practice when caring for their patients. This also had consequences for how the patient was constructed in nursing education. One way in which this came to the surface was in the division between the religious and secular nursing education systems. ‘Secular’ in this context does not mean that the systems were entirely removed from Christian values, because contemporary society was in general more religious than it is today. We have to

[376] Roy Porter, "Hospitals and Surgery," in *The Cambridge History of Medicine*, ed. Roy Porter (New York: Cambridge University Press, 2006), 181.

[377] Sigrun Hvalvik, "Nursing in the interwar time – Dilemmas and challenges in the modernization of nursing," *Nordisk sygeplejeforskning* 1, no. 04 (2011).

appreciate that all nursing education systems were rooted in Christian values, combined with a traditional and conservative outlook on gender roles, which was also related to morality and power.[378] All early nursing education systems were thus founded on the same ideology of care, and driven by a combination of humanistic and Christian values.[379] In spite of this, we observe a significant difference between the Deaconess’ nursing tradition and the more secular ones. The deaconesses saw nursing only as part of their varied religious and humanitarian work, while secular nursing schools were established for the single purpose of educating professional nurses to care for patients.

From the second half of the 19th century, and up to the period between the First and Second World Wars, society was pervaded by a great sense of optimism. As pointed out previously in this thesis, this optimism fuelled a shift in the medical paradigm by which medicine changed its approach from a holistic to a reductionist and natural science-based outlook, based on bacteriology and laboratory medicine. During the same period, the professionalization of nurses was gaining momentum, requiring nurses to acquire more specialized knowledge in order to meet the demands put on them by the doctors. Professionalization was also accompanied by an acceleration in hospital building and societal demands for a healthy population. The theoretical knowledge base acquired by professional nurses had to come from medicine and was for the most part taught by doctors, holding lectures for nursing students. In 1901, the only textbook used in nursing education was written by a doctor – the aforementioned Doctor Waage. The combination of these two arenas, holding lectures and writing textbooks enabled doctors to secure the power they needed to exert a heavy influence on the development of professional care and the way in which the patient was presented as part of nursing education. Based on this it is possible to argue that the shift in the medical paradigm had an impact not

[378] Hvalvik and Moseng, 79-81.

[379] Solveig Hauge, "Frå sjukepleie til helsepleie? Ein lærebokanalyse med fokus på bruken av begrepa sjukdom og helse i norske lærebøker i sjukepleie i tida 1920 til 1990," Publikasjonsserie (Universitetet i Oslo. Institutt for sykepleievitenskap : trykt utg.) (Oslo: Universitetet i Oslo, 1996), 39.

only on the development of nursing education, but also on how nurses came to view and care for their patients.

During the early 19th century, the NSF succeeded in drawing up a national curriculum that significantly improved the quality of theoretical teaching, and a textbook containing much of this new knowledge was published in 1921.[380] In spite of this, the NSF repeatedly had to struggle to make this curriculum mandatory for all nurses and to establish a common standard. The NSF's goal was to bring nursing into modern society as an autonomous profession, and in order to achieve this, nursing education had to embrace the developments of the new medical paradigm while at the same time maintaining the core nursing value of care.

Traditional nursing that enshrined the values of womanly care and the merciful Samaritan was not something that could easily be cast aside, even when nursing was developing as an autonomous profession. It was important to maintain values such as compassion, self-sacrifice and care for the poor and sick, especially at a time when doctors seemed to be abandoning these same values. British nursing researcher Ann Bradshaw has published a study addressing competence in British nursing in a historical perspective. Here, she emphasizes how the traditional system of nursing competence through the textbooks used, implement the aims and objectives of early nursing; *"to produce bedside nurses, whose function was to care for the sick person."*[381] In this study, Bradshaw points to four aspects of nursing that was emphasized in order to become a good nurse, and all of these can be seen as an extension of womanly values. The first was to develop moral character in connection with societal virtues. The second involved equipping nurses with the appropriate skills to care for their patients. The third involved adopting an educational approach based on learning by the example set by a superior nurse, while the fourth addressed the nurse's ability to form appropriate relationships with her patients and

[380] Grøn and Widerøe.

[381] Bradshaw.

colleagues.[382] Many of these aspects are recognizable in a Norwegian context and are reflected in Norwegian nursing textbooks right up until the Second World War. Both in Britain and Norway, the nursing education systems and their textbooks allocated the patient as a concept a prominent place within the context of traditional nursing values.

However, these values generated tension both within the nursing profession in its encounter with a society undergoing modernization, and in the medical and healthcare development specifically. [383] How was it possible for nurses to embrace and professionalize their core values, in which the patient held a key position, when their knowledge base consisted of medical knowledge rooted in a reductionist approach to the sick person? As has been pointed out by Sigrun Hvalvik, Bergljot Larsson, as leader of the NSF at the time, not only recognized, but also strategically worked hard to handle and unite these tensions that emerged as part of the profession during the early 20th century.[384]

From the start of her work as leader of the NSF, Larsson recognized the importance of embracing the traditional values and qualities inherent in women, as being the ones traditionally linked to motherhood and caring for the weakest in society. At the same time, Larsson was convinced that these values were not sufficient to define the role of a professional nurse.[385] One relevant question that arises in the wake of the tensions described above, and in Larsson’s work to embrace and develop traditional values, is whether this had significance for how the concept of the patient was viewed and constructed. What can we find of relevance in the nursing textbooks from the very beginning and up to the 1930s?

[382] Ibid., 323.

[383] Hvalvik, "Nursing in the interwar time – Dilemmas and challenges in the modernization of nursing."

[384] Ibid., 316-17, 19-20.

[385] Ibid., 317.

Early nursing textbooks – bringing the patient to the foreground

The patient was the cornerstone of early nursing. In order to carry out her duties to the patient, it was a nurse's practical skills that were regarded as the most prominent. However, these skills had to be supported by a certain amount of theory that reflected contemporary knowledge in science and medicine. In Rikke Nissen's book, published in 1877, one can sense the presence of a conflict between theory and practical care. Nissen states that a nurse cannot acquire a complete education simply by practicing care in a safe and loving environment. This may bring success to a nurse, but at a great cost to the patients exposed to this kind of training.

"But it is expensive learning experience brings; it is bought with much more suffering for the Sick, as the ignorance, perhaps with heart felt well-meaning has been laid upon them."[386]

The well-being of the patient is clearly of importance to Nissen, and was an integral part of the Deaconess' tradition. In her book, Nissen focuses a great deal on how a nurse should be trained in order to avoid harming the sick person in need of care and to bring them comfort in their suffering. Even when it came to the well-being of the 'insane,' or mentally ill person, Nissen forcefully emphasizes the ideal of care and avoidance of harm.[387] In the context of the tradition of the Christian calling and the image of nurses as caring-supporters, there is strong evidence for the sick person playing a significant role in the early formal education of nurses. However, the warm-hearted desire to care was not regarded by Nissen as sufficient to carry out the tasks of a nurse. Theoretical knowledge was needed in order to become a 'complete nurse.'[388] At the same time,

[386] Nissen and Martinsen, 20. [Men det er en dyr Lærdom, Erfaring bringer; den kjøbes ofte med mange Syges forøgede Lidelser, som Uvidenheden maaske I hjertelig Velmenen har tilføiet dem.]

[387] Ibid., 77. "*It goes without saying, that she must never allow herself to, in the smallest way, by word or in action offend the sick or abuse him."* [Det falder af sig selv, at hun aldrig maa tillade sig I mindste Maade ved Ord eller Handling, at fornærme den Syge end sige mishandle ham]

[388] Ibid., 20.

Nissen is less clear about what kind of theoretical knowledge a nurse should have in order to consider herself successfully trained. In the introduction to her book, Nissen writes:

"A nurse's task is as far as possible to relieve the suffering of the sick and to perform the doctor's orders and give the doctor report about the condition of the sick. To be able to do this, she must have exact and certain awareness about the necessities that support the business of the doctor, which is preferable nutrients, appliance of the nursing room, about the sickbed and bandaging etc."[389]

Based on the quote one may assume that Nissen was here more preoccupied with highlighting the features of good nursing rather than advocating what specific knowledge should constitute part of a nursing education. This is the essence of the content of Nissen's textbook. Despite some brief descriptions of selected diseases and a short summary of the biology of the human body, she does not allocate much space to medical theory or knowledge. She says herself; *"…it is not the intention to inspire deaconesses to be quacks, or any other way make them imagine they can be some sort of doctors."*[390] A strong argument must be held that despite Nissen finds theoretical knowledge to be necessary and valued, little emphasis is put on what this should be and what amounted for sufficient theoretical knowledge in this early stage of modern nursing.

Nissen directed her focus on the patient and the patient's needs, while emphasizing how core nursing values should be developed through education, as well as the key importance of deference and obedience to the doctor and his decisions regarding treatment of the patient. In this perspective, one can recognise what Nissen saw as a distinction between educated nurses and the unskilled orderlies who did not have the

[389] Ibid., 19. [En Sygepleierskes Opgave er saavidt muligt at lindre den Syges Lidelser, at udføre Lægens Anordninger og at give Lægen Beretning om den Syges Tilstand. For ret at kunne udføre dette maa hun have nøiagtigt og sikkert Kjendskab til alle de Hjælpemidler, der understøtte lægens Virksomhed, altsaa hensigtsmessige Næringsmidler, Indretning af Sygeværelset og den syges Leie, Forbindingsstykker o.s.v.]

[390] Ibid., 158. [«…da det ingenlunde er Hensigten at opmuntre Diakonisserne til Kvaksalveri eller paa nogen Maade bibringe dem Indbildninger om at være et Slags Læger.»]

best interests of their patients at heart, was a formal education, primarily based on practical training with a superior nurse. On several occasions, Nissen forcefully writes about how the unskilled orderlies let the sick suffer because of their lack of sufficient care.[391] At the same time, Nissen clearly articulates that loyalty and obedience to the doctor should take precedence over any other concerns that a nurse may have for her patients.

"As a nurse there is required of a Deaconess, punctual and unconditional obedience towards the doctor in everything regarding the care of the sick.[392]

It was only a couple of decades later that Doctor H. R. Waage published a new textbook on nursing that was intended to replace Nissen's book.[393] As pointed out in the chapter on sources, Waage's book was extensively read, and I intend to argue that it attracted a readership far beyond the students who were educated in the Deaconess' tradition, especially once the more secular nursing schools had emerged. At first glance, much of the book's content can be said to be familiar, and very much a continuation of Nissen's work. However, I wish to draw attention to two chapters that focus on theory. The first addresses anatomy and physiology, and the second the causes of a variety of diseases, informed by recent medical discoveries in the field of microbes.[394] The inclusion of these chapters clearly indicates that theory was gradually being more thoroughly introduced into nursing education, reflecting contemporary advances in medical science.

However, although Waage included some new knowledge in his nursing textbook, he should not be regarded as an advocate of a major new focus on theoretical knowledge in nursing education. In an article in the nursing journal '*Sykepleien'* in 1913, the same

[391] Ibid., 22, 24.

[392] Ibid., 23. [Som Sygepleierske fordres her desuden af en Dk. Punktlig og ubetinget *Lydighed* mod Lægen i alt, hvad der vedkommer den Syges Pleie.]

[393] Martinsen, *Freidige og uforsagte diakonisser: et omsorgsyrke vokser fram, 1860-1905*, 140, 42.

[394] Waage, 127-32.

doctor Waage asserted that too much focus was being given to theory in nursing education, and that he saw this as an error in terms of the development of the profession.[395] In the same article, he continued to focus on what he regarded as crucial to nursing – the nurse's obedience to the doctor, which he argued was key to the well-being of the patient. He expressed the same view in his textbook.[396]

The well-being of, and concern for, the patient also received a good deal of attention in Waage's book. Although the medical paradigm was trending towards a focus primarily directed at bacteriology and laboratories, Waage and others recognised the importance of having nurses on hand to facilitate and safeguard the needs of the patient. We may claim perhaps that the image of the doctor as a caring supporter was being transferred to the nurses, just at the time when most doctors were abandoning this image and its associated objectives in order to clothe themselves in other images. However, Waage also argues for another approach to the patient, which had not been considered by Nissen. In his description of a nurse's duties, Waage makes it clear that a nurse must exert authority and power over the patient, so that the latter behaves obediently towards the nurse when required. According to Waage, a nurse was entitled to more respect than an ordinary maidservant:

"Certainly, a nurse must show the sick all possible kindness. On the other side, she should have authority and power over them, in order to make them be obedient towards her when needed.() She must be more to her patients than a friend, and she must take on a different and more respectful position towards the sick than a maidservant"[397]

[395] *Sykepleien.* 1913, no 13, 122-125

[396] Waage, 1,3.

[397] Ibid., 2. [Thi vistnok skal Sygepleiersken vise de syge all mulig Venlighed. Men paa den anden Side bør hun have Myndighed og Magt over dem, saa hun kan faa dem til at være lydige, naar hun forlanger det. () Hun skal være mere for sine Patienter end en Veninde, og hun skal indtage en anden og mere respekteret Stilling ligeovenfor dem end en Tjenestepige]

The statement above introduces a complexity and dualistic approach to the patient that had not been present in Nissen's textbook. The holistic approach to the patient, which was highly valued by nurses, was now being challenged by an alternative view. When Waage cited authority and power in his view of the nurse-patient relationship, the emphasis on concern for, and care of, the patient based on kindness and patience was not entirely being abandoned, but was beginning to veer in a new direction. We must assume that Waage's view was based on personal experience of his patients and that of his fellow doctors. This harmonizes well with the previous arguments regarding the doctors' understanding of common people as being sorely in need of civilisation and elevation to more appropriate values and culture. The nurses' views and actions in relation to this perspective are not revealed in the sources. However, we can assume that the doctors' construction of the patient, as exemplified in Waage's textbook, had filtered through into nursing education.

As pointed to in chapter five, many doctors through history have not acted with warmth and kindness towards their patients. What impact this had in reality we can only make assumptions, based on how the further development in nursing education progressed according to the view of patients. What becomes clear from the source material is that Waage acknowledged that sick people were enduring suffering and were thus in need of the patience and care provided by a nurse.[398] In spite of this, he also seems to emphasize the existence of a hierarchic structure in care and medicine, which not only applied to the various healthcare professions, but in which the patient also constituted part of the hierarchy. A recognizable hierarchy[399] was about to develop, with the doctors at its head and the nurses below them, acting in strict obedience to the doctors. The patients occupied the base of the hierarchy. In Waage's opinion, it was clear that patients should behave obediently towards both doctors and nurses.

[398] Ibid., 5-6, 15.

[399] Schiøtz, *Folkets helse - landets styrke 1850 - 2003*, 2, 126, 68-70.

This view of the patient can be understood in terms of what Michel Foucault pointed out when he was explaining the concept of the patient as part of the professionalization of medicine and care. Foucault viewed this as part of the power gap that was about to develop between the sick (the patient) and the expert (the doctor).

Based on Waage’s view of the relationship between a patient and a nurse, we may assume that the emergence of this power gap applied not only to medicine, but was also extending into the field of care. The nurse also became an expert through formal education, and the sick taking on the role of becoming a patient was left out as the layperson also in the context of care. The question remains; did this issue have an effect on how care was taught and then delivered by nurses as a result of their education? Historians have continued to address and interpret the values expressed by Waage as a manifestation of contemporary societal views on disease and morality.[400] Despite increased medical knowledge, diseases and infections between people where to a small degree understood by the population at large, and information about their causes was from outside the medical arena, as part of their culture and social understanding of reality. Getting sick was thus explained by the upper class as a lack of personal hygiene, poor morals and bad character, not seen as part of lack of knowledge and a different approach to the world. For most people, ill health was related to social and cultural circumstances rather than the biological. With this as a backdrop, the attitude towards treating patients as someone who needed to be cultivated and raised in accordance with acceptable virtues and behaviours may help to explain the construct of the patient for which Waage was an advocate. It may also explain why he saw it necessary to impose this understanding on the teaching of nursing and care.

