

**WHO CARED FOR THE CARERS?  
A STUDY OF THE OCCUPATIONAL HEALTH OF GENERAL  
AND MENTAL HEALTH NURSES 1890 TO 1948**

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## **ABSTRACT**

This thesis set out to explore the neglected field of nurses' occupational health. Evidence from the three case study hospitals confirms that attitudes toward nurses' health changed between 1888 and 1948. The health of nurses was an issue that was always taken seriously but each institution approached the problem differently and responses showed much variation over time. There were good reasons for this but the failure to adopt a coherent and consistent policy worked to the detriment of nurse health. This difficulty helps explain the ambiguous treatment of occupational health within wider histories of nursing. This can lead to the erroneous conclusion that occupational health was somehow neglected by contemporary actors, thereby facilitating the omission of the subject from historical studies concentrating on professional projects and the wider politics of nursing. This study takes a different approach showing that occupational health issues were inexorably connected to these nursing debates. Occupational health cannot be understood without reference to professional projects. This is as true in debates where occupational health was obscured as it was in cases of overt concern.

The history of the occupational health of nurses is also important because it offers a new perspective on two other themes central to nursing history, particularly class and gender. This focus helps understand why attitudes towards the care of sick nurses changed over time and varied between different types of institutions. By concentrating on individual nurses' experiences we reveal something new about the way national conversations affected ordinary nurses' lives. Recognition that nursing presents a serious occupational health risk is a relatively recent phenomenon; it was not until the 1990s that most nurses had access to occupational health units. This study not only sheds light on why nurses' health attracted little attention before the Second World War but also explains why this situation began to change from the 1940s.

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## DEFINITIONS AND ABBREVIATIONS

Attendant	Generally used to describe male nurses until 1919 when it was replaced by nurse. However, variations occurred between hospitals. At the Cornwall Lunatic Asylum, the term attendant applied to both male and female nurses until the early twentieth century. At The London Hospital, male nurses continued to be called attendants in the 1940s.
AWA	Asylum Workers' Association
BCG	Bacillus Calmette-Guering
BJN	British Journal of Nursing
CLA	Cornwall Lunatic Asylum (1850-1930)
CMH	Cornwall Mental Hospital (1930-1948)
GNC	General Nursing Council
HMWC	Health and Munition Workers' Committee
IFRB	Industrial Fatigue Research Board
IIAC	Industrial Injuries Advisory Council
MRC	Medical Research Council
NAWU	National Asylum Worker's Union
NCW	National Council of Women
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NIIP	National Institute of Industrial Psychology
Nurse probationer	A nurse in training from 1890 until the early 1920s. The term then changed to student nurse.
NUTN	National Union of Trained Nurses
NUWW	National Union of Women Workers
PUTN	Professional Union of Trained Nurses
RBNA	Royal British Nurses' Association
SDEC	South Devon and East Cornwall Hospital (1831-1990)
TB	Tuberculosis

VAD

Voluntary Aid Detachment nurses

# CHAPTER ONE

## Introduction

This study is concerned with the occupational health of nurses from 1880 to the creation of the National Health Service in 1948. It aims to identify those factors influencing perceptions surrounding nurses' ill health and assess the reasons for change over time and differences between places. It will set nurses' health within a national context framed by political, social and cultural issues and also within a local history of three institutions. Its objective is to uncover nurses' experience of ill health and by doing so reveal more about the working lives of nurses in both general and mental hospitals.

Historians have neglected nurses' health. Several monographs mention the subject of nurses' health briefly as part of a political or educational narrative of nursing but no study has placed nurses' bodies and health at its centre. This is surprising considering nursing is recognised today as a serious occupational health risk and nurses' sickness is a considerable financial burden to government. The Healthcare Commission (2005) reported that nurses took more days off sick than most other public sector workers. The Commission estimated that the cost of sickness absence nationally for nurses and healthcare assistants was approximately £141 million per year.<sup>1</sup>

Recent research into the causes of the high levels of ill health have suggested back injury from lifting, exposure to blood and body fluids, exposure to toxic chemicals, infectious diseases, stress and workplace violence.<sup>2</sup> These specific causes

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<sup>1</sup> Healthcare Commission, *Ward Staffing*, June 2005, p.17.

<sup>2</sup> S. Hignett, 'Work-related back pain in nurses', *Journal of Advanced Nursing*, **23**, 1996, pp.1238-1246; R. Hollingdale, 'Back Pain in Nursing and Associated Factors: A Study', *Nursing Standard*, **11** (39), 18 June 1997, pp.35-38; T. Ferns and I. Chojnacka, 'Reporting Incidents of Violence and Aggression towards NHS staff', *Nursing Standard*, **19**, (38), 3 February 2005, pp.51-56; R. Jenkins and P. Elliott, 'Stressors, burnout and social support: nurses in acute mental health settings', *Nursing and Health Care Management and Policy*, **48** (6), 3 February 2005, pp.622-631; Y. Webb, A. Stear, J. Pethybridge, R. Baker, G. Elharhn 'Nursing the Nurses: why staff need support', *Nursing Times*, Vol.98 (16), 16 April 2002, pp.36-37; J. Carson, L. Fagin, & S. Ritters, *Stress and Coping in Mental Health Nursing*, London: Chapman and Hall, 1995; J.



have only been identified relatively recently. An article in *The Guardian* newspaper in 2005 that discussed the high levels of nurses' sickness found by the recent Healthcare Commission report, suggested that their cause was a generalised phenomenon: the 'high pressures of life on a ward with many staff feeling that they care for too many patients with not enough support from managers' was put forward as the root of the problem.<sup>3</sup> Prior to 1930, and the discovery of the high incidence of tuberculosis amongst nurses, nurses' health was discussed in broad, generalised terms that identified poor work conditions as responsible for both mental and physical illness. But it is striking that recent comments about nurses' health (2005) are similar to those made by sick nurses over a century before, in 1890. High patient ratios and a lack of understanding from senior nursing staff featured in conversations about nurses' health from 1890 to 1948. *The Guardian* speculated in 2005 that the Royal College of Nursing was 'likely to argue that much of the sickness absence is due to actual physical illness.' This implied that the College was unwilling to acknowledge that it is nurses' work conditions and not a specific occupational health risk that continues to have a detrimental effect on health.<sup>4</sup> The relationship between nurse organisations, work conditions and professional status remains a key theme to shaping attitudes towards nurses' health today as it was between 1880 and 1948.

The method adopted in this thesis has been to place nurses' experience of illness at the centre of the study. It asks whether these were shaped by institutional cultures, national political, social and cultural factors or the availability of nurse labour. This study will address six basic questions. What factors did the nurse believe contributed to or caused illness? How did the nurse report sick? Where was she and he cared for? Did nurses' treatment vary according to the type of hospital employed in or to seniority

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Beckford-Ball, 'Tackling Latex Allergies in Patients and Nursing Staff', *Nursing Times*, **101** (24), June 2005, pp.26-27.

<sup>3</sup> *The Guardian*, 26 June 2005.

<sup>4</sup> *The Guardian*, 26 June 2005.

in rank? Were senior nurses sympathetic or was sickness interpreted as a sign of a lack of vocation?

One of the problems a study of this type faces is the limited evidence of nurses' illness written by nurses themselves. The accounts of sickness have been drawn from nurses' letters to their employers and the nursing and lay press, and government and nurse organisations' enquiries into nursing. Probationers' registers, matrons' and ward reports have provided a valuable insight into the way senior nurses constructed nurses' health. Much of the evidence cannot be treated as 'fact': all sources carry ideological assumptions which need to be picked apart in order to gain some insight into the experiences of individual nurses and the different ways in which nurses' health was constructed. A tempered, prudent and consistently critical approach is necessary to the interrogation of this type of source whose reliability and bias is questionable.

The idea that nurses' health was constructed requires some comment as it has contributed towards the methodological approach adopted. Indeed, the aim has been to balance a social constructivist viewpoint with the experience of individual nurses. Historical studies by Foucault, Hardy and Worboys, amongst others, portray the conception of disease as socially determined.<sup>5</sup> Medical knowledge and the diagnosis and treatment of illness by health care professionals is affected by a variety of social factors including gender, class, political considerations and the influence of the mass media. Worboys suggests that the metaphor of construction is valuable because 'it suggests a process, taking place over a time, in particular settings.' He argues that the 'social' in social constructivism is less important because social relations alone do not produce knowledge. This study suggests that knowledge and practice is produced from social and material interactions following Worboys' argument that historians of

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<sup>5</sup> M. Worboys, *Spreading Germs Disease Theories and Medical Practice in Britain 1865-1900*, Cambridge: Cambridge University Press, 2000; A. Hardy, *Health and Medicine in Britain since 1860*, Basingstoke: Palgrave, 2001; L. Jordanova, 'The Social Construction of Medical Knowledge', *Social History of Medicine*, (8), 1995, pp.361-382.

medicine should not ignore ‘biology’ and the way it shapes ideas and actions.<sup>6</sup> This approach is concerned with the circumstances in which diseases emerge as an occupational health risk for nurses at different periods and why. Such a constructivist approach allows an examination of the forces that shaped conversations both inside and outside of institutions. It will help move the analysis beyond the institutional histories of the three case study hospitals and should enable the identification and explanation of common ground and difference between national and local conversations.

The chapters are organised both chronologically and thematically. The key themes are disciplined nursing ideology, class and gender. Nursing ideology refers to a system of ideas promoted through nurse education, textbooks and journal articles that shaped the image of the nurse and the practice of nursing. Late nineteenth century nursing ideology was dominated by the necessity for military style discipline as an ideal quality in nurses and as an integral part of nurses’ lives, on and off duty. By 1948, ideas had shifted towards the necessity for self-discipline and freedom. This study will examine the relationship between disciplined ideology and nurses’ health and assess whether social, cultural or political factors prompted change. It is particularly interested in the way expanding career opportunities for women, warfare and nurse recruitment shortages in the 1930s and 40s shaped ideas about health and discipline.

The theme of class examines the way ideas about nurses’ bodies and their health were related to their social class background. This study will argue that in 1890 middle class nurses were considered more susceptible to illness than their working class counterparts. By 1948 ideas had changed and working class nurses were believed to be most vulnerable. Government enquiries, doctors, senior nurses and nursing and lay press were intermittently concerned with the relationship between nurses’ class background and health throughout the period in question. I am interested in the factors that prompted such concern. Defining the class background of individual nurses

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<sup>6</sup> Worboys, *Spreading Germs*, pp.12-13.

mentioned in this study has been difficult because their father's occupation or income is often unknown. In these cases, nurses who paid for their training have been labelled middle class. Notions of class were often closely entwined with those of gender; ideas surrounding middle class femininity were central to the image of the 'new' nurse in the late nineteenth and early twentieth centuries.

The theme of gender is concerned with the way ideas about nurses' bodies were related to the social construction of femininity and masculinity. To support their case for professional status, late nineteenth century nurse leaders linked the image of the 'ideal' nurse with many of the qualities associated with late Victorian femininity. Nurses' susceptibility to illness was linked to the gendered belief that women lacked the necessary physical strength to nurse. Some nurse leaders and doctors used this idea to shape nurses' role within the general hospital. This study will argue that as ideas about femininity changed as a result of warfare and expanding work opportunities for women, the notion of gender became less influential on ideas about nurses' health. It is also concerned with the relationship between the image of the male nurse, the construction of masculinity and occupational health. Male nurses had an image of physical strength and were often employed to restrain violent patients, a role that involved a high risk of physical injury. One of the reasons this risk received little attention was because physical strength was considered an integral part of the ideal image of late Victorian masculinity and implied invulnerability to ill health.

To illustrate and explore these issues, a case study approach has been adopted. Three case study hospitals were chosen on the grounds of their purpose, historical background, system of management and ability to recruit staff. The aim was to compare the practice of nurses' health care between an asylum and general hospital and between a large and small general hospital and offer explanations for variations in practice and sickness rates. It will examine whether geographical differentiation is

substantive by comparing a rural, provincial and metropolitan institution. This approach is designed to give voice to those nurses whose treatment reflected political and social factors.

The London Hospital, a large, central, metropolitan voluntary teaching hospital, was the eldest of the three institutions. Built in 1740, it had an established system of nurse training by the late nineteenth century.<sup>7</sup> Its school of nursing opened in 1873, based on Nightingale lines. Nurse exams were introduced in 1882. Its matrons were members of a small group of elite leaders who contributed opinions nationally about the education, training and practice of nursing and the structure and organisation of its leadership. Doctors generally supported the considerable power matrons exercised over the nurses and nursing policy within the Hospital. The London's system of management differed from the other two case study hospitals in that doctors initially played no part and were not allowed to sit on either the management or the house committee. The London was governed by a lay management committee, many of whom had business interests in the City, military backgrounds and/or were landed gentry. Nurse recruits were overwhelmingly female, drawn from all over the United Kingdom and were from a mixed social background. The London always enjoyed a waiting list for entry to training even during periods of acute nursing shortages. All three case study hospitals expanded rapidly during the period in question. In 1890 The London employed twenty-three ward sisters and 182 nurses and probationers who cared for an average of 626 patients.<sup>8</sup> By 1900 the number of nurses had increased to fifty-eight ward sisters and 294 nurses and by 1914, 444 nursing staff cared for 922 patients.<sup>9</sup> In 1947 the number of nurses employed had increased again to 626.<sup>10</sup>

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<sup>7</sup> For a detailed history of The London Hospital see A.E. Clark-Kennedy, *The London: A Study in the voluntary Hospital System*, Pitman Medical, 1962-63; S.M. Collins, *The Royal London Hospital: a brief history*, London: The Royal London Hospital Archives and Museum, 1995.

<sup>8</sup> RLH, *The New Review*, LH/A/26/5, 17 October 1890, p.301.

<sup>9</sup> 'The Department of Modern Nursing', *The Hospital*, 13 June 1914, p.299.

<sup>10</sup> RLH, The London Hospital Nursing Com Mins, LH/A/12/41, 24 September 1947.

The South Devon and East Cornwall Hospital (SDEC) was a provincial, voluntary general hospital in Plymouth chosen for this study on the grounds that its geographical position, a considerable distance from London, and its smaller size made it an excellent comparator to The London Hospital. The SDEC opened in 1840 and by 1890 employed eleven nurses and eight probationers to care for 124 patients. The range of services available expanded rapidly at the end of the nineteenth century. A clinical laboratory was built in 1899 and in 1901 an X-ray department opened, one of the first in the country.<sup>11</sup> By 1934, the number of nurses had increased to twenty-six trained staff and eighty-five student nurses.<sup>12</sup> The SDEC was governed by a mixture of doctors and lay people, some of who were local landowners.<sup>13</sup> Medical staff initially sought to limit the matron's role to that of the traditional role of housekeeper and it was only in the 1930s that the matron achieved power over nursing policy. Nurse training was introduced at the SDEC during the 1880s but was criticised and reorganised by Doctors Fox and Bertram Soltan of the medical staff in 1904 who took control of the curriculum.

The disciplined nursing ideology favoured by matrons at The London Hospital was less influential on nursing practice at the SDEC. The majority of SDEC applicants were from Devon and were drawn initially from middle class backgrounds. By the 1940s recruits included more candidates from the working classes. In 1934 the SDEC combined with the Royal Albert Hospital in Devonport, Lockyer Street Hospital, the Central Hospital and the Prince of Wales Hospital providing 377 beds in total. Each

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<sup>11</sup> J. Grier, D. Mole, *Brief History of Plymouth Hospitals*, Plymouth: The Old Plymouth Society, 2004, p.24.

<sup>12</sup> PWDRO, Prince of Wales Hospital Sub-Committee Mins, 606/7/10, 4 August 1942. The title of probationer nurse changed to student nurse in the early 1920s following the 1919 Registration Act and the reorganisation of nurse training nationally and locally at the SDEC. See A.M. Rafferty, *The Politics of Nursing Knowledge*, pp.113-138.

<sup>13</sup> In 1884 the SDEC moved to a new building, funded by large donations from a number of local landowners, particularly the Earl of Mount Edgcumbe and Sir Massey Lopes, Member of Parliament for South Devon. Most of the wards in the new hospital were named after donors of £1000 or more. These large donors were rewarded with a management position on the hospital's governing committee. The Earl of Mount Edgcumbe was Patron of the hospital and Sir Massey Lopes its Chairman. See Grier, Mole, *Brief History of Plymouth Hospitals*, p.24.

hospital retained their own matron but held joint nursing committee meetings. Unlike The London, the SDEC found it increasingly difficult to attract recruits particularly during the Second World War.

The majority of historical studies of nursing staff focus on either those employed in general hospitals or mental institutions. This study is designed to compare and contrast the health of nurses employed in both types of health care service. The Cornwall Lunatic Asylum (CLA) for the reception of private patients and pauper lunatics, known locally as St. Lawrence's Hospital, was chosen to facilitate the comparison between general hospital nurses and asylum nurses and also between male and female nurses. The majority of male nurses employed between 1890 and 1948 worked in asylums. The CLA, which opened in 1820 and was situated in Bodmin, Cornwall, employed an almost equal number of male and female nurses throughout the period studied. The equality in numbers provided an excellent opportunity to investigate whether and how attitudes to male and female nurses' health varied within one institution.<sup>14</sup> The CLA's geographically isolated position means that it can hardly be viewed as representative of all asylums of the period. Initial research on a number of other asylums with the intention of including a fourth institution in the study suggested that many operated in isolation with little overlap in policy or management strategy. For this reason, it was decided not to include a second asylum in the study.

Factors such as nursing ideology, nurse education and training, class background of attendants, choice of professional representation and attitudes to basic pay and work conditions differed significantly between asylum and general nurses. Nurse training was introduced to the CLA in 1918, nearly forty years after The London and the SDEC.<sup>15</sup> A

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<sup>14</sup> For example, in 1918 seventy female nurses and seventy-five male nurses were employed at the CLA see chapter three pp.126-127. *The NAWU Magazine*, Oct. Nov. Dec. 1918, pp.6-7.

<sup>15</sup> The CLA began nurse training in response to its introduction of the Medico-Psychological examination in 1918. The Medico-Psychological Association (MPA) started a national training scheme and examination in 1893 and by 1899 over 100 asylums participated in the scheme. See P. Nolan, *A History of Mental Health Nursing*,

qualified sister tutor was appointed in September 1933.<sup>16</sup> The Asylum's system of management differed from the voluntary hospitals in so far as the Medical Superintendent enjoyed considerable power over the nursing staff. Although three matrons were employed they did not contribute to the discipline or education of nurses. As at The London, a lay committee governed the Asylum drawn from landowners, clergy, magistrates and members of parliament. Membership often passed from generation to generation within local gentry families.<sup>17</sup> The Visiting Committee was dissolved in 1929 and reconstituted to consist of fifteen people, ten of who were appointed by the Cornwall County Council and five subscribers. These subscribers were financial donors to the Asylum. The CLA expanded rapidly over the course of the nineteenth century. By 1884 the original building for 100 patients housed 760 patients: 305 males and 366 females. The number of patients continued to increase during the first two decades of the twentieth century leading to problems of overcrowding. In 1906 the Asylum housed 1000 patients increasing to 1,230 in July 1915.<sup>18</sup> Numbers remained stable during the next three decades until 1948.

Having explained the selection of case studies, the reasons for the period examined are addressed. The campaign for professional status began in 1888, prompting a House of Lord's Select Committee investigating the state of the metropolitan hospitals to consider on nurses' work conditions and their relationship to health. This Committee found that the mortality rate amongst nurses at The London Hospital had risen dramatically in the previous two years. Long working hours, poor nutrition, a high patient to nurse ratio and overcrowded accommodation were believed to be making nurses' ill. Despite this evidence that nursing carried an occupational

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London: Chapman and Hall, 1993, pp. 60-73; D. Wright, 'To know no weariness', in D. Wright, *Mental Disability in Victorian England: The Earlswood Asylum 1847-1901*, Oxford: Clarendon Press, 2001, pp.99-119.

<sup>16</sup> C.T. Andrews, *The Dark Awakening: A History of St. Lawrence's Hospital, Bodmin*, London: Cox and Wyman, p.33.

<sup>17</sup> Andrews, *The Dark Awakening*, p.108.

<sup>18</sup> See Andrews, *The Dark Awakening* for more detailed history of the Asylum.



health risk, nurse leaders did not appear concerned. The campaign for professional status could not accommodate the notion that nurses ran a significant risk of ill health as a result of their work. This study suggests that nurse leaders' concern for professional status continued to outweigh their interest in nurses' health until the 1930s when a shortage of recruits and scientific evidence of a rising incidence of tuberculosis in nurses prompted a reassessment of their attitudes to both work conditions and health problems. The study finishes with the advent of the National Health Service in 1948.

Government enquiries into nursing and the archives of nurse organisations have provided much evidence of the relationship between political events and nurses' health. I suggest that occupational health concerns changed over time. Late nineteenth and early twentieth century commentators analysed nurses' sickness in terms of infectious diseases and the effects of overwork. By the 1930s these broad categories of illness were noted only in connection with the risk posed by tuberculosis, creating the impression that this was the only disease risk nurses' faced.

The method adopted here considers the period in chronological sequences, chosen for their relationship to nursing political history, occupational health concerns and warfare. Chapters two to five are generally chronologically consecutive and are concerned with the campaign for registration from 1890 to 1919, the effects of the First World War on nurses' health and choice of occupational representation from 1914 to 1919 and the Nurse Registration Act of 1919. Chapters six and seven focus on the interwar years and the impact of the Second World War from two different perspectives, the problem of tuberculosis and the impact of ideas associated with industrial psychology.

## **Historiography**

The historiography requires some discussion. Poor work conditions and their impact on nurses' health had little or no place in the narrative of nursing history which began to be

constructed in the second half of the nineteenth century, a time when nurse organisations emerged to lobby for professional status. This historiography, according to Mortimer, ‘rapidly took on the guise of a professional project designed to valorise and justify an emergent profession for respectable women.’<sup>19</sup> Dominated by the figure of Florence Nightingale, her iconic role as first reformer and founder of modern nursing has had serious implications for nursing history. Abel-Smith’s *A History of the Nursing Profession*, published in 1960, marked a change of direction by criticising ‘the goals and aspirations of nurses both singly and as an organised collectivity’ from the political perspective of a non-nurse.<sup>20</sup> Abel-Smith said little about the role of gender, however, and it was not until the 1980s, and the publication of Davies’ *Rewriting Nursing History* that historians began to apply more rigorous analytical and social science approaches to the history of nursing.

Recent studies have suggested that nurse leaders and organisations drew directly upon gender ideologies and imagery to promote their case for registration and professional status.<sup>21</sup> Such a strategy, Davies argues, ‘explains and encapsulates the relations between the professional work of men and the “supportive” activities of women.’<sup>22</sup> D’Antonio argues that rather than being merely defined by stereotypes, ‘women actively embraced the gendered meaning of nursing for the ease with which it allowed them to create the world of productive work.’<sup>23</sup> Nurse reformers held up the qualities Victorian society considered ideal in women, according to Summers, as

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<sup>19</sup> B. Mortimer and S. McGann (eds.), *New Directions in the History of Nursing*, Oxon: Routledge, 2005.

<sup>20</sup> B. Abel-Smith, *A History of the Nursing Profession*, London: Heinemann, 1960; C. Davies, *Rewriting Nursing History*, London: Croom Helm, 1980, p.13.

<sup>21</sup> See A. Summers, *Angels and Citizens British Women as Military Nurses 1854-1914*, London: Routledge & Kegan Paul, 1988, pp.1-9; A.M. Rafferty, *The Politics of Nursing Knowledge*, London: Routledge, p.25; C. Davies, *Gender and the Professional Predicament in Nursing*, Buckingham: Open University Press, 1995, p.58; P. D’Antonio, ‘Rethinking the Rewriting of Nursing History’, *Bulletin of the History of Medicine*, Vol. 73, No. 2, 1999, p.271.

<sup>22</sup> Davies, *Gender and the Professional Predicament in Nursing*, p.58.

<sup>23</sup> D’Antonio, ‘Rethinking the Rewriting of Nursing History’, p.271.

essential attributes for nursing. Early Victorian women were believed to have distinctive qualities of gentleness, moral superiority and sympathy, derived from their biological capacity for motherhood, which qualified them for caring functions in society. Domestic skills gained from household management, such as bringing up children and managing servants, were used by hospital reformers to increase credibility in their bid to obtain an authoritarian role within the hospital environment. These women wished to supervise nurses without interference from doctors.<sup>24</sup>

The idea that some areas of work were either male or female provinces, a sexual division of labour believed to be 'natural', reflected wider contemporary ideals of femininity and masculinity.<sup>25</sup> Male boards of governors, male physicians and surgeons, ran hospitals and in order to gain the right to manage nurses, Florence Nightingale, Mary Stanley and Shaw Stewart replicated the structure of the middle and upper class household.<sup>26</sup> Gamarnikow has drawn an analogy between the patriarchal structure of the Victorian family and the gendered structure of the nineteenth century hospital, pointing to the dominant male/father/doctor role, the nurturing female/mother/nurse role and the submissive child/patient role.<sup>27</sup> Summers notes that nurses' use of skills gained in the 'private' sphere to legitimise their engagement with the male public sphere was an attempt to prove that they should not be treated as servants and should be allowed to manage nurses, unsupervised by doctors.<sup>28</sup>

Nurse training focused on 'character' training that legitimised rather than challenged established authority relations within the hospital and, Rafferty argues, reinforced anti-intellectualism that justified the exclusion of women from professional

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<sup>24</sup> Summers, *Angels and Citizens*, pp.3-4.

<sup>25</sup> B. Harrison, 'Not only the 'Dangerous Trades', *Women's Work and health in Britain, 1880-1914*, Abingdon: Taylor & Francis, 1996, p.11.

<sup>26</sup> Summers, *Angels and Citizens*, p.3.

<sup>27</sup> E. Gamarnikow, 'Sexual Division of Labour : the case of nursing' in A. Kuhn and A.M. Wolpe (eds.), *Feminism and Materialism: Women and the Modes of Production*, London: Routledge and Kegan Paul, 1978, p.96.

<sup>28</sup> Summers, *Angels and Citizens*, p.2.

work. As nurse reformers demanded that nursing receive professional status and expanding employment opportunities provided entry into previously excluded areas of the public arena, training moved away from domestic ideology towards a more technical and scientific approach adopted from medicine.<sup>29</sup> This study accepts much of the existing historiography on gender and nursing in the nineteenth century. It seeks rather to add a new layer of understanding by suggesting that notions of gender were used to explain the relationship between nurses' bodies and their health. The belief that women were naturally susceptible to illness undermined nurse leaders' case for professional status based on the premise that women's natural feminine qualities entitled them to care. Changing assumptions about male and female roles within society as result of the First and Second World Wars led to more fluid constructions of masculinity and femininity in shaping the image of the nurse. By the 1940s, the image of the nurse had changed from feminine to masculine, according to Starns. She relates the shift in 'gender identity' to a wider war-time trend as women recognised that anything associated with the military and masculinity was afforded higher status and access to power than anything associated with femininity.<sup>30</sup>

Historians of nursing, writing about a predominately female occupation, have focussed heavily on the female nurse. This study aims to redress this balance by including male nurses. There is a paucity of literature and research about male nurses and their masculinity despite a recent growth in interest in the study of masculinities which has begun to place men's social, physical, psychological and labouring lives in historical context and challenge associations of men with aggression and violence. Evans points out that men have always worked as nurses and historians' failure to recognise this perpetuates the notion that male nurses are anomalies. She suggests that social and political factors as well as prevailing notions of masculinity and femininity

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<sup>29</sup> Rafferty, *The Politics of Nursing Knowledge*, p.31.

<sup>30</sup> P. Starns, *March of the Matrons*, Peterborough: DSM, 2000, p.44.

have shaped men's participation in nursing.<sup>31</sup>

Of key interest to the present study is the way the image of the male nurse influenced attitudes towards his health. Fearing the threat male nurses posed to the gendered hierarchy of nursing in general hospitals in the late nineteenth and early twentieth centuries, some female nurses promoted a negative image of men with the aim of limiting men's employment opportunities in nursing. One of the ways they did this was to publicly question whether men were capable of caring, a theme examined by Evans and Brown.<sup>32</sup> During the 1890s, many male nurses began to be stereotyped as effeminate, in direct contravention of the Victorian ideal of masculinity that projected the virtues of strength, will power, honour and courage. Evans suggests that the accepted 'ideal' definition of Victorian masculinity acted as a barrier to men becoming general hospital nurses where a caring component was considered vital.<sup>33</sup> Many believed that 'caring' was not consistent with the functions undertaken by male asylum nurses who maintained a strong, manly image of strong physical strength. Therefore those men that did cross the divide into general nursing and illustrated the caring component of the nurse's role were labelled effeminate.

The restructuring of nursing and nursing education and the subsequent consolidation of labour took place when Victorian separatist ideologies of gender were at their most powerful.<sup>34</sup> Mackintosh points out that the Nurses' Registration Act of 1919 confined men to a separate register and thus established nursing as the first all female occupation.<sup>35</sup> War, industrial health settings and an acute nursing shortage

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<sup>31</sup> J. Evans, 'Men nurses: a historical and feminist perspective', *Journal of Advanced Nursing*, 47(3), August 2004, pp.321-328.

<sup>32</sup> G. MacDougall, 'Caring - a masculine perspective', *Journal of Advanced Nursing*, 25 (4), 1997, pp. 809-813; B. Brown, P. Nolan, P. Crawford, 'Men in Nursing: Ambivalence in care, gender and masculinity', *International History of Nursing Journal*, 5(3), 2000, pp.4-13.

<sup>33</sup> Evans, 'Men nurses: a historical perspective', p.321.

<sup>34</sup> H. Bradley, 'Medicine' in H. Bradley (ed.), *Men's Work, Women's Work, A Sociological History of the Sexual Division of Labour in Employment*, Minneapolis: University of Minnesota Press, 1989, pp. 188-202.

<sup>35</sup> C. Mackintosh, 'A Historical Study of Men in Nursing', *Journal of Advanced*

produced opportunities for the recognition of men as nurses. It was not until after the Second World War, in 1949, that the male part of the register was amalgamated, ending what Mackintosh refers to as ‘formal legislative discrimination against men nurses in Britain.’<sup>36</sup> This study seeks a fresh perspective on the relationship between male nurses, masculinity and their health. It will argue that male asylum nurses’ health was neglected by their employers, professional representatives and the nursing press because their image was one of physical strength and the risk of physical abuse was an accepted part of asylum culture.

There has been considerable debate amongst feminist and social historians about the pervasiveness of the idea of the breadwinner wage: Barbara Harrison suggests that the fact it was never realised in practice and should be treated more as a ‘myth’, ‘does not undermine its significance in the gendered structuring of work and entitlement to its economic rewards.’<sup>37</sup> Male attendants discriminated against female asylum nurses during the First World War because they feared losing their jobs while away on military service. Debate concerning whether female asylum nurses could care for male patients focussed on female nurses’ morality and the male breadwinner salary. The idea of a male breadwinner wage as sufficient to support a family without his dependents having to obtain paid work became a powerful ideological weapon at the end of the nineteenth and early twentieth centuries according to Seccombe. It was used by trade unions to articulate their demands for higher pay in a way in which the propertied classes ‘found morally unassailable’ because it upheld the belief in the sanctity of the family and argued that such a division of labour was ‘natural’.<sup>38</sup>

Many historians have examined the professionalisation of nursing although very little has been written about its relationship to nurses’ health. The main focus has

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*Nursing*, **26**, pp. 232-236.

<sup>36</sup> Mackintosh, ‘A Historical Study of Men in Nursing’, p. 234.

<sup>37</sup> Harrison, *Not only the ‘Dangerous Trades’*, p.23.

<sup>38</sup> W. Seccombe, ‘Patriarchy stabilized: the construction of the male breadwinner wage norm in nineteenth-century Britain’, *Social History*, **11**, pp.53-76.

remained the achievement of professional status and its consequent effects. One of the key concerns of D'Antonio, Rafferty and Davies, for example, is to understand the relationship between professionalisation and gender.<sup>39</sup> Summers argues that from a feminist perspective, the campaign for registration 'could only aspire to professional status in male-run institutions and on male terms.'<sup>40</sup> Mortimer notes that much of the work on the history of occupations has grappled with the meaning and definition of 'profession.' Medicine, she argues, has been accepted as one of the paradigm professions and its history recognised as an authoritative account of the professionalizing process.<sup>41</sup> Rafferty questions how nursing, a female dominated profession, could succeed in advancing an agenda of self-regulation by emulating the professional tactics of doctors, a group whose dominance depended upon nurses' subordination.<sup>42</sup> How far nurses emulated doctors' tactics is questionable: they certainly pursued a college route and strove to elevate their occupation by improving educational standards but positions of power were initially achieved by promoting skills rooted in domesticity. This, according to D'Antonio, allowed nurses to step out of 'or perhaps more importantly up from the traditional conventions of their particular starting place' but 'also created the boundaries that were often simultaneously both a source of strength and a dam around their ambition.'<sup>43</sup>

One such boundary may have been nurses' occupational health: to ignore the hazards of nursing was initially a source of pretended strength. It supported the idea that nurses were morally superior and fit to be considered a profession. After professional status was granted, it was still difficult for nurse leaders to identify health

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<sup>39</sup> D'Antonio, 'Revisiting and re-thinking the rewriting of nursing history'; Rafferty, *The Politics of Nursing Knowledge*; Davies, *Rewriting Nursing History*.

<sup>40</sup> A. Summers, *Female Lives, Moral States*, Newbury: Threshold Press Ltd, 2000, p.138.

<sup>41</sup> B. Mortimer and S. McGann (eds), *New Directions in the History of Nursing*, Oxford: Routledge, 2005, p.8.

<sup>42</sup> Rafferty, *The Politics of Nursing Knowledge*, p.67.

<sup>43</sup> D'Antonio, 'Revisiting and re-thinking the rewriting of nursing history', p.71.

hazards or raise demands to improve work conditions. As a result, the politics of professionalizing nursing left many aspects of the work itself marginal or invisible, according to Harrison.<sup>44</sup> The need to maintain a professional image involving devotion to duty meant that complaints about long working hours or poor pay were looked on as a lack of commitment and a contravention of the desirable attribute of self-sacrifice. D'Antonio argues that women bartered transient workplace exploitation and devaluation for the enduring status and prestige their identity as nurses gave them in their communities.<sup>45</sup> Our discussion will question whether exploitation was transient: evidence suggests that nurses' dissatisfaction with poor pay and long working hours continued until at least 1948. Despite significant improvements to work conditions in the period studied, some groups of nurses continued to feel exploited by both their employers and their professional body, the College of Nursing. This issue is explored in more detail in chapters four and five.

Moral superiority was perceived as an integral quality to the professional image of nurses and by emphasising it nurse leaders implied that nurses were invulnerable to disease. Brandt and Rozin also emphasise the link between health and morality. Rather than seeing disease as random and inevitable, societies have developed complex explanations for the causes and prevalence of disease. Embedded in such explanations are moral judgements that frequently link immoral behaviour as a cause of disease itself: Brandt and Rozin use the example of AIDS to illustrate the way some people believe that disease is God's punishment for sin. If morality and health are viewed as synonymous, then one who maintains a moral life need not be concerned about the dangers of disease.<sup>46</sup> The presentation of general nurses as morally superior therefore implied an invulnerability to disease. This made it difficult for nurse leaders to admit

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<sup>44</sup> Harrison, *Not only the 'Dangerous Trades'*, p.124.

<sup>45</sup> D'Antonio, 'Revisiting and re-thinking the rewriting of nursing history', p.280.

<sup>46</sup> A.M.Brandt & P. Rozin, *Morality and Health*, London: Routledge, 1997, p.1; p.4; p.389.



that nursing carried an occupational health risk.

Notions of class also shaped debates about nurses' health. Traditional historiography suggests that the major consequence of the Nightingale reforms was to turn nursing into a career for middle class women.<sup>47</sup> Another explanation for the change in class background of nurses has been the expansion of the general hospital system. This not only created a need for more nurses but changing medical knowledge meant doctors wanted efficient assistants with a wider knowledge of medical care who could observe, report and treat their patients.<sup>48</sup> In contrast Bashford associates the change in nurses' social background with the mid nineteenth century movement for sanitary reform. As part of the question of the moral/physical health and hygiene of the working class, Bashford links the increase in the number of middle class recruits with the Victorian desire to reform the working classes. By emphasising cleanliness, order and discipline, middle class nurses transformed their working class colleagues to fit an image of respectability.<sup>49</sup>

The view that nursing had become a middle class occupation by the late nineteenth century is challenged by Maggs and supported by more recent research. Maggs' study of general hospital nurses' origins concludes that nursing was a socially mixed occupation between 1881 and 1914 offering 'respectable employment to domestic servants, office or shop workers and marginal members of the middle classes.'<sup>50</sup> A similar picture is presented by Simnett's analysis of St. Bartholomew's Hospital.<sup>51</sup> Contemporary nurse commentators knew that the occupation was socially mixed but instead of referring to women from the working class spoke of women from

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<sup>47</sup> R. Dingwall, A.M. Rafferty, C. Webster. *An Introduction to the Social History of Nursing*, London: Routledge, 1988, p.69.

<sup>48</sup> Abel-Smith, *A History of the Nursing Profession*, p.17.

<sup>49</sup> A. Bashford, *Purity and Pollution Gender, Embodiment and Victorian Medicine*, Basingstoke: Macmillan Press Ltd, 1998, pp. 21-39.

<sup>50</sup> C. Maggs, *The Origins of General Nursing*, Beckenham: Croom Helm, 1983, p.78.

<sup>51</sup> A. Simnett, 'The Pursuit of Respectability: Women and the Nursing Profession', in R. White (ed.), *Political Issues in Nursing: Past, Present and Future Vol. 2*, Chichester: John Wiley and Sons, 1985.

the 'earnest class.' The standardisation of nurse training programmes was intended to wipe out any vestiges of 'class' and turn all women into members of this class. Earnestness was defined by the possession of certain basic virtues including obedience, truthfulness and kindness.<sup>52</sup> Despite the mixed social background of nurses, the occupation became dominated by a core group of middle class women. Although numerically insignificant, this group were influential in terms of status and habits of gentility. They are particularly important, as far as this study is concerned, because of their key role in shaping attitudes towards nurses' health between 1890 and 1932.

The idea that nursing was perceived as a respectable, middle class occupation helps to explain why it was not subject to state regulation to shorten working hours. 'Throughout the nineteenth and most of the twentieth centuries', Carpenter argues, 'hospitals have been explicitly excluded from the protective legislation that began in the nineteenth century with the passing of the first Factory Act.'<sup>53</sup> According to Harrison, 'middle class women's work ... was rarely considered to pose occupational health problems or to require intervention.'<sup>54</sup> Harrison and Mockett suggest that legislative intervention in women's employment was often made on the grounds that there were peculiar social problems resulting from their work, particularly the neglect of domestic and maternal duties.<sup>55</sup> Such ideas seemed to have carried a legitimate currency in a climate of debates about infant mortality and industrial efficiency.

Anxiety about a declining birth rate and concern about the health of the working class, based on Britain's need for a fit imperial race, not only placed great emphasis on women's reproductive ability but reinforced the idea that employed mothers were failures by being in paid work. Although middle class women did not escape

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<sup>52</sup> Maggs, *The Origins of General Nursing*, p.25.

<sup>53</sup> M. Carpenter, *Working for Health The History of COHSE*, London: Lawrence & Wishart Ltd, 1988, p.199.

<sup>54</sup> Harrison, *Not only the 'Dangerous Trades'*, p.106.

<sup>55</sup> B. Harrison and H. Mockett, 'Women in the factory: the state and factory legislation in nineteenth century Britain' in L. Jamieson and H. Corr (eds.), *State, Private Life and Political Change*, London: Macmillan, 1990.

accusations of being poor mothers, it was working class women that were most subject to scrutiny, particularly those working in factories and workshops. The danger of women's work and the threat it posed to the social and moral order of society was often debated in terms of occupational health risk. The production of physical and social ill health was framed within 'ideals' of appropriate behaviour and gender roles, both in relation to paid work and the domestic domain or family household. Late nineteenth century debates about the health of female cotton workers in the late nineteenth century are a good example of how the relationship between ideals of behaviour, work and health was constructed.

Women formed the majority of the cotton industry labour force and, viewed by contemporaries as a well-paid group, were economically independent. Their reputation for independence was enhanced by their jobholding following marriage and children and their high degree of unionisation. An image of independence provided a counterweight in a period when a woman's place was defined by a dominant ideology of domesticity, femininity and dependency.<sup>56</sup> This seems to have been a problem for some civil servants, health professionals including medical officers of health, and factory inspectors.<sup>57</sup> Debates about the health risks of shuttle kissing<sup>58</sup> were frequently expressed in gendered and sexualised terms focussing on an alleged immorality outside work.<sup>59</sup> One of the effects of this conflation of economic and family life was the belief that nurses' work did not threaten the social order of society. Because the late Victorian

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<sup>56</sup> A. Fowler, *Lancashire Cotton Operatives and Work, 1900-1950 A Social History of Lancashire Cotton Operatives in the Twentieth Century*, Aldershot: Ashgate Publishing Ltd, 2003, pp.23-45.

<sup>57</sup> *The Times* 20 June 1912

<sup>58</sup> Shuttle kissing refers to the weaver's practice of loading new cops of thread into the weaving shuttles by putting her lips over the outside of the shuttle eye and inhaling to draw the thread through. J. Greenlees, 'Stop kissing and steaming!': tuberculosis and the occupational health movement in Massachusetts and Lancashire 1870-1918 *Urban History*, 32, 2, (2005) p.227

<sup>59</sup> A. Fowler, *Lancashire Cotton Operatives and Work, 1900-1950 A Social History of Lancashire Cotton Operatives in the Twentieth Century*, Aldershot: Ashgate Publishing Ltd, 2003, p.46; C. Malone, 'Gendered Discourses and the Making of Protective Labor Legislation in England, 1830-1914', *Journal of British Studies*, 37, 1998.

image of nurses embodied many of society's ideal feminine characteristics, nurses were perceived as meeting the gendered expectations of women. Nurses' limited social lives as a result of the strict rules governing off duty hours protected them from the type of criticism some groups of working class women's lifestyles received.

The relationship between asylum attendants, their class background, gender and health is explored in this study. A sharp distinction is made between asylum and general nursing: although many asylum nurses and general nurses were drawn from working class backgrounds, the two groups of nurses had very different images. Whilst asylum nurses and attendants were perceived as predominately working class by the nursing press, general hospital nurses developed an image of middle class respectability. Another significant difference is that whilst asylum staff continued to be drawn from families who had been connected with the asylum system for years, general hospital nursing began to attract a more diverse type of recruit with educational qualifications.<sup>60</sup> Many attendants were working class men, employed partly on the grounds of their physical strength but also because of their low-level agricultural and workshop production skills essential for the supervision of patient labour and important to the economic activities of the asylum.<sup>61</sup> Carpenter suggests that asylum nursing was an occupation with low status and poor work conditions: the stigma of the insane was believed to rub off on those who worked with them.<sup>62</sup>

A disciplined nursing ideology is a key theme to this study which aims to examine how such ideas shaped attitudes towards and nurses' experience of ill health and whether these varied between types of hospitals and over time. Several historians have noted the relationship between the modernisation of general nursing and the imposition of a disciplined system of training that extended to control nurses' on and off

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<sup>60</sup> Nolan, *A History of Mental Health Nursing*, pp.48-50; Maggs, *The Origins of General Nursing*, p.79.

<sup>61</sup> Dingwall et al, *An Introduction to the Social History of Nursing*, p.126.

<sup>62</sup> Carpenter, 'Asylum Nursing Before 1914' in C. Davies, *Rewriting Nursing History*, p.143.

duty lives.<sup>63</sup> Rafferty suggests that it was a fundamental part of nurse education involving the development of character and self-control.<sup>64</sup> Bashford goes further, suggesting that discipline controlled behaviour, relationships and modes of surveillance of patients and staff. She applies Foucault's theory on the function of disciplinary systems to the modernisation of nursing: the imposition of timetables structured the constantly repetitive cycles of work, the precision of command, the regulation of detail and hierarchical observation and examination.<sup>65</sup> Arguing that whilst Foucault takes the army as exemplary and paradigmatic of modern regimes of discipline, Bashford suggests that the connections between nursing, religion and militarism were apparent. All three work by encouraging notions of self-sacrifice and service and demanding hierarchical obedience with the aim to create trained and disciplined 'bodies.'<sup>66</sup>

Asylum attendants were also subject to strict disciplinary control.<sup>67</sup> The late Victorian asylum resembled a 'penal colony', according to Carpenter: as pessimism set in about the possibility of curing insanity, asylums increasingly became a 'form of controlling permanently captive populations.' Carpenter notes that medical superintendents did not trust attendants to perform their duties unless compelled to do so by constant surveillance and harsh disciplinary measures.<sup>68</sup> Asylums 'rarely succeeded in their aspirations to recruit intelligent, kind attendants', according to Dingwall, instead 'they engaged ignorant and heavy handed disciplinarians ... who could only be kept in check by a regime that further diminished whatever possibility there might have been for attendant initiative.'<sup>69</sup> This limited view of attendants' role is examined in chapter four which suggests that asylum staff were capable of initiative

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<sup>63</sup> Bashford, *Purity and Pollution*, p.44; Rafferty, *The Politics of Nursing Knowledge*, p.27.

<sup>64</sup> Rafferty, *The Politics of Nursing Knowledge*, p.27.

<sup>65</sup> M. Foucault, *Discipline and Punish*, Harmondsworth: Penguin, 1991, p.178; Bashford, *Purity and Pollution*, p.44.

<sup>66</sup> Bashford, *Purity and Pollution*, p.44.

<sup>67</sup> Dingwall et al., *An Introduction to the Social History of Nursing*, p.127.

<sup>68</sup> Carpenter, *Working for Health*, pp.20-23.

<sup>69</sup> Dingwall et al., *An Introduction to the Social History of Nursing*, p.127.

particularly in relation to improving their work conditions.

The theme of power in relation to nursing work is important to this study: it aims to show who instilled nurses' discipline, improved work conditions and dictated how the practice of nurses' health care was to be delivered. Crowther suggests that a power struggle for authority over nursing arrangements arose between 1870 and 1900 arose because doctors felt threatened by the status of the new 'lady' matrons.<sup>70</sup> Abel-Smith and Witz agree that by 1880 the voluntary hospital matron had established herself as the head of an independent nursing department, controlling her own nursing staff without interference from lay administrators.<sup>71</sup> These accounts do not reveal whether all matrons held similar positions of power. The present study suggests a more complex picture with doctors, lay administrators and nurses competing for control of general hospital nurses.

Studies of the institutionalisation of the insane and role of the psychiatric profession in it, traditionally supported the argument that medical superintendents enjoyed an almost unlimited power within the asylum: Carpenter suggests that 'by the early twentieth century he appears to have become virtually an absolute monarch in the closed kingdom over which he ruled.'<sup>72</sup> New studies question the model of professional dominance and further argue that the active agency of the family in mediating forms of treatment and custody for a difficult relative was more important than has hitherto been recognised.<sup>73</sup> Smith, Murphy and Cellard view the handling of the insane as a mixed

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<sup>70</sup> A. Crowther 'Why Women should be Nurses and not Doctors.' 2002: 25 pars. Online UK Centre for the History of Nursing and Midwifery, Seminar Paper 2000-01.

Available at:<http://www.ukchnm.org/seminars01.html> [Accessed: 24 August 2008]  
<sup>71</sup> B. Abel-Smith, *The Hospitals 1848-1948*, London: Heinemann, 1964, p.68; A. Witz, *Professions and Patriarchy*, London: Routledge, 1992, p.140.

<sup>72</sup> Carpenter, *Working for Health*, p.21.

<sup>73</sup> J. Melling and B. Forsythe (eds.), *Insanity, Institutions and Society, 1800-1914: a social history of madness in comparative perspective*, London: Routledge, 1999; J. Melling, B. Forsythe and R. Adair, 'Families, communities and the legal regulation of lunacy in Victorian England. Assessments of crime, violence and welfare in admissions to the Devon Asylum, 1845-1914' in P. Bartlett and D. Wright (eds), *Outside the Walls of the Asylum*, London: Athlone Press, 1999, pp153-180, 304-311; R. Porter and D. Wright (eds.) *The Confinement of the Insane: International Perspectives, 1800-1965*,

economy of care provision with inputs from the private sector, charity and the state.<sup>74</sup> Melling and Forsythe argue that even a forceful superintendent with powerful patrons struggled to maintain freedom of action against the central state in the form of the Lunacy Commission, as well as local and central Poor Law authorities.<sup>75</sup> Carpenter's claim that the influx of general hospital trained nurses to asylum matron positions in the first decade of the twentieth century allowed medical superintendents to delegate control of the training school will be addressed, particularly in relation to the CLA. This analysis suggests that senior nurses' lack of power over any aspect of nursing including training may partly be explained by asylum nursing staff's lack of interest in national power in the form of nurse registration.

The campaign for nurse registration has been the subject of extensive historiography. According to Abel-Smith it was a thirty-year 'battle.'<sup>76</sup> General hospital nurses were divided into two camps: those in opposition followed the Nightingale line that power and status rested on the elite standing of the training hospital whilst its supporters, led by Bedford Fenwick, argued for state recognition in the form of nurse registration. Both groups recognised that registration would, firstly have an adverse effect on hospitals' finances and, secondly destabilise the division of labour and gender order. It was predicted that nurse leaders would stipulate conditions of service once professional status had been achieved.<sup>77</sup> The campaign disguised a deeper struggle for control of the private nursing market and the establishment of independent careers for nurses against the monopolistic tendencies of some elite

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Cambridge: Cambridge University Press, 2003.

<sup>74</sup> L. D. Smith, *Cure, Comfort and Safe Custody: Public Lunatic Asylums in Early Nineteenth-Century England* London: Leicester University Press, 1999; E. Murphy, 'The Administration of Insanity in East London 1800–1870', PhD thesis, University of London 2000; W. Llewellyn Parry-Jones, London: Routledge and Kegan Paul, 1971.

<sup>75</sup> J. Melling, B. Forsythe, *The Politics of Madness The state, insanity and society in England, 1845-1914*, London: Routledge, 2006, p.47.

<sup>76</sup> Abel-Smith, *A History of the Nursing Profession*, p.61.

<sup>77</sup> Dingwall et al., *An Introduction to the Social History of Nursing*, pp.80-81.

institutions.<sup>78</sup> According to Dingwall et al., voluntary hospitals had created ‘what was essentially a series of captive labour markets’ by training nurses specifically for their particular hospital making it difficult for them to move to other institutions.<sup>79</sup> This prevented nurses forcing wages up by competitive bidding.

The timing of the Registration Bill is key to an understanding of why nurses lacked power to improve their work conditions. Why did registration occur in 1919 and not before? Historians have traditionally explained the introduction of the Government’s Registration Bill at the end of the war as the ‘combined outcome of the occupation’s unity in the face of potential dilution from an influx of Voluntary Aid Detachment (VAD) nurses and a movement of public and political sympathy towards measures which enhanced the status of women, reflected in the extension of the franchise in 1918.’<sup>80</sup> Recent studies, including Rafferty and Dingwall, have challenged this view suggesting a more likely explanation that registration fitted in with the Government’s plans for post war social reconstruction.<sup>81</sup> The Government’s promise to extend welfare measures meant that it was essential that capable nurses could be easily identifiable. Rafferty notes that historians of nursing have tended to underestimate the importance of government policy in shaping nursing.<sup>82</sup>

The Registration Act has been seen as the coming of age for nursing professionally.<sup>83</sup> Bellaby and Oribabor challenge this assessment by questioning the degree of external autonomy and control nurses achieved. They suggest that internal contradictions beset professionalism in nursing: firstly registration failed to unify nurses because the College of Nursing failed to organise the occupation under the leadership of trained nurses and, secondly the state, who having granted a monopoly of practice to

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<sup>78</sup> Rafferty, *The Politics of Nursing Knowledge*, p.94.

<sup>79</sup> Dingwall et al., *An Introduction to the Social History of Nursing*, p.81.

<sup>80</sup> Dingwall et al., *An Introduction to the Social History of Nursing*, p.84.

<sup>81</sup> Rafferty, *The Politics of Nursing Knowledge*, p.77; Dingwall et al, *An Introduction to the Social History of Nursing*, p.86.

<sup>82</sup> Rafferty, *The Politics of Nursing Knowledge*, p.183.

<sup>83</sup> Abel-Smith, *A History of the Nursing Profession*, p.81.



registered nurses, ensured that no such monopoly was exercised.<sup>84</sup> Davies agrees that state recognition did not mean political autonomy; nursing continued to be controlled and regulated by the operation of the marketplace and the hospitals.<sup>85</sup> This study asks how and why nurse leaders were manipulated into a tightly constrained relationship with government where they were the weaker partners. It then examines the effect of this relationship on nurses' work conditions.

An understanding of the role of the College of Nursing is important to this question. It rapidly became the major spokesman for the profession and its attitude and policies had far reaching effects on nurses' working lives. The College was initially set up as a limited company in 1916 by Sir Cooper Perry (a member of the Army Medical Board and Medical Superintendent of Guy's Hospital), Dame Sarah Swift (Chief Matron of the British Red Cross Society and formerly matron of Guy's Hospital) and the Honourable Arthur Stanley (Chairman of the Joint War Committee of the British Red Cross Society and Order of St John, and from 1917, Treasurer of St Thomas's Hospital.)<sup>86</sup> Rafferty suggests that it was formed partly in response to the problem of the multiplicity of qualifications held by the growing number of 'nurses' but also as a way of controlling the nurse labour market.<sup>87</sup> Abel-Smith concludes that nurse leaders, including the College of Nursing, were primarily concerned with who should sit on the General Nursing Council (GNC) and what criteria should be used for admission to the nurse register rather than nurses' work conditions.<sup>88</sup>

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<sup>84</sup> Bellaby, Oribabor, 'The History of the Present - Contradiction and Struggle in Nursing' in C. Davies (ed.), *Rewriting Nursing History*, pp.147-174.

