

The Business of Ethics: Gender, Medicine, and the Professional Codification of the American Physiotherapy Association, 1918–1935

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ABSTRACT. The history of codes of ethics in health care has almost exclusively been told as a story of how medical doctors developed their own professional principles of conduct. Yet telling the history of medical ethics solely from the physicians' perspective neglects not only the numerous allied health care workers who developed their own codes of ethics in tandem with the medical profession, but also the role that gender played in the writing of such professional creeds. By focusing on the predominantly female organization of the American Physiotherapy Association (APA) and its 1935 "Code of Ethics and Discipline," I demonstrate how these women used their creed to at once curry favor from and challenge the authority of the medical profession. Through their Code, APA therapists engaged in a dynamic dialogue with the male physicians of the American Medical Association (AMA) in the name of professional survival. I conclude that, contrary to historians and philosophers who contend that professional women have historically operated under a gender-specific ethic of care, the physiotherapists avoided rhetoric construed as feminine and instead created a "business-like" creed in which they spoke solely about their relationship with physicians and remained silent on the matter of patient care. **KEYWORDS:** code of ethics, medicine, gender, ethics of care, physiotherapy, allied health professions, professionalization, American Medical Association, AMA Council on Physical Therapy, World War I.

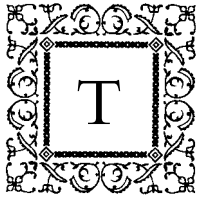
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THE history of codes of ethics in health care in the United States has almost exclusively been told as a story of how medical doctors, and more specifically physicians of the American Medical Association (AMA), developed their own professional principles of conduct. Bioethicists and historians alike have written about the monumental 1847 AMA Code of Ethics—the “world’s first national code of professional ethics”—the 1880 uprisings against that code, and the resolution put forth in the AMA’s 1912 Principles of Medical Ethics.¹ To many scholars, this is the history of medical ethics in America—a narrative of how doctors codified their relationships with patients and other physicians to maintain a certain standard of moral decency and honesty. Yet telling medical ethics history solely from the physicians’ perspective neglects the numerous allied health care workers who developed their own codes of ethics alongside those of the medical profession.

In 1935, the American Physiotherapy Association (APA), a predominantly female organization, passed a Code of Ethics and Discipline at its national convention in Atlantic City, New Jersey (see appendix 1).² At the time of its formation in 1920, the APA was a very young group. The profession had its beginnings during World War I, when the U.S. Army Surgeon General’s office recruited

1. For the “world’s first national code,” see Robert B. Baker, “Introduction,” in *The American Medical Ethics Revolution: How the AMA’s Code of Ethics Has Transformed Physicians’ Relationships to Patients, Professionals, and Society*, ed. Robert Baker (Baltimore, Md.: Johns Hopkins University Press, 1999), pp. xiii–xxxix. For a sampling of historical treatments of the AMA and its codes of ethics, see Robert B. Baker, “The American Medical Ethics Revolution,” in Baker, *American Medical Ethics Revolution*, pp. 17–51; Chester R. Burns, “Setting the Stage: Moral Philosophy, Benjamin Rush, and Medical Ethics in the United States before 1846,” in Baker, *American Medical Ethics Revolution*, pp. 3–16; Susan Lederer, “Medical Ethics and the Media: Oaths, Codes, and Popular Culture,” in Baker, *American Medical Ethics Revolution*, pp. 91–103; as well as John Harley Warner, “The 1880s Rebellion against the AMA Code of Ethics: ‘Scientific Democracy’ and the Dissolution of Orthodoxy,” in Baker, *American Medical Ethics Revolution*, pp. 52–69. See also Robert Veatch, “Medical Codes and Oaths: History,” in *Encyclopedia of Bioethics*, 2nd ed. (New York: Simon and Schuster, 1995), pp. 1419–35; as well as Albert Jonsen, *The Birth of Bioethics* (New York: Oxford University Press, 1998); and Albert Jonsen, *A Short History of Medical Ethics* (New York: Oxford University Press, 2000). For a sociological perspective on the history of the AMA’s codes of ethics, see Jeffrey L. Berlant, *Profession and Monopoly: A Study of Medicine in the United States and Great Britain* (Berkeley: University of California Press, 1975).

2. Physical therapist–ethicist Ruth Purtilo provides a brief historical synopsis of the APA’s 1935 Code of Ethics in “The American Physical Therapy Association’s Code of Ethics: Its Historical Foundations,” *Physical Therapy*, 1977, 57, 1001–6. Women made up over 90 percent of the APA since its inception in 1920. For exact membership numbers, see member rosters published yearly in the *P. T. Review* and *Physiotherapy Review*.

hundreds of women to physically rehabilitate maimed soldiers, manually remolding disabled male bodies through massage and exercise to return the men to theaters of war and to the industrial workplace.³ Immediately following the war, these rehabilitation aides formed a national association and began calling themselves physiotherapists.⁴ Fifteen years later, many of these same women came to Atlantic City to put their profession on firmer ground by constructing ethical mandates that would guide their work.

The content of the APA code of ethics as well as its context are striking. Besides the AMA, few other health care professional groups had formal codes of ethics by the 1930s.⁵ The American nursing profession, despite the Nightingale Oath, did not have an official code of ethics governing its national association until 1950.⁶ Likewise, other allied health professions with a similar history and gender composition as physical therapy—such as occupational therapy and dietetics—did not adopt professional codes of ethics until the second half of the twentieth century.⁷ Physiotherapists were thus among the first women health care workers to pioneer the territory of professional ethics.

3. See Wendy Murphy's commemorative book about the history of the American Physical Therapy Association, *Healing the Generations: A History of Physical Therapy and the American Physical Therapy Association* (Alexandria, Va.: American Physical Therapy Association, 1995).

4. Today physiotherapists call themselves "physical therapists," and in 1946 the APA became the American Physical Therapy Association. This transition in name and association title is a complex story that is most comprehensively discussed in Glenn Gritzer and Arnold Arluke, *The Making of Rehabilitation: A Political Economy of Medical Specialization, 1890-1980* (Berkeley: University of California Press, 1985), esp. appendixes, pp. 172-76.

5. Some obvious exceptions include dentists, pharmacists, and osteopaths. For more about these fields and their codes of ethics, see Chester Burns, "The Evolution of Professional Ethics in American Dentistry," *Bull. Hist. Dentistry*, 1974, 22, 59-70; Robert A. Buerki, "The Historical Development of an Ethic for American Pharmacy," *Pharm. Hist.*, 1997, 39, 54-72; and Norman Gevitz, *The DO's: Osteopathic Medicine in America* (Baltimore, Md.: Johns Hopkins University Press, 1982).

6. For a history of nursing ethics and the ANA code of ethics, see Marlene Cianci, "The Code of Ethics and the Role of Nurses: An Historical Perspective," *Nursing Connections*, 1992, 5, 37-42; Marsha D. Fowler, "The Evolution of the ANA Code of Ethics," *Imprint*, 2000, 47, 53-54; and Marjorie J. Stenberg, "The Search for a Conceptual Framework as a Philosophical Basis for Nursing Ethics: An Examination of Code, Contract, Context, and Covenant," *Mil. Med.*, 1979, 144, 9-22.

7. The Principles of Occupational Therapy Ethics were adopted in April 1977 and revised in April 1980. For the 1980 revision, see *Am. J. Occ. Ther.*, 1980, 34, 896-99. The American Dietetic Association, formed in 1917, did not adopt its first code of ethics until 1952. See Emma Seifrit Weigley, "Professionalization and the Dietitian," *J. Am. Dietetic Assoc.*, 1979, 74, 317-20. Also, the American Association for Social Workers did not have a formal code of ethics until 1947. See *Encyclopedia of Social Work*, 19th ed., s.v. "ethics and values."

A common assumption made about codes of ethics (of the past or present) is that they are tools of moral guidance, based on unchanging virtues of honesty, sacrifice, and selflessness. But when placed in their appropriate context, codes of ethics are dynamic documents that provide a unique window into the workings of interprofessional conflicts and negotiations. For the historian, codes of ethics are, above all, statements of distinct fears, concerns, and desires of a professional group of people in a specific time and place. Although some exciting work along these lines has been conducted by medical historians about codes of ethics prior to 1915, very little attention has been paid to the ethics boom that took place after World War I, when hundreds of American professional groups (both related to and outside of the medical profession) hurried to outline and secure their own collective principles of professional conduct.⁸

The post-World War I writing of codes of ethics is also important because it was a time when a wide array of female health care professionals first began to codify their work, much like their male counterparts. Although historians and sociologists have long studied the role that gender played in the process of medical professionalization, the same mode of analysis has not been applied to the historical interpretation of codes of ethics from the past.⁹ What, for instance, are we to make of professional women in the twentieth century who, for the first time in history, engaged in what was then a male-dominated practice of code making? More specifically, when so few professional

8. A notable exception here is Susan Lederer's work on the ethics of human research as well as popular usages of the Hippocratic Oath in the early twentieth century. See Susan Lederer, *Subjected to Science: Human Experimentation in America before the Second World War* (Baltimore, Md.: Johns Hopkins University Press, 1997); and Lederer, "Medical Ethics and the Media."

9. The most explicit discussion of the role that gender has played in the formation of the health care professions can be found in the histories written about women physicians and nurses. See Susan Reverby, *Ordered to Care: The Dilemma of American Nursing, 1850-1945* (Cambridge: Cambridge University Press, 1987); Joan I. Roberts and Thetis M. Group, *Feminism and Nursing: An Historical Perspective of Power, Status, and Political Activism in the Nursing Profession* (Westport, Conn.: Praeger, 1995); Barbara Melosh, "The Physician's Hand:" *Work, Culture, and Conflict in American Nursing* (Philadelphia: Temple University Press, 1982); Regina Morantz-Sanchez, *Sympathy and Science: Women Physicians in American Medicine* (Oxford: Oxford University Press, 1985); and Ellen S. More, *Restoring the Balance: Women Physicians and the Profession of Medicine, 1850-1995* (Cambridge, Mass.: Harvard University Press, 1999). For a more general historical overview of women and professionalization, see Anne Firor Scott, *Natural Allies: Women's Associations in American History* (Urbana: University of Illinois Press, 1991). For a sociological perspective on the medical profession and its exclusion of women, see Anne Witz, *Professions and Patriarchy* (London: Routledge, 1992).

groups had a code of ethics, why did physiotherapists feel the need to develop one in 1935? What did ethics mean to this fledgling group of professional women trying to make it in the medical world?