In the long run, nurses together with philanthropic women organizations came to be regarded as key personnel in the aim of promoting a healthy population through public

[400] Porter, *The Cambridge History of Medicine*, 86-91.

information and hygienic measures.[401] However, it was men, and in relation to this thesis, predominantly the professors in medicine and the doctors, who had the power to decide the ideology and values that should be adhered to. They also determined how the patient should be viewed. Because of their impact on nursing and nursing education, their views extended directly into the core essence of nursing, nursing values and nursing as a profession. What we need to explore further here is whether this also had an impact on the view of the patient from a nursing education point of departure during the early 20th century.

A modern textbook for nurses – a change in construction of the patient concept?

The idea of advancing the values of professional nursing and care in education beyond those simply associated with values connected to the womanly, received support from women's rights activists in Norway. In 1912, the editor of the Journal *Nylænde,*[402] Gina Krogh,[403] wrote in support of developments in nursing, suggesting that one had to be much more than just a good woman in order to become a nurse. Arguing from the basis of responsibility for the well-being of patients, Krogh asserted that there is no guarantee that a woman can meet the demands of the caring supporter image simply by virtue of her womanhood.[404] Her arguments for the introduction of formal nursing education of an adequate duration were rooted in the suffering and diseases to which patients were subject while in hospital or being cared for in their homes. Krogh's arguments helped to establish a connection between the traditional caring values associated with nursing, and

[401] Seip, 226, 42-43.

Schiøtz, *Folkets helse - landets styrke 1850 - 2003*, 2, 217-18.

[402] Nylænde was one of the first journal for women's right movement in Norway. It published the years 1887- 1927.

[403] Gina Krogh (1847 – 1916) was a Norwegian women's right activist, politician and editor for Nylænde the years 1887 – 1916.

[404] *Nylænde.* 1912,no 9, 164

those of modern society in which women made an important contribution to the modernization processes. The patient should now be seen as a person in need of professional care, provided by knowledgeable nurses and informed by their education. Krogh can thus be said to have lent her support to the construction of the patient as a person who is suffering and in need of professional care. However, she also distances herself quite clearly from the objectification of the sick, which constituted the medical paradigm of the time.

Several nursing schools emerged and developed in the wake of societal advances and women's rights' awareness. One of these was the 'Municipal hospital of Kristiania nursing school.'[405] In 1921, a new textbook for nurses was written at the request of the teachers working at this nursing school. According to the preface to the first edition, there had for a long time been a demand for such a book *"…based on the principals of modern nursing."*[406]

Later in this preface, the authors give an outline of what they see as modern nursing principles.[407] In order to propose an additional perspective on the authors' views, I have made my own interpretation in which I want to address three factors, the first two of which are extensions of the authors' opinions. The third factor constitutes my own interpretation of what makes this particular textbook a 'modern' textbook, important to nursing in a contemporary context. Firstly, the textbook was based on the current curriculum developed by the NSF, and that was in use at the hospital at that time. The textbook was further published following the deliberations of a national committee that discussed the content and duration of nursing education. Andrea Arntzen, who wrote one of the chapters, had, together with Bergljot Larsson, drawn up a three-year nursing

[405] This hospital is Ullevål hospital, used as training hospital for medical students from the establishment in 1887, although not formally connected to the University before the first decade of the 20th century.

[406] Grøn and Widerøe, preface. ["…en på moderne prinsipper bygget håndbok i sykepleie."]

[407] Ibid.

education curriculum,[408] and I have assumed that this is the curriculum referred to in the preface.[409] Secondly, the textbook describes nursing as more than simply the provision of individual care, using arguments that draw on public health as part of a nurse's responsibility. The book includes the following:

"Norway has the recent years to a much higher degree got access to educated nurses. The need is however growing, as more and more districts wish for a district-nurse, and the different branches of social work in orphanages, nursing homes, the supervision of foster children etc. need educated nurses."[410]

Thirdly, this book was a collaborative effort, written by both nurses and doctors. During the first half of the 20th century, this can have been no easy task, because the running dispute between doctors and nurses regarding the role of nurses and the duration of their education was approaching its peak. However, Doctor's Widerøe and Grøn succeeded in editing the book and advocating the necessity of the two professions working together on the issue of nursing education in the best interests of the patient and wider society. In referring to Abbot and his system of professions, I find it reasonable to argue that this spirit of collaboration serves to emphasise that the two professions were evolving both with links to, and separate from, each other, each according to the tasks and objectives that constituted the directions serving as the spine in respectively medical and nursing professions.[411]

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[408] Bergljot Larsson and Andrea Arntzen constituted a minority in this committee. The majority wished a division in nursing education, one for the district nurse and one for hospital nurses. This was unacceptable for Larsson and Arntzen who continued to work for a three-year nursing education for all nurses.

[409] *Sykepleien.*1917, no 4, 38-40

[410] Grøn and Widerøe, 2. [Norge har i de senere år fått mere rikelig tilgang på utdannet sykepleiehjelp. Behovet blir dog stadig større, eftersom flere og flere bygder ønsker distrikts-sykepleiersker, og de forskjellige grener av socialt arbeide i barnehjem, gamlehjem, tilsynet med utsatte pleie-barn o.s.v. trenger utdannede sykepleiersker.]

[411] Abbott, 33, 35, 52-54, 134-24, .

In my approach to a broader analysis, I wish do draw attention to the second premise first. When modern nursing developed to encompass public health provision and preventive measures such as hygiene and initiatives to combat epidemic diseases, one can argue that the objectives linked to the image of the nurse as a caring supporter were extended to include the greater part of the population. Objectives linked to an individual patient approach, in which the 'serve the sick' had the primary focus, were not replaced but were extended with additional objectives dedicated to 'serve the society.' This represented a more population-oriented approach to care. However, while for doctors their modification of objectives had shifted focus away from the individual patient, the picture is more complex when it comes to nursing.

In her book *'A study in nursing',* published in 1905, Ms. Angelique Pringle had also pointed out the transition in nursing education from a focus on 'serve the sick' towards one on 'serve the society.' as a whole. Her book was reproduced in instalments in the Norwegian nursing journal *Sykepleien* in 1915. Here, Pringle emphasizes that nursing must be carried out with the patient as its starting point, and with the objective of reversing suffering and returning the patient to good health. Pringle writes; *"in this way nursing is balanced between good health on one side and sickness on the other."*[412]

This approach to nursing supports a development that had its basis in professional care, while also emphasising that such care extended into the public health arena as part of a movement away from regarding the patient as only being a sick person that suffers. This development also emphasizes the fact that international nursing was having a significant impact on the profession in Norway. The International Council of Nursing (ICN) influenced Bergljot Larsson in the same way as Ms. Pringle in terms of pointing out how nurses should be able to incorporate both sickness and health in their approach to their profession.[413]

[412] Rendered from the nursing journal *Sykepleien.*1915, no 6, 53

[413] Hvalvik, "Den moderne sykepleien," 217-18.

The balance between sickness and the prevention of sickness was by the turn of the 1920's seen as common knowledge within nursing also from a national point of view, and had to find its way into nursing education. The introduction to the new textbook of modern nursing principles written by nurse Arntzen supports the idea that the patient as a concept was about to be constructed not only in relation to sickness but also in relation to health, and as something extending beyond simply an absence of disease. This development should probably be understood in the light of developments taking place in society as a whole, where public health was being allocated greater priority. As is pointed out by Aina Schiøtz, a change of mind-set was required[414] by everyone who was involved in public health and in advocating preventive measures in the population at large. This change in mind set could amongst many arenas be observed in the way in which nurses constructed the patient in that they now added the new 'serve the society' image to the profession, both in terms of education and nursing practice.

It may be argued that during this period, medicine had moved in the opposite direction in terms of the way it continued to promote a natural science and reductionist approach to the patient in the interests of public health. It can also be argued that as part of this medical approach, it was the societal perspective that assumed primary focus, leaning towards provision of the most effective medicines for the majority of people. In terms of safeguarding the individual in a public health context, it can be argued that nurses, by means of their professionalized care provision, contributed by adopting a focus on preventive measures for families and individuals. This represents an alternative direction in terms of the construction of the patient compared with the trend in medicine, and was achieved by expanding the image of the nurse as a caring supporter in the frame of public health. Other historians, linking nursing to social welfare and public school, have brought this approach to attention.[415]

[414] Schiøtz, *Folkets helse - landets styrke 1850 - 2003*, 2, 236-37.

[415] Ibid., 252, 71.

This development in the field of professionalized care contributed not only to a new manifestation of nursing as a profession, but also to a construction of the patient as part of a broader understanding of health, as seen from a nursing perspective. My researches into the contemporary 1921 textbook indicate that nurses continued to retain a humanist approach to the patient at this time. Such an indication also implies that Waage’s attempt to implement a more power-based relationship between nurses and patients did not get a foothold in the short run.

The first factor that I referred to earlier was the curriculum that had been drawn up by the NSF. The organisation regarded this as a strategic document expressing what leading nurses themselves valued as necessary and modern standards in nursing, regarding both theoretical and practical nursing skills.[416] The curriculum makes no specific mention of the patient. However, as mentioned, a national committee had been convened to discuss the duration and content of Norwegian nursing education. The committee was deeply divided on these two issues. In a minority statement, Bergljot Larsson and Andrea Arntzen independently forwarded a proposal for a curriculum. They refer to the fact that the benefit of patients was a strong argument for the preparation of such a curriculum,[417] and the thinking behind this can been said to have been revealed initially in the textbook edited by Grøn and Widerøe.

Again, we can look to Bradshaw and her study on competence in British nursing showing how textbooks were used to communicate a nursing education curriculum with the aim of advocating the ideas and values that were considered important to achieve the

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Seip, 243.

Schiøtz, *Viljen til liv*, 341.

[416] Moseng, *Framvekst og profesjonalisering*, 206.

Sykepleien. No 4. 1917,38-40

[417] *Sykepleien.* No 4. 1917,38-40

acquired nursing skills.[418] In the same way as is alluded to by Bradshaw in a British context, the curriculum developed by the NSF in Norway was developed on the basis of what leading nurses themselves valued as important in education. If we assume that the same ideas was the basis for Norwegian nurses, we must acknowledge that the focus in the two chapters written by Arntzen and Aagot Larsen in Grøn and Widerøe's textbook incorporates the contemporary views that nurses held of the patient, as was reflected in the NSF curriculum. The authority that nurses should exert over the sick person, advocated by Waage, had been replaced by a more considerate attitude for the holistic condition of the patient. What was considered of value now was the nurse's ability to express a high degree of compassion. Andrea Arntzen expresses this as follows;

"All familiarity and friendliness must be banned; however a nurse should always be able to familiarize herself with the state of mind of the patient and act in accordance with their need for compassion."[419]

The last factor that I addressed as important to our understanding of the new principles of modern nursing was the collaborative aspect of the authorship of the textbook. Collaboration between the medical and nursing professions is not the primary focus of this thesis. However, in referring to Abbot and his theory of jurisdiction between the two healthcare professions, we can identify in this textbook the contours of a relationship that was about to develop, in which doctors held the power to decide what a nurse could and could not do. In this case, nurses were permitted to write the chapters on the characteristics and duties of a nurse, in addition to a chapter concerning practical nursing skills, referred to in the book as 'common nursing,' while the doctors wrote everything else, including the chapters on care.[420] The textbook supports the different tasks and objectives linked to the different professions, and illustrates to a greater degree how the

[418] Bradshaw, 321, 27-28.

[419] Grøn and Widerøe, 5. [«All familiaritet og nærgåenhet må være bannlyst; men sykepleiersken skulde alltid søke å sette sig inn i den enkelte pasients sinnstilstand og behov for medfølelse»]

[420] Ibid., table of content.

social relationship between nurses and doctors contributed towards consolidating a construction of power that will also become visible in the construction of the patient as time progress.

Thus, the principles of modern nursing are revealed gradually in the evolution of the early nursing education textbooks. In progressing from Waage's book to that edited by Grøn and Widerøe, there is no doubt that there is a clear difference of approach on issues regarding knowledge, autonomy and the presentation of the patient. Andrea Arntzen draws upon this in her introductory chapter. Not only does Arntzen emphasize that a nurse must have a warm heart in her encounter with the patient, but she must also have an interest in and an awareness of social welfare. In this way, she can give advice on preventive health issues while at the same time caring for the sick.[421] One can argue that although nurses during early 20th century had acquired a higher level of medical knowledge, their traditional caring values and viewing the patient holistically had not disappeared at the expense of this development.

Based on this it is possible to argue that the reductionist approach to the patient and the values advocating authority and power that emerged in the wake of Doctor Waage's textbook did not exert a major influence on nursing education at this point. Nurses recognised the necessity to modernize and took on the responsibility to fight for the best professional education they could get in the best interests of their patients and wider society. Thus, the holistic approach to the patient seems to have been seen as an important quality that should be retained. For the nurses, this meant finding a path between the traditional values and modernization. In relation to this, one can identify sources that emphasize and support the idea that arguments for women's rights went hand in hand with developments in nursing education, an assumption supported by and argued previously by Hvalvik and Moseng.[422]

[421] Ibid., 4.

[422] Hvalvik and Moseng, 80, 85.

The significance of this is woven into what has become both the strength and weakness in modern nursing – the dichotomy between caring and a ‘caring science’ based on a holistic approach to the sick person, and the constant need to adapt to modern standards based on scientifically-based medical advances. Ever since the period between the First and Second World Wars, this tension has generated concerns regarding whether nursing could both adapt to medical knowledge and at the same time retain its approach to care rooted in the early Christian traditions.[423] In a Norwegian context, these two came in conflict as the 20th century progressed. Before exploring this in depth, I wish to address another issue that challenged the nursing profession, and which can be regarded as having an impact on how the care of patients may have led to a different construction of the patient concept as part of its professionalization.

6.3 Construction of the patient concept in the context of professionalization

It has been argued that modern nursing is a construct that emerged with the Deaconess’ tradition, in which trained and skilled nurses evolved as a group distinct from the earlier unskilled orderlies.[424] Both British and Norwegian nursing historians have argued that this construction has its roots in the ways in which both doctors and nurses have viewed historical developments.[425] However, it was the doctors, clerks and professors at the University that had the power to construct content in terms of what a nurse should and should not be. In their eagerness to train nurses into becoming skilled assistants, there was a need for the doctors to safeguard traditional gender values. The professors and doctors’ views of women and their capabilities are clearly expressed in several sources. Waage, for example, recognised the importance of nurses making a contribution to care

[423] Ibid., 89.

[424] Moseng, "Sykepleierne," 603-06.

[425] Ibid., 605-06.

that extended far beyond that derived from a Christian calling.[426] However, in his opinion, theoretical training was only useful to the extent that it would enable nurses to provide key and consistent information about patients and their conditions to the doctor.[427] Waage argued that too much theory was wasted on nursing students; *'the pupils one are working with in general are most different equipped when it comes to intelligence...'.*[428]

Here, Waage expresses nothing but ordinary views amongst most men, especially from the upper classes, regarding women and their capabilities.[429] Doctors, who were mostly upper class themselves, were representative of the standards expected of wider society. The desirable characteristics associated with women, such as trustworthiness, obedience and understanding, were all promoted as essential values for a good nurse.[430] The doctors' wish to control and limit the development of nurses in their own interest was visible in most parts of the healthcare system[431] and, as the sector developed and

[426] Waage writes about a calling that apply to the calling for the nurse to sacrifice herself for the sick that are not connected to a Christian calling, but what he refers to as a "life-calling" in a chapter that concerns what attributes a nurse should have. Waage, 14.

[427] H.R. Waage, "Litt om sykepleie og om forholdet mellom sykepleiersker og læger.» *Sykepleien.* 1913. No 13, 122-125

[428] Waage, preface.