<sup>85</sup> Davies, *Rewriting Nursing History*, pp.102-119.

<sup>86</sup> Abel-Smith, *A History of the Nursing Profession*, p.87.

<sup>87</sup> Rafferty, *The Politics of Nursing Knowledge*, p.78.

<sup>88</sup> The GNC was set up in 1919 charged with the duty of maintaining a register of all trained nurses. It consisted of nine lay members and sixteen nurse members. Of the sixteen nurse members, eleven were matrons or ex matrons and five were nurses. Only two poor law infirmaries were represented. The College of Nursing had nine members on the Council confirming its position as major spokesman for the profession. Abel-Smith, *A History of the Nursing Profession*, pp.99-113; Rafferty, *The Politics of Nursing Knowledge*, pp.96-188.

The College of Nursing's concern to improve nurses' salaries and work conditions has been the subject of some historical debate. Baly argues that 'from the start' the College set out to improve pay and work conditions citing its research into nurses' salaries in 1919 as evidence.<sup>89</sup> Rafferty disagrees, suggesting that 'salaries were left to the vagaries of market forces or whatever benefit or degree of industrial organisation could be secured from hostile employers.'<sup>90</sup> Primarily concerned with the education of its members, the College of Nursing adopted an approach that combined the professional status of the Royal Colleges of Medicine with the representative function of the British Medical Association. Often perceived as exclusive, the College of Nursing attracted less than half the country's nurses including a small percentage of those from Poor Law Institutions. Its leaders tended to be hospital matrons. Whether it was democratic is questionable: rank and file members were not directly represented on the Council of the College or active at local levels.

The College of Nursing is viewed as fitting the model of non-feminist women's organisations, which emerged in the 1920s. These included the National Council of Women (NCW) and the Mother's Union, and allowed an accepted level of political involvement for women who did not want to engage in the radical feminist politics of the early twentieth century. By seizing upon issues that they identified as the natural domain of women and claiming them as areas of expertise, women 'exercised their responsibility as citizens, contributed to social reform, yet remained a respectful distance from public politics.'<sup>91</sup> Such organisations worked closely together, particularly the NCW and the College of Nursing, and membership often overlapped. Of particular interest to this study is the NCW's concern about nurses' health in 1919.<sup>92</sup>

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<sup>89</sup> M. Baly, *Nursing and Social Change*, London: Routledge, p.154.

<sup>90</sup> Rafferty, *The Politics of Nursing Knowledge*, p.141.

<sup>91</sup> S. McGann, A. Crowther, R.Dougall *A History of the Royal College of Nursing, 1916-1989: A Voice for Nurses*, Manchester: Manchester University Press, 2009, p.41.

<sup>92</sup> NCW, 'Report of the Special Committee on the Economic Position of Nurses', *BJN*, 27 September 1919, p.190.

The College interpreted their anxiety as an implicit challenge to its effectiveness. Both organisations simultaneously carried out surveys of general hospital nurses' pay and work conditions with the NCW surveying nurses' health. The NCW survey is an important primary source not only for its statistics but also for its opinions: of particular interest is its suggestion that the image of nurses was no longer based on qualities associated with motherhood.

The question of why general hospital nurses chose a college route of collective representation compared to asylum attendants' choice of trade unionism is important. Historians agree that asylum nurses made significant improvements to their work conditions through membership of a trade union.<sup>93</sup> Dingwall et al. state that

asylum work is important as much for its contribution to the unionisation of nursing as to the professionalist model of occupational development. Although nurses in Poor Law infirmaries had begun to unionise from 1885, the asylums saw the most substantial growth of an industrial model of organisation and were a crucial arena for the struggle between these rival modes of work orientation.<sup>94</sup>

Historiography has focused on nurses' gender and class as an explanation for their choice of occupational representation. Hart argues that 'young, white, Anglo-Saxon women from affluent backgrounds working in an acute teaching hospital' pursued the college route.<sup>95</sup> Many voluntary hospital nurses were ladies or had become a nurse with social aspirations, according to Abel-Smith, and therefore disapproved of trade unionism as it involved a degree of identification and sympathy with the working class.<sup>96</sup> This explanation seems inadequate in light of Maggs' study that nursing recruits were from mixed social backgrounds. Maggs suggests that nursing ideology influenced general

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<sup>93</sup> See Carpenter, *Working for Health*; C. Hart, *Behind the Mask, Nurses, Their Unions and Nursing Policy*, London: Baillere Tindall, 1994.

<sup>94</sup> Dingwall et al., *An Introduction to the Social History of Nursing*, p.129.

<sup>95</sup> Hart, *Behind the Mask*, p.41.

<sup>96</sup> Abel-Smith, *A History of the Nursing Profession*, p.132.

hospital nurses' choice of occupational representation by instilling a sense of superiority and manipulating aspirations for social mobility.<sup>97</sup> According to Carpenter, trade unions' lack of success in recruiting general nurses arose because nurses were effectively socialised into compliance with their role.<sup>98</sup> This study will examine whether nursing ideology, class background or deteriorating work conditions and high levels of ill health during the First World War shaped nurses' choice of occupational representation at the Cornwall Lunatic Asylum and the South Devon and East Cornwall Hospital.

The formation of the National Asylum Workers' Union in 1910, by a group of charge attendants from five Lancashire Asylums, has partly been explained by the male work culture believed to dominate asylum life and the poor, working class background of attendants. Whether the choice of representation reflected the issue of nursing as a vocation has been addressed. Chatterton argues that it was the lack of alternatives rather than a sense of vocation that led women into asylum work.<sup>99</sup> Male nurses, according to Nolan, 'were for the most part not greatly interested in patient care. They valued the job security which nursing offered them and the perks such as sport and drama which the mental hospitals provided.'<sup>100</sup>

The history of occupational health has followed a similar pattern to that of the history of nursing. It has recently looked towards a more critical scholarship of workplace illness and medicine and away from narrative accounts of the 'progress' of factory legislation and the 'growth' of medical knowledge about specific industrial hazards. Historians, according to Gillepsie, have begun to explore the complex relationship between the medical knowledge of occupational hazards and attempts by

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<sup>97</sup> Maggs, *The Origins of General Nursing*, p.84-88.

<sup>98</sup> Carpenter, *Working for Health*, p.166.

<sup>99</sup> C. Chatterton, 'Women in mental health nursing: angels or custodians?' *International History of Nursing Journal*, 5, (2) Spring 2000, pp.11-19.

<sup>100</sup> P. Nolan, *A History of Mental Health Nursing*, London: Chapman & Hall, 1993, p.94.

managers, workers and governments to control these hazards.<sup>101</sup> This study will focus on three occupational health diseases and the risk they posed to nurses: infectious diseases, ‘overstrain’ and tuberculosis.

Ideas about the risk infection posed to nurses were complicated by understandings of the germ theory of disease. Despite a general consensus in medicine from the 1880s onwards that most disease germs were bacteria, a lack of agreement on both a single bacterial model and how different ‘bacteria’ produced their pathogenic actions and were introduced into the body, allowed a series of debates to flourish which identified social factors as explanations of disease.<sup>102</sup> Some nineteenth and early twentieth century commentators questioned whether nurses’ class background or gender contributed to their susceptibility to infection.

In 1932 the incidence of tuberculosis (TB) amongst nurses began to attract widespread interest creating the impression that it was a new risk and the only occupational health risk nurses faced. This study will investigate what prompted such interest at a time when the incidence of TB in the general population was in decline. Sepkowitz concludes that it took several decades of debate before the idea that nurses were at increased risk to TB was established.<sup>103</sup> Worboys argument explains why. He identifies significant continuities in medical understandings after Koch’s assertion in 1882 that consumption was a contagious disease with a specific bacterial cause rather than a constitutional condition with hereditary origins. Although acceptance that tubercle bacillus played a role in the disease grew rapidly, uncertainty of why most infected people remained healthy allowed a complex series of debates to flourish which Worboys argues became less settled over time.<sup>104</sup>

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<sup>101</sup> R. Gillespie, ‘Accounting for Lead Poisoning: the Medical Politics of Occupational Health’, *Social History*, **15** (3) October 1990’, p.303.

<sup>102</sup> M. Worboys, *Spreading Germs Disease Theories and Medical Practice in Britain, 1865-1900*, Cambridge: Cambridge University Press, 2000, p.3.

<sup>103</sup> A. Sepkowitz, ‘Tuberculosis and the Health Care Worker: A Historical Perspective’, *Annals of Internal Medicine*, **120** (1) :71, 1994, pp.71-79.

<sup>104</sup> Worboys, *Spreading Germs*, p.193; p.231.

This is an important point: throughout the 1930s and 40s researchers questioned whether nurses' bodies were vulnerable to TB because of social factors including gender and class. Bates suggests that the image of the tuberculosis gradually transformed from a hereditary illness that could strike all social groups to an affliction confined to the poor.<sup>105</sup> Epidemiological studies produced scientific evidence of the association of tuberculosis with poverty, poor nutrition and housing. The strength of one's constitution, it was argued, depended on the influences of environment, diet, behaviour and other illnesses.<sup>106</sup> This study will suggest that general discussions of tuberculosis in early twentieth century society informed specific discussions of nurses' occupational health risk to TB. Changing perceptions of tuberculosis considered it to be no longer a middle class illness but now linked to the social and environmental problems of the working class population.

Historians have given little attention to the risk tuberculosis posed to general hospital nurses or asylum nurses. Indeed nursing is almost absent in the historiography of TB. Bryder focuses attention on specialist tuberculosis nurses working in sanatoriums rather than general hospital or asylum nurses. She suggests that sanatoria's difficulties in attracting staff were due to a lack of professionalism evident by the appointment of unqualified staff to specialist TB posts, the monotonous nature of the work, poor work and living conditions, and the institutions' isolated geographical location. Fear of infection amongst nurses increased during the 1920s and 1930s, and deterred potential candidates.<sup>107</sup>

Stress is currently perceived as a major cause of occupational ill health, particularly amongst general and mental health nurses.<sup>108</sup> There is little historical

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<sup>105</sup> B. Bates, *Bargaining for Life: A Social History of Tuberculosis, 1876-1938*, Philadelphia: University of Pennsylvania Press, 1992.

<sup>106</sup> Worboys, *Spreading Germs*, p.195.

<sup>107</sup> L. Bryder, *Below the Magic Mountain, A Social History of Tuberculosis in Twentieth-Century Britain*, Oxford: Oxford University Press, 1988, pp.170-171; p.241.

<sup>108</sup> W.R.J. Anderson, C.L. Cooper, M. Willmott, 'Sources of stress in the NHS: A comparison of seven occupational groups,' *Work and Stress*, Vol. 10, 1, pp.88-95;

literature on this subject. Cooper and Dewe's *Stress: A Brief History* explores different theories and models of stress noting fatigue and mental hygiene studies as areas studied in relation to work performance at the beginning of the twentieth century.<sup>109</sup> Of relevance to this study, is how the aetiology of stress has been constructed and explained.

Historians have yet to examine whether the development of industrial psychology had any impact on ideas about the selection and welfare of nurses. Previous studies of the period between 1930 and 1945 have focussed on political narrative or nurse education and training. Abel-Smith, Dingwall and Rafferty provide excellent accounts of political events leading to the nationalisation of nursing in 1948.<sup>110</sup> They agree that nurses lacked political power and played little part in determining policy during the Second World War and in the build up to the NHS.<sup>111</sup> The most important characteristic of this period to note, according to Rafferty, is that the repeated crises in nurse recruitment stimulated a number of investigations into its causes and 'elevated nursing into an issue of the highest priority.'<sup>112</sup> Several historians, including Abel Smith, have argued that the shortages were caused by an increased demand for nurses: as more acute sickness was treated in hospital, more nurses were required for hospital work.<sup>113</sup>

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H.Firth, P. Britton, 'Burnout', absence and turnover amongst British nursing staff', *Journal of Occupational Psychology*, Vol. 62, 1989, pp.55-59; R. Payne, J. Firth-Cozens, *Stress in Health Professionals*, Chichester: Wiley, 198; A. Weinburg, F. Creed, 'Stress and Psychiatric Disorder in Healthcare Professionals and Hospital Staff', *The Lancet*, 12 February 2000.

<sup>109</sup> G. Cooper & P. Dewe *Stress A Brief History*, Oxford: Blackwell, 2004.

<sup>110</sup> Abel-Smith, *A History of the Nursing Profession*, pp.161-191; Dingwall et al. *An Introduction to the Social History of Nursing*, pp.98-122; Rafferty, *The Politics of Nursing Knowledge*, pp.157-181.

<sup>111</sup> Rafferty, *The Politics of Nursing Knowledge*, p.173; Dingwall et al., *An Introduction to the Social History of Nursing*, p.109.

<sup>112</sup> Rafferty, *The Politics of Nursing Knowledge*, p.157.

<sup>113</sup> Abel-Smith, *A History of the Nursing Profession*, p.120.

## **Nurses' Health, Discipline, Class and Gender**

This thesis addresses the key issue of nurses' health and its relationship to military style, disciplined ideology; class; gender and nurses' choice of occupational representation by breaking the period up chronologically. It tackles the problem of assessing whether and why attitudes to nurses' health changed by assessing not only the importance attached to these key themes in each chronological period but also which social, cultural and political factors influenced change. Chapter two examines the relationship between a disciplined nursing ideology, the registration debate, the nineteenth century image of the nurse and the practice of health care in the case study hospitals in the 1890s. Registration threatened to change the balance of power between nurses, doctors and lay administrators. It prompted heated debate amongst nurse leaders as to the best way to achieve professional status. Both its supporters and opponents agreed that a disciplined ideology of self-sacrifice and sacred duty would help elevate the occupation's status. This chapter compares Matron Eva Luckes' of The London Hospital and Matron Hopkins' of the SDEC responses to the question of nurse registration and Nightingale's nursing reforms. It suggests that Luckes' commitment to military style discipline was partly driven by her opposition to registration and her determination to show alternative paths to professional status. Allegations that her system of training neglected nurses' health may have been designed to undermine her cause. In contrast, Hopkins' lack of interest in registration, disciplined ideology or nursing reform suggests a different, provincial model to that of the metropolitan, teaching hospital. Hopkins' relaxed attitude to nurses' health produced a system of health care that was tolerant, flexible and without denigration. In contrast to the metropolitan and provincial institutional models, which were not subject to state regulation, the Cornwall Lunatic Asylum's commitment to a disciplined nursing regime was the result of a complicated legal and institutional framework of asylum care. The



CLA had a different culture from that of the two voluntary hospitals insofar as discipline was necessary to contain its large number of insane patients. Its nurses were drawn from working class backgrounds, performed a job of low status and were treated as employees rather than members of a profession. Health care was not part of the system of discipline but discussed in terms of the Asylum's financial responsibility towards its employees.

Chapter three is concerned with how late Victorian ideas of gender and class shaped attitudes towards nurses' health in the late nineteenth and early twentieth centuries. As part of the reform of nursing in the 1860s, nurse leaders promoted a 'new' image of the nurse to which notions of gender and class were integral. In an effort to delineate between the early nineteenth century nurse and her work as an untrained domestic servant, the 'new' nurse was promoted as trained, middle class, chaste, clean and feminine. This image, and the issue of whether nursing was to be a refined form of domestic service with a subordinate place in the hospital or a new profession for largely middle class women with real knowledge and learning separate from but working with medicine rather than in a handmaiden's role, was called into question by suggestions that the 'new' nurse was not physically or mentally strong enough for the job of nursing. Commentators linked the rising levels of nurses' morbidity and mortality at The London Hospital with the increase in the number of middle class recruits entering training. In response to allegations that middle class femininity caused nurses' vulnerability to illness, groups of actors with vested interests in the issue of nurse registration often cited nurses' health as justification of their own ideas as to what shape the 'new' nurse's role was to be. For example, some doctors wanted the 'new' nurse to act as their technical assistant rather than performing menial cleaning duties. To further this argument, doctors alleged that middle class women lacked the physical stamina for cleaning and, in order to preserve their health, should only be employed in direct patient

care, observing the patient and reporting back to medical staff. Concern over the inclusion of male nurses on the same register as female between 1890 and 1919, raised the issue of men's role in nursing. Although there were very few male nurses, fear that men threatened female jobs led to intense scrutiny of their role. This chapter examines how ideas and ideals of masculinity were cited as reason for and against the employment and registration of men as nurses.

Chapter three questions why the health and work conditions of asylum nursing staff received little public attention despite the dangerous nature of the work and society's wider interest in the health of the working classes. Concern about physical deterioration and national degeneration, prompted by recruitment for the Boer War and the Report of the Inter-departmental Committee on Physical Deterioration (1903-4), linked ill health with poor housing, inadequate diet and lack of exercise amongst the working class.<sup>114</sup> This chapter considers the type of illness that affected nurses: in the late nineteenth century only two categories of occupational health disease (infection and overstrain) were linked to general hospital. The full implications of germ theory were not immediately apparent even after it was demonstrated by eminent scientists, allowing a series of debates to flourish that identified social factors as explanations of nurses' susceptibility to illness.

Chapter four examines nurses' health and work conditions at the Cornwall Lunatic Asylum and South Devon and East Cornwall Hospital during the First World War to assess their influence on nurses' choice of occupational representation. Historians have linked asylum nurses' choice of trade union representation with the male, working class culture of late Victorian asylums whereas voluntary hospital nurses' choice of the College of Nursing is related to the all female, middle class

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<sup>114</sup> D. Dwork, *War is good for babies and other young children: a history of the infant and child welfare movement in England, 1898-1918*, London: Tavistock Publications, 1987, pp.6-21.

occupation of nursing which valued intangible rewards of vocation and self-sacrifice.<sup>115</sup>

This chapter not only considers the impact of notions of class and gender but also evaluates whether asylum nurses suffered a greater deterioration in levels of ill health during the First World War than their voluntary hospital counterparts and therefore turned to trade unionism as a practical and necessary solution to problems the College of Nursing could not address. The College focused on goals of professional status rather than material improvements to pay and work conditions and were not a viable option to CLA nursing staff.

Chapter five considers why the 1919 Registration Bill failed to significantly improve nurses' work conditions. Nurse organisations' history of disagreement during the thirty-year campaign for registration allowed the Government to step in and control the registration agenda. The Government was determined to prevent nursing becoming a powerful, autonomous body setting its own conditions of service. Nurse organisations were manipulated into a weak, negotiating position from which they were unable to demand any economic improvements. This chapter reviews the reasons why the College of Nursing adopted a conservative, cautious approach to its recommendations regarding nurses' work conditions. It is suggested that its determination to uphold the values of discipline and self sacrifice, not to appear like a trade union and to retain the support of voluntary hospital management committees shaped the College's response to government plans to include nurses in legislation aimed at providing social insurance and reduced working hours for all groups of workers.

The relationship between nursing politics, occupational health and nursing ideology is assessed further through a study of the National Council of Women and its concern for nurses' health. The NCW's survey of nurses' work conditions and health, the first of its kind, undermined the role of the College and challenged one of the central tenets of late Victorian nursing ideology, that women's natural role as mothers entitled

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<sup>115</sup> Chatterton, 'Women in mental health nursing: angels or custodians?', p.166.

them to nurse. This chapter also considers whether the growth in interest in the occupational health of some groups of workers in private industry during the First World War prompted interest in the health of nurses.

Chapter six considers why tuberculosis emerged as an occupational health problem in the 1930s and not before. Acute shortages of nurses during the 1930s and 1940s and preparations for a National Health Service prompted a number of enquiries into nursing to attach increasing importance to nurses' health and particularly the problem of TB. A review of medical literature from 1880 onwards indicated that the Victorian idea that nurses were immune from TB was challenged from the mid 1920s by a number of international studies that concluded that the declining rate of TB in the general population had produced a generation of non-immune nurses because of their lack of exposure to the bacteria tubercle bacillus. These nurses were at a high risk from disease when exposed to older patients with TB. This chapter is concerned with how the conception of TB as a disease in early twentieth century society informed discussions about specific occupational illnesses, particularly nursing. Explanations of nurses' risk suggested a range of social factors, despite Koch's discovery in 1882 that TB was an infectious disease. It compares nurses' experience of TB between the three case study hospitals. These findings are then compared with those of *The Proffit Survey*, a ten-year national research project (1932-42) which looked at the relationship between 5,000 nurses, their class background, the incidence of TB and the type of hospital employed in.<sup>116</sup> This chapter suggests that notions of class continued to explain nurses' susceptibility to illness but that the class considered most vulnerable changed between 1890 and 1948 from middle to working class.

Chapter seven assesses the influence of industrial psychology on ideas about the selection and welfare of nurses between 1930 and 1948. Recurrent recruitment

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<sup>116</sup> M. Daniels, F. Ridehalgh, V.H. Springett, *Tuberculosis in young adults - Report of the Proffit Survey 1935 - 1948 including work done by I.M. Hall*, London: H.K. Lewis & Co., 1948

problems and preparations for a National Health Service stimulated a number of enquiries into nursing that placed importance on industrial psychology. The traditional disciplined nursing ideology of the late nineteenth century was challenged by the argument that freedom and self-discipline would attract recruits and improve nurses' health. Criticism highlighted the powerful role of the matron, the selection of nurses, nurses' low morale and high wastage rates and made psychological recommendations. This chapter examines psychology's influence on the practice of nurses' welfare at the three case study hospitals and discusses whether any changes to management practice were a pragmatic response to labour shortages involving minimum expenditure or reflected the influence of industrial psychology. It identifies an important change in the relationship between notions of gender and the image of the ideal nurse. Nineteenth century nurse leaders promoted leadership skills learnt from household management as feminine and a qualification to care. By 1948, psychologists had labelled management qualities as masculine: the ideal nurse was now considered a combination of masculine and feminine qualities.

Chapter eight concludes that attitudes towards and nurses' experience of their ill health was shaped by a combination of political, social and cultural factors. It relates variations in individual nurses' experiences across time and between place to the contrasting institutional cultures of rural, provincial and metropolitan hospitals and between general and mental hospitals. It argues that changing notions of gender, class and discipline shaped both national conversations about nurses' health but also local debates at individual institutions. It places nurses' health within a political framework to conclude that nurse leaders' pursuit of professional status and identity explains why nurses' occupational health failed to be taken seriously before the 1940s. Recurrent recruitment crises and nurses' increasing dissatisfaction with poor work conditions attracted attention to the issue of nurses' health. Demands for an occupational health

service were supported by the rising incidence of TB amongst nurses, improved recruitment and retention techniques in the military services developed during the Second World War, the influence of industrial psychology and the growing popularity of a 'progressive' style of school education.<sup>117</sup>

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<sup>117</sup> M. Thomson, *Psychological subjects: identity, culture and health in twentieth century Britain*, Oxford: Oxford University Press, 2006.

## CHAPTER TWO

### **“To Help A Million Sick, You Must Kill A Few Nurses.”<sup>118</sup> Discipline and Nurses’ Illness 1890-1919**

In 1890, Nurse Mary Raymond claimed that nurses at The London Hospital ‘did not like to apply’ to see a doctor ‘and to say that they are ill. They are liable to get dismissed.’<sup>119</sup> Raymond said that these nurses feared that an admission of illness would be perceived by Matron Eva Luckes as a sign that they lacked the necessary discipline to nurse. Nurse leaders like Florence Nightingale, Ethel Bedford Fenwick and Eva Luckes espoused values of devotion to duty, self-sacrifice, hierarchical obedience and respect for authority. This chapter examines the relationship between a system of disciplinary nursing ideology that incorporated these values and the practice of nurses’ health care at the three case study institutions. It seeks to address four questions; did all voluntary hospital and asylum nurses share Raymond’s fear or were attitudes shaped by the importance attached to discipline at each institution? Who instilled discipline over nurses and what factors shaped their exertion of power?

Historians have suggested several reasons why discipline became an essential element of general nurse training during the late nineteenth century. Maggs and Starns link its emergence with the search for professional status.<sup>120</sup> The invocation of the military was common in discourse on the registration of nurses. In order to mark the ‘new’ general hospital nurse as different not only to the old style of nurse, typified by Charles Dickens’ fictional character ‘Sarah Gamp’, but other types of nurse in the late nineteenth century, nurse leaders emphasised technical training and a knowledge of contemporary medical practice as well as character, subordination and purpose. Nurses

<sup>118</sup> RLH, *Pall Mall Gazette*, LH/A/26/5, 7 September 1890.

<sup>119</sup> *Select Committee of the House of Lords on the Metropolitan Hospitals, Provident and Other Public Dispensaries and Charitable Institutions for the Sick Poor* PP 1890 (392) Vol. XVII. Chaired by Lord Sandhurst and hereafter known as the *Sandhurst Report*.

<sup>120</sup> Starns, *March of the Matrons*, p.19; Maggs, *The Origins of General Nursing*, p.14.

were trained in behaviours, relationships and modes of surveillance of their patients and each other as much as they were in trained in elementary anatomy and physiology.<sup>121</sup> Poovey argues that the domestic narrative on which nurse leaders had built a case for professional status converged quite neatly with a militaristic system of training without any sense of contradiction.<sup>122</sup> The pursuit of status was further enhanced by the adoption of elitist recruitment practices borrowed from the military nursing sector. Starns suggests that despite Nightingale's advocacy of a one portal system of entry for nurse training, hospitals in practice favoured a two-tiered system. The emerging profession was divided between middle and upper class lady pupils who paid for their instruction and avoided the more menial duties, and working class pupils who worked for their training by performing most of the domestic tasks. By the end of the nineteenth century the nursing profession was dominated by middle class women, whose social affiliations mirrored those of the military elite.<sup>123</sup>

Discipline was also necessary to overcome the notion that all women could nurse instinctively: the idea that only those who were truly dedicated were able to endure training, enhanced an image of a superior, elitist profession. To bring out the true woman as a nurse, according to Maggs, 'the training system had to instil a rigid code of behaviour and self-discipline ... to top up any quality deficient in the entrant or to draw out to the maximum the natural talent.'<sup>124</sup> Maggs argues that the process of moral training, which emphasised obedience above all else, was largely an informal process, a code of behaviour, which the recruit learnt in the same way as a child, by making mistakes and being punished, by doing well and being rewarded. The home motif that percolated this style of hospital discipline was based on the middle class

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<sup>121</sup> Rafferty, *The Politics of Nursing Knowledge*, p.44.

<sup>122</sup> M. Poovey, *Uneven Developments: The Ideological Work of Gender in Mid-Victorian England*, Chicago: University of Chicago Press, 1988, p.15.

<sup>123</sup> Starns, *The March of the Matrons*, p.18.

<sup>124</sup> Maggs, *The Origins of General Nursing*, p.15; Gamarnikow, 'The Sexual division of Labour: The Case of Nursing', pp.110-111.



construct of the family with its divisions of roles and spheres between the sexes. Rules that made the life of the probationer difficult could, according to Maggs, be justified by reference to the acknowledgement of the authority of the doctor/man.<sup>125</sup> Rafferty suggests that the disciplined order in hospitals rationalised men's right to supervise and superintend the behaviour of women.<sup>126</sup> This chapter will question whether men enjoyed such rights in all voluntary hospitals and suggest that discipline could be shaped by the political aspirations of female matrons.

Several historians suggest that by 1880 matrons in voluntary hospitals had established themselves as the head of independent nursing departments who were able to control nursing staff without interference from lay administrators or doctors.<sup>127</sup> Abel-Smith observes:

Over the nurses themselves the matron wielded absolute power. This power was reinforced by the paramilitary organisation of the nursing staff and the rigid discipline imposed in the training schools.<sup>128</sup>

This comment implies that the matron's authority was related to her competency in management and commitment to a disciplinary nurse education. A study of the matron's role in the case study hospitals will investigate whether an ability to organise both nursing and housekeeping departments and deliver a programme of nurse training dictated the degree of power accorded to the matron. The matron's abuse of power has been recognised as a source of bullying: Bowman suggests that poor work conditions 'were exacerbated by a tradition of constant bullying and purposeful fault-finding by the sisters' which had its 'parallel in the ranks of the Regular Army.'<sup>129</sup>

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<sup>125</sup> Maggs, *The Origins of General Nursing*, p.15.

<sup>126</sup> Rafferty, *The Politics of Nursing Knowledge*, p.28.

<sup>127</sup> Abel-Smith, *The Hospitals 1848-1948*, p.68; Witz, *Professions and Patriarchy*, London: Routledge, 1992, p.140.

<sup>128</sup> Abel-Smith, *A History of the Nursing Profession*, p.29.

<sup>129</sup> C. Bowman, *The Lamp and the Book: the story of the Royal College of Nursing, 1916-1966*, London: Queen Anne Press, 1967.

The introduction of discipline has also been linked with the secularisation and modernisation of medicine. Turner takes nursing as an exemplar of Weber's theories on the transformation of religious to secular culture.<sup>130</sup> modernisation has been about 'the transfer of moral regulation from the church to the clinic ... medicine occupies the social space left by the erosion of religion.'<sup>131</sup> The rituals and work practice of a range of modernising institutions, including nursing, were, Turner suggests 'anticipated by the discipline of the monastery in which bodies were subordinated to ascetic rules of practice.'<sup>132</sup> Bashford defines 'ascetic' to mean severely abstinent and austere for some spiritual benefit, a benefit to be achieved through self-discipline and hardship, sacrifice and even pain. Weber's theory suggests that religious calling or 'vocation' came to be the model for professions, which subsequently came to be defined 'by market forces, technical, mechanical and rational logic.'<sup>133</sup> Historians disagree whether religion maintained influence over nursing: whilst Bashford suggests that religion and questions of morality were an ongoing influence, particularly shaping notions of sacrifice and hierarchical obedience, Turner argues that nursing's need for religious legitimation declined as it increasingly became a secular and bureaucratic organisation.<sup>134</sup>

Discipline served a number of practical functions in voluntary hospitals. It was originally instilled, according to Baly, because Florence Nightingale regarded hospitals as lawless and corrupting places.<sup>135</sup> Hospitals were often built in morally insalubrious and shady areas.<sup>136</sup> Discipline was used to instil conformity but had a negative effect of

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<sup>130</sup> B.S. Turner, *For Weber, Essays on the Sociology of Fate*, London: Routledge & Kegan Paul, 1981, pp.177-199.

<sup>131</sup> B. S. Turner, 'Recent Theoretical Developments in the Sociology of the Body', *Australian Cultural Theory*, 13, 1994, p.27.

<sup>132</sup> B.S. Turner, 'The Discourse of Diet' in M. Featherstone, M. Hepworth and B. Turners, (eds.), *The Body: Social Process and Cultural Theory*, London: Sage, 1991, p.158.

<sup>133</sup> Bashford, *Purity and Pollution*, pp.42-43.

<sup>134</sup> Bashford, *Purity and Pollution*, p.43, Turner, *For Weber, Essays on the Sociology of Fate*, p.181.

<sup>135</sup> Baly, *Nursing and Social Change*, p.122.

<sup>136</sup> Rafferty, *The Politics of Nursing Knowledge*, p.35.

breeding an unquestioning profession that was resistant to change.<sup>137</sup> Hospital administrators supported a reform of nursing that hinged upon the adaptation of character and a disciplined order in hospitals because they wanted to rehabilitate their reputations and the economic viability of the institutions they managed. Discipline was important as a way of ensuring decorous conduct between men and women of different social classes in the new social environment of the hospital but also taught the nurse self-control in order to suppress her revulsion at unpleasant sights and smells.<sup>138</sup>

In contrast to general nursing, historians have not interpreted the strict discipline that governed asylum nurses' lives as part of a bid to achieve professional status. Indeed, Bedford Fenwick excluded asylum nurses from her campaign for registration, arguing their low status prevented them holding the title of nurse.<sup>139</sup> In order to compare the systems of discipline in hospitals and asylums, one must distinguish between the two types of environment. The asylum had its own distinctive legislative framework and culture that meant it was inevitably different from general hospitals not under direct state regulation. The Lunacy Commission, established in 1845, was a central body which provided a 'new framework for the provision and administration of institutions designed to confine the lunatic.' The Commissioners were responsible for the inspection of all such institutions. The power of the Lunacy Commission was strengthened by further legislation between 1845 and 1862 and in 1890 The Lunacy Act increased the power of the Lord Chancellor's office to monitor all places where the insane were housed and dictated their care and treatment. Melling and Forsythe suggest that Lunacy Commissioners' roles were limited, largely confined to inspections and public criticism of poor standards.

By the 1860s-70s, the optimism on which asylums were founded had faded as psychiatrists such as Maudsley moved towards the theory that madness could be

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<sup>137</sup> Baly, *Nursing and Social Change*, p.122.

<sup>138</sup> Rafferty, *The Politics of Nursing Knowledge*, p.25-29.

<sup>139</sup> Nolan, *A History of Mental Health Nursing*, p.69.

transmitted from one generation to the next.<sup>140</sup> Asylums had become ‘custodial institutions governed by a complicated legal code concerned only with excluding lunatics from society at large and confining them at the cheapest cost in secure and remote surroundings.’<sup>141</sup> Asylum nursing staff were subject to the same complex set of rules as patients and to the expectation of automatic and unquestioning obedience. This suggests a very different environment for nurses and patients at The London Hospital and the SDEC which aimed to provide care and treatment.

Constant surveillance and harsh disciplinary measures were also necessary because medical superintendents did not believe that nursing staff would perform their duties conscientiously unless they were compelled to do so. Carpenter argues that such low trust led to military, even penal, discipline being imposed on staff. Attendants and nurses were contemptuously regarded as subordinate staff whilst the medical superintendent had traditionally assumed the role of a commanding officer. Nursing staff were subject to a number of fines for misdemeanours such as allowing a patient to escape, losing a key or not turning a light off.<sup>142</sup>

Having considered the historiography surrounding discipline in voluntary hospitals and asylums, the focus of this chapter will turn to the three case study institutions and the relationship between discipline and nurses’ health.

## **The London Hospital**

In 1890, the system of nurses’ discipline and its affect on nurses’ health at The London Hospital became the focus of government and newspaper attention. Critics alleged that the Hospital’s Matron, Eva Luckes, had misused her considerable power to force nurses to work when ill and, as a result, nurses’ mortality rate had risen during the previous two years. The question of nurse registration had created public interest in nursing and

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<sup>140</sup> Melling, Forsythe, *The Politics of Madness*, p.10, p.13.

<sup>141</sup> Chatterton, ‘Women in mental health nursing: angels or custodians?’, p.13.

<sup>142</sup> Carpenter, *Working for Health*, p.24.

Luckes, as registration's leading opponent, attracted significant attention. This section will examine the reasons why London Hospital nurses' health became the focus of a government enquiry into the state of the metropolitan hospitals. It will then pick apart the relationship between discipline and nurses' health by focussing on the case of probationer nurse, Ellen Yatman. Yatman's case was chosen as evidence not because she was the only example of a nurse who clearly suffered from exhaustion as a result of long working hours but because of the way Luckes interpreted her bouts of ill health as an indication of her lack of vocation to nurse. Finally, this section will analyse how Luckes built up a strong power base and the effect this had on her relationships with other key figures within the hospital and on the system of health care offered to nurses.

By 1890, the ill health of nurses employed at The London Hospital had attracted the attention of a Select Committee of the House of Lords and national newspapers. There are three possible explanations why. Firstly, several of the Hospital's thirty lay governors resented the power that Luckes had built up during her ten years in post. This perceived problem was compounded by increasing criticism in the medical and lay press that voluntary hospitals were drifting into a state of long-term bankruptcy because of their refusal to treat paying patients. The Governors complained to the Charity Organisation Society, who in turn petitioned Lord Sandhurst, demanding that a Select Committee of the House of Lords enquire into the work of the metropolitan hospitals.<sup>143</sup> The Committee was given a broad remit which included the general management, staffing, funding, accommodation, treatment, charges and sanitary conditions of all the metropolitan hospitals, dispensaries and charitable institutions dealing with the "the sick poor" but spent a substantial amount of time examining witnesses from The London Hospital. Of the twenty-three meetings held, ten were concerned with The London and

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<sup>143</sup> A.E. Clark-Kennedy, *The London: A Study in the Voluntary Hospital System*, Vol. 2 London: Pitman Medical Publishing, 1963, pp. 104-105. The Charity Organisation Society was founded in 1869 and attempted to coordinate the work of charitable institutions and the Poor Law, offering an alternative to the welfare state as a means of realising a better society.

with allegations that it neglected nurses' health.

The second explanation for the Committee's focus on The London Hospital, reported in contemporary newspapers, was the outbreak of an acrimonious dispute that developed over nurse registration involving Luckes. The campaign for registration began in 1887 prompted by the introduction of nurse training and the demand for a distinction between trained and untrained nurses. It quickly developed into a battle between its supporters who wished to establish nursing as an autonomous profession, controlling its own fees and conditions of service, and opponents who wished to preserve and maintain the dominance of the voluntary hospitals' existing system of management. The supporters were led by Ethel Bedford Fenwick, former Matron of St Bartholomew's Hospital, founder of the British Nurses' Association and editor of the only nursing journal published in 1890, the *Nursing Record and Hospital World*. Opponents to registration were led by Dr Sydney Holland, Chairman of The London Hospital, Eva Luckes and Dr Moore of St Bartholomew's Hospital.

Several contemporary newspaper reports questioned the reliability of evidence given to the Select Committee. They suggested that Bedford Fenwick had selected the witnesses testifying about London Hospital work conditions on the grounds that they had held a grudge against the Hospital. This raises an important point since much of the evidence of nurses' illness at The London Hospital comes from witness evidence to the Select Committee. One cannot trust the evidence as factual beyond challenge. As mentioned in chapter one, all sources have ideological baggage that needs to be unpacked in order to gain an understanding of contemporary perceptions of nurses' ill health.

A third reason for the Committee's focus on The London can be found in the rising mortality rate amongst its nurses during the preceding two years: eight nurses died during 1888-1890 compared to seven deaths between 1880-1888. It is difficult to

confirm whether this was a generalised trend without comparative data from other hospitals, a point argued by the *British Medical Journal (BMJ)* at the time. The *BMJ* also questioned whether increasing mortality numbers simply reflected the fact that the number of nurses employed had risen.<sup>144</sup>

In 1890, probationer nurse Ellen Yatman told the Select Committee of the House of Lords that nursing had caused her ill health. Yatman was twenty-five when she started nurse training at The London Hospital in April 1888 but left after eighteen months because of repeated bouts of illness. She entered nurse training as a paying probationer, paying thirteen guineas for three month's training. This, and the fact that Yatman had lived at home and not worked during the gap between school and commencing training, suggests that she came from a reasonably affluent background. During her eighteen months as a probationer nurse she constantly suffered, along with 'most of the nurses' from 'being overworked' and 'generally overtired.' Yatman completed an average of eighty-three hours per week from seven am until nine-twenty pm with two hours off in the afternoon.<sup>145</sup> She was allowed one day holiday a month from ten am to ten pm, one week at six monthly intervals and would have received a month as unpaid leave at the end of the two year training period had she completed her training. The majority of her working day was spent performing menial duties including sweeping and dusting the ward three times a day, washing the patients' tea and breakfast crockery, cleaning all utensils and instruments, polishing all brass and crockery and cleaning the ward sister's room.

Yatman claimed these duties detracted from patient care. The problem of overwork, she argued, arose not only from the long working hours but from the shortage of trained staff which resulted in inexperienced nurses being placed in positions of

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<sup>144</sup> *BMJ*, 13 September 1890, p.646. I was unable to compare the mortality rate of The London Hospital with that of the SDEC because detailed records of nurses' sickness at the later hospital are only available from 1903.

<sup>145</sup> *Sandhurst Report*, p.295.

responsibility and overcrowded wards with an inadequate nurse to patient ratio.

Nurses' food was badly cooked and poorly presented, particularly for those on night duty who cooked their own meal on the ward.<sup>146</sup> When questioned why she had not complained Yatman replied that she 'did not think nurses as a rule complain, they talk to each other about it.' Her short lived nursing career came to an end when she contracted 'blood poisoning ... from sewer gas', a smell she believed emanated from the sink basins in the ward she had worked on but affected most parts of the hospital including the night nurses' quarters. Several other nurses in the seven-bedded nurses' sick room where Yatman was admitted had been given the same diagnosis.<sup>147</sup>

Yatman's case is a good starting point from which to examine the construction of late Victorian nurses' health. She represented most aspects of the image of the 'new nurse' discussed in chapter one: female, clean and middle class. What she lacked, according to Luckes, was the essential quality of self-sacrifice: she was not prepared to endure ill health as part of her commitment to sacred duty.<sup>148</sup>

The ability to endure long hours and poor work conditions was seen as a test of dedication beyond that of the ordinary worker. Records suggest that those who failed to tolerate the arduous requirements of a nurse's life were often dismissed from The London on the grounds that they lacked the necessary physical strength or vocation to nurse. Luckes used the analogy of a soldiers' commitment to personal sacrifice to illustrate the level of devotion to duty required of nurses facing the risk of contracting

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<sup>146</sup> *Sandhurst Report*, pp 293-232. Louisa Twinning, a leading campaigner for reform of workhouses and workhouse nursing, noted the detrimental effect inadequate diet had on nurses' health in a paper presented to a meeting of the Hospitals' Association in 1885. She spoke of 'the lamentable neglect even in training homes for probationers who pay largely for their board' with the result of 'an entire break-down of health.' The nature of nurses' work caused a loss in appetite, according to Twinning, and food needed to be appetising to encourage nurses to eat. See *Sandhurst Report*, p.234, for discussion of nurses' diet at The London Hospital and *The Lancet*, 26 July 1890, 1890 for a report highlighting the lack of variety and absence of fruit in nurses' diet nationally.

<sup>147</sup> *Sandhurst Report*, pp. 294-296.

<sup>148</sup> E. Luckes, *Lectures on General Nursing: delivered to the probationers of The London Hospital Training School for nurses*, London: Kegan Paul, Trench Trubner, 1888, pp. 276-278.



infection.

Women who fear infection for themselves are greatly to be pitied, but they have no business to be Nurses ... it is this element of personal danger ... which places the work of soldiers and of Nurses on the same level. Nothing can tempt the true Nurse or the true soldier from the post of danger when duty places them there. It is this very fact that sheds a halo over the ideal of a Nurses' work.<sup>149</sup>

Luckes acknowledged that a nurse's death may arise 'as a direct consequence of attending to her patient' but claimed this was a price worth paying in order to 'sanctify the work' and evoke inspiration in others.<sup>150</sup> She considered obedience an essential quality of a probationer who 'must not add to the difficulties of those whose duty it is to rule by questioning what they say. ... There may be excuses for ignorance on the part of the probationer, but be sure there can be none for disobedience.'<sup>151</sup> Indeed, an act construed as disobedient by Luckes could lead to instant dismissal. Military influence on the nursing profession was clearly evident during the late nineteenth century. Whilst Starns recognises that militarism played a part in the Nightingale system, her argument that it gained increasing importance, particularly during the Second World War, fails to attach sufficient weight to its influence in the 1890s (see chapter one, pp.20-21, chapter seven, p.246).<sup>152</sup>

Luckes interpreted Yatman's bouts of ill health as an indication of her lack of vocation to nurse. Nurses at The London with health problems were often perceived as self-centred, troublemakers who contravened the dominant ideology of self-sacrifice and obedience. Despite Yatman's admission to the nurses' sick room with an illness that had affected several other nurses, Luckes doubted the authenticity of her ill health.

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<sup>149</sup> Luckes, *Lectures on General Nursing*, p.278.

<sup>150</sup> Luckes, *Lectures on General Nursing*, p.278.

<sup>151</sup> *Sandhurst Report*, p.342.

<sup>152</sup> Starns, *March of the Matrons*, pp.17-24.

She noted in the Probationers' Register that:

Ellen Yatman was constantly complained of as an idle, unpleasant and inefficient [nurse], she was very selfish in worth, thinking last of her patients and much of her own convenience. She was an inveterate grumbler and by no means straightforward. She had no scruple in breaking her engagement when she fancied her health broken down.<sup>153</sup>

Luckes implies that Yatman imagined her ill health, a character failure Luckes often linked with a selfish personality. She believed that an ideal nurse should ignore poor health as part of her devotion to duty.

Discipline was key in the training and role of the 'new nurse' and shaped the pattern of health care offered to nurses at The London Hospital. Probationers were likened to 'metal that must be hammered into shape'; hardship, discipline and cleanliness were believed necessary to the development of self-sacrifice and 'the highest type of character.'<sup>154</sup> Rules and regulations dictated behaviour both at work and within the nurses' home.<sup>155</sup> Attendance at meal times and chapel was compulsory for all probationers. Time regulation was enforced and controlled patterns of sleeping, eating, working and exercise.<sup>156</sup> For example, probationer nurses finished night duty at 9.20am and then returned to their rooms until 10am when dinner was served. This was followed by two hours of recreation and then bed at 1pm. They were woken up at 6.30pm and allowed a further two hours of recreation before returning to duty at 9.20pm.<sup>157</sup>

Luckes was a strict disciplinarian who used the rationale of caring for nurses'

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<sup>153</sup> RLH, The London Hospital Register of Nurse Probationers, LH/N/1/2, April 1884 - August 1888, p.227.

<sup>154</sup> Miss Mollett, 'What is the present position of the Nurse in the estimation of the General Public?', *BJN*, 18 October 1913, p.311.

<sup>155</sup> S. Holland, *A Talk to the Nurses of the London Hospital*, London: Whitehead Morris & Co., 1897, pp.17-18.

<sup>156</sup> Maggs, *The Origins of General Nursing*, p.123.

<sup>157</sup> *Sandhurst Report*, p.297.

health to extend the disciplined environment imposed on probationers. She also exerted herself to implement change to nurses' work conditions. How did Luckes achieve her position of authority within a decade of her arrival as Matron? Luckes trained at the Westminster Hospital and after several months as a night sister at The London Hospital became lady superintendent at the Pendlebury Children's Hospital, Manchester. She resigned from this post after clashing with the Medical Committee over her efforts to instigate reforms in the standard of nurse training. She was appointed Matron of The London Hospital in 1880 at the age of twenty-four. Many of the Hospital Committee's members thought her too young and inexperienced at her interview. A small majority selected her because she had already constructed a step-by-step programme of reform, according to Sir Frederick Treves.<sup>158</sup>

One of Luckes' priorities was to improve nurse education: in 1881 she introduced a system of theoretical and practical training which incorporated nursing ethics.<sup>159</sup> The medical staff supported her commitment to education and disciplined ideology and its utilisation as a framework of care for nurses. Luckes' ideas about education demonstrate two dichotomies. Firstly, despite her belief that 'you can no more make a nurse of a woman who has not a gift for nursing than you can make a musician of a person who has no ear for music', she promoted an increasingly scientific approach to nurse education and practice.<sup>160</sup> Medical advances in antisepsis and anaesthesia during the 1880s meant that many people began to see both medicine and nursing as scientific.<sup>161</sup> Developments in medical practice led doctors to demand different knowledge from those who spent time with their patients.<sup>162</sup> Secondly Luckes' opposition to registration on the grounds that the essential qualities of a good nurse would be subordinated to theory and exams did not prevent her introducing

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<sup>158</sup> Clark-Kennedy, *The London*, p.95

<sup>159</sup> Clark-Kennedy, *The London*, pp. 95-97.

<sup>160</sup> *Sandhurst Report*, p.410.

<sup>161</sup> Baly, *Nursing and Social Change*, p.124.

<sup>162</sup> Dingwall et al., *An Introduction to the Social History of Nursing*, p.32.

examinations for probationers in 1882. Nursing textbooks began to proliferate during the 1880s; earlier textbooks based on simple, manuals of hygiene, written by doctors, became more elaborate and were authored by trained nurses as well as doctors, detailing instructions and rationale for nursing procedures.<sup>163</sup> Luckes contributed to this body of work in 1884 with her *Lectures on General Nursing*, adding *Lectures to Ward Sisters* in a second edition published two years later. By 1890, she had established herself as an authority on nursing practice, thus empowering her challenge to an entrenched Hospital Governors' Committee who assumed her youth meant lack of experience and sought to limit her drive for reform.

The London Hospital's Governors' Committee was made up of thirty laymen and formed a stable body with little change in membership. Doctors were not allowed to sit on it or the House Committee. Many of the governors had business backgrounds and included members of the landed gentry. Luckes' had steadily increased her power over nurses' work conditions during her first ten years in post at the expense of both the governors and the House Committee, some of whose members felt determined to bring her back under their control. The House Governor for twenty-one years, William Nixon, complained that nursing management 'had been taken out of his hands.'<sup>164</sup> Disagreements occurred over improvements and financial expenditure. Luckes' persistence and determination to make changes paid off, allowing her to implement a number of significant reforms. For example, in 1881 nurses' diets were improved by the introduction of regular meals and nurses' workload reduced with the employment of twenty-two ward maids.<sup>165</sup> By 1890 Luckes had convinced the Chairman of the House Committee, Francis Carr Gomm, that she should be 'entirely responsible for nursing

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<sup>163</sup> Maggs, *The Origins of General Nursing*, p.115.

<sup>164</sup> *Sandhurst Report*, p.318.

<sup>165</sup> RLH, E. Luckes, 'Trained Nursing at the London Hospital', *The New Review*, No. 17, LH/A/26/5, October 1890, pp.291-298. Nurses' working hours were reduced with the introduction of timetables replacing the four hours a week off duty with two hours a day. Holidays were doubled from one to two weeks.

management.’<sup>166</sup> This decision led to the allegation ‘that too much power is entrusted to the Matron’, which was debated at length by the Select Committee on Metropolitan Hospitals.<sup>167</sup> The apparent high levels of nurses’ illness and rising mortality rate amongst nurses were used to question her ability to hold a position of authority.

The system of health care developed by Luckes reinforced the discipline prevalent in all areas of nurses’ working lives. Luckes clearly cared about nurses’ health, evident by the effort she made to improve nurses’ work conditions during the 1880s. But she considered principles of dedication to duty, obedience and self-sacrifice more important. She extended health care to nurses during the 1880s partly with the aim of increasing her authority over their lives. In 1885 Luckes introduced a compulsory medical examination at the end of a month’s trial period and used this to weed out probationers who did not fit her expectations. Despite a satisfactory ward report and ‘a slight sore throat for one day’, Luckes dismissed Probationer Howard-Jones at the end of her trial period on ‘health grounds’ although Howard-Jones claimed her health to be excellent illustrated by immediately applying to another hospital in London, passing their physical examination, successfully completing her training and eventually becoming a hospital matron. Success in passing the medical examination also depended on whether Dr. Samuel Fenwick judged a probationer of sufficient physical strength to work long hours and live in the densely populated east end of London ‘away from any means of recreation.’ Fenwick was senior honorary physician and a strong ally of Luckes. He argued that probationers needed to be of a particularly strong physical constitution at The London Hospital because of the poor quality of surrounding air.<sup>168</sup>

In 1886, Luckes changed nurses’ rules to specify that probationers could no

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<sup>166</sup> *Sandhurst Report*, p.319.

<sup>167</sup> RLH, *Report of the House Committee on the allegations which have been recently made against the Nursing Department*, LH/A/17/49, 3 December 1890.

<sup>168</sup> *Sandhurst Report*, p.329; p.397; pp.449-450; p.476.

longer choose any doctor from the resident staff but had to consult physicians, Dr. Samuel Fenwick or Dr Sutton or Surgeon Mr Frederick Treves. Previously nurses had consulted junior house surgeons or physicians but Luckes argued that the change was necessary on the grounds that ‘many nurses very naturally object to consulting the young doctors about their own health.’ The idea that consultants rather than house doctors examined sick nurses was also favoured because senior doctors were believed to be more adept at uncovering nurses ‘who were generally prone to malingering.’ These comments implied some suspicion surrounding nurses’ illness. Dr Fenwick did not take most cases seriously suggesting that the majority of complaints were ‘trivial. A person has a little sore throat, she has a headache; very often those on night duty cannot sleep in the daytime; it may be any little trivial thing.’<sup>169</sup> Nurses were not given privacy during their consultation, which took place in the presence of a ward sister, house physician and consultant.

The health care developed during the 1880s thereby denied nurses’ choice, a factor that must have been difficult for experienced nurses like Janet Page. Page entered training at The London in June 1888, aged twenty-seven, with three years previous nursing experience at Highgate Infirmary. Her application for a staff nurse post was declined because of The London’s rule that nurses from provincial or smaller metropolitan hospitals must enter as a probationer and complete the two-year training programme. She was dismissed after eleven month’s training for consulting a doctor other than those designated by Luckes regarding chronic leg ulcers.<sup>170</sup> Page had leg ulcers which were badly affecting her, indeed the pain was such that her sleep was disturbed. She was worried that if she consulted the doctor appointed by Luckes to look after nurses, the doctor would not adhere to the confidential practice expected in the doctor-patient relationship. She therefore consulted Dr. Bedford Fenwick, then a junior

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<sup>169</sup> *Sandhurst Report*, p.329; p.447.