Several factors made the profession of physiotherapy in the 1920s and 1930s a unique occupation in terms of both gender and healing practice. Whereas other female healers, such as nurses and occupational therapists, primarily treated patients at the bedside, physiotherapists worked in gyms, at times leading group exercises and at other times hovering over patients on plinths (treatment tables), arduously stretching injured backs and limbs. When creating their identity as an ancillary medical profession, APA therapists resisted the Victorian image of women as caregivers, healers by nature.¹⁰ Unlike nurses and occupational therapists who held on to their Victorian roots well into the twentieth century, physiotherapists believed that their work required a unique combination of brains and brawn, thereby challenging the nineteenth-century view that women were the weaker yet more nurturing sex.¹¹

Looking at the APA's 1935 Code of Ethics against the backdrop of the larger medical arena and economic downturn that the United States experienced during the Great Depression, it becomes clear that the APA therapists codified their profession to secure their place in the medical marketplace. But the 1935 Code of Ethics reveals more than this. Behind the scenes, leading physiotherapists struggled with the rhetoric, content, and style of their professional creed. When wording their code, they invoked the vocabulary of medical professionalism as it was understood and used by the AMA; they also took great care to avoid any images of Victorian womanhood, which prized a woman's ability for caring and sympathy.

Indeed, although virtually every other health care-related professional code up to the 1930s included some sort of statement about the importance of honesty and concern for the patient's well-being, the physiotherapists made no mention of the therapist-patient relationship and instead composed a code that spoke almost exclusively to the physiotherapist-physician relationship. As this article will

10. For a useful definition of "ancillary professions," see Walter I. Wardwell, *Chiropractic: A History and Evolution of a New Profession* (St. Louis: Mosby Year Book, 1992).

11. The argument that physiotherapists created a post-Victorian identity comes from Beth Linker, "Strength and Science: Gender, Physiotherapy, and Medicine in the United States, 1918-1935," *J. Women's Hist.*, forthcoming.

demonstrate, this silence amid a continuous discourse on patient care spoke a thousand words.

PROFESSIONAL BEGINNINGS: THE MILITARY ETHIC

Most of the women who signed up to become physiotherapy reconstruction aides to rehabilitate the county's injured soldiers during World War I had little previous experience working in the medical field. Over 90 percent of the women came from schools of physical education, where they were groomed to become gym teachers at all-women's schools.¹² When the U.S. Medical Department began to actively recruit these physical educators to become physiotherapy "reconstruction aides," over 800 women jumped at the chance to become women war workers. The wartime effort to "reconstruct" maimed soldiers provided these women with a unique chance to move from an exclusively female sphere of educating other women and children to a medical arena where they largely interacted with men as both their superiors and patients.¹³

Before they could so much as place a finger on a soldier's body, physiotherapy recruits had to pass a three-month War Emergency Course set up by the Army Medical Department. By April 1918, six women's physical education schools offered their facilities to the Medical Department: Reed College in Oregon, Battle Creek Normal School of Physical Education in Michigan, New Haven Normal School of Gymnastics in Connecticut, and the remaining three—American School of Physical Education, Boston School of Physical Education, and Prose Normal School of Gymnastics—in Boston.¹⁴ The War Emergency Courses existed as a virtual boot camp in the language and practice of medicine. In addition to classes in the basic

12. For the number of physical education graduates, see Frank Granger, "The Development of Physiotherapy," *P. T. Rev.*, 1923, 3, 16.

13. For more on gender segregation within the field of physical education, see Martha Verbrugge, *Able-Bodied Womanhood: Personal Health and Social Change in Nineteenth-Century Boston* (Oxford: Oxford University Press, 1988); and Verbrugge, "Knowledge and Power: Health and Physical Education for Women in America," in *Women, Health, and Medicine in America: A Historical Handbook*, ed. Rima D. Apple (New Brunswick, N.J.: Rutgers University Press, 1992), pp. 361–82. See also Paul Atkinson, "The Feminist Physique: Physical Education and the Medicalization of Women's Education," in *From "Fair Sex" to Feminism: Sport and the Socialization of Women in the Industrial and Post-Industrial Eras*, ed. J. A. Mangan and Roberta J. Park (London: Frank Cass, 1987), pp. 38–57. Also, in this the same volume, see Patricia Vertinsky, "Body Shapes: The Role of the Medical Establishment in Informing Female Exercise and Physical Education in Nineteenth-Century North America," pp. 256–81.

14. See Emma Vogel, "Physical Therapists before World War II," in *Army Medical Specialist Corps*, ed. Robert S. Anderson, Harriet S. Lee, and Myra L. McDaniel (Washington D.C.: Office of the Surgeon General, 1968), pp. 44–57.

sciences, including laboratories in cadaver dissection, physiotherapy recruits took courses in physiology and learned how to treat simple and compound fractures, ankylosing joints, motor and nervous disorders, as well as how to manage amputation care.¹⁵

The War Emergency Course instituted at Reed College became the largest program of its kind, enrolling and producing the highest number of wartime physiotherapy reconstruction aides.¹⁶ Not every woman, though, would have been accepted into Reed's program. Along with age restrictions (recruits had to be between 25 to 40 years old) and physical fitness requirements, the army mandated that potential female recruits be of good character—or as Surgeon General William Gorgas put it, they had to possess “powers of personal subordination,” demonstrate “team play,” and exhibit “morale of the highest order.”¹⁷

The personal stories conveyed by Reed College physiotherapy students indicate that although the army rigorously enforced its standards of physical and mental health, moral fitness trumped all. Male physicians who commanded the Reed College courses took responsibility for keeping the women in shape, both physically and morally. One physician in particular, named Dr. Beach, gained a reputation for not only demanding “tough” daily workouts of running laps and performing military style chin-ups but also insisting on unwavering moral fortitude in his recruits.¹⁸ The physiotherapists' view of Dr. Beach is best exemplified in a military squad song, “Do or Die,” that they composed and sang in his honor:

Yes, I'm ready to do or die, Dr. Beach, I'm ready to do or die,
 You may make me chin beyond my reach or springboard ten feet high,
 My chest is the frontest [sic] part of my frame, my tummy is flat and low,
 And when I jump and kick myself, I always land on my toe.
 I'm willing to do or die, Dr. Beach, I'm willing to do or die,
 I'll cut up frogs and cadavers too, and the 8 hour law defy,
 I'll dress my hair in minutes two, and dress in moments five,
 With any old meals I'll gladly do, as sure as I'm alive.

15. Murphy, *Healing the Generations*, p. 50.

16. Lettie Gavin, *American Women in World War I: They Also Served* (Boulder: University Press of Colorado, 1997), pp. 101–28. See also “Harvard Medical School Physiotherapy Course, 1918,” Courtesy American Physical Therapy Association Archives (APTA), Alexandria, Va., box 37, file 4.

17. As quoted in Gavin, *American Women in World War I*, p. 104.

18. Doris Ball Crawford, “Recollections and Reminiscences from Former Reconstruction Aides,” *Phys. Ther.*, 1976, 56, 26. See also Marguerite Irvine, “Recollections and Reminiscences from Former Reconstruction Aides,” *Phys. Ther.*, 1976, 56, 29.

I'm ready to do or die, Dr. Beach, I'm going to do not die,
 I'll promise that I'll not flirt at all, or even wink my eye,
 My relationship shall be business-like, the officers I'll not see,
 And I'll look down so modest like, when a sergeant looks at me.¹⁹

With this squad song, the first generation of physiotherapists took the first step toward shaping its professional identity as one that would be inextricably linked to a well-defined military ethos. According to the military ethic of World War I, women war workers were to become defeminized not only in their appearance but also in their social interactions. As we can see from the song lyrics, the ideal body type of a physiotherapy recruit was one of plumb-line verticality.²⁰ It was also expected that a woman's body language would work in accordance with the military's corporeal ideal. The physiotherapist's gestures were to be muted, her gaze turned ever downward. She was to exhibit full bodily control, restraining not only the swing in her step but also the lilt in her voice.²¹

The most formal statement, however, of ethical physiotherapy practice came in the form of an oath called Loyalty to Country. Before being assigned to duty, each Reed College graduate recited the Loyalty to Country oath, pledging her allegiance to the country and to the U.S. military. Similar to the patriotic sentiments expressed in their squad songs, the therapists taking this loyalty oath promised to give their "property, service, and life" to defend the United States (see appendix 2).²²

The sacrificial language found in the Reed College oath was a common form of expression among other female health care providers of the early twentieth century. By the 1910s, nurses graduating from professional training schools across the United States recited the 1893 Nightingale Pledge, in which, among other things, they

19. These are just two of the verses of a seven-verse song that the Reed College graduates composed. See APTA, box 6, file 1.

20. The military ideal of a svelte body coincides with the new slimming trend among American middle-class women in the 1910s and 1920s. See Joan Jacobs Brumberg, *The Body Project: An Intimate History of American Girls* (New York: Random House, 1997).

21. One reason the military wanted to keep the physiotherapists from "flirting" (as the song puts it) with patients was to control male-female fraternization, especially among soldiers and health care workers. Making the healer-patient interaction "business-like" was a cornerstone of the military's World War I campaign against venereal disease. See Allan Brandt, *No Magic Bullet: A Social History of Venereal Disease in the United States since 1880*, 2nd ed. (Oxford: Oxford University Press, 1987).