[429] Schiøtz, *Folkets helse - landets styrke 1850 - 2003*, 2, 79, 158-60.

[430] Nissen and Martinsen, 21-23. Waage, 14-17. Grøn and Widerøe, 2-4.

[431] During 1914-1917, a tough polemics in the newspapers went on between nurses and physicians regarding nursing education. Amongst the posts are one from the Director at Rikshospitalet (the largest hospital in Norway). Dr. Cristian Magnus Falsen Sinding Larsen, stating that *"nursing by both sexes shall be educated to be the assistant of the doctors, not one by the doctors supportive autonomous profession – and by that follows that the doctors must have the deciding word in what a nurse should learn and how they should learn it."*

[sykepleie av begge kjøn skal utdannes til at være lægernes hjelpere, ikke en med lægernes sideordnet selvstendig profession,- og at lægerne følgelig maa ha den avgjørende stemme ved planleggingen av hvad sykepleierne bør lære og hvorledes de bør lære det.]

Dr. Christian Magnus Falsen Sinding Larsen, *«Respons to the post from Darre Jenssen»* [Svar på innlegg til Darre Jenssen] *Sykepleien.* Årgang 5 no 3. 1917:21-24

modernized, tensions emerged between the nursing and medical professions.[432] In many arenas, nurses encountered conservative attitudes from male doctors that greatly restricted their ability to achieve an adequate theoretical education and establish an autonomous profession.[433] In this struggle, the safeguarding of traditional nursing values and the care of the patient could be considered as two sides of the same coin. Eva Gamarnikow is a researcher who has argued for how we might understand gender issues in the context of modern nursing. Gamarnikow argues that it has been differences in the understanding of femininity during the process of constructing modern nursing that constitute the polemic division between doctors and nursing throughout history. In short, Gamarnikow argues that while nurses leaned towards a traditional womanly understanding of care, linking modern nursing to formal training, work and carrier opportunities, doctors viewed the same womanly characteristics as limiting and subordinating in the face of patriarchal power and influence.[434] The reason for me to lift this point of view is that it support my own ontological and epistemological position in history and my relation to the sources; that in history as now, simultaneously understanding of reality existed and created different approaches to viewing the world. This in turn results in the emergence of different constructions of concepts such as the patient. Such constructions are not expressed explicitly, but continue to frame relationships and our societal challenges. For nurses, some of the differences that have emerged in terms of their views on the need for formal training extended beyond the doctors, and formed part of an entire patriarchal society that was about to be challenged.

[432] C. Helmstadter, "Doctors and Nurses in the London Teaching Hospitals. Class, Gender, Religion and Professional Expertise, 1850-1890," *Nursing History Review: Official Journal of the American Association for the History of Nursing* 5 (1997).

[433] Moseng, ""En forstaaelsesfuld sykepleierske at arbeide sammen med"; legen som regissør av sykepleierens rolle," 213.

[434] Eva Gamarnikow, "Nurse or woman: Gender and Professionalism in Reformed Nursing 1680-1923," in *Anthropology and Nursing*, ed. Pat Holden and Jenny Littlewood (London: Routledge, 2016).

A construction of the patient concept as a means in nursing?

In the wake of the beginning of World War I, there emerged an increased demand for more trained nurses not only in Norway but also internationally. In order to address this need, it was proposed to introduce three-month ‘Samaritan’ courses, to be held at the Sanitary of the National Defence, supported by Colonel Dae.[435] In the following, I will use the discussions and polemics resulting from these courses to emphasize the complexity of the issues faced by nurses as part of their professionalization. This example can also serve to show how the NSF used the patient as a means in their strategy to develop an autonomous profession, and the complex issues that this strategy generated, not only in Norway, but also internationally, surrounding the development of nursing as an autonomous profession.[436]

There is no doubt that the NSF and its representatives regarded these short Samaritan courses as a threat to the creation of an adequate knowledge-based nursing education. During 1914 and 1915, a heated debate in the Journal ‘*Sykepleien’* lent support to a massive criticism of the courses and the women who had taken them.[437] In response, Colonel Dae stated that the intention of the courses was not provide education in nursing and caring skills, but to give young women knowledge about health-related issues in a home setting. However, the NSF regarded even this as a threat to the professionalization of care and caring, and clearly as something beyond simply utilising traditional womanly characteristics.[438] In January 1915, Bergljot Larsson made no secret of her opinion; *“the Samaritan educated pupils must not get access to our hospitals.”*[439]

[435] Hvalvik, "Den moderne sykepleien," 113-14.

[436] Ibid., 210-18.

[437] *Sykepleien.* 1914, no 8, no 9, no 11, and 1914 no 1.

[438] Hvalvik, "Den moderne sykepleien," 114-15.

[439] *Sykepleien.* 1915, 4 [samarittelevene maa ikke faa adgang til vores sykehus]

Of special interest in relation to the debate on the short courses are the ways in which the concept of the patient was exploited by advocates on both sides of the argument. Although the debate was brief and intense, with both sides putting their arguments very eloquently, I wish to argue that never before had patient both as a concept and in relating to the very need of the individual been exploited to such an extent in a debate about the knowledge, skills and character required of professional nurses.

Colonel Dae and his associates argued that, for women who were willing to provide help, some education was better than nothing, and that it was possible that a minimum amount of knowledge of basic nursing could in fact be provided during a three-month course.[440] Doctor Otto Holmboe supported Dae in arguing that the Samaritan courses provided an adequate introduction to nursing theory and that the three months of training served as a good means of entry into the profession.[441] An interesting notion here is that Doctor Holmboe and Colonel Dae are not co-ordinated in their arguemts concerning if this courses should actually serve as an entrance to nursing as a profession or not.

Opposite to this, nurses and the NSF used articles in their journal to continue to express a very different point of view. We can find major concerns expressed in a variety of different letters and articles for the fate of patients who were to be treated and cared for by women with only three months of training.[442] In their final contribution to the debate, the editors of the journal are very clear about their views on the courses and, after having solicited the support of doctors and the Medical Association, they wrote;

[440] *Sykepleien.* 1914, no 9, 81-82

[441] *Sykepleien.* 1914, no 11, 110-112

[442] *Sykepleien.* 1914, no 8, 76

"The soldiers are being exposed to unnecessary suffering, even death because of the unskilled care – the congestion of women helpers in the lazarettos by more and more Samaritans cannot replace a well-educated nurse"[443]

There are several ways of understanding what was a stake during this period. From the time when the deaconesses had started to educate nurses in 1868, it had always been important to maintain a clear distinction between trained nurses and unskilled orderlies. In her textbook, Rikke Nissen clearly expressed and constructed a highly unfavourable image of the orderlies. One of these images portrayed these women as lacking the proper qualities required to be a nurse, often failing in their approach to providing care.[444] Nurses' opposition to the Samaritan courses can be understood as an extension of this view. Moreover, since the establishment of the NSF in 1912, Bergljot Larsson had begun to work towards establishing a standard three-year nursing education similar to that being developed in other European countries, and in line with the ambitions of the International Council of Nursing.[445] In the light of this, the introduction of any form of shorter education must have been regarded as a threat to the professionalization of nursing as an autonomous profession, and therefore had to be stopped. Nevertheless, what is clearly revealed in the debate regarding the discussion of the Samaritan courses is the way in which the concept of the patient is used to underpin the seriousness, as the nurses saw it, of the consequences of these courses. According to opponents of the courses, the suffering of soldiers and the sick would only be exacerbated in the hands of the women who had taken them, and was supported by the notion that these women

[443] *Sykepleien.* 1914, no 11, 113-115. [*Soldatene blir utsatt for unødige lidelser, ja endog død paa grund av ukyndig pleie – ophobning av kvindelige hjælpere i lasarettene da flere samariter ikke erstatter en utdannet sykepleierske.*]

[444] Nissen and Martinsen, 22, 24.

[445] Hvalvik, "Den moderne sykepleien," 43-44.

also lacked the right character to perform care.[446] We can clearly see the link to the former orderlies and the portraiture of them as having a lack of character.

The perceived lack of character of an unskilled woman working at a hospital had been expressed even before nursing became a profession, as is eloquently argued by Carol Helmstadter in a British context.[447] Although only very little research has been carried out into the lives and work of unskilled orderlies in Norway, the sources we have seem to lend some support to the conclusion drawn from Helmstadter's studies.[448] The construction of the orderlies as filthy, drunk and unfriendly women has been reinforced during the history of nursing in an attempt to cast an unfavourable light on the inclusion of uneducated women in the nursing profession.[449] However, as has been pointed out in both British and Norwegian contexts, a concern for the well-being of the patients caused doctors to employ women of a better social class and character, who would exercise authority over the orderlies while at the same time safeguarding a minimum level of appropriate care for patients.[450]

It is hard to ignore the fact that nurses have always placed great emphasis on the well-being of the patient. Caring for the sick and caring as a basic element of nursing are the objects of intense focus, and make up the very essence of nursing. In spite of this, it is also hard to ignore the way in which patients are deliberately pushed forward in the

[446] In a report from the Swedish Ministry of War in 1913, it was claimed that these unskilled Samaritans favorited patients that appealed to them, while neglecting other patients. Moreover, they were seen leaving their posts during evening to participate in festivities with officers at hotels nearby. This was used in the argument towards the establishment of such courses in Norway. *Sykepleien.* 1914, no 8, 76f

[447] Helmstadter, 328-33.

[448] Moseng, *Framvekst og profesjonalisering*, 46-51.

[449] Ibid., 49.

[450] Helmstadter.

Moseng, *Framvekst og profesjonalisering*, 54-57.

professional struggle that emerged in nursing during the first decades of the 20th century.

In terms of the various images and objectives that apply to healthcare workers, one can hardly ignore the role that the patient played in the view of nurses as gatekeepers in connection with their professional struggle. In the context of the development of different images with associated objectives, Øivind Larsen argues that the image of a gatekeeper presupposes that there is something to safeguard. During this period, the most important thing for the nurses to safeguard was their professional knowledge and skills. A specific awareness of care that extended beyond what any untrained woman could perform was the essential feature that separated traditional attitudes to care from professionalized nursing. Professional nurses were not only struggling to achieve an education system to support professionalization, but also an acknowledgement from society that their work was a worthy profession that could be practiced outside the household.[451]

Ole Moseng points out how several historians have viewed the establishment of the NSF as a strategy that enhanced the professionalization of nursing.[452] Education can be viewed in a similar way in that it professionalised nurses by allowing them to obtain control of and access to what they themselves saw as the basic knowledge and skills they required to carry out professional care, in spite of both doctors and professors attempting to take control in these matters. In their eagerness to succeed with their professionalization strategy, it is appropriate to ask if reference to the sick person – the patient in their care – was part of a deliberate strategy on the part of the nurses. In reflecting on this I wish to argue that the way in which the patient was portrayed and constructed during the debate of the short Samaritan courses, was as a person so vulnerable that only professional care could meet his or her needs.

[451] "Sykepleierne," 599.

[452] Ibid., 616-17.

In this construct, nurses not only positioned themselves strategically with an image as professional caregivers; they also used the patient as a concept to emphasize why their profession was needed and what society should expect when nurses carried out professional care. In this way, professional care became, in the same way as professional medicine, a means of securing a healthy population. Intentionally or not, by bringing the patient into the debate, nurses contributed to a construct of the patient that was in line with societal challenges. At the same time, they were able to point to their own profession as part of the solution to these challenges, provided that their demands for an adequate education were met.

If we consider the opposing side of the discussion, Doctor Holmboe seems to express the view that the short Samaritan courses contained sufficient theoretical skills and practical training to prepare women to practice adequate care. Based on his short references to the Samaritan courses, it is not possible to draw any firm conclusions about his general views on care and nursing. However, looking to how doctors in general viewed nursing during the period leading up to about 1918, we see that most of them fully recognised the importance of skilled nurses. They also argued for their training to be both theoretical and practical, in line with their own expectations and those of society at large.[453] In spite of this, as pointed out earlier in this thesis, doctors during this period had to some extent transferred the image of the caring supporter to the nurses. As medicine advanced, the doctors had focused more on knowledge development based on the reductionist and natural science approach, and in doing so had placed less emphasis on the professionalization of care in its own right.

A reminder is that caring was still by most people, including both the professors and the doctors, viewed as something most women were considered by nature to perform adequately. However, such a view was not a liberal idea, rather a conservative that was based on traditional societal values concerning gender roles that had persisted for

[453] Moseng, ""En forstaaelsesfuld sykepleierske at arbeide sammen med"; legen som regissør av sykepleierens rolle," 210-12.

centuries. Even Doctor Waage, if somewhat reluctantly, had concluded that professional nursing required specific skills and some theoretical knowledge. However, Waage also claimed that a woman's ability to care was rooted in personal qualities determined primarily by virtue of her gender.[454] Some doctors certainly held the view that any teaching that would reinforce this natural instinct would be beneficial, and it is possible that Doctor Holmboe was also advocating this point of view.

As pointed out previously, the discussion regarding the Samaritan courses paved the way for participation by nurses in the public arena and highlighted their role as professional caregivers. So, although the debate started in response to what was regarded as a serious threat towards the nurses' professionalization strategy, it could also be viewed as an opportunity for them to promote the benefits to be gained by society in supporting their ideas for an adequate three-year education in line with international developments. During the peak of the thrilling debates surrounding the Samaritan courses in 1914-1915, the NSF and most nurses could hardly have imagined the extent to which they would have to fight for a three-year education.

"One does not take adequate consideration to the burden of the sick"

The discussion concerning the Samaritan courses had exposed a gap between nurses and doctors concerning what they considered to be the appropriate level and duration of nursing education. A huge part of this disagreement was linked to what the professions regarded as the level of knowledge necessary in order to provide the patient with adequate care. According to Gamarnikow, doctors viewed modern nursing as a threat to

[454] *Sykepleien.*1913, no.13, 126 *«it is not knowledge that decide whether a woman is a proficient nurse. The first condition is that she has the personal prerequisites required. However, of course one must claim, as of anyone who these days wish to become a skilled nurse, demand that she besides being taught practical skills also possesses a certain collection of knowledge in the subject."*

[*«det er ikke lærdommen, som i første række avgjør en kvinde til en dyktig pleierske. Den første betingelse er, at hun har de personlige forutsætninger derfor. Men selvfølgelig maa der av enhver kræves, som i vore dage vil gjælde for en fuld habil sykepleierske, kræves, at hun foruten at være opøvet i praktiske gjøremaal ogsaa besitte et fond av kundskaper i faget.»]*

their own professional power and sense of control.[455] Much was at stake. In an article, Andrea Arntzen pointed to the fact that any argument for a short education for district nurses was simply an argument to train cheap house cleaners, and had nothing to do with caring for the sick. She continues: *"one does not take adequate consideration to the burden of the sick."*[456]

With this statement, Arntzen succeeds eloquently in pointing out the complexity of the role that nurses were about to assume as they moved from the closely proscribed image of the caring supporter (based primarily on objectives drawn from the traditional calling for care), towards the modern construction of the professional nurse, by which the individual patient is somewhat 'left behind'. The renewed focus on public health, carried out at population level, paved the way for nurses to exploit both patients and public health concerns in their enthusiasm to establish an autonomous three-year education. At the same time, they also had a duty to the concept of individual care internalized within their own profession. As Grøn and Widerøe's textbook reveals, modern nursing, in the same way as for the doctors, had been drawn away from the role of a caring supporter for individuals, and towards objectives more in line with 'serve the society.'

As early as in 1879, Doctor Edvard Kaurin[457] wrote a book called *"The nurse – a short guide in nursing for nurses in cities and in rural areas."*[458] Kaurin's book was intended as a guide for anyone who wished to become a nurse, but more so, to any woman whose lot in life was to care for a sick person for short or long periods.[459] Kaurin's guide was published shortly after Nissen's textbook, and we can assume that in line with Nissen, we can see that we are only at the beginning of the development of a professional modern

[455] Gamarnikow, 112-14.