<sup>170</sup> *Sandhurst Report*, p.202; p.209; p.374.

house physician.<sup>171</sup> Anxious that she would be dismissed on health grounds if she disclosed her history of chronic leg ulcers, Page complained only of sleeplessness for which she was prescribed a draught. After two weeks and no improvement, Page consulted an ‘outside’ physician, Dr. Anderson, who admitted her as an inpatient to The London Hospital. On finding Page admitted to a ward, Luckes promptly dismissed her on the grounds of her ‘inefficiency’. Page’s failure to ask Luckes’ permission to consult an ‘outside doctor’ or apologise for doing so was interpreted as a ‘laxity in discipline’ by Luckes and Dr Samuel Fenwick, a senior consultant who advised Luckes on such matters. (He was also Dr Bedford Fenwick’s father.)<sup>172</sup> Page, Luckes recorded ‘was not at all strong and proved mentally and physically unsuitable for the work she had entered upon.’<sup>173</sup> The Sandhurst Committee heard how Page had:

proved unsuitable for further training ... She gave me a good deal of trouble during the few months she was with us, partly, though I fear, not entirely, caused by her very bad health. She may have tried to improve, but she never appeared to do so.<sup>174</sup>

As mentioned earlier (p.59), the term “trouble maker” was used to discredit nurses, particularly those with long-term health problems. Page clearly feared the militaristic style of discipline favoured by Luckes: nurses complained that it created a climate of fear and made it difficult to report sick. Former nurse Mary Raymond claimed that Probationer Vannah Edwards, aged twenty-six, who died from pneumonia after eighteen months training, had been too frightened to admit she was ill for fear of

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<sup>171</sup> Bedford Fenwick had held all the house appointments at The London but unlike his father, Dr. Samuel Fenwick had been unsuccessful in getting elected to the staff. In 1887 he married Ethel Gordon Manson. As mentioned earlier, Ethel Bedford Fenwick supported nurse registration against Luckes’ opposition. See A.E. Clark-Kennedy, *The London*, p.105 for detailed history.

<sup>172</sup> *Sandhurst Report*, p.307; p. 314; p.320.

<sup>173</sup> RLH archive, The London Hospital Register of Nurse Probationers, LH/N/1/2, April 1884 - August 1888, p.230.

<sup>174</sup> *Sandhurst Report*, p.320.

dismissal.<sup>175</sup>

Although Luckes only had formal power of suspension, in practice she routinely dismissed staff, informing the House Committee after the event. Most nurses, according to Raymond, were ‘anxious to go on [working] till they get a certificate.’ Raymond described to the Select Committee how hard Vannah had worked:

until she was quite unfit; she was so ill that she could hardly breathe and excused herself from supper; the home sister went to her room, found that she had a high fever; and sent for the house physician, who ordered her at once to be warded; 10 days after that she was dead.<sup>176</sup>

To admit illness risked being labelled unsuitable or lacking the physical or mental strength to nurse.<sup>177</sup> Luckes concluded that probationer Dora F.’s frequent episodes of minor illnesses proved that ‘the physical and mental strain of the work here was altogether beyond her powers.’ Dora was dismissed on the grounds that she was ‘not strong enough to return.’<sup>178</sup> Although Luckes encouraged nurses to share their problems with her ‘at home’ in her office every Tuesday evening, nurses did not complain, as Ellen Yatman testified.<sup>179</sup> Probationer Violet Dickinson claimed that ‘we all felt that it would be bad for ourselves if we were to make a complaint.’<sup>180</sup> Dependent for a future reference, sick probationers realised that Luckes associated poor health with an unsuitability to nurse.

Our discussion has shown that a military styled disciplined nursing ideology influenced the health care of nurses at The London Hospital. Luckes accrued significant power during her ten years as Matron by developing nurse education,

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<sup>175</sup> *Sandhurst Report*, p.308.

<sup>176</sup> *Sandhurst Report*, p.309.

<sup>177</sup> *Sandhurst Report*, p.402.

<sup>178</sup> RLH, The London Hospital Register of Nurse Probationers, LH/N/1/7, April 1898 - October 1900, p.94.

<sup>179</sup> *Sandhurst Report*, p.410.

<sup>180</sup> *Sandhurst Report*, p.313.



publishing nursing textbooks and implementing a well-organised programme of reform. She was able to shape the health care of nurses as part of a disciplined system of training that emphasised self-sacrifice and vocation to duty. She believed that ill health was to be endured as part of a nurse's commitment to sacred duty and those who were sick were often perceived to lack the vocation to nurse.

### **The South Devon and East Cornwall Hospital, Plymouth**

There appears to be a clear difference between the culture of The South Devon and East Cornwall Hospital (SDEC) and The London Hospital. This may in part be due to the different nature of small provincial hospitals and city based teaching hospitals.

However, without further analysis of several hospitals in the provinces and city no firm conclusions can be made. It is appropriate to compare and contrast the practices in South Devon with those of The London to provide, in effect, two hospital case studies to illustrate similarities and differences in their practice in the period examined. As mentioned in chapter one, the SDEC was a small provincial hospital, a considerable distance from metropolitan teaching hospitals. During the course of the nineteenth century, Devon moved from being one of the largest, most populous and prosperous areas of Britain to a remote and peripheral segment of the economy although Plymouth attracted new industrial investment in the naval dockyard.<sup>181</sup> Matron Hopkins (1886-1916) trained at a prestigious London teaching hospital (Charing Cross) but, unlike Luckes, did not view discipline as the central tenet of nursing practice. This section raises a number of questions: was Hopkins' lack of commitment to discipline related to her lack of power in the SDEC and if so, why did she lack authority? What was the system of health care offered to nurses and did it reflect Hopkins' lack of commitment to discipline?

Appointed in 1886 from a large field of applicants, Hopkins' role as Matron was

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<sup>181</sup> Melling, Forsythe, *The state, insanity and society*, p.9

limited with little control over nursing affairs. In common with other matrons of the time, including Luckes, she was not represented in the management of the Hospital and had no place on the General Hospital Committee or House Committee, which was made up of lay members and doctors. It was their opinions and votes that decided nurses' work conditions within the Hospital. Prior to the Nightingale reforms, the task of matron was that of an elevated housekeeper and it was this role that Hopkins performed despite the Hospital's employment of a full time formal housekeeper. Nightingale intended that the 'trained' matron carve out an empire of her own and take over some of the responsibilities of both the medical staff and the lay administration. In addition, it was considered her job to centralise the administration of nursing affairs.<sup>182</sup> Hopkins did not undertake any of these roles. Criticised for poor organisational skills, she lost the Medical Board's confidence when she claimed that she could no longer be responsible for missing sheets from the laundry or the large amount of breakages. Her failure to manage the housekeeping successfully allowed the Medical Board to reduce her role further and expand their own by implementing their own schemes of work. A Nursing Committee, set up in 1905, 'to have oversight of the whole of the nursing department' had no nurse members: a physician, surgeon, secretary and a member nominated by the General Committee governed the nurses, with the Matron invited to meetings only to give a monthly report.<sup>183</sup>

The Nursing Committee also removed Hopkins' powers to dismiss nurses. For example, a newly appointed staff nurse Lillian M. suffered 'a serious heart attack' on her fourth day on duty in 1910. Cross examination by a doctor revealed that she had previously suffered from two attacks of rheumatism and had a tendency to heart disease, facts she had failed to disclose at her preliminary medical examination. The Committee decided that she should be dismissed without remuneration as soon as she was

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<sup>182</sup> Abel-Smith, *A History of the Nursing Profession*, p.25.

<sup>183</sup> PWDRO, SDEC House Com Mins, 606/1/18, 23 March 1904; 2 June 1905.

discharged from hospital care.<sup>184</sup>

Hopkins' power was further undermined by her lack of commitment to nurse education. Nightingale perceived that nurse training would take the form of a tripartite division of labour: the trained 'home sister' would give singing and bible classes and teach and drill probationers in the medical instructor's lectures, ward sisters would be responsible for ward instruction and medical instructors would lecture and examine on aspects of medicine and surgery relevant to nursing.<sup>185</sup> Hopkins' failure to organise any formal programme of lectures between November 1901 and March 1905 led the Medical Board to conclude that the nurses 'were a general shambles' and, as a result, patient care had suffered.<sup>186</sup> The Board implemented their own 'more efficient and practical training of the staff': lectures were scientific based and included elementary bacteriology, asepsis and antisepsis but not any form of nursing ideology.<sup>187</sup> This is an important point because, unlike The London Hospital, nurse training at the SDEC did not promote an ethos of self-sacrifice or teach that ill health be endured as part of sacred duty. As a result, illness was treated on its own merit and not as an indication of a vocation to duty or as part of a system of discipline. A more flexible and tolerant system of health care operated at the SDEC than that offered to nurses at The London Hospital.

Sick probationers and trained nurses were allowed to consult any doctor from the senior honorary staff of the Hospital or even outside doctors.<sup>188</sup> Nurses with short and long-term illnesses were not dismissed but encouraged to recuperate at home and return to work. There is no evidence that nurses' illness provoked suspicion. In 1905, twenty-seven year old probationer Georgina B.'s diagnosis of rheumatism forced her to interrupt her training for over three years. She returned in August 1909 and gained her

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<sup>184</sup> PWDRO, SDEC House Com Mins, 606/1/20, 27 July 1910, p.186.

<sup>185</sup> Rafferty, *The Politics of Nursing Knowledge*, p.35.

<sup>186</sup> PWDRO, SDEC House Com Mins, 606/1/18, 24 March 1905, p.159.

<sup>187</sup> PWDRO, SDEC House Com Mins, 606/1/18, 7 June 1905.

<sup>188</sup> PWDRO, SDEC General Com Mins, 606/1/7, 15 March 1904, p.340.

hospital certificate eight years after starting training, in March 1911. Hopkins recorded that Georgina was ‘truthful, obedient, most polite, punctual, good memory, unselfish, conscientious and painstaking’: these positive comments highlighting good moral character suggest that she did not interpret Georgina’s poor health as indicative of a lack of vocation to nurse. Hopkins, like Luckes, judged moral character as a test of suitability to nurse but in contrast to Luckes did not perceive ill health as an indicator of its absence.

Hopkins also adopted a tolerant attitude to nurses with shorter and more frequent episodes of illness. Cecily B., aged 25, had neuralgia for five days in February 1909; two weeks later she contracted bronchitis and was off sick for four months followed by a two week episode of laryngitis six months after that. Hopkins described her as ‘most excellent in every way but health not good.’<sup>189</sup> Hopkins was able to distinguish and separate health problems from other aspects of a probationer’s character.

In summary, Hopkins was less committed to nurse education than Luckes. This lack of commitment as well as her poor organisational skills meant she commanded little authority amongst the doctors. As a result her power as matron was limited. The medical staff adopted a scientific approach to nurse education that put less emphasis on the necessity for self-sacrifice and sacred duty than the system of training at The London Hospital. However, Hopkins’ lack of authority and lack of commitment to discipline resulted in a more flexible and tolerant system of health care. Having considered the relationship between discipline and nurses’ health at a metropolitan and provincial voluntary hospital, this chapter will now compare and contrast these case studies with that of the Cornwall Lunatic Asylum.

## **The Cornwall Lunatic Asylum**

Medical superintendents rather than matrons governed asylum nurses in the late

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<sup>189</sup> PWDRO, SDEC Register of Nurses, 1490/24, 1903-1923.

nineteenth and early twentieth centuries.<sup>190</sup> The Medical Superintendent of the CLA, Dr Richard Adams, was personally responsible for all within the Asylum, with the oversight of the Visiting Committee and the Lunacy Commissioners. He delegated duties to the Asylum's three Matrons, Eliza Templar Vicary, Matron of the pauper patients (male and female); Laura Elkless, Matron of all female patients and a Miss Hope, Matron of the female private patients. Despite careful analysis of the data available through the Visiting Committee Minutes, it is impossible to identify whether the female matrons were in any way involved with the male patients. However, in most institutions in the late nineteenth and early twentieth centuries male and female patients were separated in asylums and were nursed by teams of their own sex.<sup>191</sup> At the CLA, male nurses were managed by a chief male attendant and female nurses by a female matron. The idea that nurses should only care for patients of their own sex did not change at the CLA until the end of the First World War when female nurses were employed on the male side.<sup>192</sup>

Although there is little evidence of what the role of CLA matron entailed, it is clear that it gave little power to control or improve work conditions. As in the general hospitals studied, matrons did not sit on the Asylum's management committee. Indeed, asylum matrons had even less influence than their general hospital counterparts because they were not invited to present weekly or monthly reports. The health care offered to asylum nursing staff was not usually addressed as part of a system of strict discipline. This section questions why asylum matrons had little power and whether the ideology of self-sacrifice had any influence over asylum nurses' lives.

None of the three matrons in post in 1890 had received any form of formal nurse training and this probably contributed to their lack of power. Vicary and Elkless were appointed in the 1870s before most asylums had adopted any programmes of nurse

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<sup>190</sup> Carpenter, *Working for Health*, p.21.

<sup>191</sup> Chatterton, 'Women in mental health nursing', p.14.

<sup>192</sup> CRO, CLAVC Mins, HC1/1/1/18, 25 February 1918.

training. Vicary was considered the most senior nurse with responsibility for the largest number of patients. Her role extended beyond that ‘usually performed by Matrons’ for which she was awarded a pay rise in 1896.<sup>193</sup> In contrast to general nurses at The London and the SDEC who were expected to be able to write and have some educational ability, there is no evidence of any set educational criteria for entry to employment as a nurse at the CLA. As the next chapter will discuss in more detail, asylum nursing staff were drawn from the working classes and this may have limited their access to education prior to entering asylum work. This probably meant that they did not expect much formal education while in the CLA employ and indeed little was offered. Attendants and nurses were not educated in any of the contemporary forms of nursing in terms of ideology or nursing practice until 1918 when staff were prepared for the Medico-Psychological Association examination. The 1918 programme of lectures included instruction on personal discipline and obedience.<sup>194</sup> Before 1918, asylum nurses learnt how to care for their patients by copying more experienced members of staff. The idealised image of the ‘new’ general hospital nurse and the qualities associated with her inevitably had little impact on the required qualities of asylum attendants and nurses in Cornwall.

Nursing staff were treated as employees rather than members of a morally superior profession, motivated by aspirations rather than material rewards. In contrast to The London Hospital, the act of complaining was not interpreted as a sign of a lack of vocation to nurse. Improvements to attendants’ work conditions were made in response to their collective bargaining power and not at the behest of the matrons. Groups of attendants complained directly to the Visiting Committee through the 1890s about diet, hours of employment, rate of wages, scale of pensions and lack of uniform.<sup>195</sup> The attendants’ complaints were often supported by the Lunacy

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<sup>193</sup> CRO, CLAVC Mins, HC1/1/1/7, 28 September 1896.

<sup>194</sup> Andrews, *The Dark Awakening*, p.259.

<sup>195</sup> CRO, CLAVC Mins, HC1/1/1/6, 24 June 1889; 9 June 1891; 25 July 1892; CLAVC

Commissioners' Reports who repeatedly criticised the Visiting Committee for its failure to implement improvements.<sup>196</sup> This illustrates that at least attendants were trying to improve conditions for themselves, indicating a greater level of intelligence and ability than that recognised by superintendents.

Time regulation was considered an essential part of the enforcement of discipline at the CLA, as at The London Hospital. Attendant A. W. Vanderwolfe's day followed a strict timetable: his duty commenced at 7am when patients were got out of bed, washed and ready for breakfast at 8am. He then cleaned the ward, scrubbed and polished the floor. At 10am patients were turned out on the airing courts or to work coal stacking, grass cutting or hair combing for mattress making and counted back in at 11am. Dinner was at 12pm and then patients returned to the airing courts or work at 2pm until 4.30pm when tea was served. At 7.30pm patients were cleaned and put to bed. Vanderwolfe went off duty at 8pm and rules directed that he be in bed with his light off by 10.30pm.<sup>197</sup> He was required to sleep in the Asylum and had a bedroom at the end of the ward, which was occupied by another member of staff on his day off. He shared the patients' bathroom. With no mess or recreation room, attendants ate and spent the majority of their leisure time on the wards.<sup>198</sup>

Obedience was also considered important and nursing staff's failure to comply often meant dismissal: attendant Elizabeth K. was dismissed in 1897 'for insubordination towards the Matron.'<sup>199</sup> The Matron in question had only been appointed eight weeks before this incident suggesting that new senior nurses had to earn the respect of an established staff. The Asylum's rules were designed to shape the moral character of its nursing staff: in 1890 the Medical Superintendent dismissed attendant Carrie H. for writing a letter of 'immoral character' to attendant Richard R.,

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Mins, HC1/1/1/7, 24 May 1897; 13 June 1903.

<sup>196</sup> Andrews, *The Dark Awakening*, pp.91-93.

<sup>197</sup> Andrews, *The Dark Awakening*, p.264.

<sup>198</sup> CRO, *Report of the Commissioners in Lunacy*, HC1/1/1/7, 1894; 1902.

<sup>199</sup> CRO, CLAVC Mins, HC1/1/1/7, 26 July 1897, p.174.

who was given one month's notice.<sup>200</sup>

Episodes of illness were not usually addressed as part of a system of discipline. The Visiting Committee was preoccupied with the question of its financial responsibility towards sick nursing staff. As a result, committee meetings focused on the relationship between the Asylum and the cause of illness. For example when attendant Samuel S. died of typhoid fever with pneumonia in 1898, the Committee decided that it had been 'contracted out of the asylum.' This is surprising considering another attendant, William H., was also ill with typhoid at the same time.<sup>201</sup> Wohl suggests that typhoid fever served as 'a barometer of inadequate water supplies and sewerage';<sup>202</sup> an admission of responsibility may have forced the Visiting Committee to commit to expensive improvements to the Asylum's infrastructure.

Attendant James T.'s behaviour changed significantly following a head injury received at work; he was suspended 'for indecently exposing himself to children in the asylum grounds and making indecent motions to female patients.'<sup>203</sup> The Asylum did not consider itself responsible for James' injury and did not offer any financial help towards his treatment or pension, much to the chagrin of his previous employer, Bodmin Workhouse, who wrote and complained that the Asylum had failed its employee.<sup>204</sup>

## Conclusion

Attitudes to nurses' illness and the practice of health care were shaped by institutional society. This study of the dynamics of the relationship between discipline and nurses'

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<sup>200</sup> CRO, CLAVC Mins, HC1/1/1/6, 27 October 1890, p.160.

<sup>201</sup> CRO, CLAVC Mins, HC1/1/1/7, 26 September 1898.

<sup>202</sup> A.S. Wohl, *Endangered Lives: Public Health in Victorian Britain*, London: J.M.Dent and Sons, 1983, p.127.

<sup>203</sup> S. Bezeau, N. Bogod, C.Maleer argue that disinhibited sexualised behaviour is common following a traumatic brain injury. See 'Sexually Intrusive Behaviour following Brain Injury: approaches to assessment and rehabilitation.' *Brain Injury*, Vol. 18, Issue 3, March 2004, pp.299 -313.

<sup>204</sup> CRO, CLAVC Mins, HC1/1/1/6, 26 February 1894, p.329.



health at three quite different institutions offers insights into the wider social, political and cultural context into which Nightingale's reformed occupation of nursing was developing. At first glance, it seems that differences in institutional culture were attributed to the personalities of leading actors, particularly the matrons and doctors. However, it is important to look beyond these personalities to notions of class, gender and political factors that shaped attitudes towards nurses' health, work conditions and education. By focussing on individual nurses' experience of illness, we are able to pick apart how wider conversations about nurse registration and the role of the 'new' nurse affected the ordinary nurse.

The political issue of nurse registration prompted heated debate amongst nurse leaders as to the best way to achieve professional status. Registration's supporters and opponents agreed that a disciplined, military style ideology would elevate nursing's status to that of a 'calling' requiring commitments of self-sacrifice from probationer nurses. The impact such commitments had on nurses' health inevitably drew questions, particularly from the Select Committee on Metropolitan Hospitals in 1890. Luckes' leadership of the opposition campaign resulted in intense scrutiny of her style of nurse management. In order to demonstrate that nurses did not need a register to win professional status and that alternatives, such as high standards of discipline and nurse education, may be equally as effective, Luckes regulated all areas of nurses' life under her jurisdiction including the system of health care offered to nurses.

Luckes' disciplined system of training, however, was alleged to have a number of negative effects on the health and welfare of the ordinary nurse. Nurses' difficulties in making complaints, a lack of choice regarding doctor consultations and the expectation that nurses carried on working despite ill health led to criticism of doctors and senior nurses' unsympathetic attitudes and allegations that The London Hospital neglected its nurses' health. Ill nurses were often portrayed as self-centred

troublemakers or malingerers who failed to live up to The London Hospital's high standards. Consequently, many nurses preferred to carry on working than admit they were ill for fear of losing their position.

Unlike Luckes, Matron Hopkins of the SDEC did not participate in public debate about nurse registration. Seemingly disinterested in either the political organisation of nursing or nurse education and training, Hopkins did not promote a military style of discipline that incorporated contemporary ideals of self-sacrifice. As a result, sickness was seldom viewed as a sign of a weak vocation: ill nurses were not dismissed, as at The London, but encouraged to recuperate and then return to work. Hopkin's attitude was flexible, tolerant and without denigration. A very different picture of nurses' health care emerged at the SDEC compared to The London Hospital. Whether the SDEC was typical of a provincial model is doubtful; Magg's suggests that strict discipline functioned in most provincial hospitals as a way of weeding out unsuitable recruits and improving the moral character of those that remained.<sup>205</sup>

The CLA had both a different legislative framework from that of The London Hospital and the SDEC and a distinct culture which meant that the relationship between nurses' health and discipline was inevitably different. Adams, the Medical Superintendent and the Visiting Committee set and enforced the nursing staff's regulations which were subject to regular inspection by the Lunacy Commission. The Asylum's system of discipline was strict, particularly expectations of obedience and time-regulation but this discipline was not applied in relation to attendants' own health problems. Episodes of ill health were treated as a separate entity and not as an indication of a lack of vocation to nurse. The issue of nurses' professionalism was integral to the relationship between discipline and nurses' health at The London but absent at the CLA.

CLA nursing staff were treated as employees rather than members of a morally

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<sup>205</sup> Maggs, *The Origins of General Nursing*, p.126.

superior profession. Drawn from working class backgrounds, asylum nursing was one of low status with no aspirations of registration. Indeed, Bedford-Fenwick's campaign excluded asylum nurses on the basis of their social background. There is no evidence that CLA nurses lobbied to be included in this campaign or that senior nurses considered the use of strict discipline as a method of improving their professional status. Indeed, the three female matrons employed at the CLA lacked power to implement change. Unqualified, they attached little importance to the value of self-sacrifice or nurse education.

The Visiting Committee's priority, as far as nurses' health was concerned, was its financial responsibility towards sick staff. In contrast to The London Hospital where the onus of responsibility for nurses' sickness was placed on the nurse herself and her inability to endure the long working hours and poor work conditions, the Asylum was concerned with its responsibility towards its employees' ill health and the need to protect and limit its financial commitments.

This chapter argues that the struggle for power in voluntary hospitals was often more complicated than Abel-Smith and Witz suggest.<sup>206</sup> Their argument (chapter one, pp.30-31) that by 1880, the voluntary hospital matron had established herself as the head of an independent nursing department, controlling her own department without interference from lay administrators fails to acknowledge not only any variation in individual hospitals but also matrons' lack of power at management level. Matrons at all three case study institutions were not members of either the management or nursing sub committees. Committees were made up of lay members at The London Hospital and at the CLA, and doctors and lay members at the SDEC. It was their opinions and votes that had greater weight on nursing matters than matrons.

Nurses had to look for other ways to build their authority: Luckes developed

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<sup>206</sup> Abel-Smith, *The Hospitals 1848-1948*, p.68; Witz, *Professions and Patriarchy*, p.140.

nursing knowledge and applied it to nursing practice. This study suggests Crowther's argument (chapter one, p.30), that a power struggle developed between 1870 and 1900 because doctors felt threatened by the status of the new 'lady' matrons, did not apply to all hospitals.<sup>207</sup> Luckes' power struggle was not with the medical staff of The London Hospital but with an entrenched Governors' Committee who interpreted her youth as lack of experience. Doctors acted as Luckes' ally and supported disciplinary ideology as part of the health care of nurses. By contrast, some doctors at the SDEC feared that registered nurses would challenge and undermine their own authority. In 1904 the medical staff successfully challenged the Matron's position and imposed their own regime of education. Hopkins' failure to advance nursing knowledge or develop nursing practice, based on a strong ethos of discipline, contributed to her lack of authority within the Hospital.

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<sup>207</sup> Crowther, 'Why women should be nurses and not doctors', Available at <http://www.ukchnm.org/seminars01.html>, unpaginated.

## CHAPTER THREE

### **‘The twelve hours system is a cruel strain on a woman’s strength and nerve.’<sup>208</sup> Gender, Class and the Nurse’s Body 1890-1919**

In 1892, *The Pall Mall Gazette* suggested that ‘as everyone knows, the Nursing Profession has undergone a wonderful transformation in recent times; the old ‘Sarah Gamp’ Regime having gone never to return.’<sup>209</sup> Prior to this transformation London Hospital nurses were, according to Luckes, often ‘middle-aged or old women of the scrubber class’ who ‘frightened away sentimental young women of the would-be heroine type.’<sup>210</sup> As part of their campaign for professional status nurse leaders promoted a changing image of general hospital nurses between 1860 and 1890. The ‘old’ style nurse was depicted as immoral, ignorant and working class whilst the ‘new’ nurse was considered young, chaste, clean, educated, disciplined and middle class. This chapter will examine the way notions of gender and class underpinned the construction of the idealised image of the late Victorian nurse and also shaped conversations about nurses’ health. Women’s limited physical strength and an increased number of middle class recruits were held responsible for the rising morbidity and mortality rates amongst nurses at The London Hospital. Such claims undermined nurse leaders’ campaign for professional status. In contrast, the health of working class asylum nursing staff received little attention despite the dangerous nature of their work restraining violent and insane patients. Society’s concern about the physical deterioration of the working classes and fear of national degeneration prompted by recruitment for the Boer War, failed to generate interest in the health of asylum nursing staff.

Recent studies have recognised the importance of gendered ideologies and imagery to nurse leaders’ case for registration and professional status. According to

<sup>208</sup> *The Lancet*, 26 July 1890.

<sup>209</sup> *The Pall Mall Gazette*, 21 November 1892.

<sup>210</sup> RLH, E. Luckes, ‘Trained Nursing at The London Hospital’, *The New Review*, LH/A/26/5, No. 17, October 1890, pp.290-291.

Dingwall et al., doctors' concern that nursing reform might lead to the creation of a back door route into medicine centred on the argument that women were neither physically nor temperamentally equipped to deal with certain forms of education, work and public life.<sup>211</sup> As a qualification for caring roles in hospitals, nurse leaders reclaimed the early Victorian belief that women were endowed with unique qualities of gentleness and sympathy derived from their biological capacity for motherhood.<sup>212</sup> A woman's natural capacity for healing, it was argued, overcame their delicate emotional temperament: Nightingale's heroism in the Crimea was cited as proof of the toughness of the female character.<sup>213</sup> Under the Nightingale apprenticeship style of education, it was deemed that women as 'natural' nurses did not require education prior to working in hospitals under the supervision of male physicians.<sup>214</sup>

This chapter is concerned with how the idea that women were entitled to nurse because of a predisposition towards maternal, caring qualities shaped attitudes towards nurses' health. It will suggest that the promotion of nursing as women's 'natural' work, as part of the campaign for registration, made it difficult to suggest that such 'natural' work made women ill. Some commentators admitted that nursing carried a health risk, suggesting that women's natural physical weakness and susceptibility to illness made it difficult for them to tolerate poor work conditions. Thus a significant dialectic emerged: on the one hand, unique female attributes were put forward as justification for women's entitlement to care whilst at the same time gender qualities were used to explain why such 'natural work' had an adverse effect on nurses' health.

Many of the women associated with the reform of hospital nursing brought domestic experience to their work. Florence Nightingale, Mary Stanley and Jane Shaw

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<sup>211</sup> Dingwall et al., *An Introduction to the Social History of Nursing*, p.58.

<sup>212</sup> Summers, *Angels and Citizens*, p.3.

<sup>213</sup> Crowther, 'Why Women should be Nurses and not Doctors', seminar papers 2000-01, UK Centre for the History of Nursing and Midwifery, <http://www.ukchnm.org/seminars01.html>.

<sup>214</sup> I. Palmer, 'Nightingale revisited', *Nursing Outlook*, **31**, 4, 1983, pp.229-233.

Stewart may have differed in their approaches but they all drew on their domestic experience of managing servants as qualification to manage nurses in the hospital.<sup>215</sup> In 1890, Luckes argued that ‘a Sister of a Ward must not only be a good Nurse, but she needs also all the qualifications of the general head of a household.’<sup>216</sup> Hospitals appeared to be a natural setting for female carers but were run by male lay committees and male doctors. Nurse leaders did not want nurses to be seen as doctors’ servants.<sup>217</sup> Most histories of nursing agree with Gamarnikow’s argument that a family based institutional model emerged as men assumed the dominant role of father, women the nurturing female/mother/nurse role and patients’ the submissive child role.<sup>218</sup> This model and the belief that nursing was an extension of women’s domestic role has been used to explain why men were excluded from general hospital nursing. The notion of men as nurses, according to Evans, was subsequently incompatible with the prevailing institutional family ideology of the time.<sup>219</sup> Bradley’s argument that the restructuring of nursing and nurse education took place when Victorian separatist ideologies of gender were at their most powerful is open to discussion.<sup>220</sup> Recent scholarship has moved towards recognition of the diverse and contested gender conventions in the Victorian period.<sup>221</sup>

Following Nightingale reforms, men were often relegated to asylum nursing, an area more congruent with masculinity because of the value placed on men’s superior strength to restrain violent patients.<sup>222</sup> An image of male asylum nurses as physically

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<sup>215</sup> Summers, *Angels and Citizens*, p.3.

<sup>216</sup> RLH, *Report of the House-Committee on the Allegations which have been recently made against the Nursing Department*, LH/N/17/49, 3 December 1890.

<sup>217</sup> A. Summers, *Angels and Citizens*, p.4.

<sup>218</sup> E. Gamarnikow, ‘Sexual Division of Labour : the case of nursing’, p.96.

<sup>219</sup> J. Evans, ‘Men nurses: a historical and feminist perspective’, *Journal of Advanced Nursing*, 47, 3, 2004, pp. 321-328.

<sup>220</sup> H. Bradley, (ed), ‘Medicine’, *Men’s Work, Women’s Work. A Sociological History of the Sexual Division of Labour in Employment*, Minneapolis: University of Minnesota Press, 1989, pp. 188-202.

<sup>221</sup> M.M. Feree, ‘Beyond Separate Spheres: Feminism and Family Research’, *Journal of Marriage and Family Research*, 52, November 1990, pp.866-884.

<sup>222</sup> B. Mericle, ‘The Male as Psychiatric Nurse’, *Journal of Psychosocial Nursing*, 21,

strong developed but as yet little has been written about how this image shaped attitudes towards male nurses' health. Historians disagree about the importance male physical strength played in the ideal image of Victorian masculinity. Burns notes the growing popularity of athleticism, and by extension muscular physique, from the mid-Victorian period and argues that the 'weak or soft male' was an object of revulsion. The stereotype of masculine behaviours contradicted the idea that men were suited to emotional and caring work.<sup>223</sup> Male general nurses began to experience a lack of respect that compromised their masculinity, prestige and social status.<sup>224</sup> Tosh, on the other hand, suggests that the Victorian code of manliness made scant knowledge of the body and was more about moral excellence, which, he argues, was as likely to be found in a weak body as a physically strong.<sup>225</sup>

Male general hospital nurses were few, poorly organised and, according to Rafferty, subject to the same strategies of exclusion by which female nurses were subordinated by male doctors. Nurses 'were no exception to the sociological orthodoxy that a weak group often subordinates a weaker one to improve its status.' In 1891 there were only 691 male nurses compared with 53,057 female nurses. By 1901 this figure had risen to 1,092 compared to 64,214 female nurses.<sup>226</sup>

The theme of class is important in the struggle to define the boundaries between 'old' and 'new' nurses. This definition was also crucial in nurse leaders' attempts to organise nursing more formally and establish its status within the division of labour. Conversations focussed on whether nursing was to be a new profession for educated,

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11, 1983, pp.28-34.

<sup>223</sup> C. Burns, 'A Man is a Clumsy Thing Who does not Know How to Handle a Sick Person': Aspects of the History of Masculinity and Race in the Shaping of Male Nursing in South Africa, 1900-1950', *Journal of South African Studies*, Vol. 24, No. 4, December 1988, pp.695-717.

<sup>224</sup> B. Segal, 'Male nurses: a case study in status contradiction and prestige loss', *Social Forces*, **41**, 1, 1962, pp.32-38.

<sup>225</sup> J. Tosh, 'What Should Historians Do with Masculinity? Reflections of Nineteenth Century Britain', *History Workshop*, **38**, 1994, pp.179-202.

<sup>226</sup> Rafferty, *The Politics of Nursing Knowledge*, p.82.



middle class women or a refined form of domestic service with a subordinate place in the hospital.<sup>227</sup> The traditional view that the major consequence of the Nightingale reforms was to turn voluntary hospital nursing into a career suitable for young, middle class women has been challenged by recent studies by Maggs and Simnett.<sup>228</sup> Maggs argues that nursing was a socially mixed occupation in this period offering respectable employment to domestic servants, office or shop workers and marginal members of the middle classes.<sup>229</sup> Dingwall et al. suggests that the high visibility of a few educated, articulate middle class nurse leaders involved in the registration campaign were responsible for an image of the ‘new’ middle class nurse which differed from a reality of a socially mixed occupation.<sup>230</sup> There was a highly successfully bid, according to Bashford, to link the ‘new’ nurse with the cleanliness and purity inherent in the cultural construction of the Victorian middle class woman.<sup>231</sup>

Historians have yet to address the impact the image of the ‘new’ nurse had on attitudes towards nurses’ health. This study suggests that the issue of nurses’ health, and the notion that middle class nurses had different health needs to their working class predecessors, was disseminated in this period by a variety of actors who wished to change nursing practice, define the nurse’s role as the doctor’s assistant and improve nurses’ work and living conditions.

Historians agree that asylum nurses were predominately drawn from the working classes.<sup>232</sup> A working life in hard, manual labour on farms produced the degree of physical strength necessary to restrain violent or deluded patients or administer unpleasant treatments such as cold showers. Also farm labourers were easily available

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<sup>227</sup> Dingwall et al., *An Introduction to the Social History of Nursing*, p.75.

<sup>228</sup> Abel-Smith, *A History of the Nursing Profession*, p.32.

<sup>229</sup> Maggs, *The Origins of General Nursing*, pp.63-88.

<sup>230</sup> Dingwall et al., *An Introduction to the Social History of Nursing*, p.71.

<sup>231</sup> Bashford, *Purity and Pollution*, p.37.

<sup>232</sup> Dingwall et al., *An Introduction to the Social History of Nursing*, p.126; Nolan, *A History of Mental Health Nursing*, p.48; Carpenter, ‘Asylum Nursing Before 1914’, p.134.

because most asylums were in rural areas. Attendants were also drawn from ex-servicemen because of their disciplined background and from those who had been in service to the gentry, such as butlers, who had been used to taking orders and working long hours for little pay.<sup>233</sup> Asylum work was of low status because of the dangerous work, the low wages, the exclusion from society and Victorian society's fear of the insane and suspicion that those who worked in close contact with them had become somehow tainted. The geographical isolation of asylums combined with the restrictions placed upon nursing staff's lives resulted in staff forming close bonds and strong ties of solidarity. Workers, according to Carpenter, often relied on each other to ensure their physical safety whilst carrying out dangerous work.<sup>234</sup>

Despite the risk of physical injury, asylum nursing staff's health received little attention during a period noted for the increasing concern attached to the health of the working classes. According to Heggie, fears about urbanisation and the emancipation of the working classes produced increasing interest in their health. The historical narrative of degeneration resurfaced in the 1880s when the poor health of the working classes was associated with urbanisation. It continued during the early years of the twentieth century prompted by the high levels of rejections amongst recruits for the Boer War and the Report of the Inter-Departmental Committee on Physical Deterioration, 1904 which linked the poor health of working class children with malnutrition.<sup>235</sup>

The third section of this chapter considers how understandings of nurses' occupational diseases in this period distinguished only two types of illness, infection and overstrain. Worboys' important study of disease theories and medical practice in Britain suggests that although the idea of infection as understood to mean a

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<sup>233</sup> Nolan, *A History of Mental Health Nursing*, p.48.

<sup>234</sup> Carpenter, *Working for Health*, p.29.

<sup>235</sup> V. Heggie, 'Lies, Damn Lies and Manchester's Recruiting Statistics: Degeneration as an urban legend in Victorian and Edwardian Britain,' *Journal of the History of Medicine and Allied Sciences*, Vol. 63, No. 2, April 2008.

transmission of disease by bacteria or virus was gradually accepted from 1870 onwards, the full implications of germ theory were not immediately apparent even after it was proven. A lack of agreement on both a single bacterial model and how different 'bacteria' produced their pathogenic actions and were introduced into the body, allowed a plurality of disease theories to flourish.<sup>236</sup> As far as this study is concerned, social and environmental factors continued to feature heavily in conversations about the relationship between infection and nurses' health.

### **Gender - Was nursing 'extremely hard work for a woman?'**<sup>237</sup>

It has been noted that the notion of femininity was central to the image of the 'new' nurse. Nurse leaders promoted attributes they believed to be unique to the female gender as qualification for women to work as professional nurses. However, by using gender to enhance their bid for professional status, many nurse leaders propagated an image of the general nurse that could not easily accommodate ill health. How did the notion of gender shape debates about nurses' health at The London Hospital?

Conversations suggested that it was both a source of weakness and strength. In 1890, Lord Thring, a member of the Select Committee of the House of Lords enquiring into the work of the metropolitan hospitals, asked Dr Samuel Fenwick, the physician responsible for nurses' health, if he considered 'fourteen hours, with two hours off, and twelve hours with two hours off, extremely hard work for a woman?' Fenwick agreed that woman's natural fragility made it difficult for nurses to withstand the long working hours of eighty-three hours per week causing a high incidence of varicose veins and 'flat foot'. His proposed solution was to employ more nurses.<sup>238</sup>

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<sup>236</sup> Worboys, *Spreading Germs*, p.3.

<sup>237</sup> The Select Committee of the House of Lords was set up in 1890 and chaired by Lord Sandhurst to enquire into the work of the metropolitan hospitals. *Report of the Select Committee of the House of Lords on the Metropolitan Hospitals, Provident and Other Public Dispensaries and Charitable Institutions for the Sick Poor*. PP XVI, 1890; PP XIII, 1892. Hereafter known as the *Sandhurst Report*. p.452.

<sup>238</sup> *Sandhurst Report*, p.452.

Fenwick's understanding of the relationship between gender and health reflected wider debate in the medical press at this time. A study published in *The Lancet* in 1890 supported the idea that women were not strong enough to work twelve-hour nursing shifts: 'the twelve hours system [was] a cruel strain on a woman's strength and nerve.'<sup>239</sup> As already mentioned, some doctors feared that nursing reform might lead to the creation of a back door route into medicine. To prevent this occurring, they argued that women were not physically equipped to deal with work conditions.<sup>240</sup> *The Lancet's* assertion that women were not strong enough to nurse contradicted the contemporary perception that men were at greater risk from work, particularly because of its more hazardous and strenuous nature.<sup>241</sup> Although Fenwick argued that long hours and women's natural weakness caused ill health, neither he nor his daughter-in-law, Ethel Bedford Fenwick, chose to campaign for a reduction in working hours. Their endorsement of an ideal of femininity as both a qualification to care and an integral part of the image of the professional nurse helped to obscure the relationship between work conditions and health problems.

Nurse leaders' emphasis on the cultural ideal of motherhood also distracted from nurses' ill health. The Victorian ideal of womanhood centred on marriage and the home. Women's mission in life was depicted as the guardian of moral, spiritual and domestic values.<sup>242</sup> Late nineteenth century nurse leaders drew on cultural values surrounding the image of mothers as qualifications to nurse. Despite Luckes' introduction of a more scientific based system of nurse training tested by examination, she maintained that 'women who would make the best mothers make the best nurses.' For this reason, she argued, nurses' work conditions should remain unregulated, like mothers: 'the duties of a true mother and of a real nurse are not merely mechanical, and

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<sup>239</sup> *The Lancet*, 26 July 1890.

<sup>240</sup> Dingwall et al., *The Social History of Nursing*, p.58.

<sup>241</sup> Harrison, *Not only the 'Dangerous Trades'*, p.11.

<sup>242</sup> J.F.C Harrison, *Late Victorian Britain, 1875-1901*, Abingdon: Routledge, 1991, p.157.

their work cannot advantageously be regulated as though that were the case.’ This analogy between mothers and nurses implied that nursing, like motherhood, was a vocational commitment that did not allow time off-duty because of ill health.

Complementing her opposition to state registration and her belief that individual hospitals should be responsible for their nurses’ work conditions, Luckes argued against a national system of regulation on the grounds that it would be detrimental to nurses’ welfare: ‘that it is strictly the duty of a hospital committee to provide for the welfare of its servants is beyond question.’<sup>243</sup> Luckes’ perception of nurses as fulfilling a motherly role in the hospital supports Gamarnikow’s argument that a family based institutional model of the hospital emerged in the late nineteenth century.<sup>244</sup> It is interesting to note that whilst Luckes’ powerful role as matron disturbed and challenged members of the governing committee, her analogy of nurses as mothers was hardly radical but endorsed the prevailing family ideology of the time.

More radically, Luckes argued that London Hospital nurses possessed superior physical and mental strength to that of ‘the ordinary woman.’ Such qualities enabled them to deal with the health risks of nursing: ‘I think nurses are not ordinary women, or they never would come and choose work that causes so much tax to their energies, physically and mentally and feelings altogether.’ Luckes promoted an image of the nurse as physically and mentally superior that implied almost an invulnerability to illness. She rejected demands for a reduction in working hours with the argument that superior physical strength guaranteed good health ‘barring accidents incidental to the work.’<sup>245</sup> Her conviction that London Hospital nurses were superior to those from other hospitals also contributed to her intolerant and unsympathetic attitude towards those who failed to live up to her own exacting standards.

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<sup>243</sup> RLH, ‘Trained Nursing at The London Hospital, *The New Review*, LH/A/26/5, No. 17, October 1890, p.303.

<sup>244</sup> Gamarnikow, ‘Sexual Division of Labour: the case of nursing’, p.96.

<sup>245</sup> *Sandhurst Report*, p.407.

The idea that the nurse was a superior type of woman reflected, in some ways, a wider debate surrounding the image of ‘new women’ during the 1890s. A literary stereotype, constructed as a result of debates over marriage, sexualities, political rights, labour conditions, lifestyles and fashion, the ‘new women’ signified the single woman’s bid for personal freedom in the form of a career, financial independence, suffrage and leisure.<sup>246</sup> Some sections of the press, alarmed at the assumed challenge, frequently caricatured her as a formidable virago.<sup>247</sup> Dr. Wigglesworth opposed the entry of women into the medical profession in *The Nursing Record* on the grounds that women ‘were not built to be’ doctors; those that had were criticised as masculine.<sup>248</sup>

The link between superior strength and invulnerability to illness also shaped attitudes to male asylum attendants’ health in the late nineteenth and early twentieth centuries. As already mentioned, physical strength was considered a valuable attribute amongst male attendants whose role often required the restraint of violent patients. The high patient: nurse ratio at the CLA meant that a small number of attendants had to control large numbers of patients, difficult for those of small stature or lacking physical strength. In 1901, twenty-four attendants complained that their numbers were inadequate to ‘look after’ 346 male pauper patients.<sup>249</sup> Male attendants’ work carried a significant risk of physical injury to both themselves and their patients. There were, however, no active moves by either the Visiting Committee, Medical Superintendent, Matrons or nursing staff to decrease this risk. No steps were taken to educate attendants in alternative ways to control violent patients. Enquiries into violent incidents occurred

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<sup>246</sup> See L. Hughes, ‘A club of their own: the “Literary Ladies”, New Women Writers and Fin –De- Siecle Authorship’, *Victorian Literature and Culture*, 2007, 35, pp.233-260; M. Beaumont, “A Little Political World of my Own”, *The New Woman, The New Life and New Amazonia*, *Victorian Literature and Culture*, 2007, 35, pp.215-232; A. Richardson, *Love and Eugenics in the Late Nineteenth Century: Rational Reproduction and the New Woman*, Oxford: Oxford University Press, 2003.

<sup>247</sup> Hughes, ‘A club of their own’, p.234. *Punch* magazine attributed five defining activities to the stereotype of the ‘new woman’; she smoked, rode a bicycle, frequented women’s clubs, read voraciously and wore bloomers.

<sup>248</sup> *The Nursing Record and Hospital World*, 27 October 1900, p.347.

<sup>249</sup> CRO, CLAVC Mins, HC1/1/1/62, 30 December 1901.

only when a participant was badly injured, died or a patient complained.

The Visiting Committee's enquiry into the circumstances surrounding patient Giles Hawken's death in 1898 illustrates some of the values at play in interactions between carers and patients. On arrival to the asylum, Hawken resented being pulled from his carriage and struck Charge Nurse Attendant Stevens between the eyes. Stevens claimed he did 'not use undue force.' Stevens and Attendant Solomon explained that they had held the patient from 'front and behind' and, with the aid of two patients, had manhandled Hawken into a padded room whilst he hit out. Solomon claimed 'we had difficulty in removing him to the padded room. He struck us and I had to close with him.' The Visiting Committee decided that neither of the attendants was to blame for Hawken's death, which was caused by a fall on a fireguard during the struggle.<sup>250</sup> Clearly, attendants were held to account by the Committee for violent behaviour but often retained their jobs. It is also interesting to note that two patients helped Stevens and Solomon 'manhandle' Hawken into the padded room. This suggests that the relationship between attendants and patients was often more complicated than simply that of custodian and prisoner and allowed some asylum inmates to act as nurses' assistants when required.

Attendants' image of superior strength was sustained by their reluctance to complain about the risks they faced. Their tolerance of the unpleasant aspects of their work was motivated by the prospect of claiming a pension. By 1896, over half the male attendants had worked at the asylum 'for many years.'<sup>251</sup> It was only when the Visiting Committee proposed to raise the age of entitlement to a pension, after fifteen years of service, from the age of fifty to fifty-five in December 1894, that attendants began to complain about their risk of injury.<sup>252</sup> All attendants signed a letter highlighting

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<sup>250</sup> CRO, CLAVC Mins, HC1/1/1/7, 27 June 1898.

<sup>251</sup> CRO, *Report of the Lunacy Commissioners, 1896*, HC1/1/1/6, p.13.

<sup>252</sup> CRO, CLAVC Mins, HC1/1/1/6, 27 December 1894, p.390.

the dangers that we are daily subjected to, the most trying, troublesome, unfortunate class of fellow creatures that we have to deal with in the execution of our duty, the unhealthy, disagreeable, injurious things we have to contend with daily. That Mrs Pyder (a recently retired nurse) after nearly twenty years service only enjoyed her allowance for a short time when she returned as a patient and died eight days after admission; this we venture to say, tends to show that we are subject to injury of mind as well as health through being confined with the patients for such long periods of time. Also that several other attendants have received personal injury in the execution of their duty, consequently they have completely broken down shortly after being superannuated.<sup>253</sup>

The attendants recognised that their strength lay in standing together and presenting a reasonable argument for their case. The Visiting Committee agreed to return to the original pension arrangements. The case of Mrs Pyder, cited by the attendants as an example of a nurse who suffered some form of mental illness shortly after retiring, perhaps is some indication of the degree of mental strain CLA nursing staff felt under.

The idea that asylum attendants risked their own sanity through close and prolonged contact with insane patients was taken up by several correspondents to *The Lancet* during the 1890s as part of a campaign to improve work conditions. ‘Anxiety [was] constant’ amongst attendants, one contributor suggested because, ‘they are surrounded by the most harrowing picture of humanity.’<sup>254</sup> Considerable stigma was attributed to both asylum patients and their carers, which helps explain why the occupation was of low status. In contrast, general hospital nurses were promoted as morally superior in order to attract middle class recruits believed necessary to raise the status of voluntary hospital nursing.

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<sup>253</sup> CRO, Letter from Attendants to the Visiting Committee, CLAVC Mins, HC1/1/1/6, 27 December 1894.

<sup>254</sup> *The Lancet*, 9 August 1890, p.318.



During the late 1890s, concerns over the inclusion of male nurses on the same register as female general nurses were raised. Although there were very few male general nurses, some considered that they threatened female jobs and usurped the doctor's function leading to intense scrutiny of their role. Correspondents to *The Nursing Record and Hospital World* discussed the relationship between "manliness" and male nurses as part of the question of eligibility for nurse registration. Those in support of the inclusion of men argued that 'a combination of strength and gentleness is ...the highest form of manliness, and nursing certainly tends to develop these qualities.' Opponents who advocated either a separate male register or non-registration argued that 'a strong, able bodied man is out of place ...tending the helpless sick.'<sup>255</sup> The concept of men undertaking traditionally female tasks challenged the late Victorian male stereotype of masculinity that projected manly virtues of will power, honour and courage resulting in male nurses being stereotyped as effeminate. An interesting dialectic developed in debates about male nurses' suitability to nurse. Employed on the basis of their physical strength, a desirable, masculine quality, discourses sought to disqualify them from expanding this role by highlighting their lack of feminine, caring qualities. Male nurses who possessed caring qualities, considered by some as 'the prerogative of women', were labelled as effeminate.<sup>256</sup>

It was not masculine qualities but the high cost of nurse agency fees that prompted a review of male nurses' position at the London Hospital in 1900.<sup>257</sup> Nurse agencies supplied temporary male attendants when a patient needed restraining, as in the case of delirium tremens. The desire to save money at a time when the Hospital, like many other voluntary hospitals, was suffering severe financial problems

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<sup>255</sup> *The Nursing Record and Hospital World*, 25 September 1897, p.259.

<sup>256</sup> *Nursing Record and Hospital World*, 27 October 1900, p.347.

<sup>257</sup> RLH, Letter from The London Hospital House Governor to J. Hutchinson, LM/5/1, 2 August 1899.

outweighed doctors' fears that male nurses would usurp their position.<sup>258</sup> The Hospital's Medical Council sought to improve 'the status and conditions of employment of male attendants' by suggesting that 'the present method of attending to mental cases' needed attention.<sup>259</sup> The Council proposed the permanent employment of one trained male attendant as a cost effective measure.<sup>260</sup> The House Committee rejected the Council's proposal on the grounds that it would be more economical to train female nurses or male surgical dressers already working in the Hospital to treat violent patients.<sup>261</sup> The debate was unresolved and the Hospital continued to employ temporary attendants.

Ward sisters' opposition to the employment of permanent male nurses was vociferous and may have contributed to this outcome. Ward sisters complained:

male attendants simply use[d] brute force; they have got to see that the patient does not get out of bed, and they do see to that; they put their hands on him; and naturally they are not liked.<sup>262</sup>

A witness to the Select Committee on Metropolitan Hospitals told how 'experienced sisters hardly ever want them ... a woman can manage a man except in very rare circumstances.'<sup>263</sup> Considered unsuitable for training because of their working class background and their 'coarse', 'animal' qualities, criticism in the nursing press focussed on an alleged tendency to sleep on night duty and to take bribes.<sup>264</sup> Bedford Fenwick highlighted the difference in attendants' and voluntary hospital nurses' class

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<sup>258</sup> Criticism in the medical and lay press accused voluntary hospitals of drifting into chronic bankruptcy because of their insistence on sticking to the principle of providing for the poor, encouraging the working class to depend on charity, when, according to critics, it was obvious that they could pay for their treatments. See A.E. Clark-Kennedy, *The London*, p.104.

<sup>259</sup> RLH, Medical Council: files and miscellaneous, LM/5/1, 20 May 1900.

<sup>260</sup> RLH, Letter from The London Hospital House Governor to J. Hutchinson, LM/5/1, 2 August 1899.

<sup>261</sup> RLH, Medical Council: files and miscellaneous, LM/5/1, 20 May 1900.

<sup>262</sup> *Sandhurst Report*, p.331.

<sup>263</sup> *Sandhurst Report*, p.331.

<sup>264</sup> *The Nursing Record and Hospital World*, 2 October 1897, p.278.

background as rationale to limit male attendants' role.

In summary, notions of femininity underpinned the image of the 'new' nurse but the suggestion that nursing was women's natural work obscured health problems. Despite her introduction of a scientific based system of nurse education, Luckes advocated qualities associated with motherhood as necessary qualification to nurse at The London. To further her argument against state registration, she advocated that nursing, like motherhood, should remain exempt from national regulation. Some doctors, fearing that nursing reform might lead to the creation of a back door route into medicine, suggested that nurses were not physically equipped to deal with the long working hours. Partly in reply to such conversations, and with the aim of raising the status of London Hospital nurses, Luckes endorsed the idea that nurses there possessed a superior form of physical and mental strength compared to ordinary women, an image that implied an almost immunity to illness. Male nurses were employed at the CLA on the basis of their physical strength to restrain violent and difficult patients. Although their role involved a high risk of injury, attendants made few complaints, motivated by their pension. Their tolerance of poor work conditions and the fact that they were employed in an occupation of low status, resulted in the fact that the dangerous nature of their work and their high risk of physical injury received little attention. Despite poor working conditions and the nature of the work, female nursing was gradually developing into a more respectable occupation.

### **'The Trial to Women of the Better Class'<sup>265</sup>**

The changing image of the nurse from working to middle class between 1860 and 1890 prompted conversations about the relationship between nurses' class and health. Contemporary accounts frequently linked the rise in mortality and morbidity rates amongst The London Hospital nurses with its increasing number of middle class

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<sup>265</sup> RLH, *The New Review*, LH/A/26/5, No. 17, October 1890, p.292.

recruits. Some doctors, nurse leaders and newspaper reports cited the relationship between class and physical and mental health as reason to change nurses' work conditions, the practice of nurses' work and the nurses' role as the doctor's assistant.

Evidence to the Select Committee on Metropolitan Hospitals suggested that probationers recruited to The London came from a mixed social class background, supporting Maggs' recent research.<sup>266</sup> Probationer Ellen Yatman, whose case was discussed in chapter two, noted that some recruits were 'uneducated; of course there were all kinds of social degrees in the Hospital.'<sup>267</sup> Luckes recognised the 'mixed' social background of London Hospital nurses and justified her agenda for improvements to work conditions by arguing that it would benefit all. In 1888, Luckes lobbied the Hospital Committee to improve nurses' sleeping accommodation: 'separate sleeping compartments, however small, are essential both on the grounds of comfort and discipline for the mixed classes of workers now engaged in hospital nursing.'<sup>268</sup> However, Luckes prioritised the physical and mental health needs of the core group of middle class nurses she saw as important to the future of the nursing profession. She deployed the idea that middle class nurses had a different mental outlook and needs to working class women as a tool to achieve change, particularly the need to provide better accommodation.