22. APTA, box 6, file 1.

pledged to cure the sick, even if it meant risking their own lives. In the Nightingale Pledge, a nurse also promised to “aid the physician in his work,” giving herself over to his orders.²³ As well as nurses, occupational therapists—a group of health practitioners with the same gender make-up and wartime professional beginnings as physiotherapists—devised their own creed several years after their service during World War I. In their oath, occupational therapists pledged their “whole-hearted service in aiding those crippled in mind and body.”²⁴ In a similar vein, dental hygienists, another new female allied health profession in the early twentieth century, created a code of ethics in 1923 in which a practitioner of dental hygiene was to be “ever ready to respond to the wants of her patrons.”²⁵ As these examples demonstrate, women health care providers of the early twentieth century tended to write patient-centered oaths, professing to sacrifice themselves on the altar of caring for others.

The physiotherapists, by contrast, composed a highly state-oriented code of ethics, promising alliance to the U.S. government, not to their patients. Although the notion of the common good is a shared element among the Nightingale Oath, the Occupational Therapy Pledge, and the Reed College oath, the definition of “the good” differs in crucial ways. Whereas physiotherapists dedicated their lives and skills to the betterment of their country, nurses and occupational therapists geared their efforts toward a more universal goal of improved health. The peculiarity of the Reed College oath is compounded by the fact that both the Nightingale Pledge and the occupational therapy oath required that their adherents have Christian reverence for their work. In the case of nurses, they were to “solemnly pledge [themselves] before God,” serving as His hand-maiden to nurture the ill back to health. Even in 1926, when the American Nurses Association published a suggested code of ethics (a suggestion that did not come to fruition until 1950), the nursing

23. For a reprint of the Nightingale Pledge, see Fowler, “Evolution of the ANA Code of Ethics,” p. 53.

24. Mary Binderman, MLS, director of Information Resources at the American Occupational Therapy Foundation, was kind enough to send me a photocopy of the original post-card-sized Pledge and Creed for Occupational Therapists. For a reprint of the pledge, see William R. Dunton, ed., *Occupational Therapy and Rehabilitation*, vol. 5 (Baltimore, Md.: Williams and Wilkins, 1926), p. 449.

25. Wilma E. Motley, *History of the American Dental Hygienists' Association, 1923-1982* (Chicago: American Dental Hygienists' Association, 1983). For a reprint of the ADHA's first code, see pp. 75-76.

profession continued to use language with a Christian appeal: "The most precious possession of this profession is . . . to meet the need of the world for skilled and tender care in illness and for wise guidance in attaining and maintaining health."²⁶ Similarly, occupational therapists concluded their creed with the promise that they would "pray for patience, kindness and strength in the holy ministry to broken minds and bodies" (see appendix 3).²⁷ Whereas physiotherapists identified with a highly secular goal of committing themselves to the U.S. military forces, nurses and occupational therapists portrayed themselves as part of God's universal army, soldiering against ill health.

One way to account for the difference between physiotherapists, on one hand, and occupational therapists and professional nurses, on the other, is that although the practice of physiotherapy was a reaction against nineteenth-century ideals of womanhood, the latter two professions maintained deep roots in America's Victorian past. Despite the growing professionalization of the field in the early twentieth century, nursing still involved the more customary duties of female bedside nurturing; Nurses fed, bathed, and cheered recuperating patients. Similarly, occupational therapy began as a field that aimed to nurture "nervous" patients back to health through simple forms of manual labor, such as beadwork, basket weaving, and woodworking. The manual labor of occupational therapy was not intended to be physically taxing—indeed, during World War I most soldiers received occupational therapy in bed or in their wheelchairs. Occupational therapists engaged patients in easily accomplished work goals that would preoccupy the mind so as to bring about psychic well-being.²⁸

When shaping their own professional identity, physiotherapists resisted the Victorian assumption that "softness" and the ability to nurture were biologically determined traits. Instead of emphasizing their ability to sympathize with patients, physiotherapists promoted their career as one that required athleticism and physical strength. The very fact that physiotherapists consistently elicited pain in the treatment of their patients meant that they could not be nurturers in

26. "A Suggested Code: A Code of Ethics Presented for the Consideration of the American Nurses' Association," *Am. J. Nurs.*, 1926, 26, 599–601.

27. Dunton, *Occupational Therapy and Rehabilitation*, p. 449.

28. Virginia A. M. Quiroga, *Occupational Therapy: The First Thirty Years, 1900–1930* (Bethesda, Md.: American Occupational Therapy Association, 1995).

the traditional sense of the term. In many ways, physiotherapists resembled drill sergeants more than bedside nurturers, commanders more than those who were ordered to care. One physiotherapist working during and after the war described her occupation as “hefty” work and wrote that many of her male patients would ask if she found her job to be “too much of a strain.”²⁹

As health care practitioners who challenged the Victorian ideal of woman as caregiver, physiotherapists did not automatically create a professional identity that centered on the patient. During World War I, they defined themselves as citizens first and caregivers second. They did not discuss the treatment of patients in their oath, nor in their eventual 1935 professional code of ethics, the first official statement in which they codified their work. Instead, they focused their efforts on relations with other health care workers, constructing an identity that was more in keeping with an early twentieth-century ethic of nationalism and professionalism than with an ethic of care.

THE ETHIC OF MEDICAL PROFESSIONALISM

Once World War I came to an end, the physiotherapists had little use for the Reed College loyalty to country oath; not only were there no occasions to recite such a pledge publicly, but promising one’s life to the nation had little meaning during times of peace. Although the practice of reciting the oath died along with the war, the physiotherapists’ interest in working according to a set of ethical mandates did not. Postwar physiotherapists thus shifted their thinking away from the common good of the state and focused more on the common good of the profession as a whole. Historian Robert A. Nye describes a similar transition among French physicians at the turn of the twentieth century. According to Nye, elite early twentieth-century physicians in France relied on the military honor codes of the nineteenth century to promote cohesiveness among distinct occupational groups, getting members to think less in terms of

29. This discussion about physiotherapy comes from Linker, “Strength and Science.” For the direct quotation and an account of the labor required to perform physiotherapy, see Ida May Hazenhyer, “A History of the American Physiotherapy Association,” *Physiother. Rev.*, 1946, 26, 3–13, continued in *Physiother. Rev.*, 1946, 26, 66–74, with the final entry in *Physiother. Rev.*, 1946, 26, 122–31.

economic self-interest and more in terms of solidarity throughout the profession.³⁰

By the end of World War I, there were an estimated 800 physiotherapists scattered across the country in military hospitals from San Francisco to New York City.³¹ Without structured military connections and communications, the postwar physiotherapy reconstruction aides sought out a new medium through which they could keep up professional and personal ties with one another. In 1920, under the direction of Reed College physiotherapy instructor Mary McMillan, the America Women's Physical Therapeutic Association was formed with approximately 200 members (including male therapists and physicians) on the roster. Less than a year later, the members of this organization decided to change the name of their professional society to a more gender-neutral American Physiotherapy Association, partly to entice more AMA physicians to join.³²

Lacking a military structure that would define the purpose of physiotherapy work, APA therapists turned to the AMA to fill the structural gap that the military left behind. In doing so, APA therapists fastened onto the AMA's notion of professionalism above all else. For instance, McMillan, the APA's first president, set the precedent of scheduling her association's national conferences at the same time and place as the AMA's, arguing that such an arrangement would not only enable them to secure cheaper rail tickets and more "prominent" speakers, but, more important, that it would be an overt indication of the therapists' intent to become professionals in the medical field, of "lining up the APA with the AMA."³³

In addition, the APA drafted an organizational constitution within its first year of existence, much as the AMA had done in 1847. In this document, APA therapists made their allegiance to the medical profession explicit. Indeed, according to Article II of the 1920 APA constitution, the primary purpose of the association was

30. Robert A. Nye, "Honor Codes and Medical Ethics in Modern France," *Bull. Hist. Med.*, 1995, 69, 91-111. Nye's article is one of the few accounts of the role that gender, and more specifically "maleness," played in the construction of twentieth-century medical codes of ethics.

31. Murphy, *Healing the Generations*, p. 71.

32. For discussion about the change of name, see the association's first meeting notes from 15 January 1921, titled "Preliminary Meeting of the A.W.P.T.A." reprinted in the *P. T. Rev.*, 1921, 1, 4-5. See also, "American Women's Physical Therapy Association Constitution," *P. T. Rev.*, 1921, 1, 5-7.

33. "Presidential Messages: The First Fifty Years," *Phys. Ther.*, 1971, 51, 621.

“to make available efficiently trained women to the medical profession.” In other parts of the constitution, APA therapists used the rhetoric of the “new medical sciences” to indicate their loyalty to the medical profession. At a time when the AMA espoused great enthusiasm for the new laboratory approach to medicine, the APA constitutionally declared itself to be an organization that would “establish and maintain a professional and scientific standard” of physical therapy practice.³⁴

Although the APA therapists often invoked general terms, such as the “medical profession,” to refer to their relationship with doctors, they had the AMA specifically in mind. They admitted as much in their constitutional bylaws, which stated that physicians would be granted membership only if they were “graduates of Medical Schools conforming to the standard of the American Medical Association.”³⁵ With this one statement, APA therapists made a very important step in defining themselves as part of the regular medical establishment. In essence, their organization supported the findings of the 1910 Flexner Report, which had the effect of bolstering orthodox schools of medicine and weakening sectarian schools. The APA applied the same education standards throughout their entire organizational structure, making even the members of its physician-run advisory committee—a board that included AMA-president Ray Lyman Wilbur—prove that they had AMA-approved educations.³⁶

With their constitution, postwar therapists also laid claim to a new name for themselves, changing their professional title from “physiotherapy reconstruction aides” to “physiotherapists.” According to one wartime therapist, the word *aide* was an insult, for the women who worked in the Army Medical Department “felt assured” that others saw their occupation as a “scientific profession affiliated with the medical profession.”³⁷ In essence, by changing their wartime name, APA therapists hoped to avoid the perception that physiotherapy was merely an “arm” of the medical profession, a designation that would have automatically disqualified them from being professionals in their own right.