[456] *Sykepleien.* 1924.no 6, 35. [men man tar ikke tilstrækkelig hensyn til den sykes tarv]

[457] Edvard Kaurin (1839 – 1917), was at this point doctor in the district Grong in Norway.

[458] Kaurin.

[459] Ibid., 5.

construction of nursing, pacing both nurses and patients in the traditional caring context of receiving and giving care. Kaurin welcomed skilled nurses to the Norwegian rural districts, and his enthusiasm resulted in him becoming one of the main antagonists in the continuing argument between doctors and nurses regarding the length of nursing education in general, and whether district and hospital nurses should receive distinct educations.[460] Once again, we can find that the patient constitutes a significant factor on both sides of the discussion. The concern for a lack of skilled nurses in the districts was set against the time required to provide professional care.

As in the Samaritan course debate, doctors who supported a shorter education argued on the basis that it was better that women caring for patients in the rural districts should have some education rather than none at all. There was general agreement that nurses working in hospitals required a longer education. In proposing such an argument, we can assume that this reflected a general view among doctors concerning the common people, and how they pictured life among the rural part of the population. As argued previously, ideas of class exerted just as much influence as gender in terms of the ways in which many doctors viewed their patients. Relating this into the reality of nursing and nursing education, the arguments held by these doctors may not seem deviant from their belief of what constituted the best for the patients in these areas.

On the other hand, leading nurses continued to argue that a three-year education was essential to providing adequate knowledge and training for women assigned to carry out the extended health-related objectives that now constituted the image of the skilled nurse. In 1924, an entire issue of the journal *Sykepleien* was dedicated to nursing education. Crucial to the arguments of the nurses and the NSF was that in rural districts, it was far more important for a nurse to be able to work independently and autonomously because of the large distances that doctors had to travel between patients. Moreover, in the aftermath of the First World War, there was a lack of doctors working in the

[460] Moseng, ""En forstaaelsesfuld sykepleierske at arbeide sammen med"; legen som regissør av sykepleierens rolle," 210-14.

districts.[461] This caused major concern among the inhabitants and the Norwegian state because of the potential impacts this might have on the health of the population. It is worth noticing in this context, as is correctly pointed out by Aina Schiøtz, that both the doctors and their organization, in advocating the presence of medical expertise in rural areas, did not emphasize the benefits to the patient as their main argument. Their main concern was for their own profession.[462]

The arguments for their own professional development put forward by nurses and the NSF merely serve to emphasize that the patient and patient care can be viewed from two different perspectives in terms of the development of the patient concept under different constructions of nursing. There is no doubt that the NSF as a nursing organization had the best interests of the sick at heart as part of the development of nursing education. As pointed out previously, both the textbook sources and the discussions reveal a holistic approach to care based on individual consideration for the suffering. The construction of the patient within this aspect of nursing is embedded in traditional nursing values, and is balanced by concerns emerging within modern society and its associated challenges. On the other hand, it is also right to question whether using patients as arguments in a heated debate for a three-year nursing education was considered in line with the philosophical underpinning of a holistic approach to the patient. We do not need not to look too far to obtain an understanding of how some leading nurses felt about this question.

Bergljot Larsson stated that it was not the patients that were the winners in the struggle for a three-year nursing education, in spite of the fact that the NSF had promoted this argument throughout the debate. In a lecture given in Oslo in 1932, and later printed in the journal *'Sykepleien'* the following year, Larsson argues that neither the doctors nor

[461] Schiøtz, 48-51.

[462] Ibid., 49-50.

the nurses were competent at attending to and treating the patient in a holistic way.[463] With the danger of nurses accepting the dominant prevailing construction that conformed to a biomedical and reductionist approach to the patient, Larsson can said to be taking a step backwards in her reflections about what direction nursing education should be taking.

What seems to separate the two professions, and their respective associations, is of great relevance here. Both must be said to be riding at least two horses at the same time. Both want to secure a healthy population by taking care of the sick, while at the same time to safeguard their own professions from non-professionals and to exert an increasing influence within society. While the doctors were relatively transparent in their objectives, it can be argued that nurses exploited their image as caring supporters strategically in order to assume control of their professional development and their image as a gatekeeper of professional knowledge. So, as Larsson claims, the patients did not come out as winners in this struggle. We could rather see them considered as means towards professional development and power. Weather such a construction was deliberate or not we can only assume, and we can reflect upon if that make up an important premise. What we can conclude, is that this had caused concern and this concern was explicitly addressed by Larsson at the end of the period for the formative part of early nursing education, in 1932/33.

6.4 Summary

As nursing became professionalized through education, the patient played an essential role in this development – not only as someone that required professional care, but also in terms of transforming its role from being a sick person to entering that of the formalised role of a patient, conceptualized by the objectives that nurses valued as part of their professional development. The patient constitutes the essence of

[463] Larsson, Bergljot. Regner vi med pasientens vilje som viktig faktor for å opnå et godt resultat av behandlingen? *Sykepleien.* 1933. Årgang 21 no 3.

professionalized nursing as part of a holistic approach to care that is illustrated in the nursing education textbooks referred to in this chapter.

We can recognise a clear development in the construction of the patient linked to these traditional caring values. Initially, the most dominant construct is the sufferer in need of relief from pain. This is then replaced by a construct related much more to the patient in need of professional care, regardless of his or her condition, and by which the authority and power of the medical profession exert the predominant influence. However, as argued previously, such a construct did not get a hold within the nursing tradition because nurses’ leaders, both in Norway and overseas, continued to maintain the status of the patient as the focus of all care and professional nursing. One can say that within the development of professional care a construct of the patient as a holistic person remained strong in spite of movements towards modernization and a broader theoretical base within the medicine as a whole.

As nursing developed as part of general societal modernization processes, objectives linked to the individual expanded to encompass public health and preventive health measures. However, in contrast to the trend within medical education, nurses succeeded in achieving a balance between care of the individual and public care. Thus, the image of the nurse as a caring supporter was able to incorporate the objectives of both the ‘serve the sick’ and ‘serve the society,’ and in doing so maintained a holistic construction of the patient.

However, this image becomes less one-sided if we consider how the patient was linked to the nurses’ professionalization strategy. As both the Samaritan and the three-year nursing education debates reveal, nurses themselves did not hesitate to exploit the patient as a means to advance their professional development. Professionalized care must be seen as an essential part of the establishment of an autonomous profession, and nursing was challenged both by unskilled workers and the doctors as part of the process to establish a formal and adequate education that would ensure that they obtained knowledge beyond that which they possessed by virtue of tradition and their gender. As nurses struggled to achieve the transformation of their education from its traditional

calling and womanly values on the one hand, to modern medicine on the other, so there evolved changes in their view of what patients were and how they should be treated. Part of this is manifested in the concern amongst nursing leaders towards the end of the period, emphasising that the construction of the patient had developed in a direction that should cause concern amongst both nurses and doctors.

7 Broadening the perspectives

«Mum, why do I have to be a patient? »

«Mostly you are not a patient, most of all you are you. But when you are at the hospital you also become a patient."

"I don't want to be that, I am Victor."

"Yes, you are Victor, and it does not matter what kind of different concepts people put on you, because you are Victor, and you are very good at being just that. And we have to make sure that also the doctors and nurses know who you are."

Does becoming a patient mean that you have to abandon yourself and your personhood? The quote from the scene in the movie '*The Madness of King George'* that I cited in the introduction may encourage us to think that there is some truth in this. My conversation with my son suggests that even today, becoming a patient gives rise to a fear of losing oneself when placed in a patient role. My historical analysis, outlined in this thesis, has emphasized that objectification of the patient can take many different forms, and be underpinned by a variety of ontological and epistemological approaches. The language used to give meaning can serve different purposes, but with the same effect. When the patient is objectified through language, treatment is often linked to linguistic representations, and the individual person disappears as the focus of attention.

In this chapter, I will draw on the knowledge obtained from the previous chapters to argue that historical knowledge can be used to generate awareness of some of the challenges faced today by healthcare education systems. I will also reflect on how it may be possible to incorporate this knowledge into future education and practice relating to the construction of the patient as a concept. I will draw particular attention to what may be considered the humanizing and dehumanizing aspects of the ways in which we

construct the patient from different epistemological standpoints. Initially however, I wish to place the construction of the patient in a broader historical context and create a bridge between the knowledge obtained in this thesis, and the present as a basis for meeting the future challenges in professional health education and practice.

7.1 Understanding the patient as a construct in a broad historical context

As mentioned in Chapter 5, Charles E. Rosenberg argues that in order to understand the relationship between the patient and the doctor we should start with diseases. This should not be from a biomedical approach, but as a social framing that is key to the development of the doctor-patient relationship.[464] Rosenberg can thus be placed within the same tradition as Foucault, Koselleck and others, who placed equal emphasis on the social perspectives in historical research as to those in medicine and the history of medicine and health.

I have placed emphasis on social and cultural contexts in the discussions of the extent to which nursing and medical education contributed towards shaping, and was shaped by, the context in which the patient was constructed. Moreover, I have focused on how the two education systems contributed towards constructing the patient in the context of their development through the different tasks and objectives associated with their respective professions. Such an understanding can only be reached by acknowledging that these education systems are part of society, with implications that extend beyond the learning of specialist skills and the safeguarding of one’s own professional development. As argued previously in this thesis, the professions, their education systems and patients are all integral parts of the social and cultural model of the professional healthcare sector.

[464] Rosenberg, XIII-XIV, XVI-XX.

When we examine how most medical history has been written, we can see that patients have comprised groups of people defined primarily on the basis of the diseases they suffered from. The reason for the evolution of this narrative may have something to do with the fact that society in the past was quite different from what it is today. In historical times, people encountered serious and potentially fatal diseases on a daily basis and far more frequently than we do today. One may argue that serious diseases and sickness' were a fundamental part of life. From this perspective, we can understand arguments coming from historians such as Seip (1984) and Schiøtz (2003), when conducting research into the history of medicine and health, focusing on social aspects of this history, that diseases were seen as a collective threat that called for collective measures.[465] Research on historical developments show that in considering the threats to society as a whole, regard for the individual disappeared, and individual perspectives were mostly done within other academic subjects and the realms of fiction.[466]

Most people living in the 19th century had little or no knowledge of the causes of sickness and disease. Some people inherited beliefs in the occult and resorted for explanations to an imbalance between superstition and the otherwise sympathetic forces of nature. This balance had to be maintained if the crops were to flourish, and if the family was to enjoy good health and general well-being.[467] In this historical perspective, it is reasonable to assume that the individual had a different standing in society than he or she does today. As Alver (2013) has suggested, individuals must be seen in the context of the safety and

[465] Seip, 217.

Schiøtz, *Folkets helse - landets styrke 1850 - 2003*, 2, 224-32, 36-38.

[466] To understand more about the consequences for individuals living with for example leprosy, one can go to literature. The British author Victoria Hislop's *"The Island"* and Norwegian author Caterina Cattaneo's 'I stopped counting days' [*Jeg sluttet å telle dager*] are both well written stories based on individual experiences of leprosy. Both books are based on historical events documented through archives and historical remains. Gaute Heivoll, a Norwegian author has written about the Norwegian disease, Radesyken, in his book 'The Kings' heart' [*Kongens hjerte*]. All three of them share light on individual costs and experiences on living with non-curable diseases in isolation from society.

[467] Alver, 40-41.

survival of families, rather than as an important entities in themselves.[468] If we accept this idea of reality, we achieve an understanding of how contemporary views of sickness and disease were interwoven with prevailing social and cultural attitudes. In a society that understands sickness and disease as the result of an imbalance between the population and the occult, getting sick was seen as an act of immorality and thus probably self-inflicted. This balance had to be restored. The onset of disease was generally regarded as the result of a person's inability to distinguish right from wrong, which in turn caused an imbalance between occult powers and the forces in nature resulting in a threat to the family or, in some cases, to wider society. The consequence of this was that many people tried to hide their diseases and to live as normally as possible for as long as possible. This was a cause for concern for many doctors, and both the state and the professors working at the School of Medicine became convinced that they had to gain control of these diseases in the interests of wider society.[469] They could not allow disease to afflict the population because of what they regarded as superstition and immorality. In this respect, the legislation that was introduced to sanction the quarantining of people suffering from particular diseases must be viewed in the light of social challenges as well as purely biomedical issues.[470]

We can argue that as part of the modernization processes, these various epidemic and infectious diseases paved the way for legislation that changed the social role of disease, especially when calls for quarantining measures are taken into consideration. This had a

[468] Ibid., 41-42.

[469] Doctor Ole Malm said in 1887; *"The duty of the State is to keep the family and the individual healthy. The State shall prevent that disease occur…"* [Statens PLigt er at bevare Slægten og Individet sundt. Staten skal forebygge, at Sygdom opstaar…] O. Malm, *Om en ny ordning af det civile lægevæsen [Concerning a new arrangement for the civil medical services]* (Kristiania: Cammermeyer, 1887).

[470] Quarantine as useful measures towards infections was used long before the cause of bacteria had been identified. Øivind Larsen, "Sunnhetsloven - mer enn en helselov " *Michael quarterly. Supplement* 7 (2010): 30.

May-Brith Ohman Nielsen, *Mennesker, makt og mikrober: epidemibekjempelse og hygiene på Sørlandet 1830-1880* (Bergen: Fagbokforlaget, 2008).

huge impact on most people's understanding of the world and the culture in which they lived. When the doctors spoke about *'the uncultivated common folk',* they were in fact attacking a culture and a reality they were unfamiliar with and did not understand.[471] This had consequences for the construction of the patient concept, as is illustrated in the discussions that took place between doctors on opposing sides of the argument relating to restrictions on individual rights and freedoms in the wake of new health legislation. A discussion between doctor N. Wulfsberg and G.A. Hansen reveal a dualistic approach to how to treat persons with leprosy and tuberculosis. Wulfsberg states:

"the new Act of 1885 concerning Leprosy clearly restricts citizen's rights when infected by leprosy. Leprosy is from now not a disease that should awake participatory help, but considered a crime where one falls back to punishment." [472]

To this, Hansen replies that Wulsfberg is only concerned about the humanizing factors of the disease, not realizing that they discuss an infectious disease that cause for protecting the healthy from the infected.[473]

Rosenberg argues that differences in the biological character of the various diseases determined their social role. This role was determined by whether the disease was chronic, epidemic or acute.[474] As part of this framing of disease, Rosenberg goes on to argue that the social role of sickness and the diagnosis of disease introduced a new

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[471] Schiøtz, *Folkets helse - landets styrke 1850 - 2003*, 2, 92-94.

[472] The Journal of the Norwegian Medical Association, [*Tidsskrift den norske lægeforening*] 1885, page 293, 391, 407. [den nye loven om Spedalskes Afsondringer og Indlæggelse I offentlig Pleie-eller Helbredelsesanstalt, inneholder flere bestemmelser der i betydelig Grad indskrænker de Spedalskes Borgerrettigheder. Spedalskhed er fra nu af ikke en Sygdom, der vækker Deltagelse og berettiger til Hjælp, men en Forbrytelse, hvorefter man hjemfalder til Straf.]

The Journal of the Norwegian Medical Association [*Tidsskrift den norske lægeforening*], 1896, page 482 reveal the same arguments from Hansen concerning tuberculosis.

[473] Op.cit

[474] Rosenberg, XX.

variability into how sick people should feel about themselves.[475] From the mid-19th century, the treatment provided by doctors rarely coincided with how most people understood their diagnosis. Most people did not understand why it was necessary to quarantine family members in order to prevent infection. The measures taken by the state, and directed by the upper classes, had little meaning in the day-to-day lives of most people. In the light of this, it becomes easier to understand the distance and lack of understanding that arose between healthcare professionals and the population from which most of their patients came. However, such an understanding also emphasize to what extent doctors and nurses through education and knowledge could increase their power in society. The distance between the expert and the patient was developing rapid and with huge consequences for the relationship between them.