The London Hospital increased its number of middle class recruits with the help of a three-month training scheme for paying probationers in 1881. The scheme, developed at a time when recruitment was proving difficult, was designed to increase probationer numbers without adding to hospital expenses. Middle class women, according to Luckes, were 'willing to pay for the privilege' of nursing 'but unable to bind themselves for the full term of two years training ... until they had tried the experiment.' In return for a payment of thirteen guineas, probationers had the privilege

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<sup>266</sup> Maggs, *The Origins of General Nursing*, p.25.

<sup>267</sup> *Sandhurst Report*, p.302.

<sup>268</sup> RLH, E. Luckes, 'Letter to Hospital Committee', LH/A/17/48, 20 October 1888.

of their own bedroom and exemption from night duty.<sup>269</sup> The system was criticised because of the high turnover of staff it resulted and the burden placed on staff training. However, the numbers of paying probationers were small: in 1890 only fourteen probationers paid out of a total of 134 nurses.<sup>270</sup>

Middle class nurses needed more space and privacy than working class women, according to Luckes: ‘the trial to women of the better class, of never being alone for five minutes out of the twenty-four hours, is one that perhaps can hardly be estimated without personal experience of it.’<sup>271</sup> These views probably reflected Luckes’ own class background; she came from a land-owning family and was educated as a boarder at Cheltenham College.<sup>272</sup> Eliza Homersham, a probationer who paid for training in the belief that she would be entitled to a separate bedroom complained to the Select Committee on Metropolitan Hospitals that not only had she shared a dormitory with eight other women but also what she considered working class ‘sewing women’ slept in her bed at night whilst she was on night duty. ‘No lady’, Homersham complained, ‘likes to think that her bed is occupied alternately by a stranger whose habits are different to her own.’ It was not a lack of personal space that seems to have troubled Homersham but more the fact that she was expected to share her bed with a working class woman.<sup>273</sup> The system of ‘boxing and coxing’, where day and night nurses or night nurses and servants shared a bed, continued until at least 1890.

Homersham also gave evidence to the Select Committee about the poor standard of nurses’ accommodation. Upset about the fact

that the rooms were not properly protected. On one occasion I was roused by a policeman, the front door having been left open; and he wanted someone to go over the house with him. I

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<sup>269</sup> RLH, *New Review*, LH/A/26/5, No.17, October 1890, pp.292-296.

<sup>270</sup> *Sandhurst Report*, p.398.

<sup>271</sup> RLH, *The New Review*, LH/A/26/5, No. 17, October 1890, p.292.

<sup>272</sup> Clark-Kennedy, *The London: A Study in the Voluntary Hospital System*, p.94.

<sup>273</sup> *Sandhurst Report*, p.335; p.379.

told the policeman that I thought the best thing he could do was to ask other people, certainly not me.<sup>274</sup>

She also resented fetching hot water from a copper in the basement. Homersham's comment suggests a sense of superiority and expectations about her standard of living. The introduction of an educated and articulate minority was believed to have been responsible for an increase in the number of complaints about work conditions during the 1890s. *The Hospital* reported that the arrival of

a class of women superior to that known to a previous generation has brought with its many advantages certain drawbacks. Among others it has opened the door to a restless, self-conscious and ambitious element out of place in a calling which, for its highest fulfilment, demands a large measure of person suppression and self-sacrifice.<sup>275</sup>

The 'new' nurses were perceived as ambitious and less willing to sacrifice their personal liberty through unquestioning obedience. However, these nurses may well have made complaints with the aim of trying to improve the occupation's standards rather than for disruptive reasons. Luckes interpreted complaints as an indication of a lack of suitability to nurse and routinely dismissed the nurse in question. She refused, for example, to grant Homersham leave to visit her sick father in 1885: when Homersham insisted on going, Luckes declared her behaviour 'disgraceful and dishonourable' and informed her that 'she was never to cross the door of the hospital again.'<sup>276</sup> Despite this example of dogmatic behaviour, Luckes showed herself sensitive to the need to shape health care services according to the class of nurses, perhaps anticipating future complaints. Middle class nurses were sent to family houses for convalescent care whilst those with working class backgrounds went to servants'

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<sup>274</sup> *Sandhurst Report*, p.336.

<sup>275</sup> *The Hospital*, 19 July 1890, p.240.

<sup>276</sup> *Sandhurst Report*, p.333.

cottages.<sup>277</sup>

The relationship between physical strength, class and the appropriate nature of nurses' work received considerable attention from the Select Committee on Metropolitan Hospitals and the medical and lay press during the 1890s. The debate turned on the amount of menial work expected of nurses and the value of the tasks performed. As mentioned in the previous chapter, the majority of a probationer's time on duty was spent cleaning. A debate was conducted in both *The Pall Mall Gazette* and *The Lancet* arguing that middle class nurses may be better employed in management and personal care tasks:

such nurses were not material that any master hand [would] select for stead and continuous work. Domestic tasks that come lightly to women of tougher fibre [were] a strain to them, but they work with hearty goodwill: and unreliable as their health may be they [were] a valuable element in a nursing staff.<sup>278</sup>

*The Lancet* argued that middle class nurses should spend their time on direct patient care because 'of the delicacy of their hands' rather than on 'rough tasks' which 'ought not to be imposed on ladies whose utmost strength is heavily taxed.'<sup>279</sup> In contrast, *The Hospital* argued that social background had no part to play in dictating nurses' work conditions and reinforced an ideology of nurses as self-sacrificing angels who would tolerate all working environments to fulfil their devotion to duty.<sup>280</sup>

Some of the medical profession wanted to ensure that nurses remained handmaidens to the physician and were concerned that middle class, articulate nurses may become more independent in their work and follow their own professional rules. *The British Medical Journal (BMJ)* reminded nurses that they should not consider themselves too highly trained to perform menial tasks, particularly the contentious job

<sup>277</sup> *Sandhurst Report*, p.478.

<sup>278</sup> *Pall Mall Gazette*, 11 September 1890.

<sup>279</sup> *The Lancet*, 26 July 1890, p.194.

<sup>280</sup> *The Hospital*, 16 August 1890.

of lamp cleaning: according to witnesses at the Select Committee on Metropolitan Hospitals many London Hospital probationers on night duty felt they were too busy to clean the lamps and polish inkstands but the *BMJ* argued that this was an essential part of the new nurses' scientific role in supporting the doctor's increasingly technical role.<sup>281</sup> The *BMJ* supported their case with the argument that many middle class ladies, with servants, chose to clean lamps at home rather than delegate the task.

The language of class was also deployed to explain why the incidence of flat feet was rising amongst nurses at The London Hospital. Flat feet were a common problem and were often mentioned in nurses' records as the reason for discharge: Dr. Fenwick believed it to be caused by strain of the ligament.<sup>282</sup> Mr Treves, a surgeon at The London, suggested that the increasing numbers of probationers developing the problem after a comparatively short time in the Hospital, arose because they were 'ladies who have been accustomed to not much standing, nor much walking, and [had] been accustomed to wearing rigid boots or shoes.'<sup>283</sup> It was not unnatural, Treves suggested, that the arch of the foot should sink 'in a woman of feeble physique.'<sup>284</sup> This implies that better class nurses were more vulnerable to illness, raising the question of whether Treves supported the idea that nurses should be drawn from working-class backgrounds. This may well have been the case; Treves was firmly opposed to nurse registration on the grounds that it threatened general practitioners' incomes:

Nursing is taking an increasing place in medical practice and a certain number of medical practitioners begin to feel that their position is seriously encroached upon not only to their disadvantage, but to the greater disadvantage of their patients by the increasing power and position of nurses ... nurses have taken the position that should have been occupied by these

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<sup>281</sup> *BMJ*, 13 September 1890.

<sup>282</sup> *Sandhurst Report*, p.452.

<sup>283</sup> *Sandhurst Report*, p.456, p.469.

<sup>284</sup> *Sandhurst Report*, p.456.



gentlemen.<sup>285</sup>

Treves condemned the actions of several typhoid patients he knew who had chosen to save money by employing trained nurses and reducing the number of visits from their doctor. In his opinion, no amount of training could teach a nurse to detect complications.<sup>286</sup>

There is no evidence that the Visiting Committee of the CLA perceived the health of its nursing staff as related to their class background. This is surprising considering that, as already mentioned, wider debates on the poor health of the working class during this period reflected concerns about physical deterioration, national degeneration, urbanisation and emancipation of the working classes (see p.27, p.84). As already mentioned, attendants were drawn from working backgrounds: many of the male attendants were ex-servicemen or constables whilst the female attendants often came from domestic service or were older women who were widows or who had brought up their families.<sup>287</sup>

Middle class recruitment to the CLA did not increase at the end of the nineteenth century nor were asylum nurses and attendants included in the campaign for registration. Attendants' working class background was noted as one reason why they should not be included on a register of nurses. Bedford Fenwick used her position as editor of *The Nursing Record and Hospital World* to further the prejudice held by some general nurses against asylum nurses. She perpetuated the view that a working class background was naturally equated with dishonourable behaviour.<sup>288</sup> One commentator to *The Nursing Record* distinguished between the middle class background of general nurses and their aspirations towards training and the 'uneducated male attendants' who were 'drawn from a class from which the majority of our leading nursing training

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<sup>285</sup> *Sandhurst Report*, p.459.

<sup>286</sup> *Sandhurst Report*, p.459.

<sup>287</sup> Andrews, *A Dark Awakening*, p.81.

<sup>288</sup> *The Nursing Record & Hospital World*, 12 December 1896.

schools have long ceased to admit nurse probationers.<sup>289</sup> It is interesting to note that it was only male asylum nurses' social background and not their female counterparts, that were linked to an unsuitability for training suggesting that nurse leaders' closely entwined notions of class and gender to discredit male nurses.

In summary, notions of class clearly underpinned understandings of voluntary hospital nurses' health but were ignored in conversations about the health of asylum nurses. The relationship between the class background and health of voluntary hospital nurses was used as a tool in the campaign for professional status by some nurse leaders and doctors to shape both the 'new' nurses' role and their work conditions. In contrast, asylum attendants did not lobby to improve the status of their occupation and as a result, the relationship between their health and work was largely ignored. In 1911, a Select Committee, stimulated by proposed amendments to the Asylum Officers' Superannuation Act 1909, examined asylum work conditions, concluding that:

No-one will deny the special stress and strain of asylum service. Much of the work is tedious, monotonous, wearing, not free from indignities and some personal risk and ... may well constitute an excessive strain.<sup>290</sup>

The Committee heard from twenty witnesses, most of who were medical superintendents and members of the Lunacy Commission. Only two asylum attendants were called. All agreed that asylum staff, particularly in acute wards, faced considerable danger from attack. Marriot Cooke of the Commission suggested that a reduction in working hours would improve the social quality of attendants whose intelligence and tact may reduce this risk by establishing better relationships with patients. However, the risk of employing more intelligent men, according to Cooke,

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<sup>289</sup> *The Nursing Record & Hospital World*, 6 February 1897, p.114.

<sup>290</sup> *Report and Special Report on the Asylum Officers (Employment, Pensions and Superannuation) Bill together with the proceedings of the Committee, Minutes of Evidence and Appendices*, London: HMSO, 1911, p.iv.

was that the incidence of nervous breakdowns amongst nursing staff would rise. Intelligence was associated with emotional sensitivity as a result of a middle class education. Cooke considered less educated, working class men more able to withstand the type of work.<sup>291</sup> The Report recommended a seventy-hour week, a reduction in the retirement age for women and that staff should have a right of appeal to a Visiting Committee against dismissal by the medical superintendent. These recommendations never became law, primarily because of a lack of parliamentary time.<sup>292</sup> The next section of this chapter will examine the type of illness that affected nurses.

## **Occupational Diseases**

Between 1890 and 1919, nurses' health risk was understood in terms of two categories of illness: infection and 'overstrain.' Seven of the eight deaths amongst nurses at The London Hospital between 1888 and 1890 were attributed to infections: two died from scarlet fever, one from diphtheria, two from pneumonia, one from blood poisoning after contracting a septic finger and one from suppurative meningitis.<sup>293</sup> The introduction of this chapter discussed how ideas about the risk infection posed to nurses were complicated by understandings of the germ theory of disease. Eva Luckes clearly understood the germ theory of disease but a number of other commentators within The London Hospital considered a wider range of ideas on how infection was spread. In her *Lectures on General Nursing* Luckes discussed the origins of diphtheria, 'caused by the reception and growth of a specific bacillus which poisons the system.' Klebs and Loeffler recognised that diphtheria was caused by a specific bacterium six years previously, in 1884. The high number of nurses contracting the disease persuaded The London Hospital House Committee to stop admitting diphtheria cases in 1888. Luckes shaped her teaching of nursing the diphtheria patient and ideas about infection control

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<sup>291</sup> *Report and Special Report on the Asylum Officers, Minutes of Evidence*, p.4-5.

<sup>292</sup> Carpenter, *Working for Health*, pp.50-51.

<sup>293</sup> *BMJ*, 13 September 1890.

around an understanding of the germ theory. Infection control measures included frequent hand washing in a Lysol solution particularly before eating, the banning of food from patients' rooms and instructing nurses to gargle twice a day removing false teeth before doing so.<sup>294</sup>

In October 1888, six nurses working on the same ward contracted diphtheria and scarlet fever within a three-week period. The incident provoked intense debate as to the cause of infection, particularly when paying probationer Katherine Woolley died from scarlet fever.<sup>295</sup> Katherine became ill two weeks after starting training, prompting discussion that probationers in their initial period of employment were more susceptible to infection. The *BMJ* noted that probationers who were 'not protected by a previous attack' were more likely 'to be affected when brought into contact with it.'<sup>296</sup> Luckes, on the other hand, believed that it was 'entirely due to patients who had been brought in.' The high levels of infection amongst nurses led to closure of the ward for fumigation, cleaning and painting and prompted the House Governor to regulate against the future admission of diphtheria patients.<sup>297</sup>

Obnoxious smells from inadequate sanitary facilities were also identified as a possible cause of the outbreak of infection. Miasmatic theories continued to influence thinking about contributing factors to disease although it's meaning was refined within the spectrum of contagious and infectious diseases. From the 1860s the term miasmatic was increasingly applied to catching airborne diseases either directly from other people or where the poisons came from the environment.<sup>298</sup> Several nurses believed that the smell from poor sanitation was responsible for high levels of infection including Ellen Yatman who left nursing after 18 months due to an illness she believed to be 'blood

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<sup>294</sup> Luckes, *Lectures on General Nursing*, pp.279 -299.

<sup>295</sup> Three nurses contracted diphtheria and three nurses scarlet fever. *Sandhurst Report*, p.402.

<sup>296</sup> *BMJ*, 13 September 1890, p.646.

<sup>297</sup> *Sandhurst Report*, p.402.

<sup>298</sup> Worboys, *Spreading Germs*, p.39.

poisoning, evidently from sewer gas.<sup>299</sup>

In 1889, medical staff at The London Hospital admitted ‘their perplexity’ as to the cause of ‘the various symptoms’ nurses suffered, suggesting that they pointed to ‘unsanitary conditions of some kind.’<sup>300</sup> An investigation by the House Governor concluded that the cause of the smell was not sewer gas but coal gas, ‘which is very unpleasant in smell, but not as unwholesome as sewer gas.’<sup>301</sup> With hindsight, and in our knowledge of the toxicity of coal gas, his statement seems naïve. The doctors’ concern for nurses’ health persuaded the House Committee to invest £7000 in improving the Hospital’s sanitation in 1890.<sup>302</sup>

Nurses often attributed their frequent sore throats to ‘bad smells.’ ‘Hospital sore throat’, as it was known at The London, was particularly common in the first year of training.<sup>303</sup> Probationers at the SDEC also suffered sore throats that frequently developed into tonsillitis, the most common cause of illness amongst probationers there between 1903 and 1919, claiming an average of nineteen days sick leave to recover.<sup>304</sup> Medical staff at the SDEC suggested that the ‘dreadful stench’ from the sewer ventilator was also responsible for typhoid and erysipelas.<sup>305</sup> The SDEC Treasurer agreed that ‘the insanitary and perilous condition of the drains, ward lavatories and bathrooms’ were responsible for ‘breeding disease amongst patients and nurses.’<sup>306</sup> Opinions about the cause of infection were clearly not restricted to medical or nursing staff at both general hospitals studied.

Miasmatic theories of disease included the health risk posed to nurses from the

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<sup>299</sup> *Sandhurst Report*, p.294.

<sup>300</sup> RLH, The London Hospital House Com Mins, LH/A/5, 22 October 1889.

<sup>301</sup> *Sandhurst Report*, p.392.

<sup>302</sup> RLH, *The New Review*, LH/A/26/5, No. 17, October 1890, p.303.

<sup>303</sup> *Sandhurst Report*, p.313; p.327.

<sup>304</sup> See Appendix Table A1 for Table of nurses’ illness at the SDEC 1903-1919. Database compiled from information obtained in the Probationers’ Register, SDEC, 1490/24/1903 –1923 held at PWDRO.

<sup>305</sup> PWDRO, SDEC General Com Mins, 606/1/2, 15 July 1890.

<sup>306</sup> PWDRO, SDEC General Com Mins, 606/1/7, 23 September 1909.

smell emanating from infected patients. A former chaplain of the Hospital, Henry Valentine, who resigned from his post following strange allegations that he pressurised nurses to take confession, claimed that the match-boarded or lath and plaster partitions of the sisters' rooms, adjacent to the wards, were too thin and allowed 'the smell and often the stench of gangrene or cancer' to ooze 'through the cracks and crevices of their rooms.' Whilst it is recognised that cancers have distinctive odours, they are only likely to smell offensive when infected or the decaying tissue becomes putrid. Whereas treatment from the mid twentieth century onwards involved surgical debridement of decaying tissue plus administration of antibiotics, infected patients in the late nineteenth century were also likely to have surgery as it became more popular but remained as in-patients for much longer periods of time. Valentine cited the case of a man 'who lay there for days and days, to the great hurt of all the patients ... for many days the whole ward was unfit really to live in.' Ward sisters' rules dictated they always slept in their room. Valentine recommended, on the basis of his 'little medical knowledge' picked up 'after four years in residence', that they 'be allowed to sleep in pure air at least once a month.'<sup>307</sup> The quality of air was recognised as beneficial to nurses' health by both medical and lay commentators.

Infected hands or fingers were another common cause of illness amongst general hospital nurses. Ellen Yatman claimed that nurses at The London 'frequently worked' with 'poisoned hands and arms.'<sup>308</sup> One of the eight nurses to die between 1888 -1890 was believed to have contracted 'blood poisoning' as a result of a 'germ or poison' gaining entry into the hand.<sup>309</sup> Septic finger was the third most common disorder, following tonsillitis and influenza, amongst probationers at the SDEC between 1903 and 1919. Without antibiotics to treat such infections, probationers took an average of sixty-eight days off sick. SDEC probationer Alice Dowling, aged eighteen, contracted a

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<sup>307</sup> *Sandhurst Report*, p.329.

<sup>308</sup> *Sandhurst Report*, p.332.

<sup>309</sup> *Sandhurst Report*, p.408.

septic finger after six months training and on being sent home to recover, her parents decided that she was not strong enough to nurse and prevented her return.<sup>310</sup>

The incidence of infectious diseases amongst attendants at the CLA was more sporadic, possibly because there was less contact with infectious patients than in the voluntary hospitals. Three attendants contracted typhoid between 1896 and 1898, one of who died.<sup>311</sup> Such cases of typhoid were not isolated until the opening of the Asylum's Isolation Hospital in 1900. Typhoid germs were thought to be carried in excremental discharges, spreading in the water supply, in food or in escaping sewer gases.<sup>312</sup> The CLA Visiting Committee did not investigate the cause of the typhoid outbreak. They were, however, most concerned about the threat smallpox posed to their patient population and when two cases of smallpox were reported in Plymouth and Devonport, insisted that all staff be vaccinated. Those that refused were given a month's notice.<sup>313</sup> Two attendants contracted tuberculosis (TB) in the 1890s: TB was the chief cause of morbidity and mortality amongst the Asylum's patients at the end of the nineteenth and early twentieth centuries, second to general paralysis of the insane.<sup>314</sup> Tuberculosis amongst general and asylum nurses will be discussed in chapter six.

In summary, nurses faced a higher risk from contracting infectious diseases from patients at the voluntary hospitals studied than at the CLA. Probationers were more vulnerable during their first year of training, particularly to sore throats. Ideas about the risk infection posed to nurses were complicated by understandings of the germ theory of disease. Whilst Luckes shaped nurse training at The London around her understanding of the germ theory, other commentators attached importance to miasmatic theories of disease as the chief cause of nurses' illness.

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<sup>310</sup> PWDRO, SDEC Register of Nurses, 1490/24, 1903 –1923.

<sup>311</sup> CRO, CLAVC Mins, HC1/1/1/7, 26 September 1898.

<sup>312</sup> Worboys, *Spreading Germs*, p.38.

<sup>313</sup> CRO, CLAVC Mins, HC1/1/1/7, 31 March 1902.

<sup>314</sup> Andrews, *The Dark Awakening*, p.201. See Chapter Five for further discussion of tuberculosis.

## Overstrain

In 1890 nurses' ill health was often understood as a generalised response to poor environmental work conditions and the regime of nursing: Ellen Yatman labelled it as 'overtiredness.'<sup>315</sup> Evidence to the Select Committee on Metropolitan Hospitals suggested that nurses often suffered from exhaustion from the long working hours and onerous duties.<sup>316</sup> In 1911, this broad understanding was given the more specific title of 'overstrain' by German physician Dr. Geheimerat Hecker who argued that poor work conditions caused a type of fatigue in nurses which produced identifiable physiological changes, symptoms and results. Hecker's work reflected the idea that that an increase in the pace of life placed a strain on individuals who then succumbed to physical or mental illness. This strain combined with a weakened constitution as a result of enduring poor work conditions was believed to be the cause of widespread physical and mental illness amongst nurses in Germany.<sup>317</sup>

Overstrain was the sum of 'bodily and mental suffering, of distress and renunciation, of unfulfilled aspirations and broken down existences' according to Hecker.<sup>318</sup> He developed his study of 'Fatigue and of the Toxins and Anti-Toxins of Fatigue' amongst nurses in Germany and Austria from studies by physicians on school children and industrial wageworkers in Turin, Italy.<sup>319</sup> Introduced as the first study to deal 'with the overstrain of nurses from a scientific standpoint' to the International Congress of Nurses in 1912, Hecker argued that whereas fatigue lowered the limit of irritability of neurones which after a period of recuperation returned to normal, over-fatigue meant that neurones took longer to return to normal and in order to compensate, the body produced substances which consumed bodily tissues. Symptoms of over-

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<sup>315</sup> *Sandhurst Report*, p.295.

<sup>316</sup> *Sandhurst Report*, p.295.

<sup>317</sup> *BJN*, 24 August 1912, p.147.

<sup>318</sup> *BJN*, 1 March 1919, p.134.

<sup>319</sup> *BJN*, 21 October 1911.



fatigue included rapid pulse, shortness of breath and rapid respiration, rise in temperature, decreased sense of perception and ‘decrease in working power.’ Hecker identified a broad range of physical results including acute inflammation of muscles, sinews and joints, neuralgia and cramp, nervous palpitation and enlargement of the heart, diabetes and enlargement of the liver.<sup>320</sup>

Mental strain was a symptom of overstrain, according to Hecker: excessive manual work rendered ‘one incapable of mental work’ with the result that ‘the perception by the senses becomes slower and less exact.’ He suggested that ‘an increase in nervous tension’ was characteristic of the period amongst all groups of workers caused by ‘free competition, with its necessary accompaniment of haste and speed, disgust and irritability ... together with the spread of education, resulting in superficiality.’<sup>321</sup>

Hecker’s work on overstrain was the first ‘scientific study’ of nurses’ health to suggest that physiological changes within the nervous system, caused by over-fatigue associated with poor work conditions and the pace of modern life, produced a wide range of physical symptoms associated with ill health. The idea that the strain of modern life placed difficult demands on individuals who then succumbed to psychological or biological diseases ‘became an almost ritualistic belief in the nineteenth century and in the twentieth century ... the pace of life was viewed as the root cause of much illness and disease.’<sup>322</sup> The stress of nursing, according to Hecker, was exacerbated by the intensive nature of the work, inexperienced night probationers being placed on duty on their own and the serious nature of patients’ illness.<sup>323</sup>

Hecker’s work seems to have had little immediate impact on the care of nurses.

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<sup>320</sup> G. Hecker, ‘The Overstrain of Nurses’, paper given to the International Council of Nurses in 1912. His paper was published by the National Council of Women in 1919 and printed in *BJN*, 1 March 1919, pp.134-135 as part of the Council’s enquiry into nurses’ health, to be discussed in Chapter Five.

<sup>321</sup> *BJN*, 1 March 1919, p.135.

<sup>322</sup> C.L. Cooper & P. Dewe, *Stress: A Brief History* Oxford: Blackwell, 2004, pp.2-5.

<sup>323</sup> *BJN*, 24 August 1912.

His paper was published by the National Council of Women (NCW) and copied in *The BJNI* in 1919, five years after his original presentation, as part of the NCW's campaign to raise awareness of nurses' health (to be discussed in chapter five). Despite this renewed interest in his work, its lack of impact was confirmed by an editorial comment in *The BJNI* which suggested that it was the First World War that had brought 'home to our employers that conditions for nurses must be improved.'<sup>324</sup>

No cases of 'overstrain' were formally diagnosed at The London or the SDEC during the early part of the twentieth century. Doctors at the SDEC used the term 'run down' to describe any illness related to fatigue. Elizth-G. J., aged 32, was off sick for three weeks because she was 'run down' eighteen months into her training but returned to work and qualified as a staff nurse.<sup>325</sup> Several commentators, including Sydney Holland, The London Hospital's Chairman, argued that if a nurse's mental or physical health broke down it was 'because she was not strong enough for the profession' and unable to cope with exhaustion from the long hours.<sup>326</sup>

Margaret Breay, treasurer of the International Council of Nurses and assistant editor of *The BJNI*, discussed the causes of overstrain in British nurses in a paper presented to the International Congress of Nurses in Cologne in 1912 and published in the *BJNI*. She argued that strain was an inevitable part of nursing because of the nature of caring for sick patients but that employers should take more responsibility for nurses' health by providing 'good food and sufficient time for rest and recreation.' Nurses' health problems were exacerbated by the discipline of routine work and poor salaries but, Breay argued, their main cause was a 'lack of knowledge':

Nothing is a more fruitful source of overstrain than lack of knowledge. Knowledge gives confidence and a sense of power to deal with difficult situations which is otherwise unattainable

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<sup>324</sup> *BJNI*, 1 March 1919, p.135.

<sup>325</sup> PWDRO, SDEC Register of Nurses, 1490/24, 1903-1923.

<sup>326</sup> *The Times*, 20 May 1900.

... hence the responsibility resting upon hospital authorities to provide adequate instruction and experience to their pupils.<sup>327</sup>

‘New’ nurses were identified as more susceptible than their ‘Sarah Gamp and Betsey Prigg’<sup>328</sup> predecessors because of their ‘conscientious’ and ‘sympathetic’ natures. It is interesting to note that conversations attempting to define the difference between ‘new’ and ‘old’ nurses in terms of their physical and mental qualities continued into the twentieth century and throughout the thirty-year debate about nurse registration.

Breay also considered mental nurses to be at particular risk from ‘overstrain’ because of their constant contact with the insane, the need for constant vigilance on duty to prevent self-harm amongst patients and contact with the undesirable conditions of life.<sup>329</sup> Whether asylum nurses were at risk from mental illness was called into question by The Lunacy Board’s research in 1906, which found that their incidence of lunacy was lower than in the general population aged between twenty-four and thirty-four. Fifty-two attendants out of a total of 10,100 were diagnosed with lunacy during 1906, a figure the Board still ‘found unacceptable considering that attendants and nurses were selected for their physical and moral fitness.’ The Board considered the figures conservative as they did not account for the frequent number of temporary mental breakdowns.<sup>330</sup>

Physical and mental illnesses in nurses were believed to be closely related problems in the late nineteenth century.<sup>331</sup> Luckes and some members of The London medical staff often suggested that a nurse’s ‘nerves’ or a lack of mental strength was a contributing factor to physical illness. When Nurse B. developed muscular rheumatism,

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<sup>327</sup> *BJN*, 26 October 1912, pp.330-332.

<sup>328</sup> Betsey Prigg is a nurse in Charles Dickens’ *Martin Chuzzlewit*. She is depicted as incompetent and uncaring. *BJN*, 26 October 1912, p.331.

<sup>329</sup> *BJN*, 26 October 1912, p.333.

<sup>330</sup> *Report and Special Report on the Asylum Officers (Employment, Pensions and Superannuation) Bill together with the proceedings of the committee, minutes of evidence and appendix*, London: HMSO, 1911, p.iv.

<sup>331</sup> See J. Oppenheim, “*Shattered nerves*”: *doctors, patients and depression in Victorian England*, New York; Oxford: Oxford University Press, 1991 for more discussion.

Dr Warner ‘thought her nerves had a good deal to do with her illness.’<sup>332</sup> Luckes often interpreted nervousness as a sign of immaturity and sentimentality, undesirable qualities in nurses. Nurse D., who was diagnosed as anaemic, was described as ‘highly strung and apt to be nervous about her own health. Silly and sentimental.’<sup>333</sup> As our discussion will show, the idea that nurses’ physical and mental health were closely linked continued to shape attitudes towards nurses’ ill health until 1948, the end of the period studied.

## **Conclusion**

Notions of class and gender informed the image of the ideal nurse and conversations about nurses’ health. As part of the campaign for professional status, nursing was promoted as an occupation suitable for middle class recruits during the late nineteenth century. Nurse leaders’ efforts to delineate between the early nineteenth century image of the working class nurse and the ‘new’ Victorian image of the middle class nurse were called into question by evidence to the Select Committee of Metropolitan Hospitals which suggested that the increase of middle class recruits to The London Hospital was responsible for its rising incidence of ill health. Some contemporary newspaper reports suggested that middle class nurses lacked physical strength and stamina and were less robust than their predecessors. Luckes tried to work around this problem by associating the middle class nurse with a superior type of women represented in the image of the ‘new woman’. She also engaged discourses about class and health as a basis to suggest improvements to nurses’ living conditions.

Notions of gender were evident in discussions of nurses’ susceptibility to illness. In 1890 the notion of gender was integral to the fabricated image of the nurse. Gender qualified individuals for caring, management and to stifle the threat to female hierarchy

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<sup>332</sup> RLH, London Hospital Ward Book, LH/17/A, 1901.

<sup>333</sup> RLH, London Hospital Ward Book, LH/17/A, 1901.

posed by male attendants. These notions were challenged by suggestions in the medical and lay press that women's lack of physical strength reduced her capacity for the demands of nursing. Luckes rejected the idea that women were particularly prone to ill health, promoting an image of the nurse as physically and mentally superior to that of ordinary women.

Gender issues also served to obscure nurses' health problems. Despite her support of a scientific based system of nurse education, Luckes advocated qualities associated with motherhood as a necessary part of the ideal image of The London Hospital nurse. She used the idea of motherhood as a vocational commitment to support her argument against state registration and a national set of regulations governing work conditions. Just as motherhood remained unregulated, so regulations regarding nursing should be kept to a minimum and set by individual hospitals.

The question of the registration of male attendants and their employment in voluntary hospitals prompted a debate that manipulated ideas and ideals of gender. Supporters of a register for both male and female asylum and general nurses promoted 'manliness' as a qualification to care whilst advocates of either non-registration or a separate register sought to prevent male nurses from expanding their role, by fostering a negative image of the male nurse as effeminate. Ward sisters at The London Hospital also promoted a negative image of male nurses based on brute strength in opposition to the Medical Council's plans to economise on agency fees by employing a trained male nurse.

Whilst voluntary hospital nurses' health was scrutinised as part of the debate surrounding registration, the health of asylum nursing staff, who did not lobby for professional status, received less attention. Asylum nursing remained an occupation of low status consistently attracting working class recruits with little other employment options. The CLA, unlike some other asylums, did not attract an influx of middle class,

voluntary hospital nurses to its senior posts. Most male attendants were employed on the basis of their superior physical strength that implied immunity to illness. Their work carried a high risk of physical abuse but this was an accepted part of CLA culture. Attendants endured poor work conditions, motivated by the prospect of claiming a pension.

Nurses' ill health in 1890 was understood in two broad categories: infection and 'overstrain.' An increase in the mortality rate of London Hospital nurses who had contracted infectious diseases suggested that nurses' health required urgent attention. Uncertainty of how infection was spread continued after Koch's discovery in 1882 and allowed a series of debates to flourish which identified social factors, such as class and gender, as explanations of nurses' vulnerability. The miasmatic theory of disease, sleeping accommodation close to the source of infection, contact with infectious patients and lack of sanitation were also suggested as factors. New probationers were identified as most vulnerable to infection. The most common cause of infection at both voluntary hospitals studied was sore throat and tonsillitis followed by infected fingers or hands.

In 1890, nurses' fatigue was understood to be an exhaustion caused by the long working hours and regime of nursing. In 1911, Hecker proposed a more 'scientific' approach by identifying physiological changes, symptoms and results caused by fatigue amongst nurses, which he labelled 'overstrain'. Hecker understood the changing factor between 1890 and 1911 to be an increase in the pace of modern life, a trigger for widespread illness amongst nurses in Germany that had increased nurses' vulnerability to ailments. No cases of 'overstrain' were diagnosed at The London or the SDEC suggesting that Hecker's work had little impact on the care of British voluntary hospital nurses. Although his paper was published five years later, in 1919, as part of the National Council of Women's survey into hospital nurses' health, the *BJN* admitted that

it was the First World War that had raised employers' concern over nurses' ill health.

## CHAPTER FOUR

### **A Comparison of Voluntary Hospital and Asylum Nurses' Roads to Nursing Professionalism 1914-1920**

In 1918, Francis Dudley, Medical Superintendent of the Cornwall Lunatic Asylum (CLA), claimed that the 'abnormal amount of sickness' amongst his nursing staff in the preceding year had contributed to a rapid rise in trade union membership and provoked strike action.<sup>334</sup> The aim of this chapter is to compare the influence of nurses' ill health at the CLA and the South Devon and East Cornwall Hospital (SDEC) during the First World War on nurses' choice of occupational representation. Existing historiography focuses on notions of gender and class as an explanation for asylum nurses' choice of trade unionism and voluntary hospital nurses' option for the college route. Although the influence of these notions will be assessed, this chapter is concerned with how the relationship between deteriorating work conditions as a result of the War and nurses' health shaped nurses' choice of occupational representation.

Historians have suggested that the notion of class determined why trade unions found it difficult to recruit voluntary hospital nurses but not asylum nursing staff. Abel-Smith argues that because many general nurses 'were ladies and many others had become nurses in the hope that they would be regarded as such' they were unwilling to sympathise or identify with a working class movement and trade unionism.<sup>335</sup> As mentioned in the previous chapters, recent studies like Maggs have challenged Abel-Smith's view that nursing reform transformed voluntary hospital nursing into a career suitable for middle class women. Maggs argues that nursing was a socially mixed occupation with a significant number of working class recruits.<sup>336</sup> The promotion of nursing as a way of helping the war effort seems to have elevated its image of

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<sup>334</sup> CRO, 99<sup>th</sup> Annual Report, CLA, 1918, HC1/1/3/9, p.24.

<sup>335</sup> Abel-Smith, *A History of the Nursing Profession*, p.132.

<sup>336</sup> Maggs, *The Origins of General Nursing*, pp.73-101.



respectability and temporarily influenced a change in the class background from which nurses were drawn. Summers argues that the Voluntary Aid Detachment nurses (VADs) employed to replace nurses called up for military service were the wives and daughters from the upper and middle classes. These women, she argues, embodied a crisis in Britain's 'ancien regime' and also its remedy: they were called up not only to aid the war effort but to work against the 'softening, weakening and disintegrating influences of modern social and national life.'<sup>337</sup> Such women were unlikely to identify with a working class trade union movement.

Other historians have suggested that the choice of college versus trade unionism was more about the social aspirations of general nurses than their class background.<sup>338</sup> Carpenter argues that 'official ideology' sought to create 'new nurses' from working class recruits by instilling a sense of superiority and manipulating aspirations for social mobility - 'the promise of travel, position and perhaps a successful marriage.' He attributes trade unions' lack of success in recruiting general nurses as evidence of the success of the elite hospital matrons in socialising nurses into compliance with their role as 'new nurses.'<sup>339</sup>

In comparison, the formation of the National Asylum Worker's Union (NAWU) in 1910, by a group of charge attendants from five Lancashire Asylums has partly been explained by the working class background of attendants.<sup>340</sup> As mentioned in the previous chapter, historians agree that asylum nursing staff were drawn from working class backgrounds.<sup>341</sup> Asylum work was low in status and continued to carry a stigma attached to the belief that mental illness was contagious and 'rubbed off' on those who

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<sup>337</sup> Summers, *Angels and Citizens*, p.278.

<sup>338</sup> Abel-Smith, *A History of the Nursing Profession*, p.132.

<sup>339</sup> Carpenter, *Working for Health*, p.166.

<sup>340</sup> See C. Chatterton, 'Women in mental health nursing: angels or custodians?', *International History of Nursing Journal*, Vol. 5, No. 2, Spring 2000; B. Douglas, 'The History of Digby Asylum', unpublished PhD thesis, University of Exeter, 2009.

<sup>341</sup> Carpenter, 'Asylum Nursing Before 1914', p.135; Chatterton, 'Women in mental health nursing: angels or custodians', p.14.

worked in asylums.<sup>342</sup> Carpenter argues that poor work conditions and a mutual sense of injustice, combined with a feeling of exclusion from the rest of the community, and close bonds formed among those who carry out socially despised work, prompted asylum workers to identify with the rising working class movement during the Edwardian period. From 1910 to 1913 retail prices rose faster than money wages and, as unemployment fell, an upsurge in militancy took place among miners, dockers, seafarers and transport workers.<sup>343</sup> The onset of war in August 1914 led to a general decline in industrial and political conflict as the bulk of the labour movement, including the NAWU, came out in support of the war effort.

This chapter examines how CLA and SDEC nurses' class background shaped their choice of occupational representation and also how notions of class affected their health. It questions whether an inter relationship existed between class, health and choice of collective representation. Did working class CLA asylum staff join a trade union because they experienced a greater deterioration in their health and work conditions during the First World War than that of the mixed class of nurses at the SDEC?

The notion of gender has also been identified as an important factor in shaping nurses' choice of occupational representation. Historians have suggested that the large proportion of male nursing staff in asylums explain a choice of trade unionism whereas the fact that voluntary hospital nursing was an exclusively female occupation explains the college route chosen. Feminist historians have made important contributions to the understanding of gender relations within the asylum.<sup>344</sup> There has been growing criticism of Showalter's argument that despite the fact that the number of female asylum patients and nurses outweighed men employed and cared for in asylums in the late

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<sup>342</sup> Chatterton, 'Women in mental health nursing: angels or custodians', p.15.

<sup>343</sup> Carpenter, *Working for Health*, p.42.

<sup>344</sup> M.Poovey, *Uneven Developments: the ideological work of gender in mid-Victorian England*, London: Virago, 1989; S. Shuttleworth, *Charlotte Bronte and Victorian Psychology*, Cambridge: Cambridge University Press, 1996.

nineteenth century, asylums remained highly paternalistic and controlled women through the arrangement of space and daily activities.<sup>345</sup> Melling and Forsythe suggest that there were negotiations of power between the authorities, patients and families.<sup>346</sup>

Male staff, according to Hart:

viewed themselves very differently to general nurses because they often had a background of work experience elsewhere, were excluded from the feminine Nightingale nursing structures, had poor promotion prospects and considered wages of greater importance as they had families to support.<sup>347</sup>

Female nurses' reluctance to join trade unions in the late nineteenth and early twentieth centuries reflected women's lack of involvement nationally in the male dominated trade union movement which had 'relatively little understanding of the needs and aspirations of women.'<sup>348</sup> Carpenter's view that women were more likely than men to adhere to professional and vocational values will be challenged, particularly in relation to the leading role female asylum nurses took in the CLA strike of 1918. Carpenter agrees with Abel-Smith that the

'sex of the nurse was probably significant in determining occupational attitudes, but not because of any inherent differences. Perhaps the culturally sanctioned expectation of self-sacrifice was more influential among female nurses, while

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<sup>345</sup> E. Showalter, *The Female Malady. Women, Madness and English Culture*, London: Virago, 1985, p.17.

<sup>346</sup> J. Melling, 'Sex and Sensibility in Cultural History: The English governess and the lunatic asylum, 1845-1914' in J. Andrews and A. Digby (eds.) *Sex and Seclusion, class and custody: perspectives on gender and class in the history of British and Irish psychiatry*, Amsterdam; New York: Rodopi, 2004; J. Melling, R. Adair, B. Forsythe, 'Migration, family structure and pauper lunacy in Victorian England: admissions to the Devon County Pauper Lunatic Asylum, 1845-1900', *Continuity and Change*, 12, 1997, pp.373-401.

<sup>347</sup> C. Hart, *Behind the Mask, Their Unions and Nursing Policy*, London: Balliere Tindall, 1994, p.40.

<sup>348</sup> Hart, *Behind the Mask*, p.30.

men seem to have scorned it.<sup>349</sup>

The question of vocation is considered central to determining the type of occupational representation chosen by different groups of nurses and will be examined later.

Were voluntary hospital nurses motivated by a sense of vocation that was incompatible with trade unionism compared to asylum nurses who treated their work as a job with tangible goals? Late nineteenth and early twentieth century voluntary hospital nurse leaders' notions of professionalism included the idea of nursing as a vocation. Carpenter suggests that 'official ideology' told nurses to make a virtue out of bad conditions and instilled a sense of superiority.<sup>350</sup> The image of the nurse as finding reward in spiritual contentment was antithetical to the concept of trade unionism, according to Hart. 'An integral part of the myth of the modern nurse is that trade unionism has no part in her world.' Because of this a voluntary hospital nurse 'would rise above all such material distractions as pay and conditions of service.'<sup>351</sup> Chatterton argues that it was the lack of alternatives rather than a sense of vocation that led women into asylum nursing with many regarding their work as merely a means of earning a temporary living rather than a career.<sup>352</sup> The issues raised around the idea of nursing as a vocation highlight the tension between unionism and professionalism.

From the outset the notion of professionalism was central to the College of Nursing's strategy. As noted in chapter one, the College was set up in 1916 partly in response to the problem of the multiplicity of qualifications held by the growing number of 'nurses' but also as a way of controlling the nurse labour market.<sup>353</sup> The College's stated objectives were to promote the better education of nurses, to standardise the nursing curriculum, to recognise approved nursing schools and to make

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<sup>349</sup> Carpenter, 'Asylum Nursing Before 1914', pp.142-143.

<sup>350</sup> Carpenter, *Working for Health*, p.166.

<sup>351</sup> Hart, *Behind The Mask Nurses*, p.31.

<sup>352</sup> Chatterton, 'Women in mental health nursing: angels or custodians?' p.14.

<sup>353</sup> Rafferty, *The Politics of Nursing Knowledge*, p.78.

and maintain a register of persons of appropriate proficiency.<sup>354</sup> Its Articles of Association specifically prevented the College from imposing on its members or supporting with its funds ‘any regulation which, if an object of the College, would make it a Trade Union.’<sup>355</sup> By 1919, encouragement by matrons and hospital administrators saw College membership rise to 13,047. Often perceived as exclusive, the College did not attract a majority of nurses. Its leaders tended to be hospital matrons and the high standards required for membership excluded men and large numbers of nurses with limited training.<sup>356</sup> Its view of the professional nurse was female, a view justified by Baly as ‘quite reasonable ... in the ethos of votes for women and the fact that there was almost no general trained male nurses.’<sup>357</sup> Carpenter suggests that its commitment to the notion of dedication to duty was a ‘potential Achilles’ heel’ that unions sought to exploit. The gap between the ‘modern girl’ and the rigidity of traditional nursing institutions was a contradiction, Carpenter argues, that contributed to a decline in nursing’s popularity, not least among middle class girls.<sup>358</sup>

Attempts to professionalize asylum’ nursing staff were unsuccessful. The Asylum Workers’ Association (AWA) was formed in 1895 by doctors prominent in the Royal Medico-Psychological Association in response to the Royal British Nurses’ Association’s (RBNA) refusal to admit male attendants. Doctors realised that they could improve the respectability of psychiatry as a whole if attendants received greater recognition and were held in higher esteem. According to Carpenter, the AWA was not a democratic organisation because medical superintendents dominated it. Although it encouraged staff to believe that they had an identity of interest with their superiors, asylum staff rejected its idealised image of asylum life, portrayed in the *Asylum News*,

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<sup>354</sup> RCN, The College of Nursing Ltd, Council Minutes, April 1<sup>st</sup> 1915 to March 31<sup>st</sup> 1916, 15 September 1916.

<sup>355</sup> RCN, The College of Nursing Ltd, Articles of Association, 1916.

<sup>356</sup> Rafferty, *The Politics of Nursing Knowledge*, p.79.

<sup>357</sup> Baly, *Nursing and Social Change*, p.151.

<sup>358</sup> Carpenter, *Wake Up Nurses*, p.175.

as ‘fantasies of those who were typically cosseted from the stresses and strains of daily life in the wards.’ This perspective led some asylum workers to regard their work as a form of wage labour, which gave rise to a trade union consciousness.<sup>359</sup> Nolan argues that the AWA was unreasonable to demand professionalism from attendants who had no status, were underpaid, undervalued and overworked and whose training was superficial and controlled by practitioners working in a different field from them, namely medicine and not nursing.<sup>360</sup>

Nurse training also influenced nurses’ choice of occupational representation.<sup>361</sup> Asylum nursing did not have any formal training until the 1890s and was not introduced to the CLA until 1918. In contrast general nurse training had begun in the mid-nineteenth century and was adopted by the SDEC in the 1880s. The poverty of training in asylums resulted in a ‘continued lack of status and a concomitant loss of potential for recruiting from educated, unmarried, middle class women’ according to Massie.<sup>362</sup> Brimblecombe, however, points out that asylum nursing had the first national training scheme instituted by the Medico-Psychological Association in 1890 which he misleadingly argues was ‘the first step on the path towards professionalisation.’<sup>363</sup>

Finally, historians have suggested that the contrasting nature of asylum and general nursing work may have contributed towards diverging paths of occupational representation.<sup>364</sup> Perhaps the most significant difference between asylum and general nursing lay in their occupation’s contrasting images. Whilst asylum nursing was of low status and lacked respectability, nineteenth century voluntary hospital nursing reform transformed and elevated the role of the hospital nurse into that of the heroic, selfless

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<sup>359</sup> Carpenter, ‘Asylum Nursing Before 1914’, p.141.

<sup>360</sup> Nolan, *A History of Mental Health Nursing*, p.72.

<sup>361</sup> Chatterton, ‘Women in mental health nursing’, p.16.

<sup>362</sup> L. Massie, ‘The Role of Women in Mental Health Care in Nineteenth Century England’, *International History of Nursing Journal*, 1995, **1**,(2), p.39.

<sup>363</sup> N. Brimblecombe, ‘The Changing Relationship between mental health nurses and psychiatrists in the United Kingdom’, *Journal of Advanced Nursing*, **49** (4), February 2005, pp.344-353.

<sup>364</sup> Chatterton, ‘Women in mental health nursing’, p.13.

woman. Chatterton highlights the dissonance between these images, arguing that it is for this reason asylum nurses have been written out of mainstream nursing histories: ‘battling nurses did not in with the image so carefully nurtured and sold to nurses and policy makers.’<sup>365</sup>

## **The Cornwall Lunatic Asylum**

This section examines the factors that contributed to CLA nursing staff’s choice of trade unionism in 1918. It assesses the impact of notions of class and gender but goes further to suggest that nurses’ health issues may have had some influence. Eight months after the outbreak of the First World War work conditions at the CLA deteriorated causing an immediate rise in episodes of ill health amongst its nursing staff. The cause of the change was a rapid increase in patient numbers that placed heavy demands on an already depleted staff, many of whom had been called up for military service. In March 1915, 226 pauper patients were transferred from Bristol Asylum to make room for wounded soldiers taking the total patient numbers at the CLA to 1,225.<sup>366</sup> Patients slept on the ward floors whilst the War Office was petitioned to supply bedsteads. The asylum was missing a significant proportion of its regular nursing staff. Out of a staff of seventy-two male attendants, twenty-seven had left to take up military duty by July 1915. Their places were filled by retired members of staff and by ‘men above military age’ and ‘married men with families’: the two latter groups having no previous experience of asylum work.<sup>367</sup> In the absence of nurse training before 1918, new attendants learnt from watching their more experienced colleagues. With so many experienced staff away on military service, this apprentice style of training must have been strained.

The increase in patient numbers resulted in rising working hours, increasing

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<sup>365</sup> Chatterton, ‘Women in mental health nursing’, p.18; Hart, *Behind the Mask*, p.46.

<sup>366</sup> CRO, *96<sup>th</sup> Annual Report 1915, CLA*, HC1/1/3/9. p.74.

<sup>367</sup> CRO, *BOC Report*, HC1/1/3/9, July 1915, p.26.

patient ratios and the cancellation of nurses' leave. Nurse Clara Williams joined the Asylum on 22 October 1914 and 'went absent without authority' on 29 March 1915. She claimed that 'she had repeatedly asked for three days leave but had been told that she could not be spared.' She slept in a patient's single room which she complained was 'not comfortable and without a lock.' During a month of night duty in February 1915, her rest in the day had been persistently broken by interruptions from the Matron. She told the Visiting Committee that she left without the permission of the Medical Superintendent because 'she did not feel well.'<sup>368</sup> The Visiting Committee's refusal to grant leave suggests high expectations from its staff. Williams' decision to leave without making a complaint to the Committee about her work conditions also suggests she believed her complaints would be ineffectual. The CLA Visiting Committee's negative attitude to its staff contrasts with that of the SDEC Management Committee who, as we shall see, responded quickly and favourably to nurses' complaints.

Medical Superintendent Dudley's initial optimism that the asylum was 'unusually lucky in the temporary attendants who [were] filling the places of those gone' quickly faded and by January 1915, the CLA lobbied the Parliamentary Recruiting Committee to promise 'to refrain from calling up any more of the asylum staff owing to the difficulty of obtaining suitable substitutes.'<sup>369</sup> This promise was not fulfilled: the number of attendants called up rose from thirty-four in 1915 to forty-three in 1916 and forty-nine in 1917.<sup>370</sup> The introduction of temporary attendants brought with it an increase in male staff turnover. Prior to 1915, CLA male attendants had formed a stable workforce, prepared to tolerate poor work conditions in the hope of claiming a pension. Pensions were considered a right after fifteen years of service payable from the age of fifty. In 1916, however, one-fifth of the male staff either

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<sup>368</sup> CRO, CLAVC Mins, HC1/1/1/16, 29 March 1915, p.100.

<sup>369</sup> CRO, CLAVC Mins, HC1/1/1/16, 25 January 1915.

<sup>370</sup> CRO, *96<sup>th</sup> Annual Report, CLA, 1915*. HC1/1/3/9.



resigned or were found unsatisfactory.<sup>371</sup>

One of the reasons why staff were considered unsatisfactory is that they fell short of the high standards of discipline. Despite staff shortages during the War, there was no suggestion that discipline should be relaxed in order to attract recruits or improve retention rates. Indeed, the militarism surrounding the War may have reinforced the idea that a framework of strict discipline was a good management model. Wider “jingoistic” militarism was prevalent in British society as a whole during this period, according to Starns, underpinning a structural belief system that stressed the importance of the monarchy, elitism and the aristocratic tradition.<sup>372</sup> Neither Medical Superintendent Dudley, nor the Visiting Committee suggested that strict discipline may act as a deterrent to potential recruits. Indeed Dudley considered the determining factor between a ‘satisfactory’ and ‘unsatisfactory’ nurse to be the ability to obey orders. In 1914 and 1915 Nurses Pitts, Penelly, Scutlebury and Kendall were discharged for failing ‘to peg the clock’ three times in a row on night duty.<sup>373</sup> A system of ‘peg clocks’ was used to prevent staff sleeping on night duty; each nurse would insert and turn a key every hour and the clock would record the time pegged. Nurse Scutlebury’s appeal that she had been unable to peg the clock because she was with ‘a troublesome patient’ failed because she had not recorded this information at the time in a book situated next to the clock.<sup>374</sup>

The strain on staff from the increased workload resulted in an immediate and dramatic rise in ill health that continued until the end of the War. During 1914 and the first three months of 1915, the average sickness rate was two nurses per month.<sup>375</sup>

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<sup>371</sup> CRO, *BOC Report*, HC1/1/3/9, July 1916.

<sup>372</sup> Starns, *March of the Matrons*, p.18.

<sup>373</sup> CRO, CLAVC Mins, HC1/1/1/15, 27 July 1914, 28 September 1914, 26 October 1914, 26 February 1915. The CLAVC Minutes are inconsistent in the way they refer to nurses; in some cases the nurse’s christian and surname is given whilst in others only the surname is recorded.

<sup>374</sup> CRO, CLAVC Mins, HC1/1/1/15, 26 February 1914, p.394.

<sup>375</sup> CRO, *95<sup>th</sup> Annual Report, 1914, CLA*, HC1/1/3/9.