34. “American Women’s Therapy Association,” p. 5.

35. *Ibid.*, p. 6.

36. *Ibid.* Ray Lyman Wilbur served as the chair of the APA’s advisory committee from 1927 to 1930. Wilbur was also an honorary member of the APA from 1925 to 1935. See membership lists published yearly in the *P. T. Rev.* and *Physiother. Rev.*

37. “Editorials,” *P. T. Rev.*, 1925, 5, 3.

One of the clearest definitions of professionalism in the early twentieth century, at least as it was understood by the medical profession at the time, was put forth by none other than Abraham Flexner. Five years after the 1910 Flexner Report, the New York School of Philanthropy invited Flexner (who then held the position of assistant secretary to the General Education Board) to deliver a lecture in which, among other topics, he was to address the question "Is social work a profession?" In front of an audience of social workers and philanthropists, Flexner not only argued against social work being a profession but also relegated the practices of pharmacy and nursing into the same subprofessional category as social work. Flexner rendered a highly conventional portrayal of professionalism using the physician as the ideal. The physician was the supreme professional, for unlike a craftsman who relied on his "hands," the educated medical doctor used his "mind." Flexner made this case most succinctly in his discussion of the practice of pharmacy, when he remarked that "the physician thinks, decides, and orders, [but] the pharmacist obeys . . . and does not originate."³⁸ Because pharmacists did not possess decision-making powers or capabilities, they were, in Flexner's words, no more than an "arm added to the medical profession."³⁹ Trained nurses, in Flexner's opinion, assumed a similar position, not only because of their ignorance but, more important, because of their gender. To invoke his words: "[The nurse] summons him [i.e., the physician] like a sentinel in fresh emergencies; subordinates loyally her intelligence to his theory, to his policy, and . . . seconds his efforts."⁴⁰ Exhibiting a view common at his time, Flexner had a highly gender-specific notion of professionalism. He likened the medical profession to a "brotherhood," saying that it should absorb a man's life to the point where he and his family would "organize around a professional nucleus."⁴¹

APA therapists knew that it was impossible to achieve equal footing with physicians. In addition to their practice of hands-on, manual

38. Abraham Flexner, "Is Social Work a Profession?" Paper presented at the National Conference on Charities and Correction, New York, 17 May 1915 (New York: New York School of Philanthropy, 1915).

39. In response to Flexner's speech, the American Pharmaceutical Association drafted a new code of ethics, the "Principles of Pharmaceutical Ethics" in 1922. See Buerki, "Historical Development of an Ethic for American Pharmacy," p. 57.

40. Flexner, "Is Social Work a Profession?"

41. *Ibid.*

therapy—a kind of craftsman-like molding of the disabled male body—an overwhelming majority of APA physiotherapists were women. Yet despite their realism, postwar physiotherapists still felt that they deserved to be professionals regardless of gender or their place in the medical chain of command. Repeatedly, APA therapists pointed out that unlike “unskilled” nurses, who had only three years of training at most, they had four-year physical education degrees as well as hands-on wartime skilled training in manual therapy.⁴² Physiotherapists envisioned the medical field not as a hierarchy scale but rather as a liberal democratic community. Reflecting on her work during the war, physiotherapist Ruby Decker insisted that she and her fellow therapists “worked in conjunction with the patient’s personal physicians.” “Please note the phrase: ‘in conjunction with,’” Decker continued, because physical rehabilitation “was a co-operative program with mutual appreciation and respect” between physicians and therapists.⁴³

The physiotherapists’ attempt to define themselves as medical professionals stirred up much controversy. The APA’s persistent drive to lay claim to the name *physiotherapy* irritated physician specialists—namely, a small group of physician-electrotherapist specialists who had called themselves physiotherapists before the war. Almost immediately after Dorothea Beck assumed her office as president of the APA in summer 1924, she received a letter from the American Electrotherapeutic Association saying that “the title of physiotherapist . . . should be restricted to graduate medical men only.”⁴⁴ The letter went on to request that Beck and her APA therapists change the title of their organization to American Physiotherapy *Technician* Association to avoid any “confusion” with the public and medical profession.⁴⁵

The American Electrotherapeutic Association was made up of physicians who specialized in administering physical agents as a method of treatment. The association had been formed in the late nineteenth century for the specific purpose of persuading fellow medical doctors of the benefits of electrotherapy, while combating

42. Louisa Lippitt, R.N., to Dr. Frank Granger, Madison, Wisc., 19 February 1920, APTA archives, Board of Directors (BOD) box 1, file 1. For Granger’s response, see Frank Granger to Louisa Lippitt, R.N., Boston, 26 February 1920, APTA archives, BOD 1, file 1.

43. Ruby Decker, “A Hard Look,” presented at the 43rd annual conference of the APTA, 11 July 1966, APTA archives, box 128, file 42.

44. American Electrotherapeutic Association to APA, New York, 19 December 1924, APTA archives, BOD 1, file 14.

45. *Ibid.*

the unorthodox electrotherapeutic practices of the homeopathically based National Society of Electrotherapeutics.⁴⁶ However, despite the fact that a handful of its members were also members of the AMA, the Electrotherapeutic Association fell short of accomplishing its goal of changing the attitude of regular physicians toward electrotherapy. By the turn of the century, approximately 25,000 physicians had electrical devices of some sort in their offices, but most medical doctors were reluctant to recognize their use as a legitimate therapeutic practice.⁴⁷ Feeling as if they were fighting a losing battle, electrotherapists began to incorporate other therapies into their base, including thermotherapy, hydrotherapy, psychotherapy, phototherapy, mechanical vibration therapy, climatology, exercise, and dietetics. Capitalizing on their new, more broadly appealing image, Dr. William B. Snow, editor of the Electrotherapeutic Association's journal and member of its board of trustees, coined a new phrase that would more accurately describe their work: *physical therapy*.⁴⁸

The Electrotherapeutic Association's demand that the APA change its name was not simply an issue of semantics; it was also about ownership of a new field that had gained considerable credibility as a result of World War I. For the electrotherapists, who throughout the 1910s and 1920s were struggling to become an AMA-approved specialty (approval that they did not receive until 1947, when the AMA instituted the American Board of Physical Medicine and Rehabilitation), credibility was something that they badly needed.⁴⁹ Even though by the 1920s some of them had adopted the title of "physical therapy physicians," electrotherapists still had an image problem. Morris Fishbein (editor of the *Journal of the American Medical Association* and *Hygeia*) constantly denounced electrotherapy as a form of quackery and cultism.⁵⁰ With its capacity

46. Gritzer and Arluke, *Making of Rehabilitation*, pp. 21–22. See also A. B. Hirsch to Dorothea Beck, New York, 3 February 1926, APTA archives, BOD 1, file 14.

47. Gritzer and Arluke, *Making of Rehabilitation*, p. 26.

48. *Ibid.*, p. 28. See also American Electrotherapeutic Association to APA, New York, 19 December 1924, APTA archives, BOD 1, file 14.

49. For more on the specialty status of the electrotherapists (who eventually became known as physiatrists), see Rosemary Stevens, *American Medicine and the Public Interest*, 2nd ed. (Berkeley: University of California Press, 1998).

50. Morris Fishbein, *The Medical Follies: An Analysis of the Foibles of Some Healing Cults, Including Osteopathy, Homeopathy, Chiropractic, and the Electronic Reactions of Abrams, with Essays on the Antivivisectionists, Health Legislation, Physical Culture, Birth Control, and Rejuvenation* (New York: Boni and Liveright, 1925), p. 107.

“to act on nerves and on muscles, producing visible motive effects,” electrotherapy worked only through the power of persuasion. Electrotherapy could dupe people into believing that something therapeutic was happening, when, according to “scientific measures,” it was not.⁵¹

The physicians of the American Electrotherapeutic Association were, for the most part, sympathetic to Fishbein’s criticisms. Working in the field themselves, they knew all too well how deregulated and widespread the practice of electrotherapy had become among nonmedical healers and salesmen. Indeed, it was deregulation and lay competition that led the electrotherapists to attempt to stake their claim on physiotherapy and benefit from its good name.

When Beck published the letter addressed to her by the Electrotherapeutic Association in the *P.T. Review*, physiotherapists from across the country voiced a uniform resistance to the suggestion that their name be changed from “physiotherapist” to “physiotherapy technician.” Echoing Flexner’s assumptions about professionalism, APA members argued that by using the term *technician* the Electrotherapeutic Association insinuated that APA therapists were mere craftswomen, lacking any professional training. Jessie Wright, a physiotherapist from Pennsylvania, argued that the word *technician* implied “mechanically following set technique,” which was in contradistinction to the “intelligent work” required of a physiotherapist. “Each individual case,” continued Wright, “offers different problems,” and as a result physiotherapists had to “use thought, observation and judgment in treatments.”⁵² In other words, physiotherapists saw themselves as originators of a kind of specialized medical knowledge, much like physicians.

Emboldened by the cause to retain their name, the editorial board of the *P.T. Review* decided in 1926 to change the title of their journal to the *Physiotherapy Review*. “We are a bit sorry to see the old initials ‘P.T.’ . . . go,” wrote the editors, “but for the wider good of the Association and for the profession we feel that ‘Physiotherapy Review’ holds identity with dignity and professional feeling.”⁵³ Before leaving

51. Morris Fishbein, *The New Medical Follies: An Encyclopedia of Cultism and Quackery in These United States, with Essays on the Cult of Beauty, the Craze for Reduction, Rejuvenation, Ectecism, Bread and Dietary Fads, Physical Therapy, and a Forecast as to the Physician of the Future* (New York: Boni and Liveright, 1927), p. 166.