As part of the Health Care Act of 1860, the health committees were allowed to take the measures they considered necessary against any person infected with a disease and who was considered to represent a threat to society.[476] If we are to understand the challenges that patients experienced in their encounters with healthcare professionals, it is crucial to recognise how these diseases were regarded by society and how they affected the lives of patients. Rosenberg’s assertion that we must focus on disease if we are to understand the relationship between doctors and patients is key here. It enables us to recognise that throughout the 19th century, health legislation influenced this relationship by permitting the introduction of a more dehumanizing approach to the patient, in spite of the arguments of those who were trying to encourage a balanced argument. The need to control disease had a huge impact on the shift in focus in medical education and determined what the professors came to see as their most important contribution to society, based on the expectations of the state.

[475] Ibid., XVIII.

[476] Larsen, "Sunnhetsloven - mer enn en helselov " 13.

In this way, the need to control infectious disease and epidemics can be regarded as the foundation for subsequent changes in the view of the patient, and paved the way for a new construction, not only in the medical arena, but also in society in general. New legislation reinforced this trend by isolating the sick from the healthy. In a society in which most people lived in crowded houses, both in rural areas and in the cities, isolation and quarantine, combined with measures to promote better hygiene, became the most important means towards safeguarding a healthy population.

Infectious diseases had their most severe impact on the poor, who lived in confined and poorly designed houses. Understanding disease as a social and cultural phenomenon, and not simply as a set of biomedical symptoms that manifest themselves in their physical flaws, placed the patient rather more in a holistic tradition than in the prevailing biomedical paradigm. It is within the holistic tradition that we must seek to understand the impact that the various diseases had on patients’ lives, and to what extent different realities played a part in constructing the patient as a concept in contexts beyond the realms of education. Different diseases introduced different social stigmas, which in turn contributed to the types of treatment and care that the patient received.[477] I have argued in this thesis that our understanding of reality affects the meanings that are associated with concepts. Social stigma can thus be seen as an extension of the language used to give meaning to the patient as a concept.

Several historians have included social and cultural understandings in their research in the relationship between doctors and their patients in the wake of the shift from the old medical paradigm to the new.[478] Taking my cue from this, I wish to argue that it is not

[477] Rosenberg, xiv-xviii.

[478] Porter and Porter.

Jewson.

Jens Lachmund and Gunnar Stollberg, "The Doctor, his Audience, and the Meaning of Illness. The Drama of Medical Practice in the Late 18th and Early 19th Centuries," in *The Social Construction of Illness*, ed. Jens Lachmund and Gunnar Stollberg (Stuttgart: Franz Steiner Verlag, 1992).

controversial to claim the common understanding that the professionalization of medicine and scientific advances had an impact on both the view and construction of the patient, as well as the doctor-patient relationship. Issues related to the construction of the patient were closely linked to the way in which society viewed the individual human being and how individuals viewed themselves in relation to family and society. In the field of health, this phenomenon was also linked to the construction of disease.[479]

The shift in the medical paradigm has resulted in better health for the greater part of mankind. More people survived their disease, and the imposition of hygiene measures made significant improvements to public health in general. However, from the point of view of the individual patient, the consequences and costs and of this shift can be measured in the technical and dehumanizing character of the new relationship between the sick patient and the healthcare professional. I wish to argue that this change in the medical paradigm changed the relationship between doctors and patients and, as previously argued by Porter and Porter[480], has also altered our view of the patient. Earlier research into the understanding of the relationship between the sick person and the doctor has demonstrated that when the doctor and patient shared a similar understanding of the holistic body, there emerged a co-created meaning in terms of how treatment and care should be carried out.[481] This meaning was abandoned as part of professionalization during the modernization processes, during which the expert doctor or nurse obtained knowledge and power, and the patient was forced to submit to the expert when it came to health and medical issues. This historical development was

Dinges et al., volume 96.

[479] Charles E. Rosenberg, "What is disease? In memory of Owsei Temkin.(Author Abstract)," *Bulletin of the History of Medicine* 77, no. 3 (2003): 496-98.

[480] Porter and Porter, 14.

[481] Lachmund and Stollberg, 53-58.

reinforced by linguistic representations with the objective of securing a particular point of view.

7.2 Bridging the past and the present

The patient concept is derived from the state of being a person who is suffering and in need of care and/or treatment. Later, as the modernization processes and advances in public health took hold, the concept evolved to represent a person who needs help to safeguard own health before contraction of disease to the benefit of society. Acknowledgement as a sick person reinforces personhood, and enables the person to affirm his or her health status in the popular, professional and folk sectors as defined in the healthcare model developed by Kleinman.[482] However, as argued in Chapter 3 (page 54-55), the patient as a concept is associated primarily with the professional health care sector. As a construct, the patient as a concept can accommodate a wide range of different meanings according to the context in which the construction appears and develops. However, in terms of Kleinman's model, the professional sector may be viewed as exerting dominance over the other two, at least from the Western point of view.[483]

Throughout my work on this thesis, the concept of the patient has constituted my central theme. I chose this approach in order to emphasize not only that power lies in the linguistic expression of concepts, but also to show how language and context contribute to our reflections on, and the shaping of, reality, both today and in the past. At the same time, the historical analysis has demonstrated that, as a concept, the patient did not constitute a primary focus in medical education. The sources used demonstrate a significant absence of the concept in terms of its use in medical education. My understanding of how the patient as a concept has been represented in medical education is thus also an interpretation of meaning as it appears in statements concerning the sick person in the role of patient. When it comes to nursing education,

[482] Kleinman, *Patients and healers in the context of culture*, 50.

[483] Ibid., 24-27, 71, 259-66.

the concept of the patient comes more to the fore. Both in textbooks and in discussions regarding nursing education, the patient was commonly highlighted as a fundamental premise for the nursing profession. The relative presence and absence of patient as a concept in historical sources can help to explain the differences between epistemological developments within the two professions. Medical education related very much to science, while nursing education related to holism and caring. This led to differences in linguistic developments that supported the view of the patient in a professional setting.

The understanding that it is through the use of language, reality is constructed as a means of emphasising and reinforcing a specific point of view has constituted the epistemological point of departure in this work. In line with Koselleck who argue for the connection between conceptual and social history,[484] one can also say the reality is woven into the language being used, because we use language on the basis of our understanding of what is real. In this way, patient as a concept is not intimately linked only to a sick person, but is also related to how diseases were understood, how medicine and nursing developed, and how professionalization and power have been sought for and obtained by means of education and the affirmation of knowledge.

In the wake of reductionism and the paradigm shift towards science, the patient was objectified in medical education by a use of language that strongly disassociated the sick person from their individuality, and as a means to an end that lay beyond the realms of the individual sufferer. Patients came to represent causes that required examination. They were first and foremost regarded as scientific phenomena that would help the expert doctors to meet the great challenges and threats facing society during the 19th century. However, no matter how dominant this paradigm became, there were always critical voices speaking out. Overseas doctors such as Osler and Cushing, and Norway doctors such as Scharffenberg, expressed their fears for the dehumanization of the patient in the context of medical education. As has been argued by Warner (2014), these

[484] Koselleck, "Social history and conceptual history."

doctors were also concerned that the language and methods employed within the reductionist paradigm were paving the way for dehumanization of the sick person in their encounters with healthcare professionals.[485] On this basis, we can assume that linguistic representations of concepts, also in historical times, were understood as a means of reinforcing a specific point of view. So even though there were only a relatively small number of professors at the only medical university in Norway, they nevertheless exerted a major influence on the construction of the patient within their own profession. The few critics who raised their voices had little impact on what became the dominant medical paradigm within which the patient as a concept was constructed.

Nurses, on the other hand, made attempts to emphasize a holistic caring approach to the patient during most of this period. However, as I have argued as part of my historical analysis, nurses also recognised the necessity of using the patient as an instrument in their professional struggle. In nursing education, the teachers and superintendents on the wards had to balance care for the individual with perceived threats from both unskilled orderlies and the doctors with whom they worked. Nurses gradually grew in numbers, but their power and the opportunities they had to exert influence within the healthcare sector remained limited. Their holistic approach to care, rooted in traditional womanly values, continued to come under pressure as the development of modern nursing continued.

The key point in terms of broadening the perspective will be to argue for the importance of introducing historical knowledge into the training of health professionals. I intend to highlight the factors that led to the humanization and dehumanization of the patient construct in the past, and how these factors influence our current construction of patient. In becoming a patient, a sick person enters into a system of professions that is defined and heavily influenced by both academic and abstract knowledge, and in which,

[485] Warner, "The Art of Medicine in an Age of Science: Reductionism, Holism, and the Doctor-Patient Relationship in the United States, 1890–1960," 80.

according to Abbot,[486] the power to construct meaning is closely linked to prestige, history and the tasks and objectives they are set to perform. Abbot emphasize how the professions develop as part of a system that encourages some to become more dominant than others, and how they relate to their relative status as superior or inferior.[487] Abbot goes on to argue that these hierarchical differences also affect how the professions relate to agents and stakeholders subject to their jurisdiction both within own profession and in relationship to other professions.

According to Abbot, since the patient must be regarded as one of the most important stakeholders for both doctors and nurses, the status of the professional within the hierarchy will consequently affect their view of patients. This understanding has strong roots in historical development, and is supported throughout my analysis in terms of the different ways in which both professions related historically to the patient as a concept in connection with their respective education systems. However, as pointed out in my introduction, the expectations to the modern patient, as a joint decision-maker in issues relating to his or her own health, challenge the historical views that the professions had of the patient in the past. This in itself should justify a greater awareness of the concept of the 'patient'. In recent decades, the response to this assertion has given rise to the development of several frameworks[488] within both the nursing and medical professions. Nevertheless, as will be discussed later in this chapter, both professions continue to draw on contrasting epistemological bases, thus leading to quite different constructions of the patient concept. This difference becomes emphasized if we examine the linguistic representations of the patient within in these frameworks.

[486] Abbott, 52-55, 316.

[487] Ibid., 139-40.

[488] In medicine, framework drawing on EBM has gotten a strong influence on the medical education, while within nursing frameworks drawing on person-centred and holistic approaches has dominated the education.

7.3 The patient or person in person-centredness

When Bergljot Larsson stated that; it was not the patient who was the winner in the nurses' struggle for a three-year education, she was highlighting what she saw as the fundamental influence that the will and willpower of the patient have on successful treatment and care.[489] In her opinion, both nurses and doctors had failed to permit the resource that the patient's will represents to influence their relationships with their patients. Larsson could easily have blamed the doctors. However, being a nurse herself, she instead put the spotlight directly on the nurses, by reminding them of the importance of personhood and a holistic approach, and invoking traditions from as far back as ancient Greece. In doing so, Larsson emphasizes that the patient must not only be regarded as a biological entity or placed in the role of a passive recipient of care or treatment. Her arguments thus serve very well as an eloquent criticism of the objectification of the patient that dominated the healthcare sector in the 1930s, not only in medicine and medical education, but as something that also existed in nursing and nursing education.

In her speech, Larsson values the patient as a person, and stresses the need to see the patient on the light of the resources that each one brings with them when struggling with disease and sickness. For Larsson it was crucial in education to focus on allowing the sick person to return as the most important actor in the relationship between the patient and the healthcare professional. By focusing on the patient's will and willpower Larsson must be considered as a modernist thinker and very much in line with the PCP framework developed nearly a century later. By emphasizing the nature of the patient as a person with will and willpower who should be regarded as a resource in the healing process, Larsson serves as an example of how important language is in endowing a concept with new meaning. Larsson stressed that such an attitude to the patient should apply equally to both the nursing and medical professions. The current PCP framework has developed

[489] Larsson, Bergljot. Do we take account of the will of the patients as a crucial factor in achieving good results by the treatment? [Regner vi med pasientens vilje som viktig faktor for å opnå et godt resultat av behandlingen?] *Sykepleien.* 1933. Årgang 21 no 3.

from nursing and has been adopted mainly by healthcare professionals other than doctors. As we today can see little influence by Larsson’s thinking in current medical education, we may assume that Larsson’s eagerness to address both nurses and doctors equally in terms of the view of the patient concept made little impact on the future development of both professions.

The essence of person-centredness and the PCP framework is to put the individual person at centre stage during his or her encounter with the professional healthcare sector. In this context, a framework that emphasizes the person and not the patient can be viewed as a reaction to developments within the health care sector, which is the same criticism as levelled by Larsson in 1932. This is an interesting notion in itself, and can lead us to conclude that little has happened in the period between 1932 and the 21st century. My understanding is that during the 20th century, in order for a framework such as the PCP to develop, suggests that nurses must have had only limited success in holding on to their holistic construction of, and approach to, the patient.

Developments within the professional healthcare sector have supported a construction of the patient that is increasingly influenced by a biomedical and reductionist, natural science-based paradigm – an approach first and foremost promoted by doctors and supported by their education. A relevant reflection to draw from this is if nurses have positioned themselves within this biomedical paradigm without being able to hold on to their traditional holistic values of care. In a paper published in 2015, which draws on the work of three Nordic caring scientists, Eriksson, Martinsen and Dahlberg, Maria Arman suggests that the work of the aforementioned authors has made a significant contribution to a deeper understanding of care and its potential for the well-being and health of patients.[490] The paper argues clearly that caring science within a Nordic tradition has developed with a strong humanist approach to the patient, and has distanced itself from the purely biomedical paradigm coming from medicine. We can thus

[490] Maria Arman et al., "The Nordic Tradition of Caring Science: The Works of Three Theorists," *Nurs Sci Q* 28, no. 4 (2015).

argue that, through the development of caring science, nurses have made a major contribution to theory related to the care of the patient as a unique individual. At the same time, I sense a critique in this focus of attention relating to a concern in terms of the future development of nursing. In view of this, one can argue that, as their own levels of knowledge broadened, nurses were enabled to act in response to the biomedical focus imposed by medicine and develop a theoretical basis trending in the opposite direction. The PCP framework must also be seen in the same context in response to calls for a renewed focus on a holistic approach to the sick that emphasizes person and personhood.

The PCP framework specifically incorporates the concept of the *person*. In trying to further our understanding of what 'person' means[491], we find that when examining the etymological origin of this concept we find that, in common with the patient concept, it has its roots in the ancient Greek. In philosophy, questions concerning what a person is and what person means have been thoroughly explored using a diverse range of approaches that are still relevant today. We use the Greek *prosopon* and the Latin *persona* in order to understand what a person is in the context of person-centredness. Within this understanding, the concept itself is understood using a theatrical analogy, highlighting a role or character, and exemplified by a mask that fitted to the character in question.[492] The connection between the concepts of person and patient is thus strongly associated with the professional healthcare sector, and this link is well articulated, somewhat naively but also decisively, by my son when he says *"I don't want to be a patient, I am a person."*

The idea of person-centredness draws on ideas, values and ideologies related to holism as expressed by the ancient Greek philosophers and doctors.[493] History suggests that the

[491] Dewing, Eide, and McCormack, 22.

[492] Ibid.

[493] Ibid., 22-23.

Hippocratic doctor would hardly have been able to cure a fraction of the patients that we treat today.[494] The question we must address is how is it possible for us to combine work rooted in the historical ideologies with the medical and health-related knowledge that has developed in since the mid-19th century. For many decades, the ideas of the ancient practitioners constituted a key premise for the relationship between the professional and the sick in that they focused on what mattered to the patient or the sick person. However, if we examine the writings of Larsson and later caring scientists and their repeated emphasis on the need to restore a holistic approach to patients, we see that this approach seems to have been suppressed in the wake of the change in the dominant medical paradigm, not least in nursing.