However in April 1915, four weeks after the Bristol patients' arrival, the Visiting Committee confirmed sick leave for sixteen female nurses and eleven attendants.<sup>376</sup> The numbers remained high until 1918.<sup>377</sup> In contrast to the late nineteenth century when physical injury from violent patients posed the greatest health risk to staff, the health risk during the First World War was from infectious diseases contracted from patients. In 1915, three female nurses and one female patient contracted diphtheria. Three nurses also contracted scarlet fever. Between 1915-c to 1918 seven nurses and attendants died from typhoid fever, three from tuberculosis and one from influenza.<sup>378</sup>

The rise in infectious diseases caused tension between the medical staff and some of the relatives of the diseased staff. The family of Nurse Best, who died from diphtheria, contested her diagnosis claiming that the cause of death was 'the sleeping draught of morphia' given by the medical locum, Dr. Alexander. The case was dropped when the Asylum produced evidence of the laboratory analysis of diagnosis. The Best family's criticism of how the Asylum cared for its sick nurses prompted Medical Superintendent Dudley to employ two trained general hospital nurses from Plymouth to care for sick members of staff.<sup>379</sup>

The arrival of the Bristol patients coincided with a rapid increase in the incidence of dysentery and diarrhoea amongst both staff and patients. Asylum dysentery was caused by shigella and occurred in the majority of asylums during the nineteenth and early twentieth centuries. Harold Gettings, Medical Superintendent of the West Riding Asylum, Wakefield suggested that the cause was not simply overcrowding:

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<sup>376</sup> CRO, CLAVC Mins, HC1/1/1/16, 29 March 1915, p.101.

<sup>377</sup> CRO, CLAVC Mins, HC1/1/1/16, The number of staff off sick remained high from 1915-1918. 27 March 1916, 5 temporary attendants and 5 nurses; 1 May 1916, 11 members of staff; 21 December 1916, 12 staff; 29 January 1917, 7 attendants and 19 nurses; 27 May 1918, five nurses.

<sup>378</sup> CRO, 97<sup>th</sup>, 98<sup>th</sup>, 99<sup>th</sup> *Annual Reports 1916, 1917, 1918, CLA*, HC1/1/3/9.

<sup>379</sup> CRO, CLAVC Mins, HC1/1/1/16, 22 February 1916, p.47, 96<sup>th</sup> *Annual Report, 1915, CLA*, HC1/1/3/9.

It is not a question of unsanitariness or of overcrowding . . . or of the other factors that have been proposed. They are only side issues, important in their way, but side issues all the same. It is the actual infection that matters; it is the chronic cases, the ‘carriers’, who keep the . . . infection going . . . They form the keystone of the problem, and must be detected and isolated before any permanent good can be done.<sup>380</sup>

At the CLA, one patient died from dysentery in 1915, three patients out of six cases in 1916, fourteen out of thirty-five cases in 1917 and eighteen out of 163 cases in 1918. These figures suggest that survival rates improved during the War although why is unclear. Dudley recognised that the ‘epidemic must have severely taxed the resources of the staff.’ Effective methods of infection control were not introduced until 1918 when patients were isolated and attendants given ‘strict injunctions . . . to personal ablutions and cleanliness.’<sup>381</sup> The Asylum’s failure to isolate infection is surprising considering an isolation unit had opened in 1900. Its lack of effectiveness may have been the result of the shortage of suitable nurses to staff the unit or perhaps the number of infectious cases was greater than the number of isolation beds. A policy of isolating all infectious patients was resumed in 1919 and immediately led to a dramatic decrease in the incidence of diarrhoea and dysentery: only three patient cases were recorded that year, attributed by Dudley to the success of segregation ‘together with improved diet.’<sup>382</sup>

Attendants and nurses’ poor work conditions had a negative affect on their health by the end of 1915. Long working hours, the cancellation of leave, a high nurse to patient ratio and inadequate accommodation increased nurses’ vulnerability to infection. This raises the question of why CLA nursing staff waited until 1918 to join the NAWU, when problems were considered of such magnitude as to require industrial

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<sup>380</sup> H. Pennington, ‘Don’t pick your nose,’ *London Review of Books*, Vol.27, No.24, 13 December 2005, pp.29-31.

<sup>381</sup> CRO, *BOC Report*, HC1/1/3/9, April 1918, p.27.

<sup>382</sup> CRO, *100<sup>th</sup> Annual Report, 1919, CLA*, HC1/1/3/9, p.8.

action. It is agreed here that prior to 1918 the Union was interested in issues CLA nursing staff perceived as irrelevant to their working lives.

The NAWU was formed in 1910, stimulated by the Asylum Officers Superannuation Act which intended to improve work conditions with the introduction of pension schemes on a contributory basis but resulted in a wage cut for many attendants who had previously enjoyed non-contributory arrangements. Dingwall argues that this 'crystallized many of the attendants' dissatisfactions with low pay, long hours and poor working conditions.'<sup>383</sup> Carpenter interprets asylum employees' anger at the 1909 Act as part of a much wider movement of 'political disenchantment and industrial militancy' characterising the period between 1910 and 1913.<sup>384</sup>

The Union's main concern during the War was the protection of male attendants' jobs and wages. Asylums, the Union argued, would be reluctant to employ returning military personnel at their former rates of pay once they realised that they could save money by employing women to care for male patients.<sup>385</sup> A policy of strict separation amongst the sexes had continued from the nineteenth century with male attendants caring for male patients in a separate part of the asylum to female patients who were cared for by female nurses. A shortage of attendants during the War prompted debate in the Union's magazine and the nursing press about whether female asylum nurses were qualified to care for male patients.

This debate about the role of asylum nurses did not apply at the CLA because its Visiting Committee decided not to replace male attendants with women at the beginning of the War. Despite the Asylum's difficulties in recruiting suitable men and a rise in turnover of male staff, the Committee ruled out the employment of women on the male side, a fact the Board of Control considered of such significance that it noted it in its

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<sup>383</sup> R. Dingwall et al., *An Introduction to the Social History of Nursing*, p.130.

<sup>384</sup> M. Carpenter, *Working for Health*, p.62.

<sup>385</sup> MRC, *The NAWU Magazine*, April 1916, p.4.

1916 and 1917 reports.<sup>386</sup> The Visiting Committee also made it clear that would protect attendants' wages away on military service. In December 1914, the Committee agreed that attendants 'should not lose time or money', their positions were guaranteed and any deficiency in wages would be made up.<sup>387</sup> The time spent on military service was to be included as asylum service and counted towards their asylum pension. In May 1915, eight weeks after the arrival of the Bristol patients, the Committee introduced a War bonus for head attendants and head nurses and married male attendants, 'in consideration of the increase in patient numbers and the extra cost of living caused by the War.'<sup>388</sup> Whilst all male attendants were awarded the bonus sometime during the following year, female nursing staff had to wait until November 1918. This may have engendered hostility which contributed to the upsurge in female nurses' militancy in October 1918.<sup>389</sup>

The NAWU sought to limit female asylum nurses' role to caring for only female patients. The threat women posed to male jobs was debated in terms of male versus female, an approach that may not have attracted CLA nurses. In response to the poor uptake in female union membership in the early War years, Reverend Bankart, the Union's first secretary and magazine editor, argued that women 'as a class' lacked the necessary unity to become good union members and were therefore responsible for their poor work conditions: 'women are the most sweated, defenceless and disfranchised drudges of the industrial market, *because they are unorganised*.'<sup>390</sup> Women were criticised for being 'easily cowed and notoriously ungrateful for benefits the Union fought for.' There was a strong evident association between unionism and masculinity: male staff were credited with 'being the backbone of the Union' and raising the status of

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<sup>386</sup> CRO, BOC, HC1/1/3/9, 1916 and 1917.

<sup>387</sup> CRO, 95<sup>th</sup> Annual Report, CLA, 1914, HC1/1/3/9, p.13.

<sup>388</sup> CRO, CLAVC Mins, HC1/1/1/16, 31 May 1915. Head attendants received a 10% increase, married attendants 2 guineas a week and two assistant head nurses £1.

<sup>389</sup> CRO, CLAVC Mins, HC1/1/1/18, 25 November 1918, p.316.

<sup>390</sup> *The NAWU Magazine*, April 1916, p.4.

asylum workers.<sup>391</sup> Women, according to Bankart, were untrustworthy and operated by inferior rules to men's 'distinct code of male honour.' He identified women's fickle emotional temperament as the reason why their promises to join the NAWU were often reneged. It was 'a fairly easy matter to rouse them to a pitch of enthusiasm', according to Bankart, 'but a more difficult one to keep them at it.'<sup>392</sup> Our discussion will show how this attitude to women union members had changed significantly by 1918.

Some contributors to the NAWU Magazine suggested that the threat male asylum patients posed to female nurses' morality was reason to limit women's role. The idea of moral vulnerability was also linked to nurses' sexuality. Some considered that nurses' work should be restricted because the duties involved in caring for male patients were 'repellent to the finer instincts of chaste womanhood ... the employment of women has hitherto, for the soundest medical reasons been debarred.'<sup>393</sup> Female nurses were identified as responsible for male patients' sexual behaviour by making 'themselves the stimulus of their patient's uncontrolled desires.'<sup>394</sup> One contributor implied that the work involved a risk to nurses' virginity: 'losing their modesty', he argued 'was something lost which could never be regained and no women should ever be called upon, unnecessarily to make such a sacrifice.'<sup>395</sup> The debate illustrates the sexual ambiguity surrounding the nurses' body: an emphasis on chastity suggested that nurses were asexual beings although their work involved contact with male bodies that intimated sexuality. A soldier and former attendant accused women 'of robbing them of employment' and 'our kiddies of their bread and butter, by doing our work at a cheaper rate than that for which a woman's soul and honour can be bought.'<sup>396</sup> This comment implies a similarity between the asylum nurse and the prostitute; it constructs female

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<sup>391</sup> *The NAWU Magazine*, September 1915, p.10.

<sup>392</sup> *The NAWU Magazine*, May 1912.

<sup>393</sup> *The NAWU Magazine*, August 1915, p.2.

<sup>394</sup> *The NAWU Magazine*, February 1916, p.7.

<sup>395</sup> *BJN*, 21 February 1914, p.168.

<sup>396</sup> *The NAWU Magazine*, April 1916, p.7.

sexuality in such a way that the female nurse could mean both. The ambiguous nature of the type of language used in conversations about nurses' bodies allowed some male union members to further their argument to restrict nurses' work.

In contrast to these negative portrayals of female NAWU members, the CLA nurses had already demonstrated an ability for industrial organisation before the First World War. In 1913, all seventy-three female CLA nurses signed their own petition, demanding a pay rise:

We would draw your attention to the fact that the cost of many necessaries have greatly increased and the scale of wages in many other asylums of a similar nature are larger than those paid under your committee.<sup>397</sup>

The women's petition was submitted alongside a separate petition from their male colleagues suggesting a degree of collaboration between the two groups. One possible explanation for the female CLA nurses participation in industrial bargaining was that they were following the lead given by their militant male colleagues although there is no evidence to indicate which group led the action. However, this argument is undermined in light of the leading role CLA female nurses played in the uptake of union membership and strike action of 1918, which will be discussed later in this chapter.

The CLA women's petition of 1913 indicates their recognition of the advantages of group power. It proved their capability of bargaining directly with the Visiting Committee without the need for a trade union representative as an intermediary. Whilst the women did not demand equal pay with men, their petition suggests a belief that their work should receive adequate remuneration. The petitions achieved some marginal success with women receiving a larger wage increase than men.<sup>398</sup> The CLA nurses

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<sup>397</sup> CRO, CLAVC Mins, HC1/1/1/15, 25 August 1913, p.70.

<sup>398</sup> CRO, CLAVC Mins, HC1/1/1/15, 25 August 1913, p.70. Male attendants pay rose but only after seventeen years of service from £44 10 to £47. Female nurses were more

were unlikely to have been attracted to a union which promoted a negative image of women, particularly after their success in negotiating their own wage rise. Neither male nor female asylum nursing staff's actions were constrained by the notion that their complaints indicated a lack of vocation to nurse. This undermines Carpenter's explanation of female nurses' slow uptake of NAWU membership; 'women' he argues 'were more likely to adhere to professional and vocational values.'<sup>399</sup> Our discussion suggests that it was class rather than gender that influenced nurses' choice of occupational representation during the First World War.

CLA nursing staff were predominately working class and identified with other groups of industrial workers as well as public sector workers.<sup>400</sup> In 1913 the attendants' petition for higher wages included the claim that 'in almost every branch of industry and among the employees of public bodies and institutions similar to this' wages have increased.<sup>401</sup> Unlike some asylums, the CLA did not experience an influx of middle class voluntary hospital nurses to its senior posts. Senior nurses were redeployed from either other asylums or workhouse infirmaries. Having considered why CLA nursing staff did not join the NAWU until 1918, this study will examine factors that prompted a rapid uptake in union membership and strike action in the autumn of 1918.

The most important factor according to Medical Superintendent Dudley was a further deterioration in CLA nurses' work conditions, including diet.<sup>402</sup> Diet rations were introduced at the beginning of the War and again in 1917, when nursing staff were restricted to one pound of meat per head per week and half a pound of sugar. Bread was often returned to the kitchen uneaten. Patients' health also suffered: the Board of Control noted that the 'health of inmates has latterly been unsatisfactory. A large

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successful with a rise in the starting salary from £15 to £16, after fifteen years service from £28 10 to £30 and £2 extra for night nurses.

<sup>399</sup> Carpenter, 'Asylum Nursing Before 1914', p.142.

<sup>400</sup> B. Dix, *Serving the public - building the Union: the history of the National Union of Public Employees*, London: Lawrence and Wishart, 1987.

<sup>401</sup> CRO, CLAVC Mins, HC1/1/1/15, 25 August 1913, p.70.

<sup>402</sup> CRO, 99<sup>th</sup> Annual Report, CLA, 1918, HC1/1/3/9, p.24.



proportion of the patients were found to be losing weight.<sup>403</sup> Attendants and nurses were initially more interested in financial compensation for the reduction in their rations rather than the health effects of a poor diet and petitioned the Visiting Committee who agreed to pay a compensatory grant of 4 s per head per week.<sup>404</sup>

Dudley cited nurses' poor diet as well as the increase in working hours as contributing factors to the further rise in ill health. He argued that rising staff sickness levels caused the rapid uptake in trade union membership in October 1918 and the subsequent female nurses' strike:

It has been an exceptionally trying year for the staff, six more of our attendants and three of the artisans were called up for military service. Below strength in all departments, it had to cope with the increased work due to the abnormal amount of sickness involving extra hours of duty under very depressing circumstances. During the year temporary attendant Matthews, Nurses H. Symons, E. Vague and O. Launder died of typhoid fever. Attendant French and Nurse E. Cooksly of phthisis and Nurse R. Scantlebury of influenza. With one exception they were under 30 years of age. These facts coupled with inability to obtain candidates of more mature age, caused the unrest on the female side, which reached a climax in October. The Matron's health completely broke down in the beginning of November from worry and overwork. She will not be fit for duty for some months.<sup>405</sup>

Despite Dudley's sympathetic tone towards the nursing staff in his Annual Report, the high levels of sickness caused tension between himself and the Plymouth general hospital nurses caring for the sick members of staff. Dudley accused one nurse of neglect, claiming that her failure to visit Nurse Launder between 11 pm on the 25<sup>th</sup> of

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<sup>403</sup> CRO, *BOC*, April 1918, HC1/1/3/9, p.27.

<sup>404</sup> CRO, *98<sup>th</sup> Annual Report, CLA, 1917*, HC1/1/3/9, p.7.

<sup>405</sup> CRO, *99<sup>th</sup> Annual Report, CLA, 1918*, HC1/1/3/9, p.24.

June and 6am on the 26<sup>th</sup> of June had contributed to Launder's death on the 27<sup>th</sup>.<sup>406</sup>

The accused nurse was immediately discharged.

A fear of infection and an inadequate supply of food caused several nurses to resign. Winifred Waterfield left in July 1918 'because the food is not good enough' and she was 'afraid of becoming sick.'<sup>407</sup> Others, like Temporary Nurse Richards, were dismissed because Dudley believed that they 'were not strong enough for the work.' The number of female nurses' resignations increased in the later part of 1917 suggesting a rising tension as a result of poor work conditions and a break down in leadership by senior nurses. Nurses began to leave in groups prompted by minor incidents. In October 1917, five nurses resigned when a nurse was dismissed for pulling a patient's hair.<sup>408</sup>

The Asylum's difficulties in recruiting and retaining senior nursing staff may have contributed to rising tensions. A lack of applicants for the assistant matron post in 1917 prompted Dudley to approach general nurses from infirmaries in London. One nurse from London agreed to join the Asylum but then found another post, another came and went on the same day.<sup>409</sup> Helen Jones was eventually appointed in August 1918 and became Matron in February 1919 when Margaret Hiney was dismissed. The pattern of employment changed from the later part of the nineteenth century when matrons stayed for long periods of time. During the First World War Elizabeth Taylor remained in post only eighteen months and Margaret Hiney three years, indicating the difficulties inherent in the job of leading a group of demoralised nurses.<sup>410</sup>

Margaret Hiney's appointment as matron caused significant unrest amongst female nurses who cited her style of leadership as a contributing factor to the strike.

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<sup>406</sup> CRO, CLAVC Mins, HC1/1/1/18, 29 July 1918, p.232.

<sup>407</sup> CRO, CLAVC Mins, HC1/1/1/18, 29 July 1918, p.240.

<sup>408</sup> CRO, CLAVC Mins, HC1/1/1/18, 28 October 1918.

<sup>409</sup> CRO, CLAVC Mins, HC1/1/1/18, 29 October 1917, p.42; 29 July 1918, p.232.

<sup>410</sup> CRO, 98<sup>th</sup> *Annual Report, 1917, CLA*, HC1/1/3/9, p.8; CLAVC Mins, HC1/1/1/18, 27 January 1919, p.359.

Hiney made several changes to long-standing practices in the first six months of 1918 including providing only material instead of ready-made uniform and rotating permanent female night staff onto day duty if they committed a fault at work.<sup>411</sup> On a more positive note, she increased nurses' leave to one full day a week and two hours each evening and allocated two rooms for nurses' recreation when not in use by medical locums.<sup>412</sup> Nurses complained about the changes but with no success: Nurse Ethel Dyer, who did not return from annual leave in July 1918 claiming ill health, wrote a letter of complaint to the Visiting Committee which was dismissed as 'not based on any reasonable foundation' with 'no real cause for complaint.'<sup>413</sup> The NAWU claimed that Hiney's changes had contributed to an increase in the turnover of female staff.<sup>414</sup>

In summary, male and female nurses suffered a significant deterioration in their work conditions and health during the First World War as a result of an increase in patient numbers and a consequent rise in the risk of infectious disease. The rise in episodes of nurses' sickness caused an already overstretched staff to have to cover for those absent. No CLA nursing staff joined the NAWU when it was set up in 1910 or during the early years of the War. This was partly because male and female nurses had achieved some limited success by bargaining directly with the Visiting Committee but also because the National Asylum Workers' Union was interested in issues CLA staff may have perceived as irrelevant to their working lives. A further deterioration in work conditions in 1917 and a breakdown in hierarchical relationships increased tension on the female side of the asylum, which resulted in a rise in the number of resignations. Complaints to the Visiting Committee were believed to be ineffectual. Contrary to NAWU perceptions of female asylum nurses, CLA nurses were not of a fragile, emotional temperament nor unwilling to participate in industrial bargaining. Medical

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<sup>411</sup> *The NAWU Magazine*, Oct.-Nov.-Dec, 1918, p.6.

<sup>412</sup> CRO, CLAVC Mins, HC1/1/1/18, 29 October 1917, p.42.

<sup>413</sup> CRO, CLAVC Mins, HC1/1/1/18, 26 August 1918, p.254.

<sup>414</sup> *The NAWU Magazine*, Oct.-Nov.-Dec. 1918, p.6.

Superintendent Dudley perceived nurses' poor health as the cause of both the NAWU's popularity and industrial action.

### **Female nurses and the October 1918 strike**

On 21 October 1918, female nurses' resentment at their poor work conditions came to a head resulting in a five-day strike.<sup>415</sup> This was the second strike in a matter of weeks amongst asylum workers: the first occurred on 4 September 1918 when 200 attendants from Prestwich Asylum were joined by 449 from Whittingham Asylum.<sup>416</sup> The CLA nurses' main complaint was the 'system of tyranny and despotism' adopted by senior nurses: the junior nurses maintained that hierarchical relationships had broken down. Further grievances highlighted an eighty hour week, no staff bathroom and poor meal facilities where nurses had to wash the utensils left in the mess room and cook their own food in the twenty minutes allowed for meal breaks.<sup>417</sup>

The strike followed a period of rapid growth in union membership within the CLA. Sixty-two of the seventy female staff had joined the NAWU over a period of two days but were barred from wearing their union badges. The stimulus to the growth in membership was the appointment of Mrs D. Hawken on 2 September 1918 from the Prestwich Asylum, the location of the first strike. Hawken was an existing NAWU member and took up the post of union leader at the CLA. Her refusal to remove her Union badge prompted others to follow her example. Articulate and confident, she resisted intimidation by senior nursing staff. The *NAWU Magazine* alleged that she was held 'prisoner' in a disused room overnight by the Matron 'until she could be dealt with by the Medical Superintendent the next day.'<sup>418</sup> Dudley dismissed her and four other nurses with one month's notice without consulting the Visiting Committee. His

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<sup>415</sup> Carpenter, *Working for Health*, p.711.

<sup>416</sup> F. R Adams, 'From Association to Union: Professional Organisation of Asylum Attendants', *The British Journal of Sociology*, Vol. 20, No. 1, March 1969, p.19.

<sup>417</sup> *The NAWU Magazine*, Oct.Nov.Dec. 1918, p.6.

<sup>418</sup> *The NAWU Magazine*, Oct.Nov.Dec. 1918, p.6.

rejection of a bid to reinstate the five leaders prompted thirty-nine nurses to go on strike. Acting NAWU secretary, H. Shaw, was sent from Manchester to take charge of the strike and negotiate between the nurses, Medical Superintendent and the Visiting Committee. Dudley maintained that the five leaders had given previous cause for complaint and all the nurses had broken the rule dictating that no jewellery be worn with uniform (Dudley classed the Union badge as jewellery). On 23 October, a public meeting was held at the Asylum gates where Hawken gave a ‘scathing exposure of the conditions’ at the CLA and ‘the treatment she and her fellow workers had received at the hands of the Matron, Assistant Matron and Medical Superintendent.’ By 25 October the number of nurses on strike had risen to fifty, all of who were dismissed by Dudley for ‘insubordination.’ It seems as if the Asylum’s Victorian system of discipline was breaking down. Only twenty nurses remained on duty.<sup>419</sup>

The NAWU’s coverage of the women’s role in the CLA strike suggests its attitude towards its female members had changed between 1912 and 1919. In contrast to 1912/1913, when women’s fragile emotional temperament was perceived as responsible for their reluctance to join the Union, reportage of the strike noted women’s loyalty to each other and their commitment to force the reinstatement of all strikers.<sup>420</sup> The Visiting Committee’s initial proposal to allow all but the five leaders to return to work was rejected by the strikers. The *NAWU Magazine* highlighted the radical language used by the women to emphasise their unity: the adoption of the motto “All or none”, inscribed on banners paraded through the town, incited local people to support their cause of full reinstatement. Male attendants did not join the strike although seventy-two out of a total male staff of seventy-five took up NAWU membership following a direct appeal from Shaw ‘to give such support to the women as circumstances might require.’<sup>421</sup>

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<sup>419</sup> *The NAWU Magazine*, Oct.Nov.Dec. 1918, p.8.

<sup>420</sup> *The NAWU Magazine*, Oct.Nov.Dec. 1918, p.6.

<sup>421</sup> *The NAWU Magazine*, Oct.Nov.Dec. 1918, p.7.

The threat of a male attendants' strike forced the Visiting Committee to reinstate all the sacked nurses.<sup>422</sup> The Committee agreed to 'recognise' the NAWU in its future negotiations with nursing staff and to allow Union badges to be worn but 'in such a position as not to cause any injury to the patients' which implied that the nurses' initial insistence on wearing badges was negligent for not considering the possible injury they might cause. The Visiting Committee recognised the lack of effective liaison between Hiney and Dudley in the months preceding the strike and resolved in future 'that all serious cases of neglect of duty or of improper behaviour on behalf of the asylum staff should be at once reported to the Medical Superintendent who will deal with the case as he considers necessary.'<sup>423</sup> Thus the Medical Superintendent's power over the nursing staff was extended. At the same time, Matron Hiney was given six week's sick leave because of 'worry and overwork.'<sup>424</sup>

Once the Matron had returned to work, the NAWU made further complaints to the Board of Control that she had treated 'the subordinate female staff (the strikers) with absolute lack of courtesy with possible rebellious results.'<sup>425</sup> Hiney was given further sick leave after Dr. Anderson diagnosed a severe heart complaint and two months later, in January 1919, the Visiting Committee dismissed her with three months notice 'in view of the medical opinion as to the condition of her heart.'<sup>426</sup> It is difficult to know whether this decision was shaped by Hiney's medical condition or the Union's threat of further strike action.

The Visiting Committee set about revising staff pay and work conditions. Pay was increased to £58 4s per annum for attendants and £33 for nurses. Working hours were reduced from eighty to sixty- three per week including meal times. Overtime was

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<sup>422</sup> CRO, CLAVC Mins, HC1/1/1/18, 26 October 1918, p.276.

<sup>423</sup> CRO, CLAVC Mins, HC1/1/1/18, 25 November 1918.

<sup>424</sup> CRO, *99<sup>th</sup> Annual Report, 1918, CLA*, HC1/1/3/9.

<sup>425</sup> CRO, CLAVC Mins, HC1/1/1/18, 4 November 1918, p.295; 18 November 1918, p.299.

<sup>426</sup> CRO, CLAVC Mins, HC1/1/1/18, 27 January 1919, p.359.

introduced at a rate of time and a half. The rules governing all nursing staff were revised and a contract of employment introduced for newly appointed staff to sign after three months' probation. The contract was drafted with the aim of increasing the power of the Medical Superintendent over the nurses. A draft version initially gave Dudley the right of suspension without warning for 'acts of cruelty to patients, disobedience of order and transgression of the rules... If dismissal follows, wages to be paid to the date of suspension.' The Union insisted that the words 'without warning' be deleted and that wages be paid up to the date of dismissal and not suspension. The agreement regarding the sixty-three hour week and the right of complaint was incorporated into the contract. Employees promised to 'obey the rules of the Asylum' and 'to avoid gossiping about its inmates or affairs.'<sup>427</sup>

The strike action significantly increased the Union's power to the extent that it was now able to shape CLA employees' terms and conditions of employment. Despite the disruption caused to the Asylum, Dudley endorsed the Union's aims in his report of 1918:

Though the NAWU has been working for many years it increased its membership to such an extent during the past twelve months there can be very few asylum employees who are not members. The object of this organisation being to improve the condition of asylum workers, the great majority of staff showed their confidence in it by joining in October.<sup>428</sup>

Work conditions at the CLA improved in the immediate post war years. By February 1919, the number of patients had reduced to 1,096. Despite this reduction, Dudley still considered 'the health of the female staff unsatisfactory' in contrast to the 'satisfactory' bill of health the male staff received.<sup>429</sup> A nursing sub-committee, set up in 1919,

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<sup>427</sup> CRO, CLAVC Mins, HC1/1/1/18, 30 December 1918, p.335.

<sup>428</sup> CRO, *99<sup>th</sup> Annual Report, 1918, CLA*, HC1/1/3/9.

<sup>429</sup> CRO, CLAVC Mins, HC1/1/1/19, 24 February 1919.

decided that separate sleeping accommodation away from the wards was necessary and designated a wing of the hospital with dining and recreation rooms.<sup>430</sup> Some nurses still slept on the wards but were provided with separate bathrooms from the patients'.<sup>431</sup> Despite the NAWU's campaign for a forty-eight hour week, nursing staff continued to work a sixty-six hour week in 1922.

Following its successful intervention in the CLA strike and its increase of power at local level, the NAWU extended its influence to regional and national policy. In November 1918, Dudley joined a joint committee of representatives from asylums in the south west of England to consider questions of pay and conditions of service. Shaw, the Acting Secretary for the NAWU, was recognised as the asylum workers' representative. A schedule of uniform wages, war bonuses and allowances, matching those implemented at the CLA, were set and implemented across the region.<sup>432</sup> The Ministry of Labour was now showing interest in the Union as a negotiating body and the Board of Control recognised its potential to improve work conditions.<sup>433</sup>

The end of the War saw a rapid increase in national NAWU membership, from just under 12,000 in December 1918 to 15,000 by the end of 1919. Membership between the sexes became more evenly spread, with women's membership reaching forty-six per cent of the total.<sup>434</sup> A National Programme of Reform on Conditions and Pay was drawn up which included a forty-eight hour week, a minimum weekly wage of £3 5s, equal pay for women and state registration for mental nurses, the institution of wages boards and universal recognition of the Union as the fit negotiating body by the asylum authorities. The term attendant was dropped and both men and women became known as mental nurses. In 1919, London County Council called together a Conference of Representatives of Public Asylum Authorities at which Ted Edmondson, President of

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<sup>430</sup> CRO, CLAVC Mins, HC1/1/1/19, 1 July 1919.

<sup>431</sup> CRO, CLAVC Mins, HC1/1/1/19, 26 April 1919.

<sup>432</sup> CRO, CLAVC Mins, HC1/1/1/18, 25 November 1918, p.312.

<sup>433</sup> CRO, BOC, HC1/1/3/9, 1919.

<sup>434</sup> Carpenter, *Working for Health*, p.75.



the NAWU, spoke of the position of women and equal pay as ‘the great stumbling blocks’ in the whole scheme.<sup>435</sup> He argued that because women were subjected to the same ‘stress and strain’ of work ‘in an atmosphere of lunacy’ they should be paid equally.<sup>436</sup> However, the Joint Conciliation Committee set up between the NAWU and the authorities to deal with indoor staff backed down on demands for equal pay and agreed that female nurses should receive eighty per cent of male rates.<sup>437</sup>

In summary, a breakdown in hierarchical relationships and dissatisfaction with poor work conditions resulted in demands for immediate improvements which a college route of representation, its abhorrence of strike action and emphasis on education and training could not provide. Working class nurses identified with the trade union movement and not only valued the NAWU’s support of strike action but also its negotiation skills gained in its successful intervention in the Prestwich strike four weeks previously. The fact that it was the women who led the uptake in union membership and the strike action, initially unsupported by their male colleagues, casts doubt on the notion of gender as an explanation for nurses’ choice of occupational representation.

### **The South Devon and East Cornwall Hospital**

This section examines why voluntary hospital nurses chose the College of Nursing as their occupational representative and not trade unions. If voluntary hospital nurses’ health and work conditions did not deteriorate to the same extent as asylum nurses during the First World War then this may explain why the former group chose the college route. As mentioned earlier, the College of Nursing emphasised professionalism and status as goals rather than material improvements. One of the most important questions, however, seems to be not why voluntary hospital nurses choose a college route but whether these nurses became interested in any form of collective

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<sup>435</sup> *The NAWU Magazine*, Jan.Feb.Mar. 1919, p.17.

<sup>436</sup> *The NAWU Magazine*, Jan.Feb.Mar. 1919, p.16.

<sup>437</sup> *The NAWU Magazine*, April.May.June 1919, p.13.

representation. There is no evidence that the female SDEC nursing staff expressed interest in either trade unionism or the College of Nursing during this period. The first indication of any interest in professional representation came in 1924 when membership of the College's newly formed Student Association became compulsory for SDEC student nurses.

The notion of gender has been introduced earlier to explain why voluntary hospital nurses chose a college route. Their lack of interest in trade unionism, it has been suggested, was because nursing was an all female occupation. As mentioned earlier, Carpenter suggests that women were more likely than men to adhere to professional and vocational values.<sup>438</sup> One could argue that because no male attendants were employed at the SDEC during the First World War, nurses were not influenced by male workers' rejection of vocational values. This argument is complicated by the fact that SDEC nurses were apparently initially disinterested in either route. It is therefore difficult to conclude that notions of gender influenced SDEC nurses' choice of occupational representation.

The notion of class may have been the more influential factor at the two case study institutions. As noted earlier (p.36), Abel-Smith argues that voluntary hospital nurses' decision to support a college route reflected their middle class background.<sup>439</sup> Probationers at the SDEC paid 26 guineas for the first year of training throughout the First World War. Their ability to pay implies that most came from middle class backgrounds. It was not until September 1919 that a shortage of recruits prompted the introduction of a salary of £10. Matron Hopkins took class background as well as 'respectability' into account when selecting 'suitable' recruits. G. Gray of the Falstaff Inn, Plymouth complained to the *Western Morning News* when his daughter's application for nurse training was rejected on the grounds that she 'was a publican's

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<sup>438</sup> See pp. 118-119. M. Carpenter, 'Asylum Nursing Before 1914', p.142.

<sup>439</sup> B. Abel-Smith, *A History of the Nursing Profession*, p.132.

daughter and would have to come to his house in uniform.’ Hopkins wrote that ‘it would not add to the dignity of the institution to have a nurse going into a public house, though it was her home.’<sup>440</sup> Successful recruits came from what Hopkins considered more ‘suitable’ backgrounds: Kathleen Forster-Morris’ father was a vicar and Geraldine Aldons’ father a senior surgeon. Two probationers had upper class backgrounds: Kathleen Lopes’ father was Sir Massey Lopes, Chairman of the Hospital and Constance Robartes’ father was The Honourable C.A Robartes.<sup>441</sup> Five probationers had previously worked as Voluntary Aid Detachments (VAD) who historians agree ‘were drawn to a considerable extent from the higher social classes.’<sup>442</sup> SDEC nurses’ lack of interest in trade unionism may be explained by the influence of their middle class background and an unwillingness to associate with working class activities. Hopkins considered nurses’ ‘respectable’ image important to the Hospital’s reputation. Union activity was unlikely to fit within the boundaries of this image.

Nurse education may have also influenced nurses’ choice of occupational representation. Were nurses, who had been taught ideological values of self-sacrifice, more likely to attach greater importance to the professional route of the College of Nursing and less to trade unionism? CLA nursing staff received no formal training until 1918. Their choice of trade unionism suggests that the intangible rewards of professionalism were not seen as adequate compensation for their low pay, poor work conditions and high risk of ill health. In contrast, SDEC continued training its nurses throughout the War. Whether these nurses were influenced by the notion of self-sacrifice is questionable because of the frequent number of minor complaints they made during the War.<sup>443</sup> For example, in November 1915, nurses ‘sleeping in the nurses’

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<sup>440</sup> ‘Licensee’s Protest’, *Western Morning News*, 11 July 1913.

<sup>441</sup> PWDRO, SDEC Register of Nurses, 1490/24, 1903-1923.

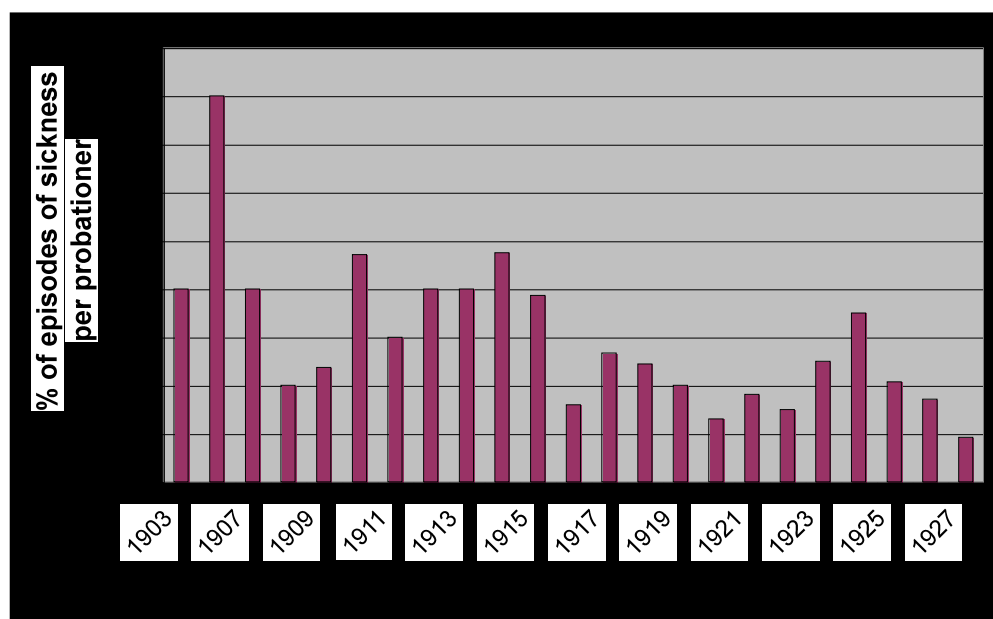
<sup>442</sup> B. Abel-Smith, *A History of the Nursing Profession*, p.86; R. Dingwall et al., *An Introduction to the Social History of Nursing*, p.73.

<sup>443</sup> Complaints of insufficient heating in the nurses’ home prompted an immediate investigation and ward sisters’ demand for a salary rise produced an increase from £40 to £45 per annum with a £3 bonus. PWDRO SDEC House Com Mins, 606/1/22, 19

house' complained of being disturbed by soldiers playing croquet. SDEC nurses had higher expectations of their employers than their CLA counterparts, such as providing a quiet environment for them to sleep during the day. Unlike the CLA Visiting Committee, the SDEC General Committee resolved all the nurses' complaints, during the War, in their favour.

Chapter three (pp.96-97) noted how a rise in nurses' complaints in the late nineteenth century was attributed to an increase in the number of middle class nurses entering the profession. This may have been the case at the SDEC during the War. The Hospital's quick resolutions may have been prompted by a desire to retain such nurses as the SDEC Chairman's daughter because of the increased prestige and status these women brought to the Hospital.

Work conditions and levels of nurses' ill health at the SDEC did not deteriorate to the same extent as at the CLA. The fact that there was no increase in the number of episodes of ill health amongst SDEC probationer nurses during the First World War compared to the preceding decade, suggests that their work conditions remained fairly stable.




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November 1915; 606/1/11 27 September 1918.

**Figure 1.** The incidence of sickness amongst probationers in the South Devon and East Cornwall Hospital 1903-1928<sup>444</sup>

In 1917, the year that CLA nursing staff suffered a significant deterioration in health, the incidence of ill health amongst SDEC nurses improved and was lower than 1914/15. Unlike the CLA, the causes of nurse sickness remained unchanged from the late nineteenth century. Tonsillitis and skin infections continued to be responsible for the majority of illness. No nurses contracted typhoid or tuberculosis during the War and only one episode of scarlet fever occurred. Probationer Winifred B. contracted scarlet fever in July 1914 and resigned in the November of that year due to ill health.<sup>445</sup>

SDEC nurses did not face the high risk of infectious diseases that CLA staff endured. There are several reasons why the infection rate was lower. The most important was that the infectious patient posed less of a threat to nurses' health in the SDEC than at the CLA. The SDEC maintained a strict policy regulating against the admission of infectious patients throughout the First World War: these patients were admitted to either of the two Fever Hospitals in Plymouth. The SDEC's Secretary received a weekly report from the Medical Officer of Health detailing infected houses and streets and instructed medical staff not to admit patients from these locations.<sup>446</sup> Unlike the CLA, the SDEC immediately isolated any inpatients who developed an infection. Such was the SDEC's concern to ensure the effectiveness of its isolation unit that it employed an architect in 1914 to modify the building. The SDEC issued a series of rules governing visitation rights to prevent outbreaks of infectious diseases in the children's ward. Finally, the SDEC continued its system of nurse education, which included lectures on the importance of infection control, throughout the War years in contrast to the CLA which introduced formal nurse training in 1918.

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<sup>444</sup> PWDRO, SDEC Register of Nurses, 1490/24, 1903-1923.

<sup>445</sup> PWDRO, SDEC Register of Nurses, 1490/24, 1903-1923.

<sup>446</sup> PWDRO, SDEC Gen Com Mins, 606/1/11, 10 July 1914; 22 July 1914; 23 July 1914.

Another possible reason why SDEC nurses remained healthier than their CLA counterparts was that numbers of patients did not rise to the same extent during the War, reducing the likelihood of health problems associated with overcrowding or overwork. Although the number of patient beds at the SDEC did increase during the First World War from 124 to 199, not all were occupied. An average of thirty beds were empty daily.<sup>447</sup> In September 1914, fifty beds were allocated to injured soldiers rising to sixty beds in October 1915. This caused consternation amongst the medical staff who successfully complained that they were unable to admit sick civilians whilst beds allocated to the military remained empty. In May 1916, the number of allocated military beds was reduced to twenty-five.<sup>448</sup> Medical staff also complained that the military beds were occupied unnecessarily as many of the soldiers were fit for discharge and ‘convalescent home treatment’ shortly after admission. Nurses were instructed to keep a close eye on soldiers to prevent them escaping to the local public house.<sup>449</sup> This suggests that most of the soldiers were mobile and required little nursing care.

As at the CLA, the call up of SDEC nurses for military service caused staffing problems and increased the nurse: patient ratio. It is not clear how many nurses went but the numbers were enough to affect the management of the Hospital. In March 1916, SDEC Chairman Sir Henry Lopes congratulated Matron Hopkins for ‘the way she had met the difficulty caused by the serious depletion of the nursing staff.’<sup>450</sup> In July 1916, the Nursing Committee applied to the Red Cross Society to supply VADs to help staff the wards. The VAD scheme, originated in 1909, supplied 12,000 VADs to military hospitals and 60,000 unpaid members to auxiliary hospitals by the end of the War. Some VADs had full hospital training, others more limited nursing experience whilst the remainder were unqualified.<sup>451</sup> Regular nurses feared competition and were anxious

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<sup>447</sup> PWDRO, SDEC Gen Com Mins, 606/1/11, 15 March 1916, p.192.

<sup>448</sup> PWDRO, SDEC Gen Com Mins, 606/1/11, 4 May 1916.

<sup>449</sup> PWDRO, SDEC Gen Com Mins, 606/1/11. 17 February 1915.

<sup>450</sup> PWDRO, SDEC Gen Com Mins, 606/1/11, 15 March 1916.

<sup>451</sup> Abel-Smith, *A History of the Nursing Profession*, p.86.

that their superior status should be given formal recognition in the form of registration. Animosity between the two groups of nurses was fuelled by the *BJN*'s criticism of the 'hauteur' of the VAD.<sup>452</sup> All VADs at the SDEC were treated as untrained and started work as first year probationers. An average of fifty nurses staffed the SDEC throughout the War, resulting in a nurse: patient ratio of one: three presuming that all staff were on duty. The most optimal ratio at the CLA was one: nine.

A significant proportion of SDEC civilian patients were heavily dependent and required considerable nursing care.<sup>453</sup> The average length of patient stay was thirty-five days compared to a national average of twenty-two days.<sup>454</sup> The allocation of military beds to long stay civilian patients in 1916 significantly increased the workload of a depleted staff. Doctors cited the shortage of nurses as reason to reduce the number of long stay 'chronic and incurable' patients and increase the turnover of surgical cases.<sup>455</sup> However, nurses' increased workload did not have a detrimental effect on their health. Figure 4.1 suggests that the number of episodes of ill health was lower in 1916/1917 than the preceding decade. The number of nurses who cited ill health as their reason for leaving the hospital rose marginally in 1914, and stayed consistent throughout the War. (See Table 4.2 below)

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<sup>452</sup> Rafferty, *The Politics of Nursing Knowledge*, pp.77-78.

<sup>453</sup> PWDRO, SDEC Gen Com Mins, 606/1/11, 27 October 1916.

<sup>454</sup> PWDRO, SDEC Gen Com Mins, 606/1/11, 15 March 1916, p.199.

<sup>455</sup> PWDRO, SDEC Gen Com Mins, 606/1/11, 15 March 1916, p.142; 27 October 1916.

Year of	No. of	Qualif	Left b	Advis	Died i	Famil	Marr	Resig	Failed Exam
1903	2	2	0	0	0	0	0	0	0
1904	0	0	0	0	0	0	0	0	0
1905	1	0	0	0	0	0	0	0	0
1906	0	0	0	0	0	0	0	0	0
1907	5	4	0	0	0	1	0	0	0
1908	6	5	0	0	0	1	0	0	0
1909	16	10	2	3	1	0	0	0	0
1910	14	11	1	2	0	0	0	0	0
1911	16	3	0	1	0	1	1	0	0
1912	7	7	0	0	0	0	0	0	0
1913	13	9	0	0	1	0	2	1	0
1914	8	6	1	0	0	0	0	1	0
1915	15	8	1	2	0	1	2	0	1
1916	5	3	2	0	0	0	0	0	0
1917	7	2	1	1	0	1	1	0	1
1918	18	7	2	6	1	1	0	0	1
1919	21	11	2	2	1	1	0	5	0

**Table 1.** The number of SDEC probationers who left training because of ill health 1903-1919<sup>456</sup>

Nurses were ‘advised to leave’ because of their unsuitability to nurse: for example Matron Hopkins dismissed Nurse Stella Weid because she was ‘very cheeky and a great flirt when opportunity occurred. Resents being told - sulky when corrected’ and Nurse Foster-Morris because she was ‘very lazy, not conscientious’.<sup>457</sup> Although the incidence of nurses’ ill health decreased during the War, staff turnover increased. For the first time since the introduction of training at the SDEC in the 1880s, over fifty per cent of probationers left before qualifying. This could be either due to the impact of an increased workload resulting from an increase in the number of civilian patients and the loss of regular staff to military service or a change in the style of nurse leadership. In 1916 Matron Hopkins retired after thirty years service and was replaced by Matron A.

<sup>456</sup> PWDRO, SDEC Register of Nurses, 1490/24, 1903-1923.

<sup>457</sup> PWDRO, Register of Nurses, 1490/24, 1903-1923.



S. Dickson. As chapter two noted, Hopkins had not favoured a military style, disciplined system of training. Although Dickson had trained and worked at the SDEC as a sister, the introduction of a new set of leadership ideas may have been disruptive. The rise in the number of nurses dismissed as unsuitable in 1918 suggests Dickson had a different set of expectations of probationers than her predecessor. The high turnover of junior nurses did not affect the appointment of senior nursing posts which, in contrast to the CLA, the SDEC had no problem with either recruiting for or retaining. In June 1916 seventy-six applicants applied for Matron Hopkins' post.<sup>458</sup> Dickson remained in post for seventeen years until 1931.

In summary, SDEC nurses' work conditions and ill health did not deteriorate to the same extent as at the CLA and therefore these nurses did not need to take action to achieve urgent or immediate improvements. Whilst CLA nurses were drawn from the working classes, SDEC nurses came from working class, middle class and upper class backgrounds, many of who were unlikely to identify with the working class trade union movement. SDEC nurses' lack of interest in trade unionism was typical of general hospital nurses nationwide according to conversations about the merits of unionisation in 1919. There is no evidence that the SDEC nursing staff were interested in any form of occupational representation until 1924 when membership of the College of Nursing's Student Association became compulsory on entering training. Student nurse Edna Whitell, who trained at the hospital in the 1920s recalled that 'it was never thought of as a trade union.'<sup>459</sup> The College set up the Association partly in a bid to raise funds but also to appear less elitist and to deter student nurses joining trade unions.

### **The College of Nursing versus the Professional Union of Trained Nurses 1919**

Debate surrounding the unionisation of general hospital nurses in 1919 also sheds light

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<sup>458</sup> PWDRO, SDEC Gen Com Mins, 606/1/11, 30 June 1916.

<sup>459</sup> H. M. Goodman, *The History of Greenbank Hospital*, Plymouth, 1978, p.90.

on why hospital nurses' chose a college route and not trade unionism. The next chapter discusses the College of Nursing and its relationship to nurse registration and work conditions in 1919 but we need to consider here how discussion of unionisation was used to further nurse leaders' case for registration. Criticism that the College of Nursing had failed to address poor work conditions in the debate on nurse registration led to the formation of the Professional Union of Trained Nurses (PUTN) in November 1919. The PUTN had a very small membership of 268 nurses compared to the 17,336 members of the College of Nursing.<sup>460</sup> Its leaders, Maude MacCallum, Isabel MacDonald and Jennie Paterson were private and independent nurses whose economic interests lay in setting up their own agencies separate from those run by the voluntary hospitals. The hospitals, they claimed, forced private nurses to 'give up the bulk of their earnings.'<sup>461</sup> MacCullum was also a prominent member of one of the strongest and most successful nursing co-operatives in London. She was later appointed a member of the first provisional nursing council and was a loyal supporter of Bedford Fenwick.<sup>462</sup> MacDonald, also an ally to Bedford-Fenwick, was secretary to the Royal British Nurses' Association (RBNA). The PUTN's focus on private nursing may account for its failure to attract hospital nurses.

Although small in membership, the PUTN received considerable press coverage by the *British Journal of Nursing* and to a lesser degree, *The Nursing Times* and *Nursing Mirror*. Nursing journals used discussion of unionism to highlight nurses' grievances and undermine the College of Nursing. The RBNA, and in particular Bedford Fenwick, the Association's leader and editor of the *BJN*, was intent on airing grievances she had been prevented from raising in official meetings about registration with Dr. Christopher Addison, to be discussed in the next chapter. Addison's

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<sup>460</sup> A. Marsh & V. Ryan, *Historical Directory of Trade Unions: Non-Manual Unions*, Vol. 3, Aldershot: Gower, 1987, p.184.

<sup>461</sup> *BJN*, 1 November 1919.

<sup>462</sup> Rafferty, *The Politics of Nursing Knowledge*, p.87.

determination to confine debate ‘within the smallest possible compass’ prevented nurse organisations seeking linked economic benefits or improvements to work conditions. The College’s cautious, conservative approach to the issue of work conditions and its’ determination not to get involved with anything that could be construed as radical was criticised for failing to improve nurses’ working lives.<sup>463</sup>

The threat of the unionisation of general hospital nurses was used to prompt government ministers to support registration. As the College of Nursing and the RBNA struggled to achieve professional status through registration in the spring of 1919, Lord Ampthill argued that a delay in registration, would

force nurses into trade unions. It is what is already happening. You have seen it in the case of the Asylum Workers’ Association and if you force nurses to form trade unions in order to secure that which they regard ... as a measure of justice and a right to them, you will simply throw them into the arms of the Labour Party. Is that a desirable thing to do at the present time?<sup>464</sup>

Ampthill recognised the sensitivity of Lloyd George’s Government to the question of unionisation, playing on this fear by presenting registration as a way of bringing both stability and of settling grievances about work conditions. As the War ended, government feared the threat of industrial disorder, particularly after a series of clashes between the police and strikers in Glasgow. The War gave a boost to the organisation of women workers by trade unions. Female membership of unions rose from 183,000 in 1910 to 1,086,000 by the end of 1918; of particular interest was the growth in new membership amongst teachers and white-collar workers.<sup>465</sup> Carpenter suggests that ‘a

<sup>463</sup> The College’s refusal to support Nancy Astor’s Committee’s resolution that it was illegal to dismiss married women ‘from any employment on the grounds of marriage’ is evidence of this attitude. RCN, The College of Nursing Ltd, Council Minutes, April 1<sup>st</sup> 1921 to March 31<sup>st</sup> 1922, p.137.

<sup>464</sup> Lord Ampthill, *Second Reading of the College of Nursing Registration Bill, House of Lords*, 27 May 1919.

<sup>465</sup> Dingwall, *An Introduction to the Social History of Nursing*, p.86.

new, more self-assertive notion of womanhood came to the fore' as a result of the War, which spread to nurses.<sup>466</sup>

Trade union activity amongst nurses was largely confined to the Poor Law sector: by late 1919, 2,500 had joined the Poor Law Workers Trade Union established in December 1918, making up 25% of its membership.<sup>467</sup> Such a sizeable membership could not be ignored and, according to an editorial in the *Nursing Times*, was interpreted as an indication of the College of Nursing's failure to lobby for improved conditions:

while we regret that nurses should ally themselves with a trade union or any union which is not a professional one, the fact that 2,500 nurses have joined must be faced ... Nurses will prefer to join a professional society which will help to ameliorate conditions but that society has yet to be formed. The College of Nursing has done much ...but it is primarily an educational and registering body and there appears to be room ... for a society of working nurses banded together on their own initiative.<sup>468</sup>

Although a Conservative dominated coalition had won the general election, Labour gained power in many working class municipalities boosting the campaign to extend trade unionism to local government services. Some local services began to introduce reforming conditions of employment for Poor Law nurses. For example, Lambeth introduced an eight-hour day and gave probationers the choice of living in or out.<sup>469</sup>

Conversations about whether general nurses would join trade unions focussed on four issues: the question of strike action, whether notions of self-sacrifice were still a necessary quality in nurses, nurses' health and notions of class. The issue of unionisation was portrayed as one of conflicting values; trade unionism was linked with

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<sup>466</sup> Carpenter, *Working for Health*, p.170.

<sup>467</sup> *The Nursing Times*, 18 October 1919, p.1081.

<sup>468</sup> *The Nursing Times*, 18 October 1919, p.1081.

<sup>469</sup> Carpenter, *Working for Health*, p.172.

materialism, the neglect of patient care and a lack of self-sacrifice whilst the College was linked with the ideology of sacred duty and superior morality.

The question of whether general hospital nurses would strike dominated the debate surrounding unionism. The College took up position as the patient's advocate: 'the hard and fast rules required' under trade unionism

cannot be applied to those engaged in nursing without detriment to the patients under their care. The aim of the College, while endeavouring to improve the conditions of nursing is, at all times to safeguard the standard of nursing of the sick.<sup>470</sup>

College members argued that to strike would betray patients 'sacred trust' in nurses.<sup>471</sup> Despite the increasing secularisation of nursing, discourses continued to refer to religiosity and questions of morality.<sup>472</sup> On the one hand, the College embodied a process of modernisation with its emphasis on training and examination yet it continued to associate nurses with sacred, religious symbols.