52. Jessie Wright to Dorothea Beck, Leetsdale, Penn., 6 April 1925, APTA archives, BOD 1, file 14.

53. “Editorials,” *Physiother. Rev.*, 1926, 6, 2.

her presidential post in 1926, Beck responded to the New York–based electrotherapist–physicians, telling them that by unanimous vote the members of the APA had decided to keep their professional title as physiotherapists.⁵⁴ To Beck and her colleagues at the APA, the matter of their professional name had been settled by virtue of democratic rule and by proof that physiotherapy, despite it being manual therapy practiced by nonphysician women, required a degree of intelligence and esoteric knowledge that many physicians did not possess.

THE AMA COUNCIL ON PHYSICAL THERAPY
AND BUSINESS ETHICS

In addition to her correspondence with the men of the Electrotherapeutic Association, Beck also sent a letter in January 1926 to the newly formed AMA Council on Physical Therapy, making a case as to why the APA should be able to retain the title of “physiotherapy.” Her strategy of going above the heads of the electrotherapists to “men high in the medical profession” ultimately failed, for the AMA had already begun to equate physiotherapy with the practice of pharmacy, an arm of the medical profession that was to be supervised and controlled by the “brains” of elite AMA physicians. Indeed, according to the minutes of the first meeting of the Council on Physical Therapy held in Chicago on 16 October 1925, presiding chairs Drs. Olin West (then secretary and general manager of the AMA) and Fishbein encouraged the other members of the council to replicate the structure and goals of the 1905 AMA Council on Pharmacy and Chemistry.⁵⁵ West and Fishbein invited Dr. W. A. Puckner, then secretary of the Council on Pharmacy and Chemistry, to attend the meeting and to instruct the newly initiated members on how to maintain “scientific standards” in physical therapy, keeping the practice out of the “hands of undesirable and unqualified” impostors to the field, much the same way that pharmaceuticals were kept from “unethical”

54. Dorothea Beck to Electrotherapeutic Association, New Jersey, 29 June 1926, APTA archives, BOD 1, file 14.

55. “Meeting of the Council on Physical Therapy, American Medical Association Headquarters, Chicago, Illinois, 16 October 1925,” Courtesy AMA Archives, Chicago, Ill., vertical file. The other members of the Council on Physical Therapy included W. T. Bovie (Boston), Arthur Compton (Chicago), Ralph Pemberton (Philadelphia), Harry Mock (Chicago), Walter B. Cannon (Boston), A. S. Warthin (Ann Arbor), Francis Carter Wood (New York City), George Miller MacKee (New York City), and A. U. Desjardins (Rochester, Minnesota).

druggists who sold unregulated nostrums to an unsuspecting public.⁵⁶

Like the Council on Pharmacy and its regulatory control over medicinal remedies, the primary purpose of the Council on Physical Therapy's was to collect variously produced electrical apparatuses sold as "physical therapy" devices—equipment that included ultraviolet lights, diathermy, and roentgen-ray therapy machines—test them, and determine which devices produced therapeutic results and which did not. And also like the Council on Pharmacy and Chemistry, the Council on Physical Therapy made an agreement with the Cooperative Medical Advertising Bureau that only council-endorsed electrical devices would be advertised in the pages of the AMA's professional and popular journals. At the encouragement of Fishbein, the council resolved to publish its physical therapy reports not only in the *Journal of the American Medical Association* and *Hygeia* but also in city newspapers to "influence the public on matters [of physical therapy]."⁵⁷

Although the council said little to nothing about the APA or its therapists during the meeting in 1925, the council's members still aimed to define professionalism in physiotherapy, much like the APA therapists did. But the way these two groups approached the task of defining professionalism differed substantially. Whereas APA therapists adopted a more conventional definition of professionalism as "thought" work as opposed to mere craftwork, the men of the AMA Council on Physical Therapy had internalized a more modern, post-World War I view of professionalism, making distinctions based not only on education but also on utilitarian calculations of the public good. In a special 1922 issue of the *Annals of the American Academy of Political and Social Science* devoted to ethics in the professions, architect Robert D. Kohn attributed the wellspring of ethical concern among the professions to the war effort, for it created a "universal desire for service, [to] sacrifice one's private interests to

56. Ibid. I thank Laura Carroll, archivist at the AMA, for providing me with Dr. Puckner's full name and biography. Quotations from "Resolution Providing the Establishment of a Council on Physical Therapy," AMA House of Delegates Proceedings, Chicago, Ill., 25–29 May 1925, APTA archives, box 41, file 17.

57. Ibid. See also "Resolution Providing the Establishment of a Council on Physical Therapy," AMA House of Delegates Proceedings, Chicago, Ill., 25–29 May 1925, APTA archives, box 41, file 17.

the common good,” and to lay aside the “money-making motive.”⁵⁸ This new outlook of equating the “service motive” with ethical practice and the “money-making motive” with unethical behavior made it possible for businessmen to be ethical professionals as well. Edward A. Filene, then president of William Filene’s Sons, proposed a simple two-pronged code of “business ethics” whereby a business had to serve the community as well as produce “merchandise of reliable quality for the lowest practically possible price.”⁵⁹ Not surprisingly, this formula of business ethics worked to benefit large manufacturers while penalizing small, independent businessmen.

In this post-World War I milieu, in which businessmen could be ethical professionals too, the AMA Council on Physical Therapy followed in step, basing the distinction between professional and nonprofessional practices as much on education as economics. When the Council on Physical Therapy published its first official report in October 1926, it highlighted the difference between the nonprofessional “salesmen,” who emphasized the “money making powers” of physiotherapy devices, and the professional large manufacturers, such as General Electric, who aimed to benefit the patient therapeutically.⁶⁰ To the council, the unethical businessman who sold his physical therapy wares solely for the purpose of financial gain was more of a threat than an uneducated manual healer was.⁶¹ The council concluded its report by asserting that an independent salesman’s dishonesty and naked self-interest should “disgust” all “conscientious practitioners of medicine.”⁶²

With this one report, the council effectively established the terms of ethical practice in physical therapy for many years to come. Although it heralded the importance of physiotherapy as a practice necessary to medicine, it condemned APA therapists to a subordinate position in the medical hierarchy and, in a less obvious way, questioned their status as professionals. The AMA concluded that

58. Robert D. Kohn, “The Significance of the Professional Ideal: Professional Ethics and the Public Interest,” *Ann. Am. Acad. Pol. Soc. Sci.*, 1922, 101, no. 190, 1–5.

59. Edward A. Filene, “A Simple Code of Business Ethics,” *Ann. Am. Acad. Pol. Soc. Sci.*, 1922, 101, no. 190, 223–28.

60. “Report of Committee on Present Status of Physical Therapy,” *J. Am. Med. Assoc.*, 1926, 87, 1302. For the committee’s discussion of General Electric, see “Meeting of the Council on Physical Therapy, American Medical Association Headquarters, Chicago, Illinois, 16 October 1925,” Courtesy AMA Archives, vertical file.

61. “Report of Committee on Present Status of Physical Therapy,” p. 1302.

62. *Ibid.*, p. 1303.

physical therapy could become a legitimate practice only if it were controlled by “graduate physicians,” who prescribed therapy after “careful physical and laboratory examinations.”⁶³ More important, the council referred to APA therapists as “therapist technicians,” despite the association’s repeated protests against the use of such terminology, which they believed implicitly questioned their status as professionals.⁶⁴

The AMA council’s 1926 report came as a severe blow to the APA therapists who fought for the right to call themselves physiotherapists. In a private letter responding to the council’s report, newly elected APA president Gertrude Beard despondently wrote to former president Beck, “It looks like our name is fated.”⁶⁵ Knowing that the AMA held a great deal of power over defining professionalism in medicine, Beck advised Beard to maintain a congenial relationship with the medical profession, writing, “the closer personal touch you can establish with the AMA and particularly with Council on Physiotherapy, the better. True—if sad—we need a ‘pull’ which is quite self-evident.”⁶⁶ Not wanting to concede their name but feeling forced to accept the medical profession’s decree, the physiotherapists’ campaign to be seen as professionals shifted from an optimistic and ambitious effort to save their professional title to a more sober and self-conscious movement for professional recognition.

UNSENTIMENTAL HEALERS

For almost ten years following the 1926 AMA Council on Physical Therapy report, the APA suffered continual interpractitioner territorial battles and grave financial losses, primarily as a result of marketplace competition coupled with a declining economy. As APA therapists moved from positions secured by the war machine to the private sphere over the course of the 1920s, they encountered a medical marketplace crowded with osteopaths, chiropractors, and nurses—all of whom claimed to practice “physiotherapy.” The therapists’

63. *Ibid.*

64. *Ibid.*

65. Gertrude Beard to Dorothea Beck, Chicago, 14 December 1926, APTA archives, BOD 1, file 10. Although the AMA and the Electrotherapeutic Association allowed the Physiotherapy Association to keep its professional title, they still called individual physiotherapists “technicians.”

66. Dorothea Beck to Gertrude Beard, New Jersey, 10 October 1926, APTA archives, BOD 1, file 25.

occupational insecurity worsened with the onset of the Great Depression. According to an APA survey conducted in 1933, therapist salaries across the country had been cut drastically, and up to a third of all private practices had been closed as a result of the country's economic downturn.⁶⁷ In addition, APA membership plummeted, despite the temporary moratorium on membership fees.⁶⁸ Dispirited and financially strapped, APA physiotherapists had little fervor to lobby for state medical legislation that would secure their name and legally exclude others from practicing their trade. By the mid-1930s, APA president Margaret Campbell, along with many other leading therapists, agreed that the APA had to make its cooperation and alignment with the medical profession more overt—or, as Campbell put it, therapists needed to “work quietly and *ethically* with the medical profession.”⁶⁹ If the AMA saw the APA therapists as ethical professionals, Campbell reasoned, then the physiotherapists could win the medical profession's unconditional allegiance.