In retrospect, we recognize in Larsson’s modern approach what she referred to as the will and willpower of the patient, which drew upon ancient philosophy, and which is now also incorporated in the PCP framework. However, the dualist approach towards the body that started with Descartes caused much of this thinking to be left behind. This dualist approach can be summarised as a failure to look beyond the disease and the sick body, and an inability to recognise the benefits of the holistic approach – the interaction between sense and experience, and between the objectively measurable and subjectively experienced.[495] While holism includes consideration of both, reductionism fails fully to regard the person before decisions are taken about treatment and cure of the patient. This is what is emphasized in the concept of person-centredness and the ideas behind the development of the PCP framework. However, in a healthcare and medical context, the replacement of ‘patient’ with ‘person’ as a concept, as the PCP framework does to some extent, creates both challenges and a wide range of opportunities.

In the PCP framework developed by McCormack and McCance, emphasis is placed on seeing the sick person as part of a relational interaction of self, family, network and all

[494] Erlend Hem, "Back to Hippocrates?," *Tidsskrift for den Norske legeforening: tidsskrift for praktisk medicin, ny rekke* 123, no. 24 (2003).

[495] Schiøtz, "Kroppens bilder - de sykes hus," 13-14.

healthcare workers.[496] This approach is regarded as essential to the development of practice and clearly essential in the development of person-centred care, in which important factors include the safeguarding of all persons involved, including the patient, next of kin and the professional healthcare workers. My analysis has focused on how language not only reflects reality but also contributes towards creating and shaping reality. As a continuation of this understanding in the context of the PCP framework, we must examine what such an expanded focus can contribute in terms of replacing the patient with the person as the dominant concept.

This shift of focus from patient to person and personhood, as indicated above, serves to emphasise that all persons involved in the care process have the potential to undermine the role of the patient in his or her encounter with the professional healthcare sector. Such an argument is not intended to overlook the need to safeguard a holistic approach or to undermine the support and sense of being valued that medical staff require in their working environment. However, I do intend to highlight some critical reflections concerning the importance of recognising the pitfalls we may encounter if we move away from the patient as a significant concept in the professional healthcare arena.

In Norway, discussion of this approach has introduced the idea that person-centredness may represent a threat to the universalistic model of care that has been predominant in the Nordic countries, forming the basis of the welfare state.[497] In a paper published in 2019, Norwegian welfare researcher Kristin Briseid discussed these challenges in a macro perspective from a political and organizational standpoint. However, I still consider it relevant to examine the link between Briseid’s study and the argument for keeping patient as a construct, because I have identified a reference to political documents in which the patient as a concept, and not the person, continues to be presented as the

[496] Kim Manley, "An overview of practice development," in *Person-Cenred Practice in Nursing and Health Care. Theory and Practice*, ed. B. McCance McCormack, T (Wiley Blackwell, 2017), 133.

[497] Kristin Briseid, "Personorientering i en norsk velferdsstatskontekst," *Tidsskrift for omsorgsforskning* 5, no. 1 (2019).

pivot of healthcare policy.[498] Norwegian healthcare policy documents refer to the 'patient's' health care service, clearly emphasising which concept it is that forms the centre of policy development. In her paper, Briseid highlights viewing person-centredness as a framework that emphasizes the content of practical healthcare services rather than the type of language that is being used.[499] At the same time, Briseid continues to argue that a PhD Program in Person-Centred Healthcare, currently open to PhD candidates at the University of South Eastern Norway,[500] will make a contribution by giving meaning to the concept of person-centredness, based on the rhetoric contained in the PCP framework.[501]

Whether deliberately or not, Briseid is supporting the argument that I have been making throughout this thesis – that language serves to both reflect society and shape reality. Currently, the patient as a concept is linked to implicit political constructions, as well as those emerging from the healthcare sector. As I have pointed out previously, this makes it difficult to understand the concept in isolation from the historical, social and cultural understandings from which it was derived. However, as previously pointed out, the concepts of both patient and person are linked to the meaning given to different constructions in different contexts. In this regard, the concepts of person and personhood can be interpreted as having different meanings depending on which philosophical basis one relate to. [502] However, in the same way as person and

[498] Ibid., 4-5.

[499] Ibid., 4.

[500] The Faculty of Health and Social Sciences at the University of South Eastern Norway developed a PhD programme in Person-Centred Healthcare in 2014. The programme was developed specifically to highlight and increase research focus on person-centredness on different levels in the health care sector. By now 13 candidates have completed their thesis with various approaches and research aiming to gain knowledge within person-centred health care. https://www.usn.no/english/research/postgraduate-studies-phd/our-phd-programmes/person-centred-health-care/completed-phds/

[501] Briseid, 5, 9-10.

[502] McCormack et al., 23.

personhood have been introduced as replacements for patient as a concept in the professional health care sector, other concepts have also been suggested.

Abandoning patient as a concept?

As pointed to by Erlend Hem in an editorial in the Journal of the Norwegian Medical Association in 2013, concepts such as client, user, customer and consumer all cause difficulties when used in the context of the healthcare sector. They are constructed with meanings associated with settings outside those immediately related to medicine, the health service and the healthcare sector, within their own social, cultural and historical arenas.[503]

When concepts are transferred from the context in which they initially originated and developed, different kinds of challenges emerge. However, they frequently fail to address the problem they were meant to resolve. We may turn to Koselleck for a theoretical understanding of why it is problematic to transfer a concept from one context to another. Koselleck argues that any transfer of concepts involves a translation that involves conceptual history.[504] This must be understood in accordance with the synchronic and diachronic understanding of all history and concepts. The synchronic understanding permits a transition from one context to another, and in doing so adds depth to the concept in question. However, the diachronic understanding that draws on historical and contextual developments tends to make the transition of concepts more problematic, because it becomes difficult to cast aside the original understanding. As part of my historical analysis, I draw on both of Koselleck’s claims, while at the same time being fully aware that the synchronic analysis draws on a context in which a concept occur, while

[503] Erlend Hem, "Pasient, klient, bruker eller kunde?," *Tidsskrift for Den norske legeforening* 133, no. 8 (2013).

[504] Koselleck, *The Practice of Conceptual History. Timing History, Spacing Concepts*, 21.

the diachronic analysis draws on the structure and origin of the concept itself in a historical timeline.[505]

If we use the concept of the patient as an example, we can argue that when replacing ‘patient’ with other concepts, such as ‘customer’ or ‘user’, we are applying a meaning that removes us from the initial values of care and cure that are associated with the context of health. A synchronic analysis of the construction of these concepts for use in the healthcare sector enables the allocation of meaning in conjunction with a specific context, such as the health care sector, while the diachronic approach will emphasize the difficulties of this transition. As argued earlier in this thesis, no concept is free from the values associated with its origin. A consequence of this is that concepts may become problematic and, as I pointed out in the foregoing, this has resulted in attempts by people to replace one concept with another. However, the patient remains a concept that is highly relevant in the medical and health arenas, and the relationship between the patient and healthcare workers is an integral part of this construct. The replacement of patient with other concepts has created challenges in the process of introducing meaning into a context that is far removed from implemented values. If we apply these concepts uncritically, we introduce a new construction of the patient concept that more closely links medicine, nursing and health to economics and the market. This explains why no concept can be studied in relation to our synchronic understanding alone. The diachronic approach will always play an important part in the construct.

In a paper published in 1986, Richardt Rada highlighted some of the weaknesses that can be identified when changing the patient concept into that of a customer or similar. Rada argues that such changes may promote the creation of new images of healthcare workers and of the objectives associated with these images. By introducing an image of doctors and nurses working to please and obey customers, Rada argues that objectives may develop that are less related to the quality of care, and more closely linked to who has

[505] Ibid., 30.

the ability to pay and who gets most value for money spent.[506] Once again, we may refer to Koselleck who argues that conceptual history is closely linked to, and must always be seen as a part of, social and cultural history.[507] Of course, we may also argue that Rada is highlighting developments in America that may to some degree be regarded as far removed from a Norwegian context, in which universalism and the welfare state have deep roots and constitute the foundation of all healthcare practice. However, in Norway too, medicine has started to develop along commercial lines. The NPM has succeeded in taking control of policymaking and has adopted an approach to health that has had a massive effect on the way in which language is used to give meaning to medical and health-related concepts. On the basis of the historical knowledge that I have obtained during my work, I will argue that healthcare workers often appear to adapt to the approaches offered by official policy and educational developments without adequate criticism.

An example taken from history and the analysis in this work is the approach that the professors adopted in the medical schools to achieve the government-supported aim of achieving a healthy population during the 19th century. As part of their own education, nurses sought professional autonomy in the wake of medical advances, and throughout the early 20th century nurtured the idea of secession from the doctors by claiming their right for a three-year education. On the basis of my analysis, I will argue that throughout these developments, none of the healthcare professionals succeeded in adopting linguistic representations that safeguarded the patient. The analysis has revealed an understanding that illustrates how important context and different understandings of reality contribute to the construction of concepts such as the patient. In this respect too, other medical and health-related objectives and tasks could easily be impacted if we lose awareness of the way in which language is used in policymaking and its influence on

[506] Richard T. Rada, "The health care revolution: From patient to client to customer," *Psychosomatics* 27, no. 4 (1986): 276-77.

[507] Koselleck, *The Practice of Conceptual History. Timing History, Spacing Concepts*, 20-22.

professional development and the framing of concepts. If healthcare becomes associated with market forces, with the patient viewed primarily as a customer or a user of services, such linguistic constructions, and others derived from them, may soon modify our understanding of the ways in which we behave towards professional healthcare workers and our understanding of care and cure.

However, if we refer to official documents, we find that ‘patient’ remains a concept commonly used and promoted as part of healthcare policy.[508] What we also find is that the linguistic terms used to conceptualize the patient have moved some considerable distance from their initial meaning of the state of being a sufferer and someone in need of care. This is where Erlend Hem’s argument is crucial. The ideal patient is now constructed as someone who has sufficient knowledge to take an active and engaging part in decision-making regarding own health, and who would prefer to direct focus on other aspects of himself rather than those related to sickness and disease.[509] However, as pointed out in the introduction, the professional healthcare sector has become so complicated, and so driven by expert knowledge, that it is now considered, both by healthcare workers and the patients alike, almost impossible to be contribute to this idealistic constructions of the patient concept without sufficient knowledge in such matters. Moreover, the NPM is a model that most professionals find hard to combine with shared decision-making and involvement of the patient (see page 11-13).

Thus, we may conclude that the importance of looking beyond the concept and examining what contextual factors that has contributed to giving meaning to the concept itself must not be overlooked. The dehumanizing and humanizing factors that contribute to giving meaning to the patient concept must be given greater emphasis if we are to

[508] Det Kongelige helse- og omsorgsdepartementet, "Samhandlingreformen (St.meld.nr. 47)," (Oslo: Departementenes sikkerhets- og serviceorganisasjon, 2009).

"Nasjonal helse- og sykehusplan (Meld.St.11 2016–2019)." 2015

[509] Hem, "Pasient, klient, bruker eller kunde?."

engage in a constructive discussion about how we frame reality related to the patient concept in the future.

7.4 Dehumanizing and humanizing factors in construction of the patient

The reductionist approach to the person and the body removed both the doctor and medical education from the humanist and holistic perspective that had constituted the main approach from ancient times and into the 19th century.[510] However, the force of this change of approach lies not in the actions of the doctors and professors at the University alone, but also in the language that was used to emphasize and underpin their thinking and their understanding of reality. We can thus argue that the doctors and professors put at risk what has often been referred to as the ‘Art of Medicine’.[511] The Art of Medicine is understood here to mean that perspectives derived from the humanities and social science, together with natural science, are taken into account in medicine if we are to adopt a holistic approach to the patient. The renewal of such an approach has been called for since the reductionist paradigm began to get a foothold in medicine. Critics have always claimed that medicine has become too mechanical and has lost its interpretative perspectives.[512]

Historians and sociologists both in the US and the UK have carried out several studies concerning the consequences of moving from a humanist to a science-based approach to medicine.[513] Most of them conclude that when medical education and practice

[510] Porter, *The Cambridge History of Medicine*, 165-75.

[511] Nylenna, ""to kulturer"," 4.

[512] Puschmann and Hare.

Warner, "The Art of Medicine in an Age of Science: Reductionism, Holism, and the Doctor-Patient Relationship in the United States, 1890–1960."

[513] Temkin.

underwent this crucial paradigm shift, the patient-doctor relationship changed radically. The patient was objectified and excluded from the decision-making process in the wake of science-based and technical approaches to the body and disease – a process that was reinforced by a language strongly pervaded by scientific terminology. Although few studies have been carried out into this issue in a Norwegian context, the Norwegian Professor of Literature Petter Aaslestad claimed in 1997, in an interview concerning ‘medical humanities and understanding the human’, which was published in the Journal of the Norwegian Medical Association, that;

“Doctors are no longer the leading intellectual in society. More and more doctors specializes within a small field, which gives them no broad understanding of what it will say to be a human being. That way, the house doctor and the general practitioner in the 18th century was a better doctor for their patients than today’s specialists.”[514]

These are harsh words to inflict on medical specialists in the late 20th century. In my Norway-focused study, this view may also apply in the context of developments in education. By applying the theory of different images and their relation to the tasks and objectives of the doctors, I have attempted to show how the reductionist approach and the evolution of the image of the doctor as a knowledge developer contributed to a

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Warner, "The humanising power of medical history: responses to biomedicine in the 20th century United States."

Pellegrino.

Jewson.

Duffy.

Christopher Lawrence and George Weisz, "Medical Holism: The Context," in *Greater than the parts: holism in biomedicine, 1920-1950*, ed. Christopher Lawrence and George Weisz (Oxford University Press, 1998).

Shorter.

[514] Reportage in the Journal of Norwegian Medical Association, 1997, page 4488-4489. [Medisinere er ikke lenger ledende intellektuelle i samfunnet, ifølge Aaslestad. Flere og flere leger spesialiserer seg innenfor et lite avgrenset område, som ikke gir dem noen vid forståelse av det å være menneske. Sånn sett var huslegen og allmennlegen på 1700-tallet en bedre lege for sine pasienter enn dagens spesialister.]

construct of the patient that met the objectives necessary to complete this image. Key to these objectives in the image of knowledge developer was access to cases of disease that would supply this knowledge – the patients. As have been pointed out in Chapter 5, the view of the patient as a case study that simply served the purpose of advancing knowledge clearly amounted to an objectification, and also determined the language used by doctors when referring to their patients. The parallel image of the doctor as a 'life saviour' was preserved as an extension of this, but the inherent goal to keep the population as a group healthy was pursued at the expense of the individual patient. A problem thus emerges whereby the patient as a concept became associated more with dehumanizing factors than was the case for earlier approaches.

As an extension of this point of view, by which the professors referred to the patient as nothing more than another biological species subject to a variety of examination methodologies,[515] we see the start of an evolution of a dehumanizing approach to person that starts to evolve. We may recognise the emergence of a dehumanizing mindset in the language expressed by the professors in their arguments relating to individual patients. As new objectives increase in importance, others must give way and be put in the background. We can observe this development emerge in the language used by the professors and doctors when they expressed their views on, and relationships to, reality when it came to what they considered to be the important factors influencing their encounters with contemporary societal and medical challenges.

From a nursing perspective, no historical studies have been carried out that address the construction of the patient as part of the development of the profession. If we once again refer to the theory of different images, I have shown that as nurses became educated as professionals, they too had to apply to specific images and objectives that were based on societal expectations, largely in the image of caring supporters. However, as nursing developed and became increasingly specialized, images such as the nurse as a 'life

[515] Negotiations in The Norwegian Medical Society 1886, rendered in the Journal of Norwegian Medical Association 1886, page 300.

saviour'[516] or the nurse as 'knowledge developer'[517] gradually began to challenge that of the image as caring supporter. For a long time, nurses and nursing were closely associated with the dual image embodied in the form of Florence Nightingale. The most prominent of these was the 'Lady with the Lamp', while the other, the 'strong nurse administrator' represented a competing image that both nurses themselves and society in general had trouble in accepting.[518] The Norwegian nursing historian Sigrun Hvalvik has pointed out that during the professionalization of nursing, nurses encountered challenging dilemmas that brought their traditions into conflict with more modern values. Traditional womanly values were considered a threat to professionalization, while modern values were thought to undermine nursing's traditional ideals.[519] We may perhaps see this as an explanation for why it has been easier to accept the image of Florence Nightingale as a caring supporter rather than the strong administrator that conforms more to values that are more modern. Early modern nursing was, as pointed out previously, closely associated with advances in medicine, and linked to the knowledge base deriving from medicine. This development continued right into the 21st century.