College supporters argued the necessity for recruits to be motivated by high moral ideals rather than material rewards. This argument supported an image of the nurse as a self-sacrificing angel: one college supporter vocalised such a sentiment in a letter to the *Nursing Times*:

It is doubtful if high salaries attract the best type of men or women into any profession; especially in the nursing profession we only want women who are attracted by such a real love for the work that salary is a secondary consideration. We do not want women whose first thought is what hours they will have to work and what salary they will receive, for no amount of training will ever make them nurses.<sup>473</sup>

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<sup>470</sup> RCN, The College of Nursing Ltd, Council Minutes, April 1<sup>st</sup> 1924 to March 31<sup>st</sup> 1925, 23 May 1924.

<sup>471</sup> *The Nursing Mirror and Midwives Journal*, 8 November 1919, p.107.

<sup>472</sup> Bashford, *Purity and Pollution*, p.49.

<sup>473</sup> *The Nursing Times*, 22 November 1919, p.1247.

Some doctors also supported the idea that a sense of vocation remained essential. An editorial article in *The Lancet* identified those nurses who had joined a trade union as lacking an ‘appreciation of nursing as a gentle art.’ ‘High professional honour’, *The Lancet* warned, would only be won by discouraging ‘a militant attitude.’<sup>474</sup> *The Lancet’s* determination to squash a nurses’ trade union may have been because of the threat unionism posed to hospitals’ hierarchical division of labour.

PUTN leader Maude MacCullum challenged the notion that health risks were to be endured as part of a nurse’s commitment to sacred duty, arguing that ‘vocation’ meant ‘serfdom’ and was the cause of ‘premature disability and dependence.’<sup>475</sup> She believed that the health risks of nursing be acknowledged and work conditions improved to reduce the levels of ill health. O’ Dwyer, another private nurse and speaker at one of the first PUTN meetings, argued that ‘the hospital system which worked to relieve one class of invalids was creating another ... Invalidity was caused by the long hours, such as no class of labourer would tolerate, the hurried meals and the strain of the care of so many acutely sick people.’<sup>476</sup> The PUTN aimed eight of its nineteen objectives towards improving the health and welfare of nurses including securing a minimum rate of pay, maximum working hours per week, the provision of hospital beds, nursing homes and sanatoria for sick nurses and a sick and accident fund.<sup>477</sup>

As nursing began to compete with other occupations such as teaching and clerical work, the idea that nurses’ commitment to duty must be total began to be questioned by probationers corresponding in the nursing press.<sup>478</sup> The idea that there was a gap between the modern girl and the rigid discipline of nursing institutions was exploited by the PUTN, particularly in London. ‘Modern’ women, it was argued, were not interested in a vocation and could no longer be expected to tolerate the strict

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<sup>474</sup> *The Lancet* quoted in *The Nursing Times*, 15 November 1919, p.1266.

<sup>475</sup> *BJN*, 1 November 1919, p.266.

<sup>476</sup> *BJN*, 15 November 1919.

<sup>477</sup> *BJN*, 1 November 1919, p.263.

<sup>478</sup> Carpenter, *Working for Health*, p.174.

discipline of nursing institutions. One London Fever Hospital probationer argued that ‘in these enlightened days, the modern girl expects comfort, good food and a certain amount of social life. If these are not offered her in hospitals she will go elsewhere.’<sup>479</sup> It is interesting that this probationer identifies modernity as the reason why women expected increased material rewards and were no longer prepared to tolerate military style discipline. Expanding work opportunities and the relaxation of traditional expectations of behaviour as a result of the War had given women a new sense of confidence and freedom. Whilst it is questionable whether the War consolidated this new status women had in society, as many women returned to domestic roles to give jobs to demobilised troops, it changed the way women thought about themselves. This London Fever Hospital nurse considered herself a ‘modern girl’ whose sense of independence and self worth gave her the confidence to make demands of her employers, the majority of her predecessors had felt reluctant to make.

Class was an important issue for the PUTN. Although it positioned itself in opposition to the College of Nursing Ltd, it was keen to attract a similar middle class membership and dispel the idea that trade unionism was associated with the working classes. Helen Klaassen, a member of the National Union of Scientific Workers, told a PUTN meeting that ‘in order to improve and safeguard the conditions of work, the efficiency of work, and the distribution of the products of industry there must be unions of professional as well as of manual workers.’ According to Klaassen, ‘the middle classes were beginning to move.’<sup>480</sup> The Union’s small membership suggests that few voluntary hospital nurses were interested in trade unionism. The PUTN blamed nurses’ apathy, identifying it as one of the greatest dangers to threaten nurses: ‘one would think that what one sees in the nursing world today might serve to arouse them to get better conditions for themselves ... nurses are too weary with long hours to take an interest in

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<sup>479</sup> *The Nursing Times*, 7 February 1920.

<sup>480</sup> *BJN*, 15 November 1919, pp.301- 302.

their own affairs.<sup>481</sup> Another reason may have been that middle class nurses were already members of the College. Although keen to attract a similar membership to the College, the PUTN did not allow matrons to sit on its Council and this may have deterred senior nurses from joining.<sup>482</sup>

As the debate about trade unionism continued throughout the later part of 1919, even the pro-College journals hinted that unionism was the way forward. Keen to reassure readers that ‘trade unionism with its strike weapon and the extreme measures to which it has become addicted has never been advocated by us’, the *Nursing Times* admitted that the NAWU had ‘worked wonders for mental nurses. A 96-hour fortnight on a three-shift plan with fourteen days leave has been established.’<sup>483</sup> The *Nursing Times* warned the College ‘that if professional societies work too slowly, the more impatient spirits will join something that will secure them benefits.’<sup>484</sup> The College of Nursing came under increasing pressure, often from its own members, to take a more active role in improving work conditions.<sup>485</sup>

Despite the publicity surrounding the PUTN, its membership remained negligible until its demise in 1921. The College, with the help of the nursing press, hospital administrations and the declining force of the wider trade union movement, recovered the initiative.<sup>486</sup> Although the College remained resolutely opposed to trade unionism, it was increasingly called upon to modify its elitism and represent its members in disputes concerning work conditions.<sup>487</sup> As already mentioned, it relaxed its exclusive attitude in 1924 and set up a Student Nurses’ Association, partly to raise

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<sup>481</sup> *BJN*, 1 November 1919, p.265; 21 February 1920, p.120.

<sup>482</sup> *BJN*, 21 February 1920, p.120.

<sup>483</sup> *The Nursing Times*, 30 August 1919.

<sup>484</sup> *The Nursing Times*, 18 October 1919.

<sup>485</sup> RCN, *Minutes of Council Meeting*, 20 February 1919, RCN/2/2, p.556.

<sup>486</sup> Carpenter, *Working for Health*, p.178.

<sup>487</sup> RCN, The College of Nursing Ltd, Council Minutes, April 1<sup>st</sup> 1927 - March 31<sup>st</sup> 1928, p.65. In 1928 the College acted as ‘the trade union representative’ of a maternity sister ‘to help improve [her] status and salary’ and a nurse, who had opted out of the Poor Law Superannuation Act, and wished to repay her contributions.



extra funds but also to discourage students from joining trade unions. By the late 1920s, debate concerning the merits of the college route versus trade unionism had disappeared from the pages of the nursing press.

## **Conclusion**

High levels of ill health related to poor work conditions played an important part in shaping CLA nursing staff's choice of occupational representation. Asylum attendants and nurses endured considerable hardship during the First World War, which had a detrimental affect on their health. A rise in patient numbers, the loss of regular staff and a reduction in food rations contributed to a rise in the number of episodes of illness. These increased demands caused tension between senior and junior nurses and a breakdown in communication between the Medical Superintendent and Matron. The Visiting Committee ignored nurses' complaints. In contrast to the late nineteenth century when physical injury from violent patients posed the greatest health risk to staff, the health risk during the First World War was from infectious diseases. Problems of overcrowding compounded with a lack of nurse training or an effective infection control policy increased nurses' vulnerability to ill health. The college route of professionalism and its emphasis on vocation and no strike rule was not an option for a group of nurses whose work and living conditions had deteriorated to such an extent that they adversely affected their health.

In contrast, SDEC nurses did not experience a similar rise in ill health. Indeed, the incidence and pattern of illness remained similar to that of the preceding decade. The infectious patient posed less of a threat than at the CLA because of the SDEC's effective infection control policy and system of nurse training. SDEC nurses enjoyed superior work conditions to their CLA counterparts: the hospital was less overcrowded and the nurse patient ratio was lower. Also diet rations had less of an impact on nurses' health. The SDEC management committee were keen to resolve any complaints and, as

a result, probationers and nurses were less militant.

Why did CLA nurses wait until 1918 before joining the NAWU? This may be explained by a general decline in militant attitudes as part of the war effort but also because the NAWU focussed on issues CLA nursing staff perceived as unrelated to their working lives. The Union was interested in protecting male attendants' jobs and wages and promoted a debate of male versus female to achieve this. These issues did not apply to the CLA because, from the outset, the Visiting Committee refused to employ women to care for male patients and also guaranteed the jobs, wages and pension contributions of attendants on military service. Female CLA nurses were unlikely to identify with the Union's male versus female debate having worked collaboratively with their male colleagues when petitioning for a wage rise in 1913.

The notion of class is an important factor in shaping the choice of collective representation in the two institutions studied. CLA nursing staff were predominately working class and identified with other groups of industrial workers as well as public sector workers. The rapid uptake of union membership in 1918 suggests an overwhelming empathy with the working class trade union movement. In contrast, SDEC nurses were a mixture of working class, middle class and upper class all of who paid for their training. There were clear class boundaries, set by Matron Hopkins, as to who was considered suitable to nurse at the Hospital: whilst the Hospital Chairman's daughter was considered respectable, a publican's daughter was not. Nurses' lack of interest in trade unionism may be explained by an unwillingness to associate with working-class activities. However, there is no evidence that SDEC nurses were interested in any form of occupational representation until 1924 when membership of the College of Nursing's Student Association became compulsory. The fact that nurses' complaints were dealt with quickly, and in their favour, seems to have resulted in apathy towards any active form of professional or industrial activity.

The idea that the notion of gender can adequately explain nurses' choice of occupational representation is undermined by the leading role female CLA nurses took in the rapid upsurge of union membership and strike action in October 1918. Their role suggests that women were as likely as men to reject professional ideology. The female CLA nurses had previously demonstrated an effective ability to participate in collective bargaining without the need for union representation at a time when the NAWU suggested that women's reluctance to join the Union was due to a fragile, emotional temperament. This chapter concludes that high levels of ill health, notions of class and to a lesser degree, nurse education had more influence on women's choice of collective representation than that of the notion of gender.

The nursing press portrayed the College as a failure for failing to raise the issue of work conditions in the debate on nurse registration, creating the impression that trade unionism provided a viable alternative. The coverage given to the question of unionisation was out of all proportion to the small numbers involved but allowed commentators to discuss the relevance of many of the values associated with nursing. Indeed, the issue was presented as one of conflicting values: trade unionism was linked with materialism, the neglect of patient care, a lack of vocation and the end of 'the art of nursing.' The College of Nursing, on the other hand, continued to associate nurses with sacred, religious symbols despite its secular approach to training and examination. Trade unions failed to attract voluntary hospital nurses suggesting that most nurses considered their work conditions to be tolerable and saw no reason to complain. The PUTN saw the struggle to increase their membership in class terms, actively campaigning to recruit middle class nurses and dispel the idea that unionism should only be associated with the working classes.

## CHAPTER FIVE

### Nurses' Registration Bill 1919

In 1919 the newly appointed Minister of Health, Dr. Christopher Addison, stated that nurses' 'conditions of employment were one of the most essential needs of the time. They had been scandalously underpaid and often grossly overworked.'<sup>488</sup> This chapter examines how nurses' campaign to be recognised as a professional body at the end of the First World War affected attitudes to their occupational health. Addison's statement raises an important question: if government ministers were aware of nurses' poor work conditions and their consequent effects on health, why were they not improved as part of the Nurses' Registration Act in 1919? A second question considered here is whether the developments in an occupational health service for other groups of workers during the First World War prompted improvements in the care of nurses' health.

The method adopted in this chapter differs from the rest of this thesis in that instead of placing individual nurses' bodies at its centre, it examines nursing politics and its relationship to work conditions and health. This approach is necessary to show the importance of the Registration Bill in shaping attitudes to nurses' health. Chapters six and seven assess the precedent established in 1919 that professional status was more important than nurses' poor work conditions.

The historiography surrounding the Registration Act has already been discussed in chapter one. However, a brief summary is necessary here to pick out important themes. The first theme of interest is the timing of the Registration Bill and how it shaped the importance attached to nurses' work conditions. Historians have traditionally explained the introduction of the Government's Registration Bill by the threat to occupational dilution and unity engendered by an influx of Voluntary Aid Detachment nurses (VADs) combined with public and political sympathy towards

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<sup>488</sup> *The Nursing Times*, 5 July 1919.

improving the status of women through female suffrage.<sup>489</sup> The more likely explanation put forward in recent studies suggests that registration fitted in with the Government's plans for post war social reconstruction.<sup>490</sup> How nursing would fit into these plans and, in particular, whether government or nurse organisations would control and stipulate conditions of entry, training and work were seen as fundamentally important by all interested parties.

The second theme studied here is concerned with nurse organisations' role in the legislation of registration. According to Dingwall et al., it was predicted that nurse leaders would be able to stipulate conditions of service once professional status had been achieved.<sup>491</sup> Why this prediction failed to materialise and how nurse leaders were manipulated into a tightly constrained relationship with government within which they were the weaker partners, will be examined. The idea that the Registration Act was the coming of age for nursing professionally<sup>492</sup> has been challenged by recent studies questioning the degree of external autonomy and control nurses achieved.<sup>493</sup> Bellaby and Oribabor suggest that internal contradictions beset professionalism in nursing: firstly, registration failed to unify nurses because the College of Nursing failed to organise nursing under the leadership of trained nurses and secondly, the state, who having granted a monopoly of practice to registered nurses, ensured that no such monopoly was exercised.<sup>494</sup>

Historians agree that the divisions within nurse organisations hampered nurse registration.<sup>495</sup> Chapter two noted the split between registration's supporters and

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<sup>489</sup> Rafferty, *The Politics of Nursing Knowledge*, p.77.

<sup>490</sup> Dingwall et al., *An Introduction to the Social History of Nursing*, p.86; Rafferty, *The Politics of Nursing Knowledge*, p.77.

<sup>491</sup> Dingwall et al, *An Introduction to the Social History of Nursing*, p.81.

<sup>492</sup> Abel-Smith, *A History of the Nursing Profession*, p.81.

<sup>493</sup> P. Bellaby and P. Oribabor, 'The History of the Present - Contradiction and Struggle in Nursing' in C. Davies, (ed.), *Rewriting Nursing History*, pp.147-174; Witz, *Professions and Patriarchy*, p.163.

<sup>494</sup> Bellaby and Oribabor, 'The History of the Present', p.160.

<sup>495</sup> Rafferty, *The Politics of Nursing Knowledge*, p.77; Dingwall et al., *An Introduction to the Social History of Nursing*, pp.77-89.

opponents in the 1880s but by 1919 factions had developed within registration's supporters. The College of Nursing and the Central Committee for the State Registration of Nurses presented separate registration bills to Parliament in May/June 1919, arousing sufficient opposition to prevent any real progress. Disagreement focussed on what was implied by registration and was exacerbated by personal and sectional issues that could not be reconciled.<sup>496</sup> The College proposed a system of voluntary accreditation ensuring a basic uniformity of curriculum and assessment between the various training schools, leaving voluntary hospitals with considerable influence over the standards required. The Central Committee, led by Bedford Fenwick, advocated the imposition of occupationally determined standards, regardless of their practical implications.<sup>497</sup>

The third theme of this chapter examines the College of Nursing's motivation to improve nurses' work conditions. Baly argues that, from its inception in 1916, the College set out to improve pay and work conditions.<sup>498</sup> McGann agrees but notes that although the College put pressure on employers to raise salaries, they failed to rise to their recommended levels.<sup>499</sup> The College's reluctance to enforce a standardised salary scale reflected its wider opposition to what it perceived as the rigidity of trade union organisation, discussed in the previous chapter. Critical of the College's ability to effect material improvements, the National Council of Women (NCW) initiated an enquiry into the impact work conditions had on nurses' health. The NCW's enquiry is examined later in this chapter not only because it illustrates which areas of nurses' health were a cause for concern but also how women's organisations used the notion of gender to access political power. Firstly, however, this study will examine the timing of the Registration Bill and its influence on the priority attached to nurses' work

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<sup>496</sup> Rafferty, *The Politics of Nursing Knowledge*, p.80.

<sup>497</sup> Dingwall et al., *An Introduction to the Social History of Nursing*, p.85.

<sup>498</sup> Baly, *Nursing and Social Change*, p.154.

<sup>499</sup> McGann et al., *The History of the Royal College of Nursing, 1916-1990*, p.57.

conditions.

### **The creation of the Ministry of Health and its attitude to nurses' registration**

The Ministry of Health was created following years of debate on the responsibilities of the state towards the nation's health. With wide-ranging responsibilities, the Ministry has been seen historically 'as uneasily balancing central, local and private interests, including poor law authorities and the private insurance companies that managed most of the nations' health insurance since 1911.'<sup>500</sup> The duties of the Local Government Board, the National Insurance Commission, the powers of the Board of Education in relation to health and the responsibility for the Midwives Act were transferred to the Ministry of Health.<sup>501</sup> Dr. Christopher Addison, who had participated in negotiations before the 1911 insurance legislation, was appointed Minister for Health. Whilst its supporters hoped that it would be a move towards a more integrated health service, its critics managed to limit the Ministry's agenda.<sup>502</sup> The Ministry had two roles in the Government's post war reconstruction plans: firstly to inspire soldiers in the promise of a 'land fit for heroes' and secondly to contain social unrest caused by the disruptive effects of war on the national economy.

From its inception in 1919 the Ministry of Health realised the advantages that could be gained from having a register of trained nurses at their disposal. It would enable the identification of trained and efficient nurses who could then be helped to move to where they were needed.<sup>503</sup> Addison suggested that nurse registration was 'an essential element in any real improvement of existing medical services, particularly for the industrial population.'<sup>504</sup> 'The Ministry of Health realised the potential of a co-

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<sup>500</sup> McGann et al, *A History of the Royal College of Nursing*, p.63.

<sup>501</sup> Baly, *Nursing and Social Change*, p.164

<sup>502</sup> E.J.C. Scott, 'The influence of the staff of the Ministry of Health on policies for nursing, 1919-1968', PhD thesis, London School of Economics, 1994, p.31.

<sup>503</sup> Dingwall et al., *An Introduction to the Social History of Nursing*, p.86.

<sup>504</sup> PRO MH 55/462, 'The Establishment of the General Nursing Council',

operative relationship with nursing’ according to Scott, ‘and sought to use this to its own advantage.’<sup>505</sup> It did not intend, however, to improve nurses’ work conditions as part of the Registration Bill and offered professional status on the condition that nurse organisations did not seek to extract linked economic benefits. Addison met the three participating organisations (College of Nursing Ltd, the Association of Hospital Matrons,<sup>506</sup> and the Central Committee for the State Registration of Nurses<sup>507</sup>) separately, on the premise that the years of bitter rivalry and disagreement between nurse leaders during the campaign for registration had made it impossible for him to achieve any form of agreement in a limited time scale if he allowed joint discussion. This strategy effectively undermined the political strength these organisations may have gained from acting together.

Despite Addison’s refusal to allow the discussion of nurses’ economic and work conditions on to registration’s agenda, he was willing to discuss the matter unofficially where he made it clear that he understood the urgent need for improvements. He often raised the matter in the course of his work as Minister for Health. In July 1919, four months before he introduced the Government’s Registration Bill, Addison again noted that:

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memorandum by Dr. Christopher Addison, Minister of Health to Cabinet on Nurses’ Registration, 1 October 1919, p.1

<sup>505</sup> Scott, ‘The influence of the staff of the Ministry of Health’, p.31.

<sup>506</sup> Rafferty, *The Politics of Nursing Knowledge*, p.90. The Association of Hospital Matrons was set up in 1918 as a rival College of Nursing backed organisation to the Bedford Fenwick- led Matron’s Council for Great Britain and Ireland. Membership was open to trained nurses who held or had held the position of matron or superintendent of hospitals and institutions concerned with the training of nurses and the care of the sick. Rafferty argues that it was created to capture as much representational power as possible.

<sup>507</sup> Abel-Smith, *A History of the Nursing Profession*, p.82. Represented on the Central Committee for the State Registration of Nurses, set up in 1908, were the Royal British Nurses’ Association, the Matrons’ Council for Great Britain and Ireland, the Society for the State Registration of Nurses, the Fever Nurses’ Association, the Association for Promoting the Registration of Nurses in Scotland, the Scottish Nurses’ Association, the Irish Nurses’ Association and the Irish Nursing Board, the Infirmary Nurses’ Association and the British Medical Association.



the conditions of employment of nurses was one of the most essential needs of the time ... But to deal with that matter was not the function of the body which decided who was to be on the register.<sup>508</sup>

This suggests that Addison always intended to limit the power of the General Nursing Council, the body set up to decide the conditions of registration; part of the Government's agenda was to prevent nursing becoming a powerful, autonomous profession.

There are several reasons why nurse registration failed to prompt a government inquiry into nurses' work conditions. Addison wanted to prevent further rivalry and animosity between nurse organisations disrupting the passage of the Government's Registration Bill. Nurse organisations held differing opinions as to the way work conditions should be dealt with: an inquiry would have allowed the disagreements that had characterised the campaign for registration to continue. The division between the College of Nursing and the Central Committee for the State Registration of Nurses played into the hands of the Ministry of Health who were able to impose their own agenda of change onto a split profession.

When the private members' procedure for legislation resumed at the end of the First World War, two of the three organisations invited to discuss registration with the Ministry of Health presented their own registration bills, both of which failed. The Royal British Nurses' Association (RBNA), who presented their Bill under the umbrella of the Central Committee for the State Registration of Nurses, failed because critics believed it would favour nurses from middle class backgrounds. The Marquess of Crewe argued in the House of Lords debate that 'we have got to see that the avenue into the nursing profession is kept open for the daughters of the working classes as much as any other class.'<sup>509</sup> The RBNA criticised the rival College of Nursing Bill for

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<sup>508</sup> *The Nursing Times*, 5 July 1919.

<sup>509</sup> The Marquess of Crewe, House of Lords Debate, 27 May 1919, col.840.

serving the interest of employers rather than nurses: Herbert Paterson, secretary to the RBNA, suggested that ‘the College Bill [was] a hospital governors’ and matrons’ Bill - i.e. an employer’s Bill. The Central Committee’s Bill [was] the Bill of the rank and file.’<sup>510</sup> It suited the RBNA to promote themselves as representing the ordinary ‘rank and file’ nurse in this instance yet they were a deliberately socially exclusive organisation: poor law and asylum-trained nurses were barred from their membership on the grounds that they had not trained in a ‘general’ hospital.<sup>511</sup>

The nursing press took sides in this debate along with national newspapers. An editorial in *The Times*, supporting the Central Committee, argued that ‘nurses are too much at the mercy of their employers and they lack effective means of making their difficulties and grievances known.’<sup>512</sup> The underlying struggle, according to Abel Smith, led to ‘a duel which would yield to the victor the cherished position of major spokesman for the nursing profession.’<sup>513</sup> The combatants struggled to gain their representatives on the first General Nursing Council.<sup>514</sup> Addison himself stated that he was unable to prevent the spectacle of two professional organisations ‘airing their private feuds before the forum of public opinion’ and abandoned attempts to bring them together.<sup>515</sup>

The Government introduced their Bill of Registration in October 1919. Reform was ‘ten years overdue’ according to Addison, but he proposed

to confine it within the smallest possible compass ... that it would merely set up a suitably composed Registration Council, on whom could be conferred by the Bill the responsibility for working out suitable regulations, subject to the approval of the

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<sup>510</sup> *The Times*, 6 June 1919, p.8.

<sup>511</sup> Rafferty, *The Politics of Nursing Knowledge*, p.86.

<sup>512</sup> ‘A Nursing Profession’, *The Times*, 29 March 1919, p.13.

<sup>513</sup> Abel-Smith, *A History of the Nursing Profession*, p.94.

<sup>514</sup> For detailed discussion of the selection of candidates for the General Nursing Council see Rafferty, *The Politics of Nursing Knowledge*, pp.96-112.

<sup>515</sup> Abel-Smith, *A History of the Nursing Profession*, p.26.

Ministry of Health.<sup>516</sup>

Nurse organisations would ‘not deal with such questions as conditions of service and hours of labour’ since it was to be the policy of the Ministry of Health themselves ‘to safeguard in the course of administration the conditions of service of nurses.’<sup>517</sup> The means by which safeguards would be put into operation were not specified but, according to Rafferty, ‘plans for rationalising the health services may well have been what officials had in mind.’<sup>518</sup> The years of disagreement amongst nurse organisations over registration were exploited by the new Ministry of Health to ensure that demands concerning conditions of work were squashed. Sir Robert Morant, Permanent Secretary to the Ministry of Health, explained to a meeting with the Association of Hospital Matrons:

the failure of the two private Bills had made it clear that there was no chance of any private Bill being carried ... The pressure of parliamentary time was very great, and there was no chance of a Government Bill being passed unless substantial agreement could be secured. This meant, therefore, that both sections must be content with something less than they had hitherto hoped for.<sup>519</sup>

The Ministry of Health’s tactics of restricting the agenda and meeting each organisation separately was successful. The result was that all three organisations complied with the Government’s instructions not to lobby for improvement to nurses’ work conditions. Bedford Fenwick and her supporters had hoped that legislation would empower the General Nursing Council to exert some control over conditions of service and eliminate

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<sup>516</sup> PRO MH 55/462, ‘The establishment of the General Nursing Council’, memorandum from Dr. Christopher Addison. 1 October 1919.

<sup>517</sup> PRO MH 55/462, ‘The establishment of the General Nursing Council’, memorandum from Dr. Christopher Addison

<sup>518</sup> Rafferty, *The Politics of Nursing Knowledge*, p.91.

<sup>519</sup> PRO MH 55/462 Meeting of Sir Robert Morant and Association of Hospital Matrons, 17 October 1919.

‘sweated labour’ from nursing.<sup>520</sup> However, Addison’s insistence that he was ‘not prepared to take the responsibility of introducing the Bill on any other terms’ other than his own or to discuss the ‘highly technical details of nursing works, and training ... in the unsuitable arena of the House of Commons’ put an end to such expectations.<sup>521</sup>

In summary, the Government supported registration because it fitted in with post war reconstruction plans. Nurse organisations’ history of rivalry and disagreement allowed the Minister of Health to control the agenda surrounding nurse registration. Despite Addison’s awareness of the need for improvements to nurses’ work conditions, he prevented nurse organisations seeking linked economic benefits as part of the Registration Bill. The next section will examine whether this reluctance to address nurses’ poor work conditions can be explained by the Government’s intention to include nurses in legislation aimed at improving all workers’ conditions, whether in factories, shops or hospitals.

## **Hours of Employment Bill, 1920**

The Hours of Employment Bill introduced in 1920 aimed to regulate the working hours of all groups of workers. ‘In the flush of post-war idealism government, employers and trade unions all pledged themselves to the legal enforcement of a 48 hour week’, according to Lowe.<sup>522</sup> The wartime effort to improve production in munitions and other heavy industries had meant a relaxation in pre-war legislation limiting the working hours of certain groups of workers. Some factory workers were on duty for up to 108 hours a week and shifts of twenty-nine hours were documented.<sup>523</sup> War-time experience put nurses under pressure to work whatever hours were necessary to deal

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<sup>520</sup> Rafferty, *The Politics of Nursing Knowledge*, p.91.

<sup>521</sup> PRO MH 55/462, Memorandum by Dr Christopher Addison, Minister of Health. 1 October 1919.

<sup>522</sup> R. Lowe, ‘Hours of Labour: negotiating industrial legislation in Britain, 1919-1939’, *Economic History Review*, **35**(2) 1982, p.77.

<sup>523</sup> H. Jones, *Health and Society in Twentieth Century Britain*, New York: Longman Publishing, 1994, p.45.

with emergencies.<sup>524</sup>

Interest in the occupational health of workers had grown considerably during the First World War, particularly in the munitions factories. The War provided the impetus to establish welfare work as a permanent part of industry.<sup>525</sup> Government interest in the scientific relationship between industrial fatigue, efficiency and health rapidly increased when the war effort faced being undermined by the declining productivity of munitions workers, as a result of chronic fatigue. In 1915, the Government set up the Ministry of Munitions, which in turn formed the Health of Munitions Workers' Committee (HMWC) to investigate the 'laws' governing industrial health and efficiency. Of particular interest to this study is the HMWC's recognition of the importance of external factors outside of the time of the hours on duty, such as fatigue and nutrition, as important in the production of occupational illness as those produced by the materials handled.

On the disbandment of the HMWC at the end of 1917, the Industrial Health Research Board (IHRB) was formed to investigate industrial health and fatigue amongst all classes of work.<sup>526</sup> The Board's function was to establish, 'through scientific analysis, precise work measurement, and calculations of energy expenditure at work, the optimum conditions and methods of work for the operatives.'<sup>527</sup> By February 1917, the Ministry was confident that welfare had both vindicated itself and more than paid for the expenditure on welfare measures through increased productivity. Although the end of War reduced the need for high productivity in munitions, the experience altered workers' expectations.<sup>528</sup> Conditions of work gained a much higher profile, supported by the increasing strength of the unions and the Labour Party.

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<sup>524</sup> McGann et al., *History of the Royal College of Nursing*, p.58.

<sup>525</sup> A. Woolacott, 'Maternalism, Professionalism and Industrial Welfare Supervisors in World War I Britain', *Women's History Review*, **3** (1), March 1994, p.29.

<sup>526</sup> A.J.McIvor, 'Manual Work, Technology and Industrial Health, 1918-39', *Medical History*, **31**: pp.160-189, 1987, pp.161-162.

<sup>527</sup> McIvor, 'Manual Work, Technology and Industrial Health, 1918-39', p.165.

<sup>528</sup> McGann et al., *History of the Royal College of Nursing*, p.58.

The Hours of Employment Bill, drafted by the Minister of Labour, prescribed a maximum of forty-eight hours per week with overtime to be paid as extra wages. The Bill's promoters argued that in terms of post-war reconstruction it would benefit not only the workers but also productivity and the economy. The Government was unsure whether nurses should be included: Sir David Shackleton, Permanent Secretary at the Ministry of Labour, thought 'nurses would probably be classed with domestic workers and therefore not included.'<sup>529</sup> Nurses' work, according to the Government, was comparable to the unregulated work of domestic workers rather than the restricted hours of women working in industry.

The question of whether nursing was a form of domestic service had occupied nurse leaders since the mid nineteenth century. Prior to the 1860s, nursing was regarded as a superior form of domestic service relying mainly on respectable, working class women.<sup>530</sup> As nineteenth century nurse leaders sought to establish nursing's status and organise its boundaries, the need to draw a line between domesticity and professionalism was considered important. Was nursing to be a 'new profession' with entry restricted to educated women or was it a refined form of domestic service drawing on the skills of servants?<sup>531</sup> Chapters two and three discuss the ways nurse leaders used notions of discipline, class and gender to establish boundaries between 'old' domestic style nurses and 'new' professional nurses. In 1919, Cox Davies summarised the College's position:

Trained nurses had now been given legal status, they had a defined position, and as professional workers they ought not to be brought under an Industrial Act ... The only way in which they could be brought under it was as domestic workers and they should not be placed in that category because domestic

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<sup>529</sup> *BJN*, 18 December 1920, p.340.

<sup>530</sup> Dingwall et al., *An Introduction to the Social History of Nursing*, p.69.

<sup>531</sup> Dingwall et al., *An Introduction to the Social History of Nursing*, p.75.

work was not recognised as skilled professional work as nursing was.<sup>532</sup>

Despite the Registration Act of 1919, the Government's plans to include nurses under the category of domestic workers in its proposed Hours of Employment and Unemployment Insurance Acts questions whether it viewed nurses as having achieved any real form of professional status.

Shackleton invited nurse organisations to discuss the proposed legislation but despite the Ministry of Labour's optimism that a consensus would be easily attainable, disagreement prevailed as to what form regulation should take.<sup>533</sup> The College of Nursing, Central Committee for the State Registration of Nurses, General Nursing Council and nurses' trade unions held different ideas about how restricting working hours would affect nurses and their work.

A reduction in nurses' hours would benefit nurses' 'spirit', according to Bedford Fenwick and the Central Committee. Fenwick believed spirituality to be integral to a person's mental wellbeing, an idea that did not gain psychiatrists' interest until the late twentieth century.<sup>534</sup> She maintained that care of nurses' 'spirituality' would improve their ability to care for patients:

in nursing, largely because the profession has never taken care of itself, the spiritual life of the nurses has been made subservient to the economic convenience of the community at large ... many who entered the profession ... have become soured, sad, soul-less, broken things.<sup>535</sup>

Spirituality included 'religion, literature, the sciences, everything, in fact, which has to

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<sup>532</sup> 'Nurses unanimous in their desire to be excluded from the Unemployment Insurance Act, 1920', *BJN*, 15 January 1921, p.36.

<sup>533</sup> RCN, College of Nursing Council Meeting, RCN/2/3, 8 April 1920.

<sup>534</sup> The Royal College of Psychiatrists Spirituality and Psychiatry Special Interest Group, *Spirituality and Mental Health Leaflet*, June 2006, <http://www.rcpsych.ac.uk/mentalhealthinfo/treatments/spiritualityandmentalhealth.aspx>

<sup>535</sup> *BJN*, 6 November 1920.

do with the intellect.<sup>536</sup> Fenwick's broad definition suggests that she viewed the pursuit of intellectual purposeful activity as a necessary requirement to nurses' mental health.

In contrast, the College of Nursing argued against a reduction in nurses' hours on the grounds that nurses needed to prove their dedication to duty. Despite the introduction of a more scientific approach to nurse education in the late nineteenth and early twentieth centuries, the College adopted many of the ideals associated with mid-nineteenth century nursing reform, upholding the notion that dedication to duty was a necessary quality in nurses.<sup>537</sup>

The College also supported a gendered ideology of motherhood as not only integral to the image of the twentieth century nurse but also as a further reason why nurses' working hours should remain unrestricted. Chapter three (p.80) noted how nineteenth century nurse leaders argued that women were entitled to nurse in hospitals because of a biological predisposition towards maternal, caring qualities. This argument supported women who wished to enter voluntary hospitals on privileged terms and not be seen as the servants of the male boards of governors or the male medical staff. It is perhaps surprising that this ideology continued to attract support long after women reached positions of power as matrons within a hospital setting. Indeed, in 1919, the College and its supporting journals extended the notion of nurses as the nation's mothers to shape work conditions:

Does any service with aims like ours measure its labour by time? Is sacrifice to be denied us? What of the English mother in an average English home? Her hours are countless yet the public seems to regard such as right and proper. Are we not doing woman's work too?<sup>538</sup>

One of the consequences of linking maternal qualities with the image of the nurse was

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<sup>536</sup> *BJN*, 6 November 1920.

<sup>537</sup> *The Nursing Mirror and Midwives Journal*, 5 July 1919, p.258.

<sup>538</sup> *The Nursing Mirror and Midwives Journal*, 5 July 1919, p.258.



to obscure the perception of nursing as a health hazard. Just as mothers cannot go off duty or report in sick because of a cold, so nurses were expected to show the same level of self-sacrifice even when work conditions threatened their health.

Critics argued that a reduction in hours would have a detrimental effect on both the continuity of care and the nurse-patient relationship. The idea that nurses should care for their patients day and night, refusing to go off duty, had become part of the 'new' nurse's image during the struggle to gain professional status. *The Nursing Mirror* used this idea to lobby against the introduction of eight-hour shifts:

The patient seems to have been quite lost sight of, and the eight-hour shift would be greatly to his disadvantage. It would be impossible to keep pace with changes in his condition.<sup>539</sup>

The College's negative reaction to the proposed Hours of Employment Bill is surprising in view of the fact that it had recommended a forty-eight hour week a year earlier. As a result of its survey in April 1919 enquiring into nurses' hours and pay, the College found that nurses' average weekly hours varied between fifty-two and seventy-one for day duty shifts and fifty-nine and eighty-four for night duty.<sup>540</sup> It recommended the introduction of a forty-eight hour week in its *Report of the Salaries Committee* (April 1919). When asked to respond to the proposed Hours of Employment Bill in 1920, the College changed its mind, perhaps resenting state interference and the implications this would have on its standing as a self-regulating, autonomous organisation. Some members argued that legislation on working hours would put 'the profession on the same basis as manual labour ... in contradiction to the highest instincts of the profession.'<sup>541</sup> Despite the Registration Act, some nurses continued to worry about nursing's professional identity and this proved an obstacle to improving work

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<sup>539</sup> *The Nursing Mirror and Midwives Journal*, 5 July 1919, p.258.

<sup>540</sup> RCN, *Report of the Salaries Committee on Salaries and Conditions of Employment of Nurses as submitted to the Council*, RCN/4/1919, April 1919.

<sup>541</sup> RCN, College of Nursing Council Minutes, RCN/2/2, 8 April 1920, Vol. 3, pp. 1-10.

conditions.

Rather than recommending the forty-eight hour week, the College insisted that nurses be included in a 'Special Order' Bill that allowed the Minister of Labour to consider nursing as a unique occupation and set hours accordingly. The College recommended a fifty-six hour week 'taken over a period of four weeks, the time on duty not to exceed ten hours in twenty four hours.' The majority of College members supported this idea indicating their belief that self-regulation was the ideal model for governing working hours. If they had to be subject to state regulation, however, it would be on their recommended terms and not the Government's.

The College was determined that hospital management and matrons retained as much control of work conditions as possible. They opposed the Ministry of Labour's proposal that overtime be paid as extra wages, arguing that management and matrons should still have the right to compensate overtime with extra time off duty at the hospital's convenience, reinforcing the matron's authority over the nurse.<sup>542</sup> The question of working hours compromised the College. It sought self-regulation on the grounds that nurses' needs were unique and incomparable with other groups of workers while also realising that action was necessary to prevent nurses being exploited in the same way as many unregulated industrial workers.

A comparison of the National Union of Trained Nurses' (NUTN) and the Professional Union of Trained Nurses' (PUTN) responses to the Hours of Employment legislation clearly illustrate the College's restricted viewpoint. Both union organisations supported the legislation with the NUTN citing the detrimental effect long working hours had on nurses' health as the reason for its necessity. The Unions suggested that hospitals' economic interests had influenced the College to change its mind. A forty-eight hour working week would mean the employment of extra nurses at an increased cost to hospitals. The NUTN disagreed with the General Nursing

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<sup>542</sup> RCN, College of Nursing Council Minutes, RCN/2/2, 8 April 1920, Vol. 3, pp. 1-10.

Council's (GNC) request to the Ministry of Health that nurses' working hours be regulated under a separate Bill. The experience of dealing with nurse organisations over registration would, the NUTN argued, have deterred the Government from wanting to deal with them as a separate case: 'with the best will in the world the Minister of Health had too much on his hands to bring in another controversial Nurses' Bill.' Exclusion from regulation, the NUTN argued, meant continued economic exploitation whilst inclusion would give nurses 'a lever to compel their employers to deal justly with them.'<sup>543</sup> The Hours of Employment Bill was eventually dropped, to be revived again unsuccessfully in 1924.

## **Unemployment Act of 1920**

The second piece of government legislation intended to affect most groups of workers concerned unemployment insurance. Unemployment had fallen during the War as men were conscripted and large numbers of women had taken their work places. As war ended, a workforce used to official direction compounded difficulties finding employment for homecoming troops. A brief post war boom was followed by rising unemployment. Growing industrial unrest and a fear that unemployment would contribute to the rise of 'bolshevism' may have prompted the Government to introduce the Unemployment Act of 1920. The Act intended to bring a larger section of the workforce, including nurses, into the remit of compulsory unemployment insurance. Agricultural and domestic workers were exempt as it was thought there was little unemployment in these groups.

Nurse organisations, unusually united in agreement that legislation would undermine their professional status, decided to vote against the Bill. Unlike Addison's approach to the Registration Bill, where nurse organisations were consulted separately in order to prevent disagreement, the Minister of Labour held a joint enquiry attended

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<sup>543</sup> *BJN*, 18 December 1920, p.341.

by representatives from the College of Nursing Ltd, Royal British Nurses' Association, National Union of Trained Nurses, British Hospitals Association and Queen Victoria Jubilee Institute.

Bedford Fenwick, representing the Royal British Nurses Association, interpreted the act as a threat to professional status. Were unemployed nurses, she asked, 'to tramp daily in queues to the Employment Exchanges with 'chars' and other out-of-work women for a weekly wage of 12s? It is scandalous that the law provides that they should do so.'<sup>544</sup> On the one hand, her response suggests a sense of superiority and snobbery that nurses were a class above other groups of women workers but it also shows nurse leaders' determination to raise their professional status by creating social boundaries.

What was strikingly absent from nurse organisations' discussion of the Unemployment Act was finance provision for unemployed nurses. Charities, including private convalescent and holiday funds, claimed in the press that it was common for nurses to be unemployed due to ill health. There seems to be little other evidence, however, that unemployment was high: in 1922, 701 nurses out of nursing population of 122,804 had registered as unemployed although it is unknown whether these were trained nurses.<sup>545</sup> E. Nicholls, secretary of the NUTN, suggested that old age accounted for the majority of unemployment: they 'may be no longer young, this fact makes it increasingly difficult for them to obtain work ... Few matrons would accept a nurse over forty.'<sup>546</sup> Several commentators considered the physical hardship of nursing unsuitable for those over the age of thirty-five when women had 'usually lost adaptability and the powers of readily receiving new impressions.' The life expectancy for women in 1920 was approximately fifty-five years of age.<sup>547</sup> A. Hughes suggested

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<sup>544</sup> 'An unjust tax', *BJN*, 26 March 1921, p.177.

<sup>545</sup> Female and Male Nurses in Full-Time Equivalents, 1921, Census of Population, quoted in Abel-Smith, *A History of the Nursing Profession*, p.257.

<sup>546</sup> *BJN*, 19 November 1921, p.324.

<sup>547</sup> J. Hicks and G. Allen, 'A Century of Change: Trends in UK Statistics since 1900',

that younger women were more suitable to senior nursing posts not only because of their adaptability but also their willingness to work harder and longer.<sup>548</sup> How older women funded periods of unemployment was seemingly of little concern to either the College or the RBNA. As will be discussed later, the College had set up a pension fund but few nurses received annuities.

Nurse organisations were determined to convince the Minister of Health that ‘there was little unemployment amongst hospital nurses.’ Sick nurses were already insured under the National Insurance Act but, according to the RBNA, did not always apply for benefit ‘because they found the panel system irksome.’<sup>549</sup> Digby notes that the panel system had evolved into a two-tier system of health care with panel patients frequently queuing at the back door to enter cramped surgeries whilst paying patients chose personally convenient times for appointments, were greeted by a maid and waited in a comfortable room for an extended appointment with the doctor.<sup>550</sup> Some nurses complained that they did not like being cared for by provincial panel doctors, preferring London specialists, and resented disclosing personal information to insurance companies.<sup>551</sup> Class assumptions, according to Digby, shaped conversations about whether working class panel patients were second-class citizens compared to middle class paying patients. This helps explain the RBNA’s comment: middle class nurses may have objected to participating in a scheme they considered only suitable for the working classes.

In an attempt to convince the Ministry of Labour not to include nurses in the Unemployment Bill, the College of Nursing organised a referendum of its members.

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House of Commons Library Research Paper, 21 December 1999,  
<http://www.parliament.uk>

<sup>548</sup> A. Hughes, ‘Nursing as a Vocation’ in A. Munro, *The Science and Art of Nursing the Sick*, Glasgow: Maclehouse, 1873, p.95.

<sup>549</sup> *BJN*, 15 January 1921, p.37.

<sup>550</sup> A. Digby, *The Evolution of British General Practice, 1850 -1948*, Oxford: Oxford University Press, 1999, pp.318-322.

<sup>551</sup> *BJN*, 12 April 1913, p.309.

Nurses were asked only one question, framed to support the College's viewpoint: 'Do you wish the College to use every effort to get, if it is possible, nurses excluded from this Act?'<sup>552</sup> The College lobbied hospital matrons to rally 'a sufficiently strong protest' against the legislation and instructed collection of only the signatures of those nurses 'who wish to be exempt ... under this Act.'<sup>553</sup> No mention was made of recording the signatures of those nurses who supported it. Cox Davies, representing the College, reported to the Minister of Labour that eighty per cent of the 3,000 nurses questioned were opposed to inclusion.<sup>554</sup> The College encouraged nurses to lobby their MPs and the Minister of Labour to support an amendment making a special case for nurses. The amendment was successful and the new Act of April 1922 excluded nurses.

In summary, the Government supported nurse registration realising the advantages that could be gained from an easily identifiable workforce to its newly created health reforms. The rivalry and disagreement between nurse organisations not only intensified each organisation's desire to achieve overall control of the registration process and governing body but also allowed the Government to step in and control the agenda. Addison's determination to achieve the passage of the Registration Bill on his own terms excluded consideration of work conditions. The Government's reluctance to deal with nurses' working hours may be explained by their intention to include nurses in legislation aimed at regulating the hours and unemployment benefit of all groups of workers. Whilst the Central Committee for the State Registration of Nurses supported nurses' inclusion in the Hours of Employment Act on the grounds that it would improve nurses' 'spirituality', the College of Nursing argued that regulation of hours would detract from notions of self-sacrifice and motherhood, qualities it continued to believe

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<sup>552</sup> RCN, Letter from the College of Nursing Ltd. to Members, RCN/1/1/1918/2 undated.

<sup>553</sup> RCN, Letter from M.S. Rundle, Secretary to the College of Nursing to hospital matrons, RCN/1/1/1918/2, 12 October 1921.

<sup>554</sup> 'Nurses unanimous in their desire to be excluded from the Unemployment Insurance Act, 1920', *BJN*, 15 January 1921.

essential to the 'ideal' nurse. Government's plans to include nurses in the same category as domestic workers in its Hours of Employment Act, 1919 and Unemployment Act of 1920 provoked outrage amongst nurse organisations. Since 1860, nurse leaders' campaign for status had sought to draw a boundary between the image of the 'old' domestic, working class nurse and the 'new' middle class, professional nurse. Despite the affirmation of professional status in the form of the Registration Act, it seems the Government continued to view nursing as a form of domestic service.

### **The Politics of Nurses' Occupational Health**

Concern about the effect poor pay and long working hours were having on nurses' health attracted the attention of the National Council of Women (NCW) in 1919. Interest in nurses' health by a non-nursing organisation not only raised public awareness of poor work conditions but focussed attention on the role of the College of Nursing. The National Union of Women Workers (NUWW) was formed in 1895, changing its title in October 1918 to the National Council of Women. Led by middle class women, the NCW took up issues that could be considered their natural domain claiming them as areas of women's expertise. Their concern for nurses' health was interpreted by the College of Nursing as an implicit challenge to its effectiveness in improving work conditions.

Recent studies suggest that women did not enter national politics in large numbers once women over thirty obtained the franchise in 1918 though they were politically active in other ways.<sup>555</sup> Some women believed that obtaining the vote was only part of the process to equality in citizenship. During the 1920s a number of groups formed including the National Federation of Women's Institutes, the Young Women's

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<sup>555</sup> S. Innes, 'Constructing Women's Citizenship in the Interwar Period: the Edinburgh Women Citizen's Association', *Women's History Review*, **13** (4), December 2004, pp.621-647.

Christian Association and the Mother's Union with the aim to educate and further women's issues. Such groups became an accepted form of political involvement for women who did not want to engage in the radical feminist politics of the pre war years.<sup>556</sup> The NCW reflected this approach to politics: its Council meeting in 1918 discussed a diverse range of subjects including hostels for mothers and babies, equal pay and laws of naturalisation.<sup>557</sup> Several nurse organisations, including the College of Nursing, had close links with the NCW and sent representatives to its meetings and conferences. The College was often invited to respond to NCW resolutions and commented on a wide range of subjects including women police patrols and infant protection.<sup>558</sup> In 1918, such were the close political ties between the two organisations that the College Council placed its 'aims and objects' before the NUWW.<sup>559</sup> The issue of nurses' occupational health, however, was to prove divisive.

In February 1919 the NCW invited the College of Nursing as well as the Royal British Nurses' Association, the Poor Law Matrons' Association and the British Medical Association to a preliminary conference with the intention of forming a joint committee to enquire into nurses' hours and pay.<sup>560</sup> The initiative for this conference came from Dr Herbert Crouch, a supporter of the National Union of Trained Nurses and medical adviser to the Nurses' Co-operation for many years. Crouch saw many nurses suffering from chronic complaints that he believed were due to the hardships they experienced as probationers. He offered the NCW £500 to cover their committee's costs.<sup>561</sup> Although the College had already decided to set up its own committee to investigate nurses' work conditions, 'in order to avoid overlapping' it suggested 'co-

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<sup>556</sup> McGann et al., *History of the Royal College of Nursing*, p.56.

<sup>557</sup> RCN, Report of the Council Meeting and Conference of the NUWW, RCN/29/2/3, 8-10 October 1918.

<sup>558</sup> RCN, College of Nursing Council Mins, RCN/29/2/3, 21 June 1918.

<sup>559</sup> RCN, College of Nursing Council Mins, RCN/29/2/3, 21 June 1918.

<sup>560</sup> RCN, College of Nursing Council Mins, RCN/29/2/3, 20 February 1919.

<sup>561</sup> RCN, Correspondence of Arthur Stanley, RCN/1/1/1919/1, March 1919; S. McGann et al, *A History of the Royal College of Nursing*, pp.56-57.



operation between the two bodies.’ Agreement was reached to work together; the College argued that ‘it [seemed] a waste of effort for two committees to be working independently.’<sup>562</sup> Clearly appreciating the limited political weight its own findings would carry in comparison to the NCW’s, the College stated:

any recommendation for the economic betterment of nurses would have greater weight with the public, and even with the nurses themselves, if coming from a Committee composed largely of persons who are recognised authorities on women’s work and welfare.<sup>563</sup>

Criticism in both the nursing and national press that the College was dominated by the financial interests of employers had undermined its authority.

Within weeks of deciding to work together, and much to the annoyance of Ogilvie Gordon the NCW’s President, the College changed its mind and returned to the idea that it should hold its own independent inquiry. Gordon complained that ‘this overlapping is to be regretted since the NCW is, as a neutral body to which the various nursing associations are affiliated, in a unique position to conduct such an inquiry.’<sup>564</sup> Disagreement arose over the composition of the joint committee: the College was adamant that it should consist of women whose names carried political weight and include only a small number of nurses, while the NCW proposed that the committee comprise of two representatives from each nursing organisation. As justification for its withdrawal, the College noted that its ‘Salaries Committee had already made such progress with its enquiries and so enlarged its personnel that any suggestion of merging its work, and membership in your Special Committee has become more than ever

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<sup>562</sup> ‘Nurses’ Hours and Pay’, Letter from M.M. Ogilvie Gordon, President of the National Council of Women, *The Times*, 25 March 1919, p.10.

<sup>563</sup> RCN, Letter from M.S. Rundle, Secretary to the College of Nursing Ltd to M.M. Ogilvie Gordon, 4 February 1919, reported in College of Nursing Council Mins, RCN/29/2/3, 20 February 1919.

<sup>564</sup> *The Times*, 25 March 1919.

impracticable.<sup>565</sup> Having decided to hold its own enquiry, the College planned to introduce its Registration Bill in the immediate future, hence its reluctance to become closely involved in any potentially controversial debates. Keen to distance itself from any issues which demanded a trade union like response and sensitive to develop the professional status of nurses, the College adopted distinctly conservative strategies to deal with the problem of nurses' work conditions.

One possible reason for the College's cool attitude is that it wanted to distance itself from NCW politics. McGann points out that whilst the NCW was not an overtly political group, its ten-person committee consisted of former suffragists including Elizabeth Haldane and Rosa Barrett.<sup>566</sup> The NCW's aim 'to promote the civil, moral and religious welfare of women, to focus and redistribute information likely to be of service to women workers' certainly suggests a feminist agenda but its intention to expand its membership to include men in 1918 implies that its motives were not radical. In a review of its constitution the word 'women' was eliminated so that societies governed by men with women members were eligible for affiliation.<sup>567</sup>

Political lobbying on behalf of the health of women workers had always been one of the NCW's main interests. In 1913 its concern for women factory workers prompted a campaign to lobby government departments about the 'totally inadequate number of women factory inspectors' whose work was of 'great value and importance ... in respect of the safety and welfare of women engaged in industry.'<sup>568</sup> The NCW's wide-ranging experience of investigations into women workers' health put it in a good position to examine nurses' health and meant its findings would carry authority.

The more likely explanation why the College changed its mind was that it feared that the outcome of a joint enquiry would put it under pressure to take more

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<sup>565</sup> Letter from M.S. Rundle, Secretary to the College of Nursing Ltd, to M.M. Ogilvie Gordon, RCN/29/2/3, 12 March 1919.

<sup>566</sup> McGann et al., *History of the Royal College of Nursing*, p.57.

<sup>567</sup> *BJN*, 19 October 1918.

<sup>568</sup> *BJN*, 18 October 1913.

responsibility for improving work conditions. It was keen to retain hospital managements' support, particularly during the process of nurse registration, and was therefore wary of increasing hospitals' financial burden. Whether the NCW deliberately timed their enquiry to coincide with the gathering pace of nurse registration is unclear but it put the College in a difficult position. Both organisations simultaneously sent separate questionnaires to hospitals enquiring into nurses' work conditions. This was the first time that national organisations had investigated the salaries, hours and accommodation of nurses on such a wide scale but the opportunity 'to prove the necessity for a thorough inquiry' was lost.<sup>569</sup> The impact that one large, joint enquiry might have made was limited by being disseminated across two reports.