To express their desire to work ethically with the AMA in the most forthright way, the APA took on the task of composing a professional code of ethics. At the 1934 annual convention, APA leaders instituted a special committee on ethics, demanding that its members compose a written code of ethics that would conform to the AMA's code. When constructing the code, the APA ethics committee did not refer to the Reed College oath, and with good reason. As philosopher Robert M. Veatch points out, oaths and codes of ethics are two very distinct forms of ethical pronouncements that serve different functions. Of the two, codes of ethics are more modern, a by-product of a highly bureaucratic society. As such, they provide a complex set of rules and “comprehensive standards to guide the practicing health practitioner, patient, or other decision makers” in their attempts to negotiate the murky waters of specialized health care and individual interests.⁷⁰ Oaths, on the other hand,

67. Margaret Campbell to Catherine Worthingham, 27 February 1933, APTA archives, BOD 1, file 23. See also “Editorials,” *Physiother. Rev.*, 1934, 14, 121.

68. See “Chapter News,” *Physiother. Rev.*, 1934, 14, 35; and “Chapter News,” *Physiother. Rev.*, 1933, 13, 155, 154, 149. For the membership fee moratorium, see *Physiother. Rev.*, 1933, 13, 150.

69. Emphasis added. “Chapter News,” *Physiother. Rev.*, 1933, 13, 153; “Chapter News,” *Physiother. Rev.*, 1935, 15, 152. Therapists also talked about transferring the publicity “campaign initiative to the medical profession.” For more on this, see “Chapter News,” *Physiother. Rev.*, 1934, 14, 119; and again in “Chapter News,” *Physiother. Rev.*, 1935, 15, 68.

70. Veatch, “Medical Codes and Oaths: History,” pp. 1419–27.

have a long history of functioning as simple moral statements expected to be recited in a group setting. Whereas oaths are more general in intent, codes of ethics—written documents that are supposed to be read, not recited—outline details of interprofessional relationships, providing a comprehensive list of rules that can be studied and cited by other professional groups.

The women who drafted the APA 1935 Code of Ethics did not think of themselves as moral philosophers; instead, they considered themselves to be the guardians of a new professional field that needed to be put on firmer ground.⁷¹ When thinking about the content of their Code of Ethics, the physiotherapists reacted to a specific set of problems pertaining to their own professional survival in the medical world of the mid-1930s. Leading up to the implementation of the 1935 Code of Ethics, the editors of the *Physiotherapy Review* offered explicit guidelines to be followed in the creation of their profession's creed. From the editorial, it is clear that the APA therapists had studied the Council on Physical Therapy's 1926 report very closely. The editors emphasized that APA therapists should distinguish themselves from trade workers—who “kept one eye on the clock and the other on the union”—and from businessmen “who had one eye on the work and the other on the balance sheet.”⁷² In keeping with the spirit of the council's 1926 report, the editors claimed that as professionals, the APA therapists were beyond the purely selfish motivation of profit, claiming that physical therapy should be performed “for its own sake, regardless of financial returns.”⁷³

In addition, the editors urged its fellow APA members to downplay the gender make-up of their field, advising the ethics committee to adopt a more masculinized rhetoric of medical professionalism. Most striking, the editors felt that it was of utmost importance to avoid any hint of “sentimentalism” in the organization's creed.⁷⁴ By the early twentieth century, *sentimentality* had become a gender-laden term in medical circles. The medical profession's resistance to sentimentalism was in part a reaction against

71. Buerki, “Historical Development of an Ethic for American Pharmacy,” p. 55. Buerki makes the same point about the pharmacists who drafted the 1848 Code of Ethics for Pharmacists.

72. “Our Profession,” *Physiother. Rev.*, 1935, 15, 27.

73. *Ibid.*

74. *Ibid.*

Victorian medicine, perceived, at least, as an era of stoicism and gentility. As historian Regina Morantz-Sanchez demonstrates, it was during the Victorian period that the American public revered women physicians, for they alone had the unique ability to “combine sympathy and science—the hard and soft sides of medical practice.”⁷⁵ But during the rise of the new laboratory medicine at the turn of the twentieth century, the organized medical profession began to resist the “soft side” of medicine, conflating it with sentimentality, sympathy, caring, and all-around irrational feminine behavior. Sentimentality hindered the practice of “hard” science, for it undermined the possibility of creating a clear separation between subject and object, healer and patient.⁷⁶

To a great extent, the AMA Council on Physical Therapy fueled the APA therapists’ fear of waxing sentimental. In 1934, Dr. Howard A. Carter, member of the Council on Physical Therapy, wrote an article for the *Physiotherapy Review* complaining that there was “too much poetry in [the physiotherapists’] so-called scientific papers.”⁷⁷ He urged them to cease their “armchair philosophizing and wishful thinking” and stick to data and scientific findings instead.⁷⁸ From the time that the therapists started their own journal in 1921, they indeed devoted many pages to humor columns, marriage and birth announcements, as well as to articles geared toward morale boosting. But over the course of the 1920s and 1930s, APA therapists shed the feminine characteristics of their journal, transforming it into a more streamlined, professionalized publication that aimed at objectivity rather than subjectivity. By adhering to the rhetorical and aesthetic rules woven into the male-dominated medical profession, APA therapists implicitly sided with antifeminine tenets of medical professionalism.

75. Morantz-Sanchez, *Sympathy and Science*, p. 5.

76. For a more comprehensive treatment of the relationship between gender, medical professionalism, and science, see Ellen Singer More and Maureen A. Milligan, eds., *The Empathic Practitioner: Empathy, Gender and Medicine* (New Brunswick, N.J.: Rutgers University Press, 1994). The articles of particular relevance are: Susan Lederer, “Gender, Animal Experimentation, and the Doctor-Patient Relationship,” pp. 59–73; Ellen S. More, “‘Empathy’ Enters the Profession of Medicine,” pp. 19–39; and Regina Morantz-Sanchez, “How Women Physicians Became More Empathic than Men,” pp. 40–58. See also Morantz-Sanchez, *Sympathy and Science*.

77. Howard A. Carter, “The Council on Physical Therapy,” *Physiother. Rev.*, 1934, 14, 181.

78. *Ibid.*

CONTRACTING WITH THE AMA: THE 1935 APA
CODE OF ETHICS

Despite the APA's push to create a professional image sanitized of motherly sentimentality and selfish greed, certain AMA physicians still remained wary of the new occupation. Throughout the early 1930s, the APA headquarters received a stream of complaints from physicians who accused APA therapists of practicing without a doctor's prescription.⁷⁹ These accusations reached their peak in the early 1930s, when private-practice physicians lost 47 percent of their pre-Depression income.⁸⁰ This was a time before widespread health insurance and managed care, when most patients paid for medical care out of pocket and "weighed the need to pay the doctor a visit against a widening range of more appealing spending options," such as movies, food, shows, and transportation.⁸¹ With money tight and competition stiff, some physicians went so far as to argue that the physiotherapists should be eliminated completely. As one California APA therapist reported in 1932, many doctors with whom she worked felt "that physiotherapy should only be done by a physician," because APA members "were taking a good deal of business away from them."⁸²

In response, the APA created a Committee on Publicity to target physicians and laymen alike, assuring them that APA therapists were part of the medical establishment and willing to adhere to its mandates of professionalism, including the rule that physiotherapists should only treat with a physician's prescription. The APA took to the radio waves, and in a 1934 public announcement President Campbell clearly defined physical therapy as a treatment that "must be directed by a physician."⁸³ In addition to taking advantage of the new advertising technologies, the Publicity Committee urged APA

79. See, for example, APA to Catherine Worthingham, 27 December 1932, Chicago, Ill., APTA archives, BOD 1, file 23; and Dr. Harold Behneman to APA, 14 February 1933, San Francisco, Calif., APTA archives, BOD 1, file 23.

80. Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982).

81. Nancy Tomes, "Merchants of Health: Medicine and Consumer Culture in the United States, 1900-1940," *J. Am. Hist.*, 2001, 88, 519-47. For direct quotation, see p. 528. Tomes estimates that during the 1910s and 1920s, 80 percent of health care spending came directly from patients.

82. Catherine Worthingham to APA, 17 November 1932, San Jose, Calif., APTA archives, BOD 1, file 23.

83. "Radio Talk by Our President," *Physiother. Rev.*, 1934, 14, 124, emphasis added.

members to take a more grassroots approach to educating doctors about their profession. Chairman of the committee Margaret Wallace wrote that calling up doctors in the community and saying to them, “You know, we do not accept any cases without orders” is an “excellent type of publicity.” Tell them, she instructed, that an APA therapist is “just like an ethical druggist who does not give out special medicines without orders.”⁸⁴ The APA therapists hoped it would be to their advantage to be seen akin to pharmacists, who had also agreed to be “ethical” practitioners, administering drugs only with written prescriptions from doctors.⁸⁵

But Campbell and other leading APA therapists had no grounds on which to take disciplinary action against those therapists who might stray from the rules of medical professionalism. Although confirming the importance of cooperating with the medical profession, the APA’s original 1920 constitution remained a toothless document. Nothing in the constitution, that is, allowed APA presidents to bar members who conducted physiotherapy without a doctor’s prescription.⁸⁶

With their 1935 Code of Ethics, however, the APA made official its intent to rely exclusively on a physician’s prescription and to reprimand members who refused to abide by these rules of referral. APA therapists made their aims clear in the title for the creed, calling it a Code of Ethics and *Discipline*. Time and again throughout their very brief code, the APA therapists made reference to the importance of deferring to physicians as the overseers of physiotherapy. The code opens with a pithy two-sentence rule that in many ways encapsulates the driving assumption behind the document: “Diagnosing, stating the prognosis of a case, and prescribing treatment shall be entirely the responsibility of the physician. Any assumption of this responsibility by one of our members shall be considered unethical.”⁸⁷ Again, under the section titled “Professional Practice

84. Margaret Wallace, “Editorial,” *Physiother. Rev.*, 1934, 14, 120.

85. For the established relationship between pharmacists and the AMA, see Chapter III, section 4 of the AMA’s “Principles of Medical Ethics (1912),” in Baker, ed., *American Medical Ethics Revolution*, p. 354.