What one also find is that as the professionalization of care has progressed, a biomedical construction of the patient has moved into the realm of nursing and nursing education.

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[516] Special educations within nursing, such as intensive care nurse, anesthetic nurse, nurse practitioner and midwife (which all in Norway are two year education after three year nursing education) all pull in the same direction of specialization and something more than a caring supporter. The Journal *"Sykepleien"* has repeatedly papers and discussions concerning this topic.

Steinar Moen, "Skrikende behov for spesialsykepleiere!," *Tidsskriftet sykepleien*, no. 1 (2016).

[517] Society and especially within the Higher Education Sector, have a huge impact in educating nurses with a PhD to do nursing and caring research in order to contribute to knowledge development within nursing as a scientific subject. Nursing theory and nursing philosophy is hence areas that has had a rapid development the last decades both in Norway and Internationally.

Smith.

[518] Kari Martinsen, *Pleie uten omsorg? Norsk sykepleie mellom pasient og profesjon*, ed. Kari Wærness (Oslo: Pax, 1979), 93-99.

[519] Hvalvik, "Nursing in the interwar time – Dilemmas and challenges in the modernization of nursing."

This development has been the subject of both concern and criticism within a Norwegian and Nordic context, especially on the part of Kari Martinsen and other caring theorists, who have contributed alternative proposals as to how to relate to the patient.[520] The same criticisms can also be said to have influenced development of the PCP framework. Originally, this framework was developed in a British and Irish context, but is now becoming universal.[521] The need to return to a holistic approach to the sick person can thus be seen to be achieving global relevance.

The idea that the dominant medical paradigm has exerted too great an influence in the field of nursing education has received support from recent research.[522] The extent of this influence has caused concern because its inherent dehumanization of the patient has now extended beyond the realms of medicine. If healthcare professionals continue to promote a purely biomedical approach in terms of their education, we are in danger of enforcing a medicalization of society. This danger has also been emphasized by Illich, who regards modern medicine as a threat to health and humanity in general.[523] Supporters of this argument continue to call for a renewed focus on humanizing factors, and the need to incorporate these into the healthcare professions to a much greater degree. As I see it, it may be sufficient to argue for more holistic approaches in both language and our approaches to the patient in this respect.

Kari Martinsen has argued that performing the process of caring for a person and the practice of professionalized care is to understand what power is given to you in that

[520] Arman et al.

[521] Brendan McCormack et al., "Person-centredness - the 'state' of the art," *International Practice Development Journal* 5, no. Suppl. (2015).

[522] Petersen Karin Anna and Boge Jeanne, "Omsorg som glasur over ein medisinsk logikk i statlege føringar for norsk sjukepleieutdanning," *Tidsskrift for omsorgsforskning* 6, no. 1 (2020).

[523] Illich, *Limits to Medicine: Medical Nemesis: The Expropriation of Health*.

situation and handle that power in the best interests of the person under your care.[524] I will continue to assert, as an extension of Martinsen’s arguments, that as part of this power to do ‘right’ also lies the responsibility to use language to give relevant meaning to the constructs of the nature of caring and the concept of the patient. This has become clear to me as a result of my investigations into how nurses have not only brought the patient to the fore in textbooks and as a focus of nursing skills as part of their professional struggle, but also in the way in which they have employed the patient as an instrument in their professional development. As pointed out in Chapter 6, the leaders of the NSF were at pains to emphasise that a patient was a person who could only be cared for by professional nurses with specialised training and expertise. In this regard, the language used by nurses can also be seen as a way of providing content to specific concepts such as ‘patient’ and ‘care’. It is a matter for discussion as to whether this development helped to secure an awareness of humanizing factors, but as Larsson pointed out in 1932, it was not the patient that was victorious in the process of nursing professionalization, in the short run.

The professors in medicine and the doctors who taught the nurses also had to promote a construction in line with what the profession valued as the important objectives of highlighting the image of the caring supporter. My findings indicate, as pointed out previously, that the respective education systems of the two professions have had a major influence on their different constructions of the patient concept. Furthermore, these different constructions have continued to play a part in the professions’ respective education systems up until the present day. In my historical analysis, I have drawn attention to the way in which social and cultural history must be regarded as part of conceptual construction in an historical context. Specifically, attempts has been made to emphasize the relationships and traditional understandings of gender and power in the diachronic construction of the patient as a concept.

[524] Kari Martinsen, *Fenomenologi og omsorg: tre dialoger*, ed. Katie Eriksson, 2. utg. ed. (Oslo: Universitetsforl., 2003).

In this process of meaning making, both historical and cultural contexts contribute to construction. Once again, with reference to Foucault and the imbalance in power between patient and doctor that developed as part of the professionalization of medicine. In this process, language contributed towards initiating a specific break in terms of our understanding of how the patient is viewed. Foucault refers to this as the medical or clinical gaze, and links it to the way in which language is used to change the focus from the individual person to the body and its parts. Kari Martinsen draws on Foucault’s ideas concerning the biomedical approach, and argues how this break in understanding created an opportunity to control people by dividing them into ‘the sick’ and ‘the healthy’. This distinction is based on the identification of measurable and statistically significant biological anomalies in a human being that can be evaluated diagnostically with a view to finding a cure. Martinsen claims that it is this that distinguishes natural science-based medicine from humanist, caring-based nursing.[525] The humanizing element lies not in whether we select the person or the patient as a concept, but in the linguistic meaning making that contributes to the construction of the concept we select.

So, what on this basis can I draw from my analysis concerning the humanizing and dehumanizing factors within the professional healthcare sector? I will argue, in agreement with John Harley Warner, that the shift in the medical paradigm towards reductionism and natural science clearly resulted in a dehumanization of the sick person. While Warner argues for this on the basis of his investigations into how doctors related to the new paradigm,[526] my view is based on the evolution of the linguistic construction of the patient as a historical concept. The representation of language in my sources emphasize the same dehumanizing factors in a Norwegian context in health care education as Warner identifies in his American context. Warner also highlights what he

[525] Reference to Martinsen is here based on an article that look into the development of Caring Science in a Nordic tradition. Arman et al., 291.

[526] Warner, "The humanising power of medical history: responses to biomedicine in the 20th century United States."

sees as a counterweight to this development, and draws for support on earlier physicians such as Puschmann, Billings, and Osler, stating that the more widespread teaching of medical history to student doctors may serve to balance out the dehumanizing approach introduced by the biomedical paradigm.[527] The views of doctor John Nessa on the nature of science and the doctor-patient relationship generate some resonance here when he also calls for a renewed focus on the humanities in medical education as a counterweight to the biomedical approach that had been dominating both education and practice;

"My point is that the image of the doctor parallel to the technological development has been given features that re confusingly similar to the slave doctor: a summery treatment of the patient decided by diagnosis without emphasize independently communication with the patient." []

"Science is about 'knowledge' and a far more broad concept than 'evidence'."[528]

Such criticisms can also be said to lie at the heart of the concept of person-centredness, as well as in Martinsen's call for renewal of the caring approach. Both Martinsen and the developers of person-centredness draw specifically on humanist traditions in their respective frameworks, seeing these as important counterweights to contemporary developments in nursing education and practice. However, while medical education has been carried out under the dominance of the biomedical paradigm since the mid-19th century, more recent developments in nursing and the approach to care and caring have been subject to much of the same influence. This in turn has triggered a renewed focus on the role of humanizing factors in the nursing profession.

[527] Ibid., 91-92.

[528] Both quotes are taken from Bondevik and Engebretsen. [Poenget mitt er at legerolla, parallelt med teknologifiseringa har fått trekk som til forveksling liknar slavelegen: ei summarisk behandling av pasienten bestemt av diagnose utan å leggje sjølvstendig vekt på dialogen med pasienten.] [Kunnskap handlar om 'knowledge' og er eit langt vidare omgrep enn 'evidence']

Bondevik and Engebretsen, 461-62.

There are similarities between the way in which Martinsen views the distinction between medicine and nursing and the results of my own analysis of the historical construction of the patient in medical and nursing education. Both professions exploited opportunities introduced by the prevailing modernization processes, in which the patient became ‘lost’ as a person, and the concept of personhood was to some extent left behind within the professional healthcare sector. The counter balance to this may be to pursue the idea of admitting humanist approaches and values into the health care sector by demonstrating how these can add value and contribute to the advance of medical ideas, technological developments, biomedicine and modern nursing. In order for this to happen, I refer once again to Kagan, who argued for the importance of bridging the gap between natural science and the humanities. [529] Some of this can be achieved by introducing the teaching of a social and cultural understanding of conceptual history into future health care education systems.

7.5 Future challenges

“Working with historical sources and the power of handover by traditions can give us the courage to be a bit rebellious – for the sake of patients and next of kin.”[530]

I have not tried to be ‘rebellious’ during my exploration of the historical patient as a concept. Nevertheless, as a historian, I have tried to argue the case for the important roles that historical knowledge and awareness have in our present understanding of various concepts. I have also pointed out what I believe to be some of the challenges we face when analysing historical linguistic representations that are linked to our understandings of reality and the various contexts in which reality is shaped. I have also argued for the value of a diachronic analysis of the patient as a concept in informing our current understanding. The essential new finding from my work is the link that I have

[529] Kagan, 40-42.

[530] Kari Martinsen, "Fra diakonisse til robot," *Klinisk Sygepleje*, no. 1 (2017): 32. [Arbeidet med historiske kilder og tradisjonens overleveringskraft kan være med på å gi oss mot til å være litt opprørske – for pasientenes og de pårørendes skyld.]

established between the different epistemological realities that emerge when we focus on the patient in an educational context.

Based on a diversity of epistemological understandings, the emergence of a number of different frameworks has created some divergence in the meaning-making of the patient concept as a result of their use of language. The EBM framework was introduced to medicine in 1991, although the theories behind the concept can be traced much further back in history.[531] The thinking behind the EBM framework involved an intention to offer patients the best available treatment based on existing scientific research and advances in clinical practice.[532] While we may agree that its foundations were good, there was soon a recognition of a development of a hierarchy in terms of the relative values of knowledge and evidence that emerged as part of this framework. This hierarchy established Randomized Controlled Trial (RCT) studies as the EBM's gold standard, while at the same time relegating any exploration of patients' own experiences and values to the bottom.[533] This hierarchical approach to existing knowledge about patients and their treatment saw the emergence of a new view of the human body as a mechanical entity. Within this epistemological approach to knowledge, it was the reductionist view of the body, focusing on causal relations, that determined the nature of the patient construct and how doctors and researchers related to the sick in the context of advancing medicine, treatment and knowledge. Linguistic representations emphasizing this approach show clear signs of dehumanization and objectification in relation to the nature of the patient.

Opposite to this other frameworks has developed, such as the PCP framework, which I have discussed thoroughly in relation to the patient as a concept throughout this thesis. However, caring science,[534] which has adopted an approach by which patients and their

[531] Bondevik and Engebretsen, 441.

[532] Ibid., 441-42.

[533] Ibid., 446.

[534] Arman et al.

experiences are placed at the heart of research and clinical approaches, has developed considerably as an autonomous discipline during recent decades. One of the challenges related to this approach is that within the current medical paradigm, research and frameworks that adopt an epistemological standpoint that takes the patient's views and experiences into consideration, consistently fail to meet the gold standard, and are thus frequently overlooked when it comes to treatment.

Moreover, the EBM framework has succeeded in being implemented in the training of healthcare professionals outside the limited field of medicine by making use of the principles of Evidence Based Practice or Evidence Based Policy.[535] Nursing and nursing education is an example of a professional discipline that is eager to adopt this framework. However, this leaves nursing education in the same dilemma as it faced at the turn of the 20th century, trying to achieve a balance between traditional, holistic nursing values, while at the same accepting modern medical and health-related advances that lean heavily on EBM approaches.

For Bergljot Larsson, it was vital that the idea of care was not cast aside. Her argument was to professionalize it and make it relevant to modern society. Her arguments were grounded in womanly traditions but were also innovative in the sense that she adopted a strategic view of how nursing could be relevant as part of contemporary modernization processes that influenced medicine, while at the same time challenge traditional gender and social issues. In order to succeed, it was crucial to separate nurses from the unskilled orderlies, as was emphasized throughout the discussions concerning the Samaritan courses and the nurses' struggle for a three-year education (see page 176-179). There is thus nothing novel about nurses today discussing the status of the concept of care in their education. From a historical perspective, I wish to argue that nursing today faces many of the same dilemmas that it encountered during the early modernization processes. But now the context has changed. Nursing can still be regarded as a profession caught in a

[535] This understanding of evidence based practice is based on the review of the concept Evidence Based Medicine in Bondevik and Engebretsen (2017) Bondevik and Engebretsen, 446.

dilemma created by the existence of two different paradigms –scientific medicine on the one hand, and traditional nursing values supported by caring science on the other. To some extent, this dilemma can be seen as having been made more complex by the introduction of the NPM and EBM, not least because the EBM has opened the door to evidence-based practice.[536] Another view on the current dilemma in nursing education is that while society at large has developed rapidly since the Second World War, nursing education in Norway has changed minimal on an organisational level. For the most part, it consists of the same subjects and the same amount of practical training as was the case when the three-year training system was established in 1948.[537] However, policy documents that determine the overall focus of nurses' training, and the textbooks used by students, have evolved line with scientific advances in medicine and caring science, causing discussions the last three to four decades concerning what nursing is.[538] These discussions may as I see it contribute to emphasizing the gap between the scientific and holistic approach in nursing education, making it still hard for nurses to embrace both traditions equally.

In a recent study involving a systematic analysis of the Professional Policy Documents and State Guidelines for Nursing Education in Norway for the period 1921 to 2019, researchers discovered that natural science-based material made up the majority of subject content in the period 1950 to 1967, and once again between 2000 and 2019.[539] This development has caused much concern among caring science researchers such as Martinsen, Katie Eriksson[540], Inger Ekman[541] and others. I believe that it should also be a

[536] Ibid.

[537] Moseng, *Framvekst og profesjonalisering*, 227-28.

[538] Åshild Fause and Anne Micaelsen, *Et fag i kamp for livet* (Bergen: Fagbokforlaget, 2001), 305-12.

[539] Karin Anna and Jeanne.

[540] Arman et al.

[541] Inger Ekman, *Personcentrering inom hälso- och sjukvård: från filosofi till praktik* (Stockholm: Liber, 2014), 35-42.

cause for concern in the field of medicine as a whole, because such trends have the potential to impact greatly on the status and construction of the patient, and will only serve to reinforce the dehumanization of the patient within the healthcare sector. If a medical paradigm based on natural science and the reductionist approach continue to determine the premises for all healthcare research and professional development in the future, I believe that we are in danger of simply continuing to reduce the sick person to a mechanistic biological entity. I also believe that we are in danger of regressing to a time when all healthcare professionals are viewed as assistants to doctors. Another highly visible development is that sick people are now able to seek treatment and care outside the professional healthcare arena, in what Kleinman refers to as the 'folk' sector, and which Alver has adopted into a Norwegian context, showing how people again relate to several of the health care sectors in their approach to healing.[542] We may say that we are currently observing a new divergence of the sectors, within which a dogmatic approach has so far played the leading role on both sides, as they did in the 18th, 19th and early 20th centuries.[543]

Tomorrow's healthcare sector is facing a much greater complexity in terms of health-related issues than it has ever experienced before, and the pitfalls are many. The adequate education of genuine and autonomous healthcare professionals is crucial if society is to address its future health-related challenges. It appears that medicalization, EBM and natural science-based knowledge continue to exert a firm hold on policymaking and the healthcare sector as a whole. However, as has been pointed out by several researchers in the healthcare arena such as Illich, Foucault, Martinsen, McCormack & McCance and others, the implementation of a single paradigm will most probably only generate more problems than it solves.