The rivalry and quarrelling that had dogged the campaign for nurse registration continued although in this case a non-nursing organisation was involved. The NCW blamed the nursing press affiliated to the College for starting a campaign 'urging matrons not to answer the NCW questionnaire both on account of its 'inquisitorial' character and because the College of Nursing had already sent out their questionnaire.'<sup>570</sup> Bedford Fenwick opposed the College and joined the NCW's committee, using *The British Journal of Nursing* to further their aims.

The College of Nursing gained the upper hand by organising a much bigger survey than its rival but with a narrower scope of investigation. It sent out two questionnaires covering a broad spectrum of care.<sup>571</sup> Of the 1,297 copies of questionnaire one sent out, 514 replies were received and of the 569 copies of questionnaire two, 240 replies were received. The NCW sent 580 questionnaires to general hospitals and received only 176 replies. This poor response was attributed to

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<sup>569</sup> *BJN*, 27 September 1919.

<sup>570</sup> *BJN*, 27 September 1919.

<sup>571</sup> Question 1 to general hospitals, Poor Law institutions, epileptic colonies and dispensaries and Question 2 to nursing institutions, convalescent homes, medical officers of health, works and collieries and consumptive sanatoria. RCN, The College of Nursing, *Report of the Salaries Committee on Salaries and Conditions of Employment of Nurses*, RCN/4/1919, April 1919.

busy matrons being faced with two detailed questionnaires. The College of Nursing gained two fold; not only did it retain control of its agenda but also the fact that it had significantly more replies on which to base its report increased its authority.

The NCW questionnaire was designed to establish a link between long hours, inadequate rest, low salaries, unsatisfactory accommodation, medical care facilities and the poor physical health of nurses.<sup>572</sup> In comparison, the College maintained a narrower focus of investigation. Rather than exploring links between ill health and poor work conditions, it concentrated on measuring the number of hours worked, time allocated to meal breaks, the quota of staff on duty, type of accommodation and salary. Only two lines of its twenty-seven page final report referred directly to nurses' health and that was in connection with how to deal with ill nurses on duty: 'definite steps should be taken to ensure nurses not going on duty when unfit to do so' but how this was to be achieved was not specified.<sup>573</sup>

Unlike the College of Nursing, the NCW attempted to measure the extent of ill health amongst nurses and its causes. Respondents were asked what the average percentage of sickness amongst nurses excluding epidemics was, the average number of breakdowns in the first, second and third years of training and the most common causes of sickness.<sup>574</sup> The term 'breakdown' referred to an episode of illness that caused the nurse to take time off work. Whether the College refused to work with the NCW because they anticipated that its broader questionnaire would uncover high levels of ill health is unknown. If so, its fears were unfounded: the NCW found that sickness levels were lower amongst nurses than expected. In fact, levels were 'far below that which is taken by insurance societies as a general rate to be expected amongst healthy women of

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<sup>572</sup> NCW, 'Report of the Special Committee on the Economic Position of Nurses, *BJN*, 27 September 1919, pp. 189-194.

<sup>573</sup> RCN, College of Nursing, *Report of the Salaries Committee on Salaries and Conditions of Employment of Nurses*, RCN/4/1919, April 1919, p.3.

<sup>574</sup> NCW, 'Report of the Special Committee on the Economic Position of Nurses', *BJN*, 27 September 1919, p.192.

corresponding age.’ The NCW blamed their findings, which they claimed were not a true depiction of nurses’ health, on hospitals’ poor record keeping. More than half of responding hospitals were not able to identify the common causes of sickness amongst its nurses because of a lack of records.<sup>575</sup>

Hospitals’ poor recordkeeping regarding nurses’ health illustrates how new the concept of occupational health was to some sections of the workforce. The growth in health and welfare measures for factory workers during the First World War, mentioned earlier, had not reached the nursing profession. Why hospitals did not adopt a similar approach is unclear. Possible explanations are that few voluntary hospitals could afford to implement workers’ welfare schemes. Because there was an abundant supply of nurses following the War, supplemented by an influx of VADs, hospitals were able to replace sick nurses with healthy recruits and did not have to improve nurses’ welfare or work conditions as a way of attracting or retaining recruits. The next two chapters argue that a shortage of nurses in the 1930s and 40s prompted hospitals to reassess and improve their health care offered to nurses. Finally, nurse organisations’ reluctance to raise the issue of poor work conditions during the campaign for registration, may have allowed hospitals to claim ignorance of nurses’ health problems.

Inadequate nurses’ accommodation, identified as a health risk in 1890, continued to be considered a cause of poor health. Although the College of Nursing’s report discussed the issue, it did not make a direct link with its detrimental effect on nurses’ health. According to the NCW, overcrowding remained a problem with many nurses sharing bedrooms and bathrooms thus lacking good quality of air: all bedrooms were recommended to have a window opening direct ‘to the outside air.’ High standards of personal hygiene were encouraged to reduce the risk of contracting infections. The NCW recommended that nurses should take a daily bath in a bathroom

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<sup>575</sup> NCW, ‘Report of the Special Committee on the Economic Position of Nurses’, p.189.

not shared by more than four people with a maximum time of 15 minutes allowed per nurse.<sup>576</sup>

Only one large hospital out of the 176 who responded to the NCW survey had kept an accurate record of the average number of ‘breakdowns.’ This hospital recorded a high sickness rate with ‘one in every fifteen nurses always off duty owing to ailment.’ Twice as many probationers broke down in the first year of training than the second, and episodes of illness were more numerous in the second than the third. The NCW concluded that third year probationers ‘represented the very strongest’. The number of breakdowns was much higher than it should be, the NCW argued, considering the high standard of health required to pass the medical examination at the start of training.<sup>577</sup>

Despite the evidence from their survey to the contrary, the NCW concluded that

Under the present system of training at nearly all hospitals an alarming percentage of Nursing Students are disabled, and of those who complete their training an even higher percentage contract permanent physical troubles, with the result that a large number of women are left with decreased powers of useful work, and, incidentally, with their position as potential mothers seriously prejudiced.<sup>578</sup>

For the most part, the NCW’s report referred to nurses’ physical health in vague, generalised terms using language such as ‘break down’ or ‘below the ideal.’ Constipation and a potential risk to future reproductive health were the only two specific health risks identified. The report drew the rather obvious conclusion that constipation was caused by a lack of toilets and insufficient time to go to the lavatory between breakfast and reporting on duty rather than any scientific research. More

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<sup>576</sup> NCW, ‘Report of the Special Committee on the Economic Position of Nurses’, *BJN*, 27 September 1919, p.190.

<sup>577</sup> NCW, ‘Report of the Special Committee on the Economic Position of Nurses’, p.192.

<sup>578</sup> NCW, ‘Report of the Special Committee on the Economic Position of Nurses’, p.189.

importantly, however, the report linked the nature of nurses' work and system of training with a risk to reproductive health.

The NCW's claim that nursing jeopardized women's ability to have children was made without any reference to scientific evidence of either miscarriage or infertility problems. Indeed, its questionnaire did not investigate nurses' gynaecological histories. The claim challenged one of the foundations of Victorian nursing ideology, the idea that women's natural role as mothers qualified them to nurse. This chapter has already discussed how such ideology continued to be promoted by the College of Nursing and its supporters as an argument why nurses' working hours should remain unrestricted. The NCW suggested that nursing 'seriously prejudiced' student nurses' position as 'potential mothers.'<sup>579</sup>

The idea that women's work threatened their reproductive ability was not new. The first chapter of this thesis (pp.27-28) notes the gendered conclusions of debates and investigations into the occupational health of other female groups of workers which linked the effects of work with reproduction.<sup>580</sup> Harrison argues that a view of women's physical constitution as 'ill suited to the rigours of employment utilised the idea of biological susceptibility in relation to reproductive functioning to deny women participation in the public domain.'<sup>581</sup> While this argument may have applied to enquiries into lead-poisoning in female pottery workers or matchmaking, it is unlikely that an organisation like the NCW would have proposed limits to women's role in public life.

Why the NCW suggested that nursing was a reproductive risk is debateable. Many aspects of nursing stood in direct opposition to those occupations identified as such a risk at the end of the nineteenth century.<sup>582</sup> Chapter one discussed how

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<sup>579</sup> NCW, 'Report of the Special Committee on the Economic Position of Nurses', p.189.

<sup>580</sup> See Harrison, *Not only the 'Dangerous Trades'*, p.3.

<sup>581</sup> Harrison, *Not only the 'Dangerous Trades'*, p.101.

<sup>582</sup> C. Malone, 'Gendered Discourses and the Making of Protective Labor Legislation in

government scrutiny focused on married, working class women whose employment was said to have a detrimental effect on their domestic and maternal skills. Interest in these women's lifestyles often supposed a level of immorality. In contrast, nursing strove to recruit middle class women, was dominated by middle class leaders and promoted an ideology that emphasised the importance of cleanliness, discipline and moral respectability. It was an occupation made up almost entirely of single women who were subject to strict rules on and off duty. The College of Nursing noted that these rules affected male visitors:

In most hospitals it is the rule that of the male sex only fathers and brothers may be entertained by the Nurses, on no account may a Student call, and it is rarely rendered possible for a male friend to be entertained - that a man should call in the evening is almost unheard of.<sup>583</sup>

Leaders of nurse organisations affiliated to the NCW may have been convinced that registration was finally within their grasp, and buoyed up by confidence from the praise nurses' war work had received, felt it no longer necessary to link the ideology of motherhood with their bid for professional status. The risk of exposing the contradictory nature between maternalism and professionalism diminished. For, as Woolacott notes, professionalism 'meant that women did not define themselves as mothers, that they chose not to stay at home even part of the day, that they had a range of skills and abilities comparable with men's, and that they sought to participate within the masculine public sphere.'<sup>584</sup>

Another reason why the NCW suggested that nursing was a reproductive risk may have been to persuade the state to intervene to improve work conditions. Factory

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England, 1830-1914', *Journal of British Studies*, **37**, April 1998, pp.166-191.

<sup>583</sup> RCN, College of Nursing, *Report of the Salaries Committee*, RCN/4/1919, April 1919, p.11.

<sup>584</sup> A. Woolacott, 'Maternalism, Professionalism and Industrial Welfare Supervisors in World War I Britain', *Women's History Review*, **3** (1), 1994, p.31.



legislation regulating women's work had often been presented as necessary for women's protection, causing widespread agitation and opposition amongst feminist activists.<sup>585</sup> What is interesting is that the NCW, an organisation with feminist interests, presented a case of women's occupational health risk on similar grounds to that which feminists had often opposed. Protective legislation was one of the most important foci of feminist politics outside of suffrage during the late nineteenth and early twentieth centuries.

Neither the NCW's nor the College of Nursing's reports discussed nurses' mental health. The military style discipline favoured by some hospitals was neither criticised nor identified as a cause of nurses' illness. This approach contrasted with that of nursing enquiries in the 1930s and 1940s, which linked strict discipline with nurses' mental health problems (to be discussed in chapter seven). Some commentators, however, had begun to identify a link between discipline and nurses' welfare. For example, in 1920, Dr Comyns Berkely, a gynaecologist and honorary treasurer of the College of Nursing, suggested:

Three and sometimes four years of strict discipline under the rule of another woman, accompanied by hard physical and mental work, an atmosphere of sickness and suffering, a perpetual sense of unnecessary restrictions ... and all the time there lurks around the spectre of fear. For if she thinks for herself and speaks out fearlessly and independently ... she will incur the displeasure of the authorities at the present moment, run the risk of losing her certificate.<sup>586</sup>

Comyns Berkely suggests that senior nurses' discouragement of independent thinking was detrimental to nurses' well being. His idea is similar to that raised by Bedford Fenwick who emphasised the importance of 'spirituality' and character issues to

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<sup>585</sup> Harrison, *Not only the 'Dangerous Trades'*, p.144.

<sup>586</sup> *Nursing Times*, 30 October 1920, p.1264.

support her argument for a reduction in working hours (pp.172-173). This thesis will argue that it was not until the 1940s that similar ideas to Berkely's and Fenwick's began to gain wider popularity. A shortage of nurses and the development of psychometric testing during the Second World War prompted a reassessment of attitudes towards discipline and its effect on nurses' mental health.

Our discussion will show that one of the most significant changes between 1919 and the 1940s concerns responsibility for nurses' mental health. In 1919, the nurse rather than her employer was considered responsible. Matron M. Vivian of Princess Christian's Hospital, Weymouth suggested that it was a nurse's duty to view life through 'rose-coloured spectacles. A gloomy view of life, pessimistic forebodings and an unhealthy conception of her responsibilities is a very poor outlook.' The idea that she should maintain a 'well-balanced mind' was believed to be part of a commitment to duty. The advice for those who could not find happiness from their work was 'to give it up.'<sup>587</sup> Chapter seven will show how ideas changed during the next two decades, placing responsibility on employing hospitals rather than individual nurses.

The NCW's report made little impact on improving the health care of nurses: with far fewer replies than the College of Nursing it was not able to offer an extensive overview of nurses' work conditions. Despite the NCW's previous experience in occupational health campaigns, their report's conclusion highlighting the 'need of drastic revision of the present conditions under which students work' did not produce any significant change.<sup>588</sup> Researching an article for *The Woman's Leader* on nurses' work conditions in 1920, Dr. Herbert Crouch, instigator of the NCW's investigation, was:

curious to know whether the report of the National Council of

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<sup>587</sup> *The Nursing Mirror and Midwives' Journal*, 8 November 1919, p.96.

<sup>588</sup> NCW, 'Report of the Special Committee on the Economic Position of Nurses', p.192.

Women ... had had any effect, he wrote to a large hospital to ask whether nurses' hours of duty had been improved. He was informed that the hours were being investigated but the badminton and tennis clubs had been instituted.<sup>589</sup>

The College of Nursing report confirmed its priority in maintaining the support of hospital management. It sought to convince management that it had no intention of insisting government legislate their recommended scale of salaries. The College's policy was to continue the existing system whereby salaries were set at employers' discretion. Their publication of recommended salaries encouraged hospitals to reconsider their position, as in the case of the South Devon and East Cornwall Hospital who implemented a new scale of salaries in March 1920 but not at the amount recommended by the College.<sup>590</sup> It used its report to promote an image of nurses as disinterested in financial gain per se but worthy of financial reward as a reflection of professional status.

One of the College's most important recommendations made was the introduction of a pension scheme. Hospital nurses had few pension rights. The ill health of retired nurses often featured in emotive newspaper articles to raise money for charity. Indeed, the use of charity money to aid sick nurses was seen as an indication of the College's failure to address nurses' economic problems. In 1920, the editor of *The Daily Telegraph* started a Shilling Fund aimed at raising money from military personnel for sick nurses. Stories of individual nurses were told to encourage donation: the editor argued that 'we feel that were the heartrending cases of misery and want amongst some of our nurses more widely known, there are thousands of people who would give their shillings.' A nurse complained, at a Labour Party meeting in 1920, that *The Daily Telegraph's* 'charity appeal was a poor substitute for justice and was a menace to the economic position of nurses.' Little is known about this nurse's background apart from

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<sup>589</sup> *BJN*, 18 December 1920, p.341.

<sup>590</sup> PWDRO, SDEC Hospital House Com Mins, 606/1/24, 8 November 1919.

her self-description as ‘the nurse Lord Burnham refused to see’: Lord Burnham was Edward Levy-Lawson, owner of *The Daily Telegraph*. From the tone of her report, published in *The British Journal of Nursing*, it is clear that she supported the trade unionists speaking on the meeting’s theme of ‘economics’.<sup>591</sup> Clearly some general nurses considered trade unionism necessary to improve nurses’ financial position.

The College was accused of perpetuating the image of the nurse as an object of charity for its own financial gain. Critics suggested that it was partly funded by the Nation’s Fund for Nurses, a charity set up in 1918 under the War Charities Act, to raise money for sick nurses. According to *The Nursing Times*, the College had appealed to the public to subscribe to the Nation’s Fund by pointing out that nurses ‘were poor, over-worked, underpaid creatures who [could] barely support themselves and had no means of making provision for their old age.’<sup>592</sup> The College’s Chairman, Sir Arthur Stanley, was a member of the Fund’s Management Committee. The Professional Union of Trained Nurses obtained extracts from the Nation’s Fund balance sheets which appeared to show that the College had received £80,635:16s 4d in donations from the Fund during 1919-22. Stanley denied that such money existed.<sup>593</sup>

Questions were raised doubting the College’s motivation to improve nurses’ salaries if their funding depended on the image of the nurse as a victim in need of charity. Bedford Fenwick argued ‘a huge charity fund, especially one administered under the influence of employers, tends to lower the standard of pay and to encourage an inevitably dependent spirit.’<sup>594</sup> In its defence, the College argued that it was ‘working hard to obtain fair pay for nurses but in the meantime it [had] done magnificent in helping many old or sick nurses who would otherwise have drifted to the poor law infirmary or even the workhouse for maintenance.’<sup>595</sup>

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<sup>591</sup> *BJN*, 28 February 1920, p.132.

<sup>592</sup> *The Nursing Times*, 15 November 1919, p.1217.

<sup>593</sup> *BJN*, August 1924, p.190.

<sup>594</sup> *BJN*, 21 February 1920, p.115.

<sup>595</sup> *The Nursing Times*, 15 November 1919, p.1218.

In 1919, the College recommended that a superannuation fund be set up through the Royal National Pension Fund. Sir Cooper Perry, one of the three founding members of the College, was also a member of the Fund's Council. Despite the Fund's financial success (it had invested funds of £2,160,912 in 1921) only 2,891 nurses received annuities. Although membership had increased in 1920, few nurses could afford to continue paying their premiums. As a result, over 3,000 nurses cashed in their policies between 1918-21. The Fund admitted, at its AGM in 1921, that a pension 'average only 10s per week' was only a 'small addition to an official pension' and that for many nurses there was no alternative to 'accept weekly doles or end their days in the workhouse.'<sup>596</sup>

## **Conclusion**

In spite of the hope raised by its advocates, the Registration Bill did not improve nurses' work conditions or address issues related to nurses' health. The bitter rivalry and disagreement between nurse organisations, which characterised the campaign for registration, intensified in 1919 as each fought to achieve overall control of the registration process and its governing body, the General Nursing Council. This history of disagreement and the College and Central Committee's failed attempts to introduce their own bills of registration, allowed Addison, Minister of Health, to gain control of registration's agenda and exclude linked economic benefits. Such was nurses' determination to gain professional status, that they accepted his terms. Addison was aware of nurses' poor work conditions but saw no advantage in linking improvements in work conditions to registration. His aim was to have a list of trained, competent nurses that could aid the organisation of the newly created Ministry of Health. Any expectations that registration would automatically lead to improved work conditions

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<sup>596</sup> The Royal National Pension Fund for Nurses, *Report of the Thirty-Fourth Annual General Meeting*, RCN/26/6/23, 23 June 1921, p.2.

were squashed by government from the outset.

The Government's decision to prohibit discussion of economic conditions in connection with registration may have been driven by their intention to include nurses in legislation aimed at improving work conditions for all class of workers. Nurse leaders' refusal to cooperate can be partly understood in class terms. It could be argued that elitism, social status and a sense of superiority shaped nurse leaders' belief that nurses should not be bracketed with working class women who worked as domestics for fear that it would undermine their newly gained professional status. However, membership of a professional occupation involves more than gaining a registration certificate and these nurse leaders were determined to belong to a group with socially defined boundaries. Although registration had given trained nurses the credentials to claim professional status, nurse leaders were concerned with the occupation's social standing and the need to demark its boundaries and discriminate 'insiders' from 'outsiders'.

The College of Nursing did not consider improvements to work conditions a priority. Its determination to be a self-governing organisation compounded with its concern not to appear like a trade union saw nurses excluded from early state efforts to improve the lot of workers. The College also wanted to retain voluntary hospitals' support, leading it to oppose the imposition of standard scales of pay and working hours. It continued to uphold the notion of self-sacrifice and dedication to duty not only as necessary qualities to nurse but also as justification for the length of working hours and the maintenance of adequate standards of patient care. Criticism that it was partly funded by perpetuating an image of the nurse as an object of charity undermined its authority to investigate nurses' health. Its refusal to form a joint enquiry with the National Council of Women was not because it wanted to distance itself from the NCW's increasingly radical politics. The NCW had not been radicalised but was

actively moving towards a position of sexual equality within its membership. The more likely explanation is that the College did not want to be drawn into any contentious issues at a time when the question of registration hung in the balance, particularly as the Minister of Health's determination to prohibit economic improvements from registration's agenda made the issue politically sensitive.

The National Council of Women's interest in the occupational health of nurses in 1919 was prompted by concern about the effect poor pay and long working hours were having on nurses' health. The College of Nursing perceived the NCW as a threat to its powerful position in dictating how the health risk attached to nursing should be dealt with. A power struggle ensued as both organisations investigated nurses' work conditions. An opportunity to investigate nurse's health on a national scale by a well-respected body with wide political connections and experience of other investigations into the health of women workers was lost. The College emerged the victor in so far as it received more replies to its questionnaire and was able to control a narrow agenda of enquiry that did not connect poor work conditions with health problems.

The most interesting aspect of the NCW's report was its claim that nursing posed a potential risk to motherhood. The idea that nursing damaged women's ability to reproduce challenged one of the central images of late Victorian nursing ideology that women's natural role as mothers qualified them to nurse. The notion that work carried a reproductive risk had been raised before with other occupations but only in connection with married, working class women, who, it was argued, lacked domestic and maternal skills and led immoral lifestyles. What was new was the suggestion that an occupation, perceived to be composed of middle class, single women with a superior morality, posed a similar risk. The NCW, an organisation with feminist interests, was typical of feminist groups who had often opposed government intervention on grounds of women's reproductive vulnerability. Their finding suggests that those nurse leaders

affiliated to the NCW felt it no longer necessary to link the ideology of motherhood with their bid for professional status.

The development of an occupational health service for ammunition workers during the First World War did not create interest in the health of nurses. The NCW survey demonstrated that nurses continued to work long hours, were poorly paid and lived in overcrowded conditions. Although it found the rate of nurses' sickness to be better than the average woman in the general population, a fact blamed on hospitals' poor record keeping rather than a true picture, their report suggested that there was considerable room for improvement in factors contributing to nurses' health. Voluntary hospitals' limited finances and continued power to set their own standards of work plus nurse organisations determination to belong to a self governing profession explain why nurses' occupational health care began to fall below the standard offered to workers in private industry.



## CHAPTER SIX

### **“The disease which is most feared.”<sup>597</sup> The Interwar Years: the problem of tuberculosis and its threat to nurses’ health 1930-1948**

In 1945, the King Edward’s Hospital Fund’s review of nurses’ health concluded that the problem of tuberculosis amongst general hospital nurses was of such urgency that immediate recommendations were needed to reduce the risk.<sup>598</sup> This chapter examines why tuberculosis was perceived as a major threat to nurses’ health during the 1930s and 1940s and the effect this threat had on the development of an occupational health service for nurses. One of the central arguments of my thesis suggests that nurse leaders attached little importance to nurses’ health problems during their campaign for registration (1890-1919) as a tool to achieve professional status. Hope that registration would bring improvements to work conditions was short lived and nurses’ health received little attention during the early 1920s. From 1925 onwards, however, a number of national and international studies identified tuberculosis as a serious occupational health risk for general nurses who were believed to be at a higher risk of contracting TB than their sanatoria counterparts, particularly in their first year of training. Although the medical press published the results of these studies, they initially made little impact. It was the chronic shortage of nurses throughout the 1930s and 1940s that created a sense of urgency, stimulated further research and propelled the problem of TB amongst nurses into wider debates which related illness not only to the physical environment and regime of nursing but also to nurses’ social background.

We now think of TB as a disease caused by an infection with the bacteria *Mycobacterium tuberculosis*. The HIV epidemic and poverty explain TB’s re-

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<sup>597</sup> G.S. Erwin, *Tuberculosis and Chest Disease for Nurses*, London: J & A Churchill, 1946, p.142.

<sup>598</sup> King Edward’s Hospital Fund for London, *Memorandum on the Supervision of Nurses’ Health For consideration by hospitals*, London: Geo. Barber & Son Ltd, 1945, p.7.

emergence in the last decade in both developed and developing countries.

Malnourishment, health work, silicosis and long-term drug or alcohol abuse are also known to increase the risk of disease.<sup>599</sup> Between 1930-1948, however, understandings of tuberculosis were related to class, gender, fatigue and mental stress, poverty and the urban environment. Historians are concerned how Koch's discovery in 1882 that consumption was a contagious disease with a specific bacterial cause, rather than a constitutional condition with hereditary origins, shaped understandings of TB.

Worboys suggests that significant continuities in the medical understanding of consumption persisted after Koch's discovery. Although acceptance that tubercle bacillus played a role in the disease grew rapidly, uncertainty of why most infected people remained healthy allowed a complex series of debates to flourish which Worboys argues became less rather than more settled over time. He suggests that the 'dominant seed and soil metaphor' allowed constitutional notions to be refashioned in terms of the vulnerability of the human 'soil'. The seed and soil metaphor was central to the reconstruction of tubercular aetiologies and pathologies because it enabled clinicians to square the contradictory views of pathologists, clinicians and Medical Officers of Health.<sup>600</sup> Worboy's explanation offers a way of understanding the debates surrounding nurses' susceptibility to TB during this period. Conversations about nurses' health questioned why a significant number of nurses in close contact with the disease failed to be infected. Their vulnerability to the disease was understood in terms of their gender, class or environmental conditions.

The theme of class was important in shaping general conversations about tuberculosis during this period. Ott traces the cultural transformation of TB in America from 1870. She describes the changing 'layers of meaning' that surrounded its

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<sup>599</sup> C. Hadijichristodoulou, P. Christie and S. O'Brien, 'Pulmonary Tuberculosis and deprivation in Scotland', *European Journal of Epidemiology*, **17**, 2001, pp.85-87.

<sup>600</sup> M. Worboys, *Spreading Germs Disease Theories and Medical Practice in Britain, 1865-1900*, Cambridge: Cambridge University Press, 2000, pp.231-234.

diagnosis, and how, among the middle classes, this ‘most flattering of all diseases’, was, as awareness of the social associations grew in the 1880s, transformed into a disease that was the consequence of acquired or inherited degeneracy and confined to the poor, working class. The demographics of consumptive mortality had been invisible when the disease was understood as an expression of the inner life of upper and middle class white Americans. The linchpin of the change from middle to working class disease, according to Ott, was the new understanding of TB as an infectious disease. It eroded the belief that explained TB in terms of an individual’s constitution and, as a result, TB eventually became an issue of civic order.<sup>601</sup>

After decades of comparative lack of interest, medicine, the state and public health services mobilised a major, coordinated campaign against tuberculosis in Britain from 1900. Bryder suggests that this sudden interest was prompted by concern for ‘national efficiency’ rather than discovery of the tubercle bacillus itself. Whilst the question of who was most likely to contract the disease remained unresolved, there appeared to be certain indisputable trends confirmed by mortality statistics, that TB was a disease of poverty and coincided with poor, working class areas.<sup>602</sup> Commentators disputed which aspects of the lives of the poor were responsible suggesting overcrowding, insanitary conditions, malnourishment or ‘bad habits’ as possibilities. Bryder demonstrates that having TB often entailed a stigma tantamount to a crime: TB patients were isolated both physically and morally. Often rejected by family and friends, if they survived they hid their past from insurance companies, employers or spouses.<sup>603</sup>

The causal connection between housing, sanitation, nutrition, race and certain

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<sup>601</sup> K. Ott, *Fevered Lives: Tuberculosis in American Culture since 1870*, London: Harvard University Press, 1996, pp.1-8.

<sup>602</sup> L. Bryder, *Below the Magic Mountain A Social History of Tuberculosis in Twentieth-Century Britain*, Oxford: Oxford University Press, pp.10-13.

<sup>603</sup> Bryder, *Below the Magic Mountain*, p.5.

modes of behaviour were widely studied at the time and more recently by historians.<sup>604</sup> Winter and Bryder dispute the importance of malnutrition as a cause of disease. Winter argues that, during the First World War, the transfer of large populations to urban centres of war production and their concentration in munitions factories as well as a deterioration in housing conditions caused a rise in TB mortality rates rather than malnutrition.<sup>605</sup> Whilst Bryder agrees that housing and working conditions were important factors, she suggests that malnutrition played a bigger part than Winter gives credit for.<sup>606</sup>

Gender is an important theme of this thesis and initial investigations suggested that it would underpin understandings of why tuberculosis was perceived as a problem for general nurses during this period. Young women's growing susceptibility to TB, indicated by slight increases in the tuberculosis mortality rates for females, aged fifteen - twenty-five, during the First World War and the 1920s, has been explained by a number of factors. According to Buxton and Mackay, writing in 1947, a biological predisposition caused by the fact that 'females tend[ed] to mature earlier than males and the responsibilities of life felt at an earlier age' combined with 'endocrine gland disturbances during puberty' was responsible.<sup>607</sup> Bryder notes how women's emancipation and the change in women's social habits and lifestyle from 1900, particularly their employment in industry and entry into competitive wage earning, were all considered possible causes. Modern life was believed to be damaging to young women of all classes.<sup>608</sup>

The idea that the pace of modern life damaged physical and mental health was not new and links with Hecker's study of overstrain amongst German nurses in 1911,

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<sup>604</sup> Bryder, *Below the Magic Mountain*, p.97.

<sup>605</sup> J.M. Winter, *The Great War and the British People*, London: Macmillan, 1986.

<sup>606</sup> Bryder, *Below the Magic Mountain*, p.6.

<sup>607</sup> O. V. Buxton and P.M. Macculloch Mackay, *The Nursing of Tuberculosis*, Bristol: John Wright & Sons Ltd, 1947, p.10.

<sup>608</sup> Bryder, *Below the Magic Mountain*, pp.120-121.

discussed in chapter three (pp.107-109). Hecker understood nurses' susceptibility to 'overstrain' in terms of an increase in the pace of life. Strain combined with a weakened constitution as a result of enduring poor work conditions led to an increased susceptibility to physical and mental illness. Several commentators during the 1930s and 40s suggested that nurses' physical and mental strain were causal factors in TB.<sup>609</sup>

Notions of class not only shaped understandings of TB during the inter-war years but also shaped conversations about nursing. Rafferty suggests that recurrent 'crises' in nurse recruitment during the 1930s and 40s elevated nursing into an issue of the highest priority.<sup>610</sup> Discourses focused on how to make nursing 'more attractive to women suitable for this necessary work.'<sup>611</sup> The shortage of recruits was linked to an alleged decline in nursing's attractiveness as a career for well educated, and hence almost inevitably, middle class girls.<sup>612</sup> Nursing was assumed to be losing ground to other middle class professions such as business, teaching and social work.<sup>613</sup> Abel-Smith suggests that what was said about education 'may really have been a polite way of making statements about social class.'<sup>614</sup> Nurses, he argues, were now drawn more from the lower middle classes and working classes and less from the upper classes. Recent research suggests that it is unlikely that nursing ever did recruit widely from the middle classes and that competition for nurses in this period was coming from 'low-level white collar posts in the commercial sector - clerks, typists and shop assistants.'<sup>615</sup> This historiography raises several questions: what was the class background of recruits at the case study institutions during the inter-war years and did this affect perceptions of nurses' vulnerability to TB? How did an occupation determined to attract 'suitable'

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<sup>609</sup> Buxton et al, *The Nursing of Tuberculosis*, 1947, p.11.

<sup>610</sup> Rafferty, *The Politics of Nursing Knowledge*, London: Routledge, 1996, p.157.

<sup>611</sup> Lancet, *Final Report*, preface.

<sup>612</sup> Dingwall, *An Introduction to the Social History of Nursing*, p.99.

<sup>613</sup> Rafferty, *The Politics of Nursing Knowledge*, p.148.

<sup>614</sup> Abel-Smith, *A History of the Nursing Profession*, p.153.

<sup>615</sup> Dingwall, *An Introduction to the Social History of Nursing*, p.101; Rafferty, *The Politics of Nursing Knowledge*, p.148.

middle recruits manage the suggestion that its nurses were at risk to a disease associated with the poorer, working classes?

Other reasons than a shortage of 'suitable' recruits have been put forward to explain the recurrent recruitment crises. Several historians, including Abel Smith, have argued that the shortages were caused by an increased demand for nurses: as more acute sickness was treated in hospital so a higher proportion of the nursing profession was required for hospital work.<sup>616</sup> Widespread dissatisfaction over pay and poor conditions of service and, according to Bryder, an increasing fear of tubercular infection, initially in sanatoria and following the Second World War in general hospitals, also contributed to recruitment problems.<sup>617</sup>

Historians have given little attention to the health risk tuberculosis posed to general hospital or asylum nurses. Indeed nursing is almost absent in the historiography of TB. Kirby and Bryder focus attention on sanatoria nurses.<sup>618</sup> Bryder suggests that sanatoria's recruitment problems were due to a lack of professionalism evident by the appointment of unqualified staff to specialist TB posts, the monotonous nature of the work, long hours, poor living conditions and pay, and the isolated location of many of the institutions.<sup>619</sup> To overcome staffing difficulties, some former inpatients joined the nursing staff.<sup>620</sup>

Employment and working conditions had been recognised as important factors in the epidemiology of TB. Excessive TB rates in the boot and shoe trade, investigated by the Medical Research Council (MRC) in 1915, were found to result from the failure to attract robust workers and a lack of ventilation. Other industries with high TB rates

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<sup>616</sup> Abel-Smith, *A History of the Nursing Profession*, p.120; Rafferty, *The Politics of Nurse Education*, p.141.

<sup>617</sup> Dingwall et al., *An Introduction to the Social History of Nursing*, p.98; Bryder, *Below The Magic Mountain*, p.241

<sup>618</sup> S. Kirby is currently researching a HEFCE funded project at UWE titled 'Contact, contagion and communication: The Role of the Nurse in relationship to Tuberculosis (TB) 1930-1970.'

<sup>619</sup> Bryder, *Below the Magic Mountain*, p.172.

<sup>620</sup> Ott, *Fevered Lives*, p.113.

were those with pneumoconiosis risk, which predisposed workers to tuberculosis.

Discourses concerning the reasons why rates were so high often focused on the personal habits and customs of employees, supporting the idea that TB was a social problem.<sup>621</sup>

This chapter will examine whether TB was considered a health problem among nurses at The London Hospital, which had no recruitment problems throughout the 1930s and 1940s, compared with the South Devon and East Cornwall, which recorded frequent nurse shortages. It examines how these hospitals cared for tuberculous nurses and questions whether treatment was influenced by either hospitals' ability to attract staff or the nurse's seniority. It also asks whether nurses' illness, particularly TB, contributed to high wastage rates which remained between twenty-eight and thirty-two per cent nationally.<sup>622</sup> Having considered the historiography, our discussion will first focus on attitudes towards nurses' risk of contracting TB before 1925.

### **TB not considered a health risk to nurses 1890-1924**

Until the mid 1920s, the general consensus amongst doctors was that the disease posed little threat. This opinion was based on the work of Dr. Theodore Williams of the Brompton Hospital for Consumption who published two influential studies in 1882 and 1909. Williams examined the incidence of TB amongst all resident staff at the Brompton from 1848 to 1888, concluding that TB amongst nurses was more likely to be hereditary than infectious. Koch's discovery in 1882, he argued, prompted doctors and scientists to assess how far phthisis was infectious. Low levels of the disease amongst nursing staff led Williams to identify factors other than contact with infectious patients as important. None of the six matrons, who slept in rooms next to the wards, contracted TB during the study. Between 1842 and 1867, five nurses out of an unknown total died of phthisis, and from 1867-1882, only one nurse out of 101. One death was attributed

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<sup>621</sup> Bryder, *Below the Magic Mountain*, pp.125-127.

<sup>622</sup> Baly, *Nursing and Social Change*, p.165.

to 'poverty after leaving the hospital' and another to the nurse's marriage to a consumptive patient.<sup>623</sup> Of the other groups of hospital workers studied by Williams, dispensers, who had the least contact with patients, showed the highest proportion of consumptives (9.61%) whilst the nurses and female servants, who had the closest contact, had the smallest percentage (0.98%).<sup>624</sup> Resident medical officers (3.76%) and porters (4.18%) were more affected than nurses.

Facing criticism of incomplete data and poor record keeping, Williams updated and confirmed his findings in 1909, which had become influential, entering the standard medical texts of the day as evidence of the comparative immunity of hospital staff from tuberculous infection. Nurses were not included in this later study because of the rapid turnover in staff. Of the few who had been in post for at least twenty years, phthisis was 'almost unknown.' Williams concluded that it was the 'individual strength of constitution, on which mainly depends the question of infection or non-infection ... The healthy individual can defy the tubercle bacillus, the same person depressed by want, impure air or recovering from acute disease cannot.' Williams argued that there was no danger to health workers as long as they took 'proper precautions' with handling sputum.<sup>625</sup> This view continued to attract proponents. A standard American pulmonary text of the 1920s stated: 'there is no danger from the expired air of consumptives. For this reason a tuberculosis sanatorium is probably the safest place one can be so far as the danger of infection is concerned.'<sup>626</sup> William's work was criticised in 1910 by Dr. Edward Squire, senior physician at Mount Vernon Hospital, for basing his results on inquiries into the health of former residents rather than medical examination.<sup>627</sup>

Squire's own fifteen year study (1895-1910) of 167 sisters and nurses from

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<sup>623</sup> *The British Medical Journal (BMJ)*, 30 September 1882, pp.618-619.

<sup>624</sup> *BMJ*, 30 April 1910, p.1040.

<sup>625</sup> *BMJ*, 21 August 1909, pp.435-437.

<sup>626</sup> G. W. Norris, H R Landis, *Diseases of the Chest*, Philadelphia: W B Saunders, 1924 quoted in A.Kent, M.D. Sepkowitz, 'Tuberculosis and the Health Care Worker: A Historical Perspective', *Annals of Internal Medicine*, Vol. 120 (1), January 1994, p. 72.

<sup>627</sup> *BMJ*, 30 April 1910, p.1039.



Hampstead Hospital and five year study of sixty-eight sisters and nurses from Northwood Hospital (both tuberculosis hospitals) concluded that the ‘risk of infection in hospital is not entirely a negligible quantity, though the risk is a small one and affects the nurses and servants of the institution rather than the members of the resident medical staff.’ Unlike Williams’ research, Squire’s study was based on the results of nurses’ medical examination, including X rays, on commencing and leaving employment at the hospital. The majority of nurses included were general hospital probationers who had been seconded for one year of their three-year training course. The risk of infection was from specific nursing tasks, Squire concluded, such as cleaning sputum cups and flasks, handling soiled handkerchiefs, clothing or bedding and not from direct infection from the patient. Contracting infection ‘directly from patients coughing or from general air infection from dried sputum should be practically non-existent in the wards of a well-ordered hospital.’ Squire believed order and discipline to be a key component of infection control. In contrast to future studies, Squire found that nurses with no previous nursing experience were least likely to develop TB.

One of the most interesting aspects of Squire’s study is that it challenged the idea that TB was a disease of the poor. His results suggested that more nurses than servants contracted TB, a result he claimed surprising. To counterbalance this finding, he suggested that more infected nurses than servants applied to work in sanatoria; nurses chose hospitals where the ‘conditions of life were favourable to their condition’ whereas the servants ‘coming from a more ignorant and prejudiced class would avoid a consumption hospital.’<sup>628</sup> Squire’s comment reflects the way physicians’ judgements about workers’ diseases were based on social misapprehensions. Evidence, which can be interpreted as indicating class as a causal factor in TB, may simply reflect the preconceived prejudices of the source’s author.

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<sup>628</sup> *BMJ*, 30 April 1910, pp. 1040-1042.

## A threat to nurses' health 1924-1932

The idea that tuberculosis posed a significant health risk to general nurses was strengthened by the work of Norwegian Dr. Johannes Heimbeck in 1924. *The Lancet* identified Heimbeck as a pioneer in devising an accurate measurement of the risk nurses faced from TB.<sup>629</sup> Heimbeck serially tested 420 student nurses in Oslo on entry into nursing and then annually in order to establish the tuberculin skin test conversion rate as well as the rate of development of active tuberculosis.<sup>630</sup>

The development of tuberculin skin tests in the early twentieth century facilitated Heimbeck's research. Austrian scientist Von Pirquet developed a cutaneous test in 1907. His technique involved dropping tuberculin on cleaned skin that was subsequently scratched: a person who had not yet become infected by the tubercle bacillus experienced no reaction at the site of the scratch. A person who had previously been in contact with the bacillus and infection had taken place, experienced an area of redness and swelling within twenty-four to forty-eight hours. In the same decade, Mantoux introduced the intra dermal technique, allowing the administration of an exact dose of tuberculin with a needle and syringe.<sup>631</sup>

Heimbeck reported that of 420 student nurses studied, 220 were tuberculin-negative at entry but skin tests had converted in 210 (95%) by the end of training.<sup>632</sup> Forty-eight (22%) cases of clinical tuberculosis occurred in this group compared with three (1.5%) among 200 initially tuberculin-positive nurses. By 1946, 105 (37%) of 284 initially tuberculin-negative nurses had developed active tuberculosis. Heimbeck concluded that tuberculous risk was much greater if nurses converted from tuberculin-negative to positive during training than if already positive on entry.<sup>633</sup> The decline in

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<sup>629</sup> *The Lancet*, 23 September 1922, p.713.

<sup>630</sup> J. Heimbeck, 'Immunity to Tuberculosis' *Arch Intern Med*, Vol. 41, March 1928, pp.336-342.

<sup>631</sup> Bryder, *Below the Magic Mountain*, pp.3-4.

<sup>632</sup> J. Heimbeck, 'Tuberculosis in hospital nurses', *Tubercle*, 1936, 18: pp.97-99.

<sup>633</sup> Kent and Sepkowitz, 'Tuberculosis and the health care worker', p.3.

the prevalence of TB in the general population meant many nurses had not experienced contact with the disease and therefore had not developed a resistance. Set against this group of tuberculin-negative nursing recruits was a population of older patients with pulmonary tuberculosis. Writing for the American Hospital Association in 1931, D. Stewart suggested:

At the present time young people in good homes and in careful communities can grow up with scarcely enough acquaintance with tuberculosis infection to build up any defence against it. In a gathering place of tagged and untagged infections, such as a general hospital, such unprotected young people are as sheep among wolves.<sup>634</sup>

A series of studies followed which reached similar conclusions to Heimbeck as sanatoria and general hospital medical staff reported the tuberculin conversion rate and incidence of tuberculosis among nurses and other employees.<sup>635</sup> In 1930, *The Lancet's* interest in TB saw the publication of approximately fifty-three articles on various aspects of the disease and its treatment.<sup>636</sup> Included for publication was Ross's report of the incidence of TB in Canadian nurses, which concluded that 'it seems unquestionable that nurses are especially liable to contract tuberculosis.'<sup>637</sup> Hospitals were, according to *The Lancet*, ignoring the risk nurses faced from the disease:

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<sup>634</sup> D. A. Stewart, 'The general hospital and tuberculosis patients.' *Transactions of the American Hospital Association*, 1931, pp.463-6 quoted in Kent and Sepkowitz, 'Tuberculosis and the health care worker', p.3.

<sup>635</sup> J.A. Myers, 'Tuberculosis among Nurses', *The American Journal of Nursing*, Vol. 32, No. 11. (Nov., 1932), pp.1159-1168; J.S. Whitney, 'Tuberculosis among Young Women With Special Reference to Tuberculosis among Nurses'; *American Journal of Nursing*, Vol. 28, No. 8, 1928, pp.766 -768; E.L. Ross, 'Tuberculosis in Nurses', *Canadian Medical Association Journal*, 1930; 22, pp.347-354; D.W. Jones, 'An inquiry into the incidence of tuberculosis among nurses in a New Zealand Hospital', *Tubercle*, 1933; 29, pp.59-67; E.K.Geer, 'Primary tuberculosis among nurses.' *Am Rev Tuberc.* 1934; 29 pp.88-97.

<sup>636</sup> Rafferty, *The Politics of Nursing Knowledge*, p.238.

<sup>637</sup> 'Incidence of Tuberculosis amongst Hospital Nurses', *The Lancet*, 1930, vol.i, pp.874-875.

It is only of late that certain hospitals have squarely faced their responsibilities in relation to the tuberculosis risks run by their nurses. In the past little has been done to determine the exact degree of these risks, and ...it is difficult to devise methods to prove whether or not the nursing care of the tuberculous really is a hazardous occupation.<sup>638</sup>

British hospitals relied on reports from Scandinavia and from America.<sup>639</sup> For the first time, according to Badger and Spink, writing in 1936, the American 'nursing profession was shown that at least half their students had never been exposed to tuberculosis before entering training and this group were especially likely to develop active tuberculous disease.'<sup>640</sup> British nurses' risk to TB was perceived as part of an international problem caused by declining TB rates in the general population.

Like Britain, America had a shortage of nurses during this period and, as a result, TB amongst nurses gained increasing importance. Evidence was now available, according to J. Myers, Professor of Medicine, Preventive Medicine and Public Health at the University of Minnesota 'to prove that tuberculosis among nurses is a serious disease from the standpoint of disability.'<sup>641</sup> Myers questioned whether student nurses should continue to nurse TB patients. He compared the exposure of class after class of student nurses and doctors to a type of ongoing study 'rarely equalled by animal experimentation, except that in animal work it is possible to control the dosage and kill an animal at any time.'<sup>642</sup> Dr. Maurice Fishberg, (Chief of the tuberculosis service of

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<sup>638</sup> *The Lancet*, 19 April 1930; 23 September 1933.

<sup>639</sup> *The Lancet*, 11 September 1937, p.629.

<sup>640</sup> T. L. Badger & W.W. Spink, 'Sources of Tuberculous Infection Among Nurses', *American Journal of Nursing*, 1936, Vol. 36, No. 11, p.1100. In March 1942 the *BJN* published the results of H. Israel's study of 'Tuberculosis amongst student Nurses' using the *AJN* as its source. In a note following this article, the *BJN* described the *AJN* as containing 'up-to-date matters of interest and instruction for nurses all over the world', *BJN*, March 1942, p.52.

<sup>641</sup> J.A. Myers, 'Tuberculosis among Nurses', *The American Journal of Nursing*, Vol. 32, No. 11, November 1932, p.1159.

<sup>642</sup> J.A. Myers, H.S. Diehl, R.E. Boynton, B. Trach, 'Development of tuberculosis in adult life', *Arch Intern Med*, 59, 1937, pp.1-31.

the Montefiore Hospital and physician to the Bedford Hills Sanatorium, New York) denied that such a risk existed and argued that Myer's views 'may be accepted by the public and thus make it more difficult to recruit nursing staffs.'<sup>643</sup>

Adverse publicity surrounding the problem of TB amongst nurses in Britain was linked to the shortage of nurses. The *Lancet* played a key role in both analysis of the reasons for the recruitment problems and in raising public attention to nurses' risk of TB. In 1930, it published a letter from Dr. Esther Carling, Superintendent of Berkshire and Buckinghamshire Joint Sanatorium, which predicted an impending crisis of nurse recruitment, particularly in smaller hospitals and sanatoria.<sup>644</sup> Carling was respected as a pioneer woman doctor and was particularly interested in the treatment of tuberculosis and the development of sanatoria. She had been active in the suffragette movement.<sup>645</sup> Carling argued that the absence of a register for trained TB nurses exacerbated the depressed status of TB nursing, compounding problems of recruitment and diminishing prestige of staff posts.<sup>646</sup> She campaigned throughout the interwar period to have TB nursing approved for state registration by the GNC. Carling also focused on work conditions as a reason for the lack of staff and predicted that 'more and more the doctor depends on the nurse; less and less will he find her.'<sup>647</sup> Carling's letter to *The Lancet* attracted sympathetic replies from doctors and seems to have provided the stimulus to

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<sup>643</sup> M. Fishberg, 'Response to recent facts on transmission of tuberculosis', *Journal of the American Medical Association*, 1931, 97, pp.316-319. Fishberg made discoveries concerning the incidence of tubercular infection in school-age children and helped to introduce the pneumothorax treatment of the disease. In 1916 he published his *Treatise on Pulmonary Tuberculosis*, which became a standard text on the topic and was reissued in four editions before 1932. See A. Johnson (ed), *Dictionary of American Biography*, London: Oxford University Press, 1928 -1981.

<sup>644</sup> E. Carling, 'Recruitment for Nursing, *Lancet*, 11 October 1930, vol. ii, p.826.

<sup>645</sup> McGann et al., *A History of the Royal College of Nursing 1916-1990*, p.76.

<sup>646</sup> *The Lancet Commission on Nursing : appointed in December 1930, to inquire into the reasons for the shortage of candidates, trained and untrained, for nursing the sick in general and special hospitals throughout the country, and to offer suggestions for making the service more attractive to women suitable for this necessary work : Final Report*, London, 1932 p.369.

<sup>647</sup> Carling, *The Lancet*, 11 October 1930, p.826.

the establishment of The Lancet Commission in 1932.<sup>648</sup>

The Commission's terms of reference were to 'inquire into the reasons for the shortage of candidates trained and untrained ... and to offer recommendations for making the service more attractive to women suitable for this necessary work.' Competition from other women's occupations offering 'better salaries and better prospects' was identified as the main problem.<sup>649</sup> It did not mention nurses' risk of contracting TB as a contributing cause. Indeed nurses' health did not feature in *The Lancet's Final Report* based on 686 replies to 1031 questionnaires sent to hospitals in England and Wales. Shortages of all grades of staff were reported in all types of hospital, most marked in those not approved as training schools and least acute in the London voluntary hospitals.<sup>650</sup> To counteract the effects of 'wastage', hospitals had to re-recruit half their establishment of probationers in order to replenish their complement of trainees every year. The greatest part of this loss occurred in the first year and was attributed to inefficiency, examination failure, unsuitability, ill health or dislike of the work.<sup>651</sup>

The Lancet Commission's recommendation that the minimum age of entry be reduced to seventeen to solve the shortage of nurses was met with considerable opposition: age, it was argued, was an important contributory factor to nurses' susceptibility to TB and strain.<sup>652</sup> Ross's study of TB among Canadian nurses concluded that 'younger nurses are more likely to break down.'<sup>653</sup> G. R. Erwin, Medical Superintendent at Liverpool Sanatorium, argued that the emotional strain of the first

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<sup>648</sup> Rafferty, *The Politics of Nursing Knowledge*, p.144; McGann, *A History of the Royal College of Nursing*, p.76.

<sup>649</sup> *Final Report of The Lancet Commission*, p.xxiv.

<sup>650</sup> A. Bradford Hill 'Statistical Analysis of the Questionnaire issued to Hospitals by the Lancet Commission On Nursing. Final Report submitted to the Commission by Bradford Hill.' *Final Report of The Lancet Commission*, 1932 supplement, p.i-iii.

<sup>651</sup> 'Second Interim Report: The Lancet Commission on Nursing', *Lancet*, 1932, vol. I, p.xi.

<sup>652</sup> *Final Report of The Lancet Commission on Nursing*, 1932.

<sup>653</sup> *The Lancet*, 19 April 1930, p.874.

year of training increased nurses' susceptibility to infections. He suggested that with experience, as nurses learnt to withstand emotional 'shocks' such as death and haemorrhage, so appetite and weight improved.<sup>654</sup> Bedford Fenwick, determined to restrict entry to eighteen and over, argued that the authors of the *Final Report* 'have little knowledge or understanding of the mental and physical strain which they propose to put girls scarcely out of the schoolroom.'<sup>655</sup> Fenwick supported Erwin's argument that immature girls were susceptible 'to any infection and further that physically they are unsuited for the strain of hospital life.'<sup>656</sup>

Much of the Lancet Commission's attention was devoted to bridging the gap between leaving school and entering the occupation. Allowing candidates to sit for the preliminary state examination whilst at school was, according to Rafferty, suggested to relieve pressure on hospitals overburdened with the teaching of preliminary subjects.<sup>657</sup> Writing in *The Times* in 1934 in support of these proposals, regius Professor of Physic at Cambridge University, Langdon Brown argued that the first year of nurse training was 'overweighted.' He described lecturing to 'young women obviously suffering from severe physical fatigue ... a greater demand is made at this stage from nurses than from medical students.'<sup>658</sup> Langdon's language is interesting because it suggests that nurses may have been suffering from fatigue as an illness in its own right, unconnected to TB.

In summary, nurses were identified as at significant risk from TB from 1924 onwards. Nurses had experienced less contact with the disease than their predecessors and had not developed a resistance. Commentators in America and Britain argued that the publicity surrounding nurses' risk of contracting the disease acted as a deterrent to potential recruits and contributed to the shortage of nurses. The Lancet Commission was the first enquiry of many in the 1930s and 40s to investigate nursing's recruitment

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<sup>654</sup> Erwin, *Tuberculosis and Chest Diseases for Nurses*, p.141.

<sup>655</sup> *BJN*, March 1932.

<sup>656</sup> *BJN*, November 1933 p.324.

<sup>657</sup> Rafferty, *The Politics of Nursing Knowledge*, p.151.

<sup>658</sup> *The Times*, 12 January 1934, p.8.

problems but did not explore occupational health issues.

### **Case study hospitals in the 1930/40s**

Despite the increased attention given to nurses' risk of TB, The London Hospital did not protect its nurses by isolating tuberculous patients. TB patients were nursed in 'the open ward with the usual precautions, such as separate feeding utensils.' The Hospital tried to keep the number of TB patients to a minimum, ruling that patients suffering from chronic pulmonary tuberculosis were ineligible for admission 'unless there be some grave and urgent complication.' A small minority, however, managed to slip through the net and gain entry to await transferral to sanatoria.<sup>659</sup> The London acted as a clearing-house for such patients. In 1930, 13,611 inpatients were admitted of whom less than one per cent (103) had a diagnosis of tuberculosis either on or during admission.<sup>660</sup> Obviously the number of undiagnosed cases cannot be measured. These figures are similar to an American study in 1939, which X-rayed 3,977 patients on admission to fourteen general hospitals, excluding children and people previously diagnosed with TB, and found that 0.7% had active TB. The study concluded that this rate was of 'considerable significance in the infection of student nurses' and hypothesised that if the same condition prevailed throughout the United States, 45,000 unrecognised cases of tuberculosis were admitted to general hospitals.<sup>661</sup> Despite these rather alarming statistics and the lack of infection control measures employed to protect staff and patients, very few London Hospital nurses were diagnosed with TB in the inter-war years.

In 1930, only one nurse was diagnosed with 'suspected TB' out of a staff of 697.

The experience of Ivy G., the nurse in question, suggests that any nurses exhibiting

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<sup>659</sup> RLH, General Standing Orders, The London Hospital, LH/A/1/38, 1933.

<sup>660</sup> RLH, Medical Index of Patients, The London Hospital, LH/M/2/78, 1930.

<sup>661</sup> R.E. Plunkett, 'Case-Finding, an Evaluation of Various Techniques', *Amer. Rev. Tuberc.*, Vol. 39, No. 2, February 1939, pp.256-265.



signs of tuberculosis may have been sent home. Ivy, aged twenty and described as a 'pale, delicate looking probationer', was admitted to the nurses' sick room in June 1930 with an infected finger and rheumatism. The rheumatism cleared up but she continued to suffer from persistent pyrexia. Fever was known to be a symptom of tuberculosis as well as night sweats, cough and dyspnoea, haemoptysis and loss of weight. None of these were peculiar to TB and might be absent from individual cases. Dr. Rowlands, the physician in charge of sick nurses

could not find anything definite to account for her daily rise of temperature and decided it was inadvisable for her to continue training. It was suspected that she had a tendency to lung trouble but various investigations did not prove this to be the case. It was considered as to whether it might be advisable for her to have sanatorium treatment for a time as a preventive measure but after consulting with her people it was decided that in the circumstances and taking everything into account it would be best to go home to Wales.<sup>662</sup>

Rowlands' decision to end Ivy's nursing career at The London may be explained by the difficulties in diagnosing TB; the clinical features of Ivy's illness resembled other chest ailments. There is no record whether X rays were used to aid diagnosis at any of our case study institutions. Bryder notes that the use of X-rays did not necessarily make diagnosis more accurate; the fact that they required interpretation meant a misreading could lead to active tuberculosis being incorrectly diagnosed.<sup>663</sup> It is also possible that Rowlands was unwilling to diagnose TB because of the stigma attached to the disease. Although Ivy lost her job at The London, such a diagnosis would have reduced any future chances of her finding employment. A third possibility is that The London did not want to associate its nurses with a disease linked to the poorer working classes although there is no evidence to support this argument. General conversations about

<sup>662</sup> RLH, *The London Hospital Official Ward Book*, LH/N/6/53, 1930.

<sup>663</sup> Bryder, *Below the Magic Mountain*, p.105.

tuberculosis in society linked it to malnourishment and poor accommodation; if London Hospital nurses were known to be vulnerable to TB, then accusations may have followed that it failed to care for its nurses adequately.

SDEC doctors were also reluctant to make definite diagnoses of TB during the 1930s but, in contrast to The London, did not send nurses home. Kathleen P., aged eighteen, ‘was threatened with a TB infection of chest’ in her third year of training,<sup>664</sup> first year probationer Marie F., aged twenty-four, suffered a ‘threatened TB infection of the lungs’<sup>665</sup> and Cynthia G. had ‘a laparotomy to divide adhesions and calcified gland removal ? TB.’<sup>666</sup> Kathleen and Marie were given long periods of sick leave but both recovered and returned to work. Dr Robinson decided Cynthia was ‘not fit enough to continue training’ after nine months sick leave.<sup>667</sup> According to Esther Carling, the reluctance to diagnose TB was tied up with the shortage of nurses as well as the difficulty of diagnosis:

So great is the need for nurse labour that diagnostic acuteness is blunted...as regards the girls themselves, there is always the next exam looming ahead. So both the employers and the employed must struggle on to keep the machine going and to maintain necessary status within it. Further symptoms when offered are evasive and explainable. When the crash comes the nurse is sent off for treatment, the hospital’s rush persists, and it seems to be nobody’s business to follow up possible implications.<sup>668</sup>

SDEC Matron Dickson reported a shortage of recruits in 1931, 1932, 1936 and 1937 but a waiting list in 1934. These shortages were partly due to the Hospital’s expansion programme in 1931 and the need to increase its complement of nurses from sixty-eight

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<sup>664</sup> PWDRO, SDEC Register of Nurses, 1490/27, 1931, p.8.

<sup>665</sup> PWDRO, SDEC Register of Nurses, 1490/27, 1933, p.16.

<sup>666</sup> PWDRO, SDEC General Com Mins, 606/1/16, 23 April 1937.

<sup>667</sup> PWDRO, SDEC General Com Mins, 606/1/16, 23 April 1937

<sup>668</sup> *BMJ*, 13 January 1945.

to eighty-two. The SDEC General Committee claimed that the increasing number of salaries needed to staff its expansion programme meant that it could not afford to raise salaries to attract recruits.<sup>669</sup>

Dickson disagreed that competition from other occupations or that a fear of contracting TB were causing recruitment problems at her Hospital. Instead she cited the prohibitive cost to student nurses of purchasing their own uniforms and textbooks, the payment of a £5 deposit on entry to training and low student nurse salaries as the major deterrents. She also linked the decline in the birth rate during the First World War and an inability to bridge the gap between sixteen when girls left school and eighteen, the minimum age of acceptance for nurse training. The idea that SDEC recruits struggled financially suggests that they were drawn from working class backgrounds and not from the upper and middle classes that characterised SDEC nurses during the First World War, discussed in chapter four (p.142). All nurses paid for their training until 1919 when recruitment problems prompted the introduction of a £10 first year salary.

As an alternative, and less costly, solution to its staffing problems, Dickson publicised improvements to work conditions.<sup>670</sup> Hours were reduced by extending meal and off duty times and early morning prayers at 6.30 am were made optional.<sup>671</sup> Despite these moves, nurses felt that there was still significant room for improvement: probationer Phylis B. only stayed for three months of training during which time her parents alleged the Hospital neglected her health through overwork and underfeeding.<sup>672</sup> Publication of the SDEC's claim that work conditions had improved, prompted twelve nurses to write an anonymous letter to the local press arguing that conditions remained poor.<sup>673</sup> A further move to attract recruits involved the employment of extra domestic

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<sup>669</sup> PWDRO, SDEC General Com Mins, 606/1/15, March 1929; 22 May 1929.

<sup>670</sup> *Western Morning News*, 23 September 1932.

<sup>671</sup> PWDRO, SDEC General Com Mins, 606/1/15, 2 November 1931; 29 December 1931.

<sup>672</sup> PWDRO, SDEC Register of Nurses, 1490/25, 1921-25.

<sup>673</sup> PWDRO, SDEC Nursing Com Mins, 606/1/30, 21 October 1932.

staff to reduce the amount of cleaning nurses performed.<sup>674</sup>

It was not just a shortage of recruits but a higher than average wastage rate that caused staffing problems at the SDEC. Between 1930 and 1940, 359 SDEC probationers were recruited and 164 (46%) left before qualifying. The national wastage rate was between twenty-eight and thirty-two per cent.<sup>675</sup> No analysis or audit was undertaken of why the rate was so high or what measures the Hospital could take to reduce it. The table below details the reasons why SDEC nurses left training.

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<sup>674</sup> PWDRO, SDEC General Com Mins with Prince of Wales House Com Mins, 606/1/16, 23 April 1937.

<sup>675</sup> Baly, *Nursing and Social Change*, p.165.

**Table 2. Reasons why probationers left South Devon and East Cornwall Hospital 1930-1940**

Year	Total entering training	Left before qualifying	Ill health	Unsuitable	Did not like work	Failed Exam	Other	Not strong Enough
1930	21	14 (66%)	1	2	1	2	4	4
1931	29	14 (48%)	3	5	2	1	3	0
1932	40	17 (43%)	6	2	5	1	3	0
1933	35	13 (40%)	3 (1TB)	4	3	0	3	0
1934	23	6 (26%)	3	2	1	0	0	0
1935	25	14 (56%)	4	5	0	1	0	4
1936	32	15 (47%)	1	1	0	5	6	2
1937	32	16 (50%)	4 (1TB)	3	4	0	5	0
1938	39	20 (51%)	7	0	6	0	7	0
1939	38	25 (66%)	3	0	6	3	9	4
1940	45	25 (54%)	3 (1TB)	4	3	5	9	1

Thirty-eight probationers of the 164 who left cited illness as their reason for leaving. Three (8%) were considered to be suffering from TB. One other nurse contracted TB during this period but continued working at the Hospital. 1929 was perhaps the worst year as far as the incidence of TB amongst nurses was concerned: two of the twenty-seven recruits who left out of an intake of forty-five were diagnosed with the disease. Both probationers were in their first year of training. As already mentioned, the initial stages of probationers' nursing careers had been identified by several studies as the period of highest vulnerability to the disease.<sup>676</sup> Viola N. completed three months of training before contracting TB and pleurisy and Angelina C., four months but died eight months later from TB meningitis.<sup>677</sup>

During the 1940s SDEC doctors began to make definite diagnoses of TB and, at

<sup>676</sup> E.L. Ross 'Incidence of Tuberculosis amongst Hospital Nurses', *The Lancet*, 19 April 1930, p.874; W. Branson, 'The Health of Nurses at St. Bartholomew's Hospital', *The Lancet*, 13 January 1934, p.91.

<sup>677</sup> PWDRO, SDEC Register of Nurses, 1490/25, 1929.

the same time, changed the way nurses were treated. It is not clear why this changed occurred. Instead of sending nurses home for long periods, they were now referred to Didworthy Sanatorium. Third year probationer, Margaret B., aged eighteen, was diagnosed with ‘phthisis’ in 1940, admitted as an inpatient for four months and then transferred to Didworthy Sanatorium. She did not return to work. Three other nurses were admitted to Didworthy Sanatorium between 1940 and 1944, staying for lengthy periods of at least six months before returning to work.<sup>678</sup>

The SDEC Hospital House Committee remained unconcerned about the threat TB posed to staff or patients until 1947 when the high number of inpatients with pulmonary tuberculosis led it to ‘recommend the Board to take steps to ensure that any such cases inadvertently admitted should not be allowed to remain but sent to either a sanatorium or home.’ It is unclear how the Medical Board responded to this recommendation but whatever measures were taken were considered inadequate by the Nurses’ Representative Council (formed in 1945) who protested ‘that so many cases of open tuberculosis were still being nursed in the wards.’<sup>679</sup> The publicity given to scientific evidence that nurses’ faced a high risk of contracting tuberculosis seems to have had little impact on the SDEC’s or The London’s practice of infection control although it may have raised nurses’ awareness of the risk they faced.

Research suggests that the treatment of Cornwall Mental Hospital (CMH) nurses who contracted TB depended on their personal wealth and seniority.<sup>680</sup> In 1944, S. Roodhouse Gloyne argued that the TB rate amongst mental hospital patients and staff had improved significantly since 1918 because of better environmental conditions and improved standards of diagnosis. The mortality rate was still considered excessive,

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<sup>678</sup> PWDRO, SDEC Register of Nurses, 1490/27, 1929-1956, 1941; 1943; 1944.

<sup>679</sup> PWDRO, Prince of Wales Hospital House Com Mins and Joint meeting of House Committee and Medical Board Mins, 606/1/17, 1943-1948, 20 June 1947, p.173;14 May 1948.

<sup>680</sup> The Cornwall Lunatic Asylum was renamed the Cornwall Mental Hospital in 1930.

however, because of contact with unrecognised TB.<sup>681</sup> In September 1931, four nurses, one ward maid and the assistant medical officer, at the CMH, were diagnosed with pulmonary tuberculosis. Nurses Carhart and Stevens were admitted to Tehidy Sanatorium. Stevens recovered and was able to return to work but Carhart remained ill. She was discharged from Tehidy after six months and offered sick pay of five shillings per week. Her employers allowed her to live in a hut at the isolation hospital and be treated by the mental hospital medical staff. After a further six months, there was no improvement in her health and she was given one month's notice 'to make other arrangements.' Homeless and too ill to work, Carhart left the hospital to an unknown fate.

Assistant Matron Sweet resigned from her post, informing her employers of her pulmonary tuberculosis and was offered three month's sick leave with full pay and the value of her emoluments. Like Carhart, she was allowed to live in one of the Hospital's huts but with a different aim, 'so that she may get up her strength before going to Switzerland for treatment.'<sup>682</sup> The Victorian belief that Alpine air had a favourable effect on tuberculosis was challenged in the early twentieth century though the Alps continued to attract sufferers. Sweet was advised in Switzerland she was suffering not from TB but from anaphylaxis caused by the wrongful injection of horse serum administered by CMH doctors.<sup>683</sup> She instructed a solicitor to take up her case of negligence against the hospital who claimed:

that a deliberate and calculated attempt to hide from our client and her parents the real nature of her illness had been made by the medical officer concerned and who must be solely responsible for the wrongful treatment given to our client ...

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<sup>681</sup> S. Roodhouse Gloyne, *Social Aspects of Tuberculosis*, London: Faber and Faber, 1944.

<sup>682</sup> CRO, CMHVC Mins, 1931-1932, HC1/1/1/27, September; October; November 1931, p.194; p.196; p.241.

<sup>683</sup> CRO, CMHVC Mins, HC1/1/1/27, 30 May 1932, p.385.

Our client was definitely informed that she was to have at least twelve months sick leave with full pay and emoluments yet whilst she was still in Switzerland in a grievous state of health, she received a communication informing her that her engagement had been terminated.<sup>684</sup>

The Hospital did not admit liability and Sweet dropped the case, unsettled. The Visiting Committee Minutes clearly indicate that Sweet was offered three month's sick leave and not the twelve she later claimed. This case reveals that nurses' seniority influenced the treatment and care of nurses with TB although both junior and senior nurses were eventually dismissed as a result of their illness. Junior nurses received only a small percentage of their salary as sick pay with no value of their emoluments whilst senior nurses received full pay for three months and the value of their board and lodging. Sweet's personal wealth provided access to the outdated idea that special climates favourably affected the course of the disease. The case also reveals that some doctors attempted to vaccinate against tuberculosis with horse serum in the early 1930s. Whether this type of treatment was only offered to senior nurses is unclear although there is no record that Cahart received horse serum. Debate about whether nurses should receive vaccination against TB continued throughout the 1930/40s and will be discussed later in this chapter.

Some commentators suggested that mental and physical strain were as important as infection in the spread of TB in hospital staff.<sup>685</sup> Carling argued that it was wrong that young nurses should be 'subjected to the additional strain of passing examinations while doing full duty in the wards. Night duty produced an even greater strain.'<sup>686</sup> Evidence from the SDEC and The London Hospital suggests that nurses suffered from many different forms of mental strain during this period but they were not related to TB.

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<sup>684</sup> CRO, CMHVC Mins, HC1/1/1/27, 30 May 1932, p.389.

<sup>685</sup> Buxton et al., *The Nursing of Tuberculosis*, p.11.

<sup>686</sup> *The Lancet*, 11 September 1937.



At the SDEC, Marie B. left after suffering attacks of ‘hysteria’, Dorothy L. because of ‘her extremely emotional and hyper-sensitive’ temperament and Phyllis P. because of ‘nerves’ and ‘fear of the work.’<sup>687</sup> Probationer Rose P, described as ‘well educated but very highly strung’ left after four weeks because ‘she could not cope’ and suffered from ‘physical strain.’<sup>688</sup> Nurses’ physical and mental illness continued to be perceived as closely related problems: German physician, Geheimerat Hecker, identified mental strain as a symptom of physical strain in 1911, discussed in chapter three (pp.106-109).

At the London Hospital, probationer Georgina R. suffered a ‘mental collapse’ having been told to ‘exercise more self-control’ if she was to continue training. It is interesting to note that matrons increasingly attached importance to the quality of self-discipline, a point raised in the next chapter. Probationer Phyllis H., aged twenty-six, had an acute attack of rheumatism and developed pericarditis after four month’s training. Described as ‘timid, nervous and easily overwhelmed’, Phyllis attempted suicide by throwing herself down the staircase whilst a patient in the nurses’ sickroom. She was certified mental and admitted to Peckham House Mental Home. Winifred R., aged nineteen, described as ‘nervous and slow’ with an unhealthy appearance, took an overdose of morphine tablets shortly after sitting her Final Examination paper which she believed she had failed. Like Phyllis, Winifred had also suffered a recent physical illness (an appendectomy) from which she recovered, again supporting the idea that a close relationship existed between physical and mental health. Winifred failed her exams and was sent home.<sup>689</sup>

In summary, TB patients were nursed on open wards at both The London and the SDEC but it was not until 1947 that SDEC nurses voiced their concerns. Doctors were reluctant to make definite diagnoses of TB prior to the 1940s. This may have been

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<sup>687</sup> PWDRO, SDEC Register of Nurses, 1490/26, 1922-1934; Dorothy L. 1930; Phyllis P. 1931; Register of Nurses 1490/28, 1932-1947, Marie B. 1938.

<sup>688</sup> PWDRO, SDEC Register of Nurses, 1490/26, 1922-1934, Rosie P. 1932.

<sup>689</sup> RLH, The London Hospital Official Ward Book, LH/N/6/53, 1930; Georgina R. 1 February 1930; Phyllis H. 22 March 1930; Winifred R. p.129.

because of the stigma attached to the disease or its association with many aspects of the lives of the poorer working classes. The London Hospital did not experience recruitment problems in the 1930s and 40s and dismissed nurses who displayed signs of TB. In contrast, the SDEC suffered from recurrent staff shortages and allowed nurses long periods of sick leave but encouraged them to return to work. Treatment of nurses' tuberculosis at the CMH may have depended on rank and personal wealth.

### **Hospital environment, nurses' lifestyles and military styles of discipline**

Nurses' susceptibility to TB was also related to their lifestyles, the environment surrounding hospitals and notions of discipline. City general hospitals, according to Erwin, had the 'contributory factors of fatigue due to ward work in a stuffy atmosphere, combined with greater incentives to go out late at night, render[ing] breakdown more likely.'<sup>690</sup> The idea that an urban environment contributed to a higher incidence of TB amongst general hospital nurses than those working in sanatoria in the countryside reflected, in part, the view that TB was a disease of civilisation, a response to the known prevalence of tuberculosis in the urban slums of Victorian and Edwardian Britain.<sup>691</sup> Not only urban pollution but urban lifestyles were blamed particularly the 'stuffy' atmospheres of 'smoke and stale air found in 'trams, bus or train ... cinemas, crowded dance halls and public houses.'<sup>692</sup> The idea that nurses' socialising contributed to their poor health related to the argument that the pace of modern life was damaging to young women.<sup>693</sup> 'Rest, fresh air and exercise, graded to the physique of the individual' were promoted as an antidote.<sup>694</sup> In 1920, L. E. Hill illustrated that the death rates in country areas were on average thirty-five per cent lower than in the cities for males and thirty to

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<sup>690</sup> Erwin, *Tuberculosis and Chest Disease for Nurses*, pp.140-141.

<sup>691</sup> Bryder, *Below the Magic Mountain*, p.21.

<sup>692</sup> Buxton and Macculloch Mackay, *The Nursing of Tuberculosis*, p.11.

<sup>693</sup> Bryder, *Below the Magic Mountain*, p.120.

<sup>694</sup> Buxton et al. *The Nursing of Tuberculosis*, p.11.

thirty-three per cent for females.<sup>695</sup>

Querying the ‘strain theory’ in tuberculosis causation, A. Bradford Hill of the Royal Statistical Society (later Emeritus Professor of Medical Statistics, London School of Hygiene and Tropical Medicine) refuted the argument that the increasing employment of women was linked to rising TB rates by demonstrating that the percentage of females in employment had changed very little from 1911 to 1931.<sup>696</sup> Bradford Hill pointed out that the county boroughs with a higher proportion of females in paid employment had lower pulmonary tuberculosis mortality rates.<sup>697</sup>

In 1937, as nursing recruitment problems intensified following economic recovery and employment opportunities for women expanded, some commentators suggested that the promotion of a relaxation in nurse discipline would detract attention away from the problem of TB amongst nurses. National newspapers publicised attacks upon hospitals detailing regimentation, petty rules and tyranny as impediments to recruitment.<sup>698</sup> Allegations were made that nurses ‘ran the risk of injury to their own health. To ask young girls to go on working when they may be overtired or overwrought by what they have seen or heard may tend to blunt those finer feelings of sympathy and kindness so essential in the nursing profession.’<sup>699</sup> Dr Peter Edwards claimed, at a BMA meeting, that the increased publicity given to the risks of contracting TB exacerbated recruitment problems. His solution was to give nurses ‘the same freedom as girls employed in industry.’ Edwards cited the case of Cheshire Joint Sanatorium where an experiment to allow trained nurses to manage their hostel without interference from either the medical superintendent or the matron ‘had proved an

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<sup>695</sup> MRC, L.E.Hill, *The Science of Ventilation and Open air Treatment*, (SRS 52, Part 2; 1920), 183,185 quoted in Bryder, *Below the Magic Mountain*, p.120.

<sup>696</sup> Bryder, *Below the Magic Mountain*, p.120.

<sup>697</sup> A. Bradford-Hill, *Journal of the Royal Statistical Society*, 99/2, 1936, pp. 264; 266; 268-9; 281; 285; Bryder, *Below the Magic Mountain*, p.124.

<sup>698</sup> *The Times*, 14 September 1936, p.8.

<sup>699</sup> ‘Nurses’ Hours’, *The Times*, 1 Feb. 1936, p.8.

unqualified success.<sup>700</sup>

The relationship between TB, discipline and nurses' health was the focus of a study by Dr. Sheila Bevington, a psychology lecturer at the London School of Economics. Bevington's survey of staff relations and discipline in hospitals in 1943 (for which she held a Leverhulme Research Studentship at the Institute of Industrial Psychology) was based on 500 nurse interviews at five hospitals. She concluded that whilst nurses were satisfied with their treatment in cases of serious illness, many were dissatisfied with 'the handling of minor ailments and difficulties placed in the way of "reporting sick."' The treatment of nurses' minor ailments was identified as important in the early detection of TB. Bevington suggested that hospitals' disciplined environment deterred nurses from reporting sick: at one hospital, nurses could only report sick at nine am; if sick at any other time, nurses 'had to confront Assistant Matrons, of whom some apparently adopted unsympathetic attitudes expressed in the comment "you come here to nurse and not to be nursed."<sup>701</sup> Assistant Matrons often had more contact with nurses and probationers than Matrons, who delegated the day-to-day routine management of the hospital.

One nurse, a thirty-year-old sanatorium patient, highlighted the importance of reporting minor symptoms of illness in the early detection of TB. Writing in *Time and Tide* in 1945, her reminiscence of nursing during the early 1930s identified the difficulties of reporting in sick as responsible for the high levels of disease:

In my hospital days it seemed to be regarded as wrong that a nurse should be ill. Unless her symptoms were alarming she hesitated to report them. One heard of nurses being liable to imagine some of their ills. This often deterred a nurse from admitting to minor but important illnesses. Had there been one person at my training school allocated to take the place of a

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<sup>700</sup> *The Lancet*, 11 September 1937, p.629.

<sup>701</sup> S. Bevington, *Nursing Life and Discipline*, London: Lewis, 1943, p.19.

parent or headmistress, who would take a primary interest in the nurses' health ...many of the nurses now in sanatoria could be nursing today, thereby minimising somewhat the present shortage.<sup>702</sup>

This nurse suggests that some senior nurses continued to view probationers' illnesses as an indication of their lack of vocation to nurse. Chapter two (p.59) discussed how Luckes cast doubt on the authenticity of nurses' sickness by suggesting that some nurses imagined their ill health, a character failure she linked with a selfish personality. The idea that nurses should ignore their ill health, as part of their devotion to duty, continued to influence their behaviour in the 1930s.

G.S. Erwin, Medical Superintendent at Liverpool Sanatorium, argued that education contributed towards nurses exaggerating their symptoms of illness:

Some nurses, especially as they receive lectures about diseases with which they are dealing, show a morbid introspection which leads to the exaggeration of trivial symptoms, themselves of no significance, to resemble those of the particular disease, say tuberculosis, which is most feared. A medical examination may be necessary to clear the mind of such fears, but either as a result of this, or of more acute observation of other healthy people, this stage passes and gives way to a confidence that proves more lasting.<sup>703</sup>

Erwin's suggestion that first year nurses passed through a stage of 'morbid introspection' implies a more serious and unhealthy form of mental state than Luckes' earlier allegations that they 'imagined ill health'. The term 'morbid' refers to a mental state 'unwholesome or sickly marked by exaggerated or inappropriate feelings of gloom or apprehension.'<sup>704</sup> Erwin's comment that nurses 'exaggerated trivial symptoms'

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<sup>702</sup> King Edward's Hospital Fund for London, *Memorandum on the Supervision of Nurses' Health*, London: Geo. Barber & Son Ltd., 1945.

<sup>703</sup> Erwin, *Tuberculosis and Chest Disease for Nurses*, p.142.

<sup>704</sup> *Shorter Oxford English Dictionary*, Oxford: Oxford University Press, 2002.

draws similarities with allegations made by London Hospital nurses in the 1890s that doctors were suspicious and did not take their health problems seriously (see chapter two, pp.63-64). By the 1930s, understandings of nurses' alleged tendency to exaggerate ill health were set within a psychological framework of ideas that identified stages of emotional development related to nurse education. Chapter seven will discuss the increasing importance attached to psychological ideas and its impact on the welfare of nurses during the 1940s.

How did the College of Nursing respond to the problem of nurses with TB? The College made no public acknowledgement of the issue until 1935 when its Cambridge branch highlighted the case of nurses discharged from sanatoria as 'fit for light work' but who then took up employment in caring for children or private patients. The branch demanded that prolonged treatment and aftercare be provided and local authorities be urged to provide suitable accommodation and conditions of work 'under which they may remain as normal members of the community.' The College resolved that an annual medical examination be introduced for nurses in training schools.<sup>705</sup> In November 1935 the College approached the Ministry of Health to discuss the problem of nurses suffering from TB including treatment, aftercare and employment.<sup>706</sup> The College sent a representative to the Joint Tuberculosis Council, which drew up a list of precautions for nurses in general hospitals nursing TB cases. The College also requested the statistics on nurses' mortality from TB from the Registrar-General but were told that these figures were difficult to obtain because death certificates were often incomplete.

The Registrar-General's failure to supply the numbers requested suggests that the poor record keeping related to nurses' health, highlighted by the National Council of

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<sup>705</sup> RCN, College of Nursing Mins, 1 January 1935-31 December 1935, Branches Standing Com Report to Council, pp.141-160.

<sup>706</sup> RCN, College of Nursing Mins, 1 January 1935 - 31 December 1935, College of Nursing Professional Association Committee Report to Council, November 1935, p.189.

Women's survey in 1919 as an impediment to improving nurses' health (discussed in chapter five, p.186) extended beyond hospitals to government organisations. The NCW noted that only one hospital out of the 171 surveyed kept 'a careful record of sickness.'<sup>707</sup> The Registrar's failure may indicate a national lack of interest in nurses' health despite scientific evidence of hospital nurses' susceptibility to TB.

## **Vaccination**

As mentioned earlier, Matron Sweet of the Cornwall Mental Hospital was treated with an injection of horse serum in 1931. In the late nineteenth and early twentieth centuries, animal experimentation was performed in an attempt to identify therapeutic sera for tuberculosis. These studies were stimulated by the successful development of serum therapy against a variety of infectious diseases.<sup>708</sup> Serum therapy for TB was disappointing, according to Gatman-Freedman et al., because no effective formulation was ever developed.<sup>709</sup> In 1912, Henri Spahlinger, a Swiss bacteriologist, discovered a vaccination for TB derived from the blood of black horses.<sup>710</sup> Spahlinger's ideas remained unpopular among British tuberculosis specialists with a few exceptions. In 1937, Dr Eugene Opie and Jules Freund reported in the *Journal of Experimental Medicine* that 'the harmless' preventative obtained by killing the tubercle bacilli by heat and adding heated horse serum was as effective as BCG. Opie and Freund believed it protected the inoculated individual for one to two years, long enough to 'influence favourably the delicate balance between asymptomatic or covert infection and progressive manifest disease.'<sup>711</sup>

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<sup>707</sup> NCW, 'Report of the Special Committee on the Economic Position of Nurses', *BJN*, 27 September 1919, p.192.

<sup>708</sup> A. Cassadevall, M.D. Scharff, 'Return to the past: the case for antibody based therapies in infectious diseases', *Clinical Infect Dis.* 1995; **21**, pp.150-161.

<sup>709</sup> A. Gatman-Freedman, A. Casadevall, 'Serum Therapy for Tuberculosis revisited: Reappraisal of the Role of Antibody-mediated immunity against mycobacterium tuberculosis', *Clinical Microbiology Reviews*, 1998, July, 11(3): pp.514-532.

<sup>710</sup> Bryder, *Below the Magic Mountain*, p.192.

<sup>711</sup> E.L. Opie & J. Freund, 'An experimental study of protective inoculation with heat

Heimbeck researched the question of whether nurses could be vaccinated against TB in a trial of BCG vaccination at Ullevål Hospital, Oslo in 1927. Bacillus Calmette-Guerin (BCG) vaccination was discovered in France in 1921. In 1908 Leon Calmette and Camille Guerin devised a vaccine by attenuating a bovine strain of the tubercle bacillus on a culture of potatoes, glycerine and beef bile. They worked on this until 1921 when they devised a strain that did not produce TB but gave immunity against disease.<sup>712</sup> Heimbeck offered BCG vaccination to student nurses who gave a negative reaction to a tuberculin test, showing that they had not previously been infected with the tubercle bacillus. The relationship between tuberculin testing and skin reaction was explained earlier in this chapter (pp.208-209). Those nurses who experienced a negative reaction and who refused the vaccine were studied as a control group. The tuberculosis morbidity rate among this group during their training period was six times higher than the vaccinated group and the mortality rate was seven times higher.<sup>713</sup> This was considered adequate proof of the value of BCG by the Scandinavians: vaccination was made compulsory for negative reactors among staff in state mental hospitals and the dental service, and for student nurses and medical students.<sup>714</sup>

J. Myers, Professor of Medicine at the University of Minnesota, opposed BCG vaccination of nurses on the grounds that contact with any substance that brought about a positive tuberculin reaction was a risk because a reaction denoted hypersensitivity, a sensitivity that was needed to produce illness.<sup>715</sup> The aims of BCG were to induce tuberculin sensitivity and potentate the defence mechanism enabling the recipient to

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killed tubercle bacilli', *Journal of Experimental Medicine*, **66**, December 1937, pp.761-788.

<sup>712</sup> L. Bryder, 'We shall not find salvation in inoculation', BCG vaccination in Scandinavia, Britain and the USA, 1921-1960.' *Social Science and Medicine*, **49**, 9: November 1999, pp.1157-67.

<sup>713</sup> J. Heimbeck, 'Tuberculosis in hospital nurses.' *Tubercle*, 1936, **18**, pp.97-99; Bryder, *Below the Magic Mountain*, p.139.

<sup>714</sup> Bryder, 'We shall not find salvation in inoculation', p. 1160.

<sup>715</sup> J.A.Myers, 'The Prevention of Tuberculosis among nurses', *The American Journal of Nursing*, Vol. 30, No. 11, November 1930, pp.1361-72.



combat re-infection when exposed to pathological strains of bacterium later. This primary infection enabled the vaccinated person to mobilise immune processes more rapidly when challenged by further natural infections. NICE guidelines in 2005 supported Myer's idea, advising that BCG vaccination should not be given to someone who is already sensitive to tuberculin proteins.<sup>716</sup>

British scientists showed little interest in BCG vaccination during the inter-war years. In the 1920s the Medical Research Council's (MRC) own research workers rejected BCG. Public health authorities were not convinced that evidence from other countries supported the vaccination. F.R.G. Heaf, Professor of Tuberculosis at the Welsh National School of Medicine, criticised the Scandinavian research highlighting the absence of controlled trials and the difficulty in separating anti-tuberculosis measures such as general hygiene and the high ratio of beds for treatment. Sir George Buchanan, Chairman of a Ministry of Health Immunisation Committee set up in 1931, argued against a BCG vaccination programme on administration grounds and the difficulties isolating those vaccinated until immunity was ensured at about 4 weeks. According to Buchanan, Britain already had a well-developed scheme for TB which vaccination would interfere with.<sup>717</sup>

An acute shortage of nurses in TB institutions during and immediately after the Second World War prompted the first serious appraisal of the introduction of BCG in Britain.<sup>718</sup> Fear of infection, intensified by the publication of surveys showing a high rate of disease amongst nurses, was believed to be inhibiting women from taking up TB nursing. Esther Carling maintained that parents were increasingly averse to allow their daughters to nurse in sanatoria. In 1943, in response to this crisis, tuberculosis specialists asked the Ministry of Health to initiate a study and to supply BCG to nurses.

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<sup>716</sup> National Institute for Health and Clinical Excellence, CG33 Tuberculosis: quick reference guide, 20 March 2006,

<http://www.nice.org.uk/nicemedia/pdf/cg33quickreffguide.pdf>.

<sup>717</sup> Bryder, *Below the Magic Mountain*, p.139.

<sup>718</sup> Bryder, 'We shall not find salvation', pp.1161-62.

It was not until 1949 that BCG was first offered to nurses.

## **The Proffit Survey**

As already mentioned, the Second World War heightened interest in TB. A rise in its incidence plus disruption of the TB service, when sanatoria were converted to war hospitals and their patients discharged home, added to fears of the spread of disease. Investigation into its extent and causes focused on its incidence, particularly among young women.<sup>719</sup> One such investigation was the Proffit Survey, which included five thousand female nurses in its study. Driven by the fact that TB was ‘still the main killing and incapacitating disease’ between the ages of fifteen and twenty-four than any other single disease during this period, the Royal College of Physicians used a legacy from J.M.G. Proffit to fund a large-scale investigation into the epidemiology of TB in the young adult population. Ten thousand young adults were divided into four occupational groups (nurses, medical students, navy boys, office workers) and a group of contacts drawn from people living in a family with a case of TB. The intention was to observe each group over a period of ten years (1934-1944) however, nurses became the project’s focus as the War made it difficult to study the other groups in the same detail. The Survey concluded that young women were more likely to develop TB than men in similar surroundings and tuberculosis morbidity was four times higher amongst general student nurses than among young women in the general population. It was found that this increased morbidity was due, in forty-three per cent of cases, to a recent primary infection and, in fifty-seven per cent of cases, to a combination of genetic, environmental and nutritional factors. The Survey concluded that nurses’ resistance to TB was the result of a delicate balancing act between these three factors: ‘the precarious balance may be tipped in one or the other direction by changes in the other two’.<sup>720</sup>

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<sup>719</sup> Bryder, ‘*Below the Magic Mountain*’, pp.229-241.

<sup>720</sup> M. Daniels, F. Ridehalgh, V.H. Springett, *Tuberculosis in young adults - Report of the Proffit Survey 1935-1948 including work done by I.M. Hall*, London: H.K. Lewis

Evidence that contact with the bacterium *m. tuberculosis* was not the main cause of infection but that risk depended on a number of other factors, prompted discussion of the part played by nurses' class backgrounds and their work environment.

This thesis argues that ideas about the relationship between nurses' class and health changed between 1890 and 1930. Chapter three (pp.96-98) suggests that late nineteenth century middle class nurses were perceived as more vulnerable to illness than their working class predecessors. Rising morbidity and mortality rates at The London Hospital were explained by an increase in the number of middle class recruits believed to be entering training. Luckes used the idea that middle class nurses were unable to cope physically with arduous working conditions or mentally with the lack of privacy in nurses' accommodation, to promote the necessity for improvements to work conditions. In contrast, the Prophit Survey concluded that working class nurses were more vulnerable to illness than their middle class counterparts. The Survey found that class background played a part in determining what type of hospital recruits gained entry to and consequently the type of environmental conditions nurses' experienced at work. Working class nurses were more likely to work in hospitals where work conditions had an adverse effect on health and, as a result, the incidence of TB was higher than in the more prestigious, voluntary hospitals employing a higher percentage of middle class recruits with better work conditions.

The Prophit Survey reached this conclusion by dividing the 5,000 nurses studied into two groups. Group A nurses were predominately drawn from working class backgrounds and worked in long stay hospitals who admitted all classes of patients and catered for chronic and advanced types of disease including open cases of TB. Group A hospitals all had tuberculosis wards and all had difficulty in attracting nurse recruits. As part of their training, Group A probationer nurses were seconded to tuberculosis

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& Co., 1948, preface, pp.v-viii, pp.205-213.

wards or sanatoria for three months.<sup>721</sup> Nurses' workload was noted as heavier than Group B nurses because they had more patients to care for, many with high levels of dependency.<sup>722</sup>

Group B had a higher number of nurses with no previous occupation suggesting that they came from middle class backgrounds. This assumes that these nurses came from families with a sufficient income to support them to stay at home in the gap between school and nursing. Group B hospitals had waiting lists of recruits and were therefore able to apply more rigorous standards of selection choosing 'the healthiest and best-educated.' Only one out of the five group B hospitals had a tuberculosis ward and unlike group A hospitals, open cases of tuberculosis were rarely admitted. Nurses had fewer patients to care for, with more generous bed spacing between patients.<sup>723</sup> The London Hospital, although not included in the Proffit Survey, was typical of a group B Hospital. The Hospital enjoyed a waiting list of applicants throughout the 1930s and sought to recruit 'suitable' middle class recruits.

The Proffit Survey also found that the TB rate amongst group A nurses was consistently higher than B, irrespective of initial tuberculin reaction and of variations in individual hospitals. The difference was attributed to a greater exposure to tuberculosis, lower resistance to disease due to poor diet and hard work in the hospital and a greater selection of nursing entrants to Group B hospitals.<sup>724</sup> Nurses' vulnerability to TB was perceived as closely related to social background: this may have determined not only the type of hospital nurses gained entry to but also the quality of lifestyle experienced prior to nursing.

The Proffit Survey confirmed Heimbeck's conclusions that those nurses found

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<sup>721</sup> Daniels et al, *Tuberculosis in young adults*, p.8.

<sup>722</sup> Group A nurses had 30-43 nurses per hundred bed compared with 67 to 72 nurses per hundred beds in group B hospitals. M. Daniels et al, *Tuberculosis in young adults*, pp.9-22.

<sup>723</sup> Daniels et al., *Tuberculosis in young adults*, pp.9-22.

<sup>724</sup> Daniels et al., *Tuberculosis in young adults*, p.154.

to be tuberculin negative by mantoux test on entry to training were more likely to develop TB in the first year of training. The incidence of TB amongst nurses who had a positive reaction to the test was low in the first year but tended to increase with each year of nursing experience.<sup>725</sup> This result suggests that a high percentage of nurses came into contact with the disease during training and that resistance was reduced by hard physical work and poor diet.

### **A compensable disease**

As a result of the Proffit Survey's Report *Tuberculosis in Young Adults (1935 -44)* and the *Dale Committee's Report (1948)* which refined the selection of diseases for insurance under the National Insurance (Industrial Injuries) Act 1946, the Industrial Injuries Advisory Council (IIAC) prescribed tuberculosis as an occupational health risk for nurses in 1951. The 1946 Act ruled that a disease could be prescribed if it could be treated as a risk of occupation and not as a risk common to the general population. This point was problematic because of TB's prevalence amongst the population at large and also the difficulty in determining with certainty the source of infection. Nurses' risk of TB infection came from 'close and frequent contact' with patients and with infected materials.<sup>726</sup> It was possible to isolate TB as an occupational risk, the IIAC argued, by an initial medical examination on entry to training to rule out existing disease, the fact that nurses lived 'under more hygienic conditions than the general population' so disease could not be caused by poor housing and that nurses had 'a somewhat restricted contact with the outside world and therefore with the general risks.'

This latter comment is interesting because it constructs an image of the nurse as angelic and chaste, drawing allusions to the notions of morality surrounding the image

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<sup>725</sup> Daniels et al, *Tuberculosis in young adults*, p.viii.

<sup>726</sup> Industrial Injuries Advisory Council, *Report of the Industrial Injuries Advisory Council on the question whether Tuberculosis and other Communicable Diseases should be prescribed under the Act in relation to Nurses and other Health Workers*, 1950 -51, Cmd. 8093. November 1950, p.379.

of the 'new' nurse in the late nineteenth century, discussed in chapters two and three. The IIAC made sense of the criteria defining occupational disease by thinking of nurses as a type of nun, living apart from society. It suggests that the image of the morally superior nurse promoted by nurse leaders in the 1880s and 90s continued to influence ideas surrounding nursing well into the twentieth century despite the secularisation of medicine.

Setting the conditions of claims was problematic. First and foremost, it was necessary to establish that '*close and frequent contact*' with tuberculous infection had occurred. The IIAC established that such contact occurred in the wards of general hospitals as well as tuberculous wards and sanatoria. Indeed, general nurses were believed to be at particular risk from caring for undisclosed cases. Although medical evidence to the Committee agreed that TB may not become clinically manifest for many years, the 'vast majority of active tuberculous cases' were diagnosable 'within a comparatively short time of the causal infection.' Despite lengthy debate concerning the difficulties in attributing illness to the nature of employment and not other causes after years had passed, the IIAC dictated that nurses could claim after six weeks from entry into employment and within two years of leaving. Three years, it was argued, would 'err on the side of generosity.' The IIAC did not rule out claims being made a number of years after employment had lapsed if it could be proved that tuberculosis was from employment.<sup>727</sup>

The Proffit Survey and the Industrial Injuries Advisory Council's Reports contributed to a movement supporting the development of an occupational health service for nurses. There was a general consensus amongst the groups reporting on nurses' health, particularly in relation to TB, that facilities were inadequate. Recognition that such a service could reduce the incidence of TB amongst nurses gained considerable support during the 1940s. In 1939, the Athlone Committee reported many

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<sup>727</sup> *Report of the Industrial Injuries Advisory Council*, pp.7-12.

hospitals' failure to perform initial medical examinations on nurse recruits or routine examination during training. The Committee recommended that medical examination plus X-ray examination, be universally implemented at intervals throughout training to avoid 'breakdowns in health' and allow 'treatment at an early stage in tuberculosis and other conditions.'<sup>728</sup> The Athlone Committee's recommendations were shelved because of the outbreak of war and six years later the King Edward's Hospital Fund lamented the absence of an accepted standard for the supervision of nurses' health:

The requirements regarding the medical examination of student nurses before admission vary widely at different hospitals, the practice with regard to immunisation follows no general rule, and on such questions as routine medical examination and the keeping of health records it must be admitted that other organisations –schools, industrial bodies employing large members of staff, etc. - have been allowed to lead the way.<sup>729</sup>

The idea that the health care offered to nurses was falling behind other occupational groups took hold. The King Edward's Hospital Fund pressed the point that 'recent advances in preventive medicine and staff welfare work' were cause for hospitals to review 'the supervision given to the health of the staff.'<sup>730</sup>

The King Edward's Hospital Fund's *Memorandum on the Supervision of Nurses' Health* and the Proffit Survey's *Tuberculosis in young adults* recommended that hospitals establish a system of confidential medical records for nurses recording family history, baseline measurements of weight, haemoglobin and chest X-ray. Both organisations suggested the implementation of a system of routine annual medical checks. Attention was drawn to the importance of nurses' diet and accommodation in

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<sup>728</sup> King Edwards Hospital Fund for London, *Memorandum on the Supervision of Nurses' Health*, p.1.

<sup>729</sup> King Edward's Hospital Fund for London, *Memorandum on the Supervision of Nurses' Health*, p.1.

<sup>730</sup> King Edward's Hospital Fund for London, *Memorandum on the Supervision of Nurses' Health*, p.8.

helping to build resistance to infection. The Fund considered the problem of TB amongst general hospital nurses of such urgency that it required ‘immediate steps to minimise the risks’.<sup>731</sup> The Proffit Survey argued that the handling of infected material had been wrongly prioritised as the highest risk procedure ‘while scant attention is paid to the more serious risks of air-borne infection (as during bed-making and ward-sweeping).’ Infection control should, the Survey argued, take into account the importance of hand washing and the use of masks during high-risk procedures.<sup>732</sup> Nurses under the age of thirty were recommended for annual weight and X-ray examinations. The IIAC suggested that BCG vaccinations be implemented not only to improve nurses health but to ‘save the Fund the expense of many avoidable claims.’ With this in mind, the Ministry of Health issued a circular encouraging sanatoria to employ already infected nurses. The IIAC debated whether the prescription of tuberculosis as a serious health risk for nurses might frighten potential recruits but decided on balance that it would help recruitment by fostering a sense of security.<sup>733</sup>

## **Conclusion**

Why was tuberculosis perceived as a significant threat to nurses’ health in the 1930s and not before? The key factor to influence scientific and medical opinion during the 1920s was the realisation that declining TB rates in the general population had produced a generation of young adults with no resistance to the disease because of their lack of exposure to the bacteria tubercle bacillus. Young nurses were believed to be particularly vulnerable because of their close contact with an older generation of patients who had pulmonary tuberculosis. The development of skin diagnosis testing in the early twentieth century facilitated Heimbeck’s research in Oslo, which strengthened

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<sup>731</sup> King Edward’s Hospital Fund for London, *Memorandum on the Supervision of Nurses’ Health*, pp2-.7; Daniels et al. *Tuberculosis in Young Adults*, p.202.

<sup>732</sup> Daniels et al., *Tuberculosis in young adults*, p.ix.

<sup>733</sup> *Report of the Industrial Injuries Advisory Council*, pp.11-14.



the argument that general nurses were at significantly more risk of developing TB than young women in the general population.

General discussions of tuberculosis in early twentieth century society informed discussions of specific occupational illness, particularly nursing. Changing perceptions of TB meant that it was no longer considered a middle class illness but was now linked to the social and environmental problems of the working classes. This conception informed conversations about the rising incidence of TB amongst nurses. The question puzzling researchers before Heimbeck's study was why, if the disease was infectious, did so many nurses working in sanatoria remain healthy? In 1882 Williams' study of nurses at the Brompton Hospital of Consumption concluded that TB was more likely to be hereditary than infectious with poverty and the environment exacerbating the risk of those with a weak disposition. With the benefit of hindsight it is possible that this group of nurses had built up a resistance to the disease. Explanations of nurses' risk to tuberculosis continued to suggest a range of social factors, including class, gender and the environment, after Koch's discovery that TB was an infectious disease.

Fatigue and mental strain were also believed to reduce nurses' resistance to TB. Evidence suggests that nurses suffered from mental strain at both the SDEC and The London Hospital but that it did not necessarily contribute to TB and could be considered as a separate form of occupational illness. A lack of mental strength continued to be linked to physical illness but psychological ideas began to shape understandings of nurses' health. Claims that nurses imagined their ill health continued but interpretations shifted from the belief that sickness indicated a lack of vocation to nurse to the idea that it was a temporary phase, resulting from nurse education.

The recurrent recruitment crises during the 1930s and 1940s prompted conversations about nurses' health. Nurses' risk of contracting TB played an increasingly prominent part in analysis of the shortage of nurses. Despite *The Lancet's*

warning, in 1932, that hospitals' failure to address nurses' health problems was contributing to their exposure to TB, its extensive survey of work conditions in 1932 made no mention of the problem. This suggests that hospitals did not consider the risk of TB as a cause of recruitment problems in the early 1930s. Evidence at the SDEC supports this conclusion: Matron Dickson identified a range of factors responsible for the Hospital's shortage of nurses including the expense of uniform but not fear of TB infection. Dickson seems to have attached little importance to a significant number of nurses who were suspected of contracting TB at the SDEC in 1929/1930.

Why were doctors at the SDEC and The London Hospital reluctant to make a specific diagnosis of TB during the 1930s? The clinical features of TB resembled other ailments making diagnosis difficult. Its stigma may have affected the nurses' future chances of employment. The disease's associations with many aspects of the lives of the poorer working classes may have implied that a hospital with a high nurse TB rate was failing to care for its staff. Hospitals needed to promote a favourable image to counterbalance competition from other occupations. The SDEC doctors' reluctance to diagnose TB may have been tied up with its shortage of nurses and its wish not to lose experienced nurses and probationers. A diagnosis of suspected TB shaped its treatment of nurses: it meant that a nurse could be sent home to recover for as long as necessary, at no financial cost to the hospital, and then be allowed to return to work. The London Hospital did not experience a shortage of nurses during the 1930s and dismissed nurses with suspected TB. Nurses' treatment of TB at the CMH may have depended on their seniority and personal wealth. Evidence suggests that senior nurses received full pay and the value of their emoluments whilst junior nurses received only a small proportion of their wage.

The problem of TB amongst SDEC nurses began to be taken more seriously during the 1940s when doctors began to make definite diagnoses, nurses were sent to

sanatoria for treatment and concern grew about the number of cases of open TB on the wards. It is not clear what was responsible for this change in approach although the impact of the shortage of nurses during the Second World War, stimulating national interest in both the risk TB posed to nurses and the development of an occupational health service may have played a part. Health services for nurses were recognised as having fallen behind those offered to other occupational groups. During this period a number of organisations argued that hospitals should take a more active role in preventing TB. No attempt was made, however, to encourage the State to regulate the recommendations made. Hospitals remained at liberty to set their own standards of care for nursing staff.

The influence of nurses' class background on susceptibility to illness continues to be an important theme of this study. Research during the 1940s regarding nurses' risk to TB challenged late nineteenth century perceptions that middle class nurses were more vulnerable to illness than their working class counterparts. The Proffit Survey concluded that working class nurses were more susceptible to TB. This change reflected a shift in society's understanding of the relationship between class and health, particularly in relationship to TB and its associations with many aspects of the lives of the poor working classes. The Proffit Survey noted that nurses' class background played a part in determining what type of hospitals nurses gained entry to. Working class nurses were more likely to work in hospitals which admitted advanced cases of tuberculosis. They also endured more arduous working conditions and received less nutritious diets lowering their resistance to infection.

Evidence from the SDEC and The London Hospital confirms the findings of the Proffit Survey. More nurses contracted TB at the SDEC than The London. The SDEC admitted more TB patients than The London. Both hospitals treated patients with pulmonary TB on open wards rather than in isolation. Many SDEC recruits were from

working class backgrounds and found it difficult to afford uniform and textbooks. The SDEC experienced recurrent recruitment problems; all applicants were accepted for training and then selected for suitability once in post. Very few nurses contracted TB at The London Hospital. Nurses were from a mixture of working class and lower middle class backgrounds. The London Hospital had a waiting list of applicants and was able to select the healthiest and best educated. Despite its regulation prohibiting the admission of pulmonary TB patients, the numbers admitted were at a similar rate to those identified by an American study as cause for concern.

Did the theme of gender continue to shape discourses on nurses' health?

Discussion of gender differences in susceptibility to TB occurred when mortality rates increased by twenty-five per cent for men and thirty-five for women aged twenty to twenty-five during the First World War.<sup>734</sup> From 1921-1930 mortality rates for women, aged ten to thirty, exceeded men. Below the age of ten and from the age of forty, men were significantly more vulnerable to disease than women.<sup>735</sup> To some extent, discourses continued to search for an explanation of nurses' susceptibility by drawing on this gendered vulnerability. Criticism of nurses' lifestyle linked with the idea that women's emancipation and increased rates of employment had contributed to the rise in mortality rates. One commentator, O. Buxon, suggested that the constitution of women's nature contributed to the problem. The Proffit Survey also found that young women were more likely to develop TB than men in similar environments. Harrison argues that debates about the damaging consequences of some kinds of work on women's health sometimes resulted in measures regulating against women participating in the work force.<sup>736</sup> This was not the case in nursing although recommendations were made that recruits with a negative reaction to skin testing on entry to training should not

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<sup>734</sup> Bryder, *Below the Magic Mountain*, p.105.

<sup>735</sup> Tuberculosis deaths by sex and age, England and Wales, 1921-1930, *NAPT Council Report, 1932* quoted in Bryder, *Below the Magic Mountain*, p.9.

<sup>736</sup> Harrison, *Not only the 'Dangerous Trades'*, pp.55-75.

be allowed to nurse TB patients but found work elsewhere in the hospital.

The reports of the Proffit Survey and the Dale Committee and the Industrial Injuries Advisory Council's prescription of TB as an occupational health risk for nurses in 1951 contributed to the development of an occupational health care service for nurses by defining minimum standards of care although no moves were made to enforce hospitals to adopt such standards.

## CHAPTER SEVEN

### **The influence of industrial psychology on the recruitment and welfare of general and mental nurses 1930-1948**

In 1947, Sir Robert Wood directed his Government-appointed Inquiry into nursing's recruitment problems to adopt a 'scientific' approach, drawing on 'psychological and statistical research - social, industrial and educational.'<sup>737</sup> Wood's Inquiry, stimulated by the prospect of providing nursing services for the National Health Services, marks the increasing importance attached to psychological ideas in relation to the selection and welfare of nurses after the Second World War. The aim of this chapter is to assess why nursing enquiries shifted away from the traditional approach of a committee of doctors and nurses to a panel of experts drawn from the fields of psychology and education. These experts favoured new ideas of freedom and self-discipline as a solution to the recruitment problems and nurses' welfare. In the late 1930s, nurses' discontent with pay and work conditions questioned the role of the College of Nursing and renewed the movement to unionise nurses. Financially insecure, voluntary hospitals were limited in their ability to respond and any recommendations involving non-monetary changes were taken seriously. This chapter asks whether psychology or the shortage of nurses prompted changes in attitudes towards nurses' discipline at the three case study institutions.

The theme of nurses' discipline and its relationship to health is important to this thesis. Chapter two noted how nineteenth century concepts of self-sacrifice and hierarchical obedience encouraged the