86. One APA member, Margaret Cleveland, explicitly expressed concerns about the APA’s inability to police its members. See Margaret Cleveland to Gertrude Beard, January 1927, Cleveland, Ohio, APTA archives, BOD 1, file 25.

87. See “Code of Ethics and Discipline,” *Physiother. Rev.*, 1935, 14, 157. The code has also been reprinted in appendix I.

and Behavior,” the code states that a physiotherapist “shall not attempt to criticize the physician or dictate technique or procedure.”⁸⁸ Finally, under the section “Advertising,” the code mandates that physiotherapy advertisements should include “a statement that the work is medically supervised.”⁸⁹

Aside from making its dependence on the medical profession explicit, the executive officers of the APA armed themselves with a creed that they could use to police delinquent members. The final section of the code, titled “Discipline,” gave the APA president the power to punish members who did not adhere to the code of ethics.⁹⁰ At this point in the organization’s development, the only real tool of punishment was revoking memberships. As the reasoning went, if a therapist did not have her name on the APA membership roster, she would squander a steady supply of patients that normally came from physician referrals and therefore lose her practice.

Although the code was a way to demonstrate loyalty to the medical profession, it was also a means for APA therapists to uphold their identity as professionals and, in turn, to prevent further subordination in the medical chain of command. For instance, although APA therapists agreed freely to give up the ability to diagnose and prescribe treatments, they rejected the physicians’ requests that they relinquish their private practices. Ever since 1926, when the Council on Physical Therapy recommended that “technicians should be discouraged from establishing individual [private practices],” APA therapists resisted the effort.⁹¹ With one-third of its therapists operating their own private practices and another third working in the nation’s school systems, the APA refused to acquiesce to the physicians’ demands.⁹²

Initially, the APA tried to combat the medical profession’s squeeze on their private practices by trying to demonstrate that independently practicing physiotherapists would diminish medical marketplace competition. Playing into the medical profession’s hotly contested debates over physician specialists, APA president Hazel

88. *Ibid.*

89. *Ibid.*

90. *Ibid.*

91. “Report of Committee on Present Status of Physical Therapy,” *J. Am. Med. Assoc.*, 1926, 87, 1303.

92. “Editorial,” *Physiother. Rev.*, 1934, 14, 121. APA to Catherine Worthingham, 27 February 1933, Chicago, Ill., APTA archives, BOD 1, file 23.

Furscott wrote a letter to the Council on Physical Therapy in 1929 arguing that if a general practitioner “sends his patient to another physician who is practicing the technique of physical therapy, he turns his case over . . . and may lose his patient.” But, she continued, “if he refers the case to an ethical technician, he may supervise and direct the treatment at will.”⁹³ In other words, if the treatment of physical therapy fell solely into the hands of a physician who would develop his practice around delivering physical therapy, the competition for patients would increase. At least with APA “ethical” technicians at the disposal of physicians, Furscott reasoned, a general practitioner could continue to procure fees from initial patient evaluations as well as subsequent follow-up visits.

In addition to appealing to arguments of marketplace economics, Furscott also made the claim that physiotherapists were in many ways analogous to pharmacists, who also had their own private practices. In her letter to the AMA, she contended that physicians should be taught techniques in physiotherapy just as they learned their *materia medica*.⁹⁴ The doctor, according to Furscott, “should write his [physical therapy] prescription in dose form as he does a prescription of medicine, and he should direct and supervise the application of the agencies of Physical Therapy as he does the procedures in Medical Therapy.”⁹⁵ And like the pharmacist who had his own place of business where he administered medications, physiotherapists, Furscott argued, should have their own private practices where the physical therapy “prescription shall be filled.”⁹⁶ The APA’s argument was perfectly logical: Physicians had private offices, druggists had private offices, and so, too, should physiotherapists. For it to be otherwise was nothing less than the AMA failing to recognize that the members of the APA were ethical professionals, too.⁹⁷

With their Code of Ethics, physiotherapists tried to make one last stand to keep their private practices, for as professionals, they felt entitled to the privilege of maintaining private offices. Under Article I of their code, “Professional Practice,” the APA claimed that when a therapist treated a patient under a doctor’s orders, “the patient shall

93. APA to AMA Council on Physical Therapy, 20 August 1929, Chicago, Ill., APTA archives, Box 41, file 17.

94. *Ibid.*

95. *Ibid.*

96. *Ibid.*

97. *Ibid.*

be referred back to the physician for periodical examinations.”⁹⁸ Such a statement of practice would have been unnecessary if the APA assumed that all physical therapy treatments were going to take place under the same roof as a prescribing physician, that is, under a doctor’s *direct* supervision. In other words, a formal system of patient referral would have been pointless if physicians were working next to a physiotherapist with the ability to monitor the patient’s progress themselves.

But in focusing their efforts so singularly on fostering a solid relationship with the medical profession, the APA therapists neglected to make any mention of the therapist–patient relationship. This absence is particularly noteworthy because most other medically related codes of ethics of the time devoted entire sections to discussions about the professional care of the patient. From its original code of ethics adopted in 1847 to the revised Principles of Medicine in 1912, the AMA always mentioned honesty and the patient–healer relationship as essential components of ethical practice. The same is true for the American Pharmaceutical Association which, in its revised Principles of Pharmaceutical Ethics of 1922, compels the pharmacist to “hold the health and safety of his patrons to be the first consideration” of his practice.⁹⁹ Focused attention on the patient can also be seen in codes of ethics that were written by other contemporary professional women. In 1923, the Dental Hygienists’ Association adopted a patient-centered code of ethics, claiming that “the dental hygienist should be ever ready to respond to the wants of her patrons,” to “care” for even the simplest cases, seeing every procedure as an operation “performed on living, sensitive tissue.”¹⁰⁰ The 1926 Suggested Code of the American Nursing Association used similar language of concern for the patient in that the leaders of the organization saw themselves as satisfying a greater “need of the world for skilled and tender care in illness.”¹⁰¹

Perhaps the APA therapists’ decision to remain silent about the therapist–patient relationship was a mere oversight. More likely, their omission was an example of shrewd decision making; it was a way, in

98. “Code of Ethics and Discipline,” p. 157.

99. For a reprint of the 1922 “Principles of Pharmaceutical Ethics,” see *Annals of the American Academy of Political and Social Science*, pp. 268–71. For direct quotation, see p. 269.

100. For a copy of the 1923 code of ethics, see Motley, *History of the American Dental Hygienists’ Association*, pp. 75–76.

101. “A Suggested Code,” p. 599.

other words, to overcompensate for the gender make-up of their organization. In medical circles, the healer–patient relationship often served as the most likely venue through which woman practitioners would express their sentimentality for patients and their care.¹⁰² Thus, by failing to comment on the healer–patient relationship, APA therapists maintained their gender-neutral, non-Victorian identity with greater ease. Moreover, by 1935, APA therapists already had a long history of creating a defeminized identity, beginning with their military Reed College loyalty oath, in which therapists promised to maintain a businesslike relationship with physicians and patients.

GENDER AND CODES OF ETHICS

The APA's 1935 proclamation testifies to the fact that gender played an instrumental role in the writing of its Code of Ethics. In a very real sense, APA therapists used their first code of ethics as a way to overcompensate for the gender make-up of their field. They used an acceptable form of professional codification as a way to challenge the AMA legitimately, which continually refused to grant equality to men and women alike in the newly burgeoning allied health field. Despite the AMA's refusal to see physiotherapy along the same lines as the male-dominated practice of pharmacy, APA therapists insisted that they were equal to pharmacists, for even the AMA, at the initiation of the Council on Physical Therapy in 1925, had itself made the argument that the two practices should be seen as analogous. But such an analogy did not translate into everyday practice. Throughout the 1920s and early 1930s the AMA supported pharmacists who owned private practices but refused the same arrangement to physiotherapists.

In short, gender remained an unstated yet important difference between the fields of pharmacy and physiotherapy. Whereas approximately 4 percent of all practicing pharmacists in the early twentieth century were women, the opposite was true for physiotherapy, where men constituted anywhere from 1 to 4 percent of the profession up to the mid-1930s.¹⁰³ Another striking difference

102. Morantz-Sanchez, "How Women Physicians Became More Empathic Than Men," p. 55.

103. On the issue of gender and pharmacy, including statistics of the number of female practitioners from the years 1870–1940, see Teresa Catherine Gallagher, "From Family Helpmeet to Independent Professional: Women in American Pharmacy, 1870–1940," *Pharm. Hist.*, 1989, 31, 60–77. For the number of physiotherapy male members, see membership directories printed annually in *P. T. Rev.* and *Physiother. Rev.*

between these two ancillary professions, both dependent on a physician's prescription, is the wording of their ethical codes. Unlike the APA code, the official 1922 Principle of Pharmacy Ethics devotes an entire section to the pharmacists' "duties" to the public, wherein it is stated that he "should hold the health and safety of his patrons to be the first consideration" of his practice. Although differences between the 1935 APA code and the Principle of Pharmacy Ethics are too many and too complex to outline here, the question of what role, if any, gender played in the resultant differences between the two codes remains.

The APA Code of Ethics also complicates the notion that there exists a predetermined gender-specific ethic of care.¹⁰⁴ Many social scientists and philosophers have contended that women, especially female health care providers, have historically been caregivers who have nurtured men, children, and other women at home and at work. Most famously, Nell Noddings and Carol Gilligan have both argued that according to their observation of women's behaviors and experiences, women tend to put themselves "at the service of other[s]," striving to "find options that avoid bringing harm to anyone."¹⁰⁵ Likewise, a similar deterministic assumption of woman as caregiver permeates historical studies of the early twentieth-century professions in the United States. In this literature, female health-related professionals are often depicted as "service-oriented," and "cooperative" by nature, whereas their male counterparts are usually "profit-seeking," competitive, and ultimately concerned about protecting their occupational territory.¹⁰⁶

If care-based, service-oriented ethics is the rule among female health professionals, then physiotherapy is the exception to the rule.

104. For a sampling of the ethics of care argument, see Carol Gilligan, *In a Different Voice: Psychological Theory and Women's Development* (Cambridge, Mass.: Harvard University Press, 1982); and Nell Noddings, *Caring: A Feminine Approach to Ethics and Moral Education* (Berkeley: University of California Press, 1983). For a more recent critique of the ethics of care theory, see Helga Kuhse, *Caring: Nurses, Women and Ethics* (Oxford: Blackwell Publishers, 1997).

105. Noddings, *Caring*, pp. 2, 33. Latter quotation comes from Gilligan found in Susan Sherwin, *No Longer Patient: Feminist Ethics and Health Care* (Philadelphia: Temple University Press, 1992), p. 46.

106. Much of the historical literature on the 1921 Sheppard-Towner Maternity and Infancy Act and the U.S. Children's Bureau supports the idea that there were gender-specific approaches to professionalization and the dissemination of expert knowledge in the early twentieth century. Some of the best books on this topic include Molly Ladd-Taylor, *Mother-Work: Women, Child Welfare and the State, 1890-1930* (Urbana: University of Illinois Press, 1994); Kriste Lindenmeyer, *Right to Childhood: The U.S. Children's Bureau and Child*

From their military oath to their correspondence with the AMA Council on Physical Therapy and their 1935 Code of Ethics, APA therapists made it clear that they thought more about the ethics of medical professionalism—an ethic that after World War I included business ethics—than the patient-centered ethic of care. To the therapists themselves, the 1935 code was a supremely professional act that had decisively “set physical therapy above” cult practitioners (such as chiropractors) “who pursued their work without heed to ethics and with little consideration of proper and adequate training.”¹⁰⁷ As ethical professionals, they considered themselves to be more dignified than blue-collar workers or money-hungry salesmen.

With their Code of Ethics, APA therapists relinquished the license to diagnose and prescribe treatment in the name of professionalism. To be sure, the Code of Ethics can be interpreted as the ultimate act of self-subordination; after all, the physiotherapists effectively gave up any chance of becoming completely autonomous professionals. But from the therapists’ perspective, the code won them a secure place in the medical profession. And to a certain extent, they were right. When the AMA Council on Physical Therapy issued its second report in 1936, the board of physicians stated that although they were originally concerned about “the ethical standing of physical therapy,” they now considered it to be an upstanding medical practice and a permanent part of modern medicine.¹⁰⁸ Moreover, the council fully endorsed APA physiotherapists. “These technicians thoroughly imbued with medical ethics,” concluded the council, “are logically of value” to the medical profession. Indeed, by the 1930s, many physicians blamed the prevalence of quackery on physicians who failed to refer patients to professional physical

Welfare, 1912–46 (Urbana: University of Illinois Press, 1997); Richard A. Meckel, *Save the Babies: American Public Health Reform and the Prevention of Infant Mortality, 1850–1929* (Baltimore, Md.: Johns Hopkins University Press, 1990); Robyn Muncy, *Creating a Female Dominion in American Reform, 1890–1935* (Oxford: Oxford University Press, 1991); and Sheila M. Rothman, *Woman’s Proper Place: A History of Changing Ideals and Practices, 1870 to the Present* (New York: Basic Books, 1978). Nancy Cott complicates the notion that there were gender-specific views of professionalization after World War I by looking at several female professional groups after enfranchisement. See Cott, *The Grounding of Modern Feminism* (New Haven, Conn.: Yale University Press, 1987).

107. Hazenhyer, “History of the American Physiotherapy Association,” p. 70.

108. “Report of the Committee on the Present Status of Physical Therapy,” *J. Am. Med. Assoc.*, 1936, 107, 586, emphasis added.

therapists.¹⁰⁹ The AMA recommended that the medical profession support the APA professionals, for, as one physician-analyst argued, increasing the use of physical therapy “will do more, perhaps, than any other thing to eradicate sectarianism.”¹¹⁰

The APA code not only helped shape the terrain of the allied medical field, it also played a role in the way that gender entered the medical discourse on professionalism, explicitly and implicitly. In their code, the physiotherapists avoided the rhetoric of sentimentality and any discussion of the patient to establish themselves as medically related professionals, a standing jeopardized not only by their gender but also by their already subordinate position in the medical hierarchy. It seems that the physiotherapists of yesterday might have agreed with one of today’s experts on moral philosophy and feminism, Susan Sherwin, who suspects that “women’s proficiency at caring is somehow related to women’s subordinate status.”¹¹¹ The physiotherapists avoided the rhetoric of care to prevent further subordination, to avert a position where they would be forced to give up their own private practices, and more significantly, to relinquish their identity as professionals.

With their creed, APA therapists agreed to the terms of ethical practice set out by the medical profession, and, in turn, physicians guaranteed therapists a steady patient population. Accordingly, the APA Code of Ethics spoke almost exclusively to the physician-physiotherapist relationship, for it served as a kind of quasi-contract with medical doctors. Although such an agreement required that the therapists subvert their tendencies toward a feminine rhetoric of care and relinquish a considerable degree of autonomy as health care providers, APA therapists willingly paid the price of adhering to the rules of medical professionalism. They wanted to maintain their professional identity and keep their occupation afloat in a tumultuous marketplace, and with their code of ethics, they said as much.

109. Louis S. Reed, *The Healing Cults, A Study of Sectarian Medical Practice: Its Extent, Causes, and Control* (Chicago: University of Chicago Press, 1932), p. 113. This study was part of the 1932 study performed by the Committee on the Costs of Medical Care. For more on the CCMC, see *Medical Care for the American People: A Final Report of the Committee on the Costs of Medical Care* (Chicago: University of Chicago Press, 1932).

110. Reed, *Healing Cults*, p. 120.

111. Sherwin, *No Longer Patient*, p. 50.

APPENDIX 1: THE AMERICAN PHYSIOTHERAPY ASSOCIATION
CODE OF ETHICS AND DISCIPLINE

Adopted at the A.P.A. Convention, Atlantic City, N.J., June 1935. Printed in *Physiotherapy Rev.*, 1935, 14, 157.

I. PROFESSIONAL PRACTICE

- a. Diagnosing, stating the prognosis of a case, and prescribing treatment shall be entirely the responsibility of the physician. Any assumption of this responsibility by one of our members shall be considered unethical.
- b. The patient shall be referred back to the physician for periodical examinations.
- c. A member shall not attempt to criticize the physician or dictate technique or procedure.

II. ADVERTISING

- a. Members shall not procure patients by means of solicitors, agents, circulars, displays, or advertisements inserted in commercial periodicals.
- b. Announcements in medical journals or business cards, not stating fees, are permissible. A statement that the work is medically supervised should appear on the announcement.
- c. A member may use the term "Physiotherapist" or "Physical Therapist" on an office door.

III. BEHAVIOR

- a. Members shall not indulge, before patients, in criticism of doctors, co-workers, or predecessors who have handled the case.
- b. It is well to bear in mind that our reputation as individuals and a group depends upon professional accomplishments and upon adherence to the standards of our organization.

IV. DISCIPLINE

- a. Charges and evidence against offenders will be weighed and acted upon by the Executive Committee.

APPENDIX 2: LOYALTY TO COUNTRY OATH

Reed College, Oregon (courtesy of the American Physical Therapy Archives, American Physical Therapy Association, Alexandria, Va., box 6, file 1).

The Republic of the United States is my country, the Stars and Stripes my flag. No matter what race I sprang from, or what other nations may claim

my friendship, my motto and my watchword is America First. I will do my best to make her loved at home and respected abroad.

Above all party interests, I will stand by our elected rulers; and will abide by the decisions of the majority, respecting, however the just rights of the minority. I will never join any insurrection or rebellion against the Constitution, and will never give aid or comfort to any enemy of our country. I denounce anarchy and every organization that tolerates violation of law. I will follow no party that does not carry the flag of the Union.

I believe that my country, a democracy in a republic, can secure to her citizens a full measure of life, liberty and the pursuit of happiness. To no man will I sell, deny, or delay right or justice; and I believe that no state should deprive any person of life, liberty or property, without due process of law.

I will never discriminate against any citizen because of his religion.

I pledge to my country constant loyalty. I pledge respect and obedience to her laws. I pledge my property, my service, and if need be, my life to defend her.

APPENDIX 3: THE AMERICAN OCCUPATIONAL THERAPY
ASSOCIATION PLEDGE AND CREED FOR OCCUPATIONAL
THERAPISTS

Adopted at the Annual Convention, Atlantic City, N.J., 1926. Printed in: William R. Dunton, ed., *Occupational Therapy and Rehabilitation*, vol. 5 (Baltimore, Md.: Williams and Wilkins, 1926), p. 449

Reverently and earnestly do I pledge my whole-hearted service in aiding those crippled in mind and body.

To the end that my work for the sick may be successful, I will ever strive for greater knowledge, skill and understanding in the discharge of my duties in whatsoever position I may find myself.

I solemnly declare that I will hold and keep inviolate whatever I may learn of the lives of the sick.

I acknowledge the dignity of the cure of disease and the safeguarding of health in which no act is menial or inglorious.

I will walk in upright faithfulness and obedience to those under who guidance I am to work and I pray for patience, kindness and strength in the holy ministry to broken minds and bodies.