[542] Alver, 211-28.

[543] Schiøtz, *Folkets helse - landets styrke 1850 - 2003*, 2, 148-49.

The concept of the patient, and the state of being in the role of patient, are still viewed as crucial in the encounter between the sick person and the professional healthcare sector. Moreover, education as an arena for the preservation of the constructs of key concepts has emerged as more significant than was initially envisaged. The power inherent in the education of healthcare professionals has been revealed as essential for understanding of the means by which the concept of the patient is constructed. The analysis done as part of this research has shown the importance of including focus on language also in education. All health care educations need to focus on the language it uses in relation to the humanizing and dehumanizing approaches we adopt in relation to the patient.

To me it has been important throughout this thesis to promote a historical awareness of how concepts have been constructed and modified over time, and in different contexts, and how this should serve as a reminder of the power that lies within the professional healthcare sector to contribute to such constructions. One of the huge challenges that I see facing the future is how we promote more interdisciplinary health-related research while at the same time attempt to overcome the ontological and epistemological differences that constitute the current dichotomy between medicine and caring. We must recognise, as highlighted by Abbot, that all healthcare professionals are part of a system in constant development, and are mutually dependent on each other. As nurse Charlotte Munck pointed out as early as in 1928:

“There is no doubt that this development has been of infinitely great value for the science in medicine, which without the interest of nurses and scholarly help would have had extraordinary difficulties of having their progress and wonderful discoveries and clear theories transferred to the practical life in the clinics on such a universal measure, which is now the case.”[544]

[544] Munck, Charlotte. *Sykepleien.*1928. no 8, 88. [Der er ingen tvil om at hele denne utvikling har vært av uendelig stor værdi for den medicinske videnskap, som uten sykepleierskenes interesserte, forstaaende og

7.6 Summary and concluding remarks

My historical analysis of the presentation of the patient concept through written representations within the context of both medical and nursing education has revealed the power that lies in the specific use of language to create meaning to a concept that extends beyond its linguistic meaning when put into context. The exploration of the historical sources linked to education as part of the professionalization processes has led to insight into the extent of the impact that social and cultural norms, combined with values and virtues, have had on the complexity of our historical understanding of the human relationships involved.

The construction of the patient concept within the nursing and medical professions was built on different knowledge bases and understandings of reality within the context of the constantly evolving modernization processes. This resulted in an understanding of the historical patient that is strongly linked to disease and societies changing responses to this as knowledge advanced and education developed. I have discussed how the various constructs that emerged over time have been permitted to continue, and explored why a given construct can be said to have exerted greater dominance than others. Developments in society during the 19th and 20th centuries have contributed to the dehumanizing effects that were introduced with reductionism, and subsequently reinforced by the NPM and EBM frameworks. As a counterweight to this development, the work of a number of caring scientists with the aim of highlighting how humanizing factors can be taken into account by introducing the humanities and historical awareness to the education systems for all healthcare professionals have been brought forward in the discussions in this chapter.

Historical events and historical knowledge must be understood on their own terms. At the same time, historical knowledge can also contribute towards raising an awareness of,

skolerede hjælp vilde ha hat en overordentlig vanskelighet ved at faa sine fremskridt, vidunderlige opdagelser og klare teorier overført i det praktiske liv i en saa universel maalestok, som tilfælde nu er.]

and resolving, present and future challenges. When it comes to the patient as a concept, the knowledge we obtain from history can contribute towards placing a greater emphasis on a more humanizing approach, and promoting a renewed and holistic focus on the construct of the patient. By means of an historical analysis of how language has been used to shape reality, we may learn that dehumanizing factors have the potential to promote an objectification of the individual, which today cannot be regarded as sustainable. The development of a language that combines biology with social and cultural elements, and which promotes a holistic approach in all health-related fields, will help us to reflect on how most people view themselves in the role of being a patient. This in turn will help to clarify the relationship between the sick individual and healthcare professionals. I believe that this calls for a renewed focus on the concept of person-centredness in education policy documents, healthcare research frameworks and textbooks in all disciplines. Person-centredness, in combination with other frameworks and academic subjects that focus on a holistic approach, can help us both to reflect on, and shape, the reality of the patient as a concept. As I have attempted to assert throughout this thesis, historical knowledge and research into the history of medicine and health can contribute towards generating greater awareness.

Placing the knowledge gained through this work with the relation to the initial aim and research questions developed to frame the analysis, I will argue that the representation of the patient concept in the historical sources reveal differences in relating to reality. The language used to express these differences in the construction of the patient concept vary in line with the epistemological understanding and the contextual reality in which it was framed. The knowledge gained from the historical analysis have been discussed in a contemporary exploration of the usage of such knowledge for health care educations today and the future. I have argued that different concepts have been introduced as a solution to replace the patient within the health care sector and the challenges of such an approach based on the meaning making that occur in different context and in different understandings of reality. Finally I have argued for the importance of focusing on the way language contribute to a construct of the patient concept that can contribute to both humanizing or dehumanizing aspects to flourish through the professional education

systems in both nursing end medicine. This has again been linked to the difference in power that has contributed to various constructions in the historical patient concept.

8 Epilogue

“Don’t stop asking the hard questions. That’s how the world changes.”[545]

Through this work, my family has been undoubtedly present in our everyday life. Some of the dialogues I have had with my children have guided me in my writing, but more so in the understanding of my work. Their open minded and unveiled approach to life and to my work have not only been fruitful but sometime served as a revelation to myself, and the understanding of the sources and the context in which the analysis has been conducted. Their questions have sometimes been endless, and my responses have many times been both uncommitted and less thoughtful than they had deserved. Most of their questions and comments have however stayed with me long after they were asked, and have helped me in seeing things from a different perspective than my own. It is when we stop asking and stop listening to questions we are in danger of missing something important.

For many years, it has been acknowledged that the aging population with long lasting and complex health challenges will require new technology in addition to increased and specific knowledge of highly skilled professionals.[546] In addition, a new threat came during 2020, the pandemic COVID-19. Epidemic viruses with no vaccines or cure is no longer a science fiction watched as a movie or read about in books. It is a lived experience for all of us, calling for renewed thinking concerning global health and health threats. This threat has been experienced and caused interventions in the life of all living persons, regardless of whether you have caught the disease or not. The COVID-19 pandemic has led to discussions concerning what needs to be the primary focus of attention regarding

[545] Geillis Duncan. Outlander. Novel by Diana Gabaldon (1991) and TV-series (2014).

[546] Det Kongelige helse- og omsorgsdepartementet, "Nasjonal helse- og sykehusplan (Meld.St.11 2016–2019)," 19-27.

"Nasjonal helse- og sykehusplan 2020 - 2023 (Meld.St.7 2020-2023)," (Departementenes sikkerhets- og serviceorganisasjon, 2019), 14-17.

health, diseases, developments of vaccines and priority of resources in health care service, research and education.

Restrictions have been many, isolation and quarantine as measures for both sick and healthy have been based primarily on biomedical approaches and research. The lack of anti-viral vaccines has led to doctors and health care politicians to use measures that are not new; they have been used before in meeting with earlier pandemics and was the first measures taken in order to secure a healthy population from a sick person. Before the huge breakthrough in medicine and medical knowledge, quarantine and hygienic measures were all doctors could offer in their meeting with earlier epidemics, firstly used in relation to cholera outburst during the 18th century.[547] Despite all the knowledge that has developed since the age of Cholera in the late 18th century, biomedicine has no efficient cure in the meeting with new and unknown viruses that cause pandemics. That should be an eye-opener to us all. We still use historical measures, proven efficient, in meeting with the greatest global health threat in over 100 years. In spite of this, research that constitute knowledge of these measures on both short and long-term effects for people and society outside the health care arena, is to small extent included in pandemic risk assessments.

What history teach us is that the significance and effects of the different measures taken stretches far beyond bio-medicine, epidemiology and a reductionist approach to the person. History and historical demographic studies from earlier pandemics, such as the Spanish flu, tuberculosis, cholera and others reveal that a bio-medical solution falls short when new pandemics is to be fought and especially in seeing the long term effects of measures inflicted on the population. We need to include social, cultural, economic and demographic structures in order to understand the entire picture in this regard. During the COVID-19 it have occurred to me that we also face a new construction of both disease and patients, both on group and an individual level. When every person is reduced to a

[547] Leiv Torstveit and Per Vesterhus, "Kolera og karantene i Kristiansand," *Tidsskrift for Den norske legeforening* 125, no. 24 (2005).

carrier of a potential deathly disease, as could easily have been an interpretation based on media coverage and official health care officials in these matter, it affect our way of relating and interacting with each other. *Social distancing* has developed as a concept during 2020, the long term effect of and linguistic perception of this concept need to get attention in future research, also in relation to understanding concepts such as patient and the sick person. To draw on history in these regards can turn out to be helpful.

The understanding of how language shape and constitute reality through concepts and the development of these, have relevance that stretches beyond the health care sector. At the same time, health, medicine and nursing have been the context of my work. As my knowledge have increased and developed, the notion of how important interdisciplinary approaches are in order to succeed with future challenges within health has expanded and rooted in my consciousness. This is especially relevant when it comes to understanding whom and with what ontological and epistemological base dominates the understanding of reality and truth within health, and the power that rests in these matters. At the same time, the challenges of interdisciplinary work has also been rooted as part of personal experiences through this work.

From my perspective and with my knowledge base I have tried to frame this by exploring the construction of patient as a concept historically and contextually linked to education and the development of the two most influential professions in the professional health care sector, doctors in power and nurses in numbers. Further, discussions of recent developments and challenges of today and the future has been explored with the base of how historical knowledge influence and have impact on how we understand concepts today, exemplified with the use of patient. I have also brought to the attention what can be the consequences of leaving concepts related to one specific sector to the benefit of other concepts linked to other arenas and with different historical developments.

All concepts develop. That means to take into account and include both social, cultural and historical perspectives as well as biological and technological, in order to be understood and have legitimacy in the population as well as within the health care sector. Despite this, humanist perspectives within most areas have the last decades constantly

been charged with proving their relevance in society.[548] Experiencing how concepts such as health and patient in the meeting with COVID-19 jump to natural science based explaining and measurements in order to secure the population have convinced me more than ever how important humanist and social science perspectives are.

In order to safeguard a global population, we need to go beyond what can be explained and treated biologically. We must increasingly value perspectives that are based on a more holistic approach and understanding to patients, health care workers, society and reality. We need to go beyond medicine and medicalization to grasp the challenges we face globally. Reality needs to be explored through a broader understanding of truth. We must continuously ask the difficult questions that push us outside the comfort-zone. Reality can partially be understood and grasped by the way we construct phenomenon and concepts through language. This also give us the possibility to change the path of the future by focusing on what language that constitute humanizing and holistic perspectives of all concepts, both within and outside the health care arena.

As my PhD journey now comes to an end, I can easily join the words coming from the wisdom paradox; *the more you learn, the more you are exposed to what you do not know.*

[548] Det Kongelige kunnskapsdepartement, "Humaniora i Norge (St.meld.nr 25)," (Oslo: Departementets sikkerhets- og serviceorganisasjon, 2017).

Torbjørn Røe Isaksen, "Hva vil vi med humaniora?," *Nytt Norsk Tidsskrift* 34, no. 1 (2017).

Anne Kveim Lie, "Do we need History?," *Tidsskrift den Norske Legeforening [Journal of the Norwegian Medicine Association]* 24 (2011).

When you have gone just so far that you are not able to take one more step,

then you have gone exactly halfway through what you are capable of.

-Saying from Greenland-

[Når du har gått akkurat så langt at du ikke orker å gå et skritt til,

da har du gått akkurat halvveis av hva du klarer.]

-ordtak fra Grønland-

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Protocols from negotitations at the School of Medicine. [Forhandlingsprotokoll for Medisinsk fakultet 1870-1912]: RA/S2536/Aa/L0004-L0007

Negotiations at the Norwegian Medical Society 1902-1904. [Forhandlinger, det Norske Medicinske Selskab 1902-1904]: RA/PA1301/D/Dd/L0004/0006

The Nursing Education – The National Archive

The Norwegian Nursing Association has delivered the part of their archive that includes documents and protocols from governing bodies. [NSF har i første rekke avlevert de delene av sitt arkiv som omfatter dokumenter og protokoller fra styrende organer].

Protocols from governing bodies 1915-1933. [Protokoller fra styrende organer i NSF i perioden 1915-1933]: RA/PA1270/Aa/Aba/Abb/Aca/Acb

The Norwegian Nursing Association’s contact with State and governing authorities. [NSF sin kontakt med Stat og myndigheter]: RA/PA1270/L005

The Norwegian Nursing Association and their Cooperation with Nordic and International nursing associations regarding educational issues. [NSF sitt nordiske og internasjonale samarbeid, som blant annet inneholder dokumentasjon knyttet til NSF sitt arbeid med internasjonal utdanningskomité]: RA/PA1270/L001/L002/L004

9.1.3 Online sources

Overview of Norwegian doctors from 1800-1908:

https://www.nb.no/items/URN:NBN:no-nb_digibok_2006112900003?page=3 Volume 1

https://www.nb.no/items/URN:NBN:no-nb_digibok_2006120701081?page=3 Volume 2

https://www.nb.no/items/URN:NBN:no-nb_digibok_2007011101032?page=3 Addition

Overview of Norwegian doctors from 1909-1925:

https://www.nb.no/items/URN:NBN:no-nb_digibok_2006120801064?page=3

Sources concerning governmental work on the Norwegian Health Care Act

https://www.stortinget.no/no/Saker-og-publikasjoner/Stortingsforhandlinger/Saksside/?pid=1814-1870&mtid=39&vt=a&did=DIVL90790

Sources concerning governmental work on the Act of Leprosy https://www.stortinget.no/no/Saker-og-publikasjoner/Stortingsforhandlinger/Saksside/?pid=1871-1891&mtid=34&vt=a&did=DIVL97582

Sources concerning governmental work on the Act of Venereal diseases https://www.stortinget.no/no/Saker-og-publikasjoner/Stortingsforhandlinger/Saksside/?pid=1892-1900&mtid=55&vt=a&did=DIVL66282

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Sources concerning governmental work on the Act of Tuberculosis

https://www.stortinget.no/no/Saker-og-publikasjoner/Stortingsforhandlinger/Saksside/?pid=1892-1900&mtid=55&vt=a&did=DIVL65262

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History: https://snl.no/historie (date of confirmation of website 20.11.20)

Patient: https://sml.snl.no/pasient (date of confirmation of website 20.11.20)

Current Norwegian Health Care Act:

The Act of Patients and User Rights: https://lovdata.no/dokument/NL/lov/1999-07-02-63 (date of confirmation of website 20.11.20)

9.1.4 Literature and movies

Poems:

Donne, John. *Mediation XVIII, Devotions upon Emergent Occasions.* 1624

Novels:

Cattaneo, Caterina. *Jeg sluttet å telle dager* [I stopped counting days]. 2014

Gibran, Khalil. *Profeten* [The Prophet]. 1923

Heivoll, Gaute. *Kongens hjerte* [The King’s heart]. 2011

Hislop, Victoria. *Øya* [The Island]. 2005

Movies and TV-series:

The Madness of King George. Movie. 1994. https://www.imdb.com/title/tt0110428/

Gabaldon, Diana. *The Outlander.* Novel (1991) and TV-series (2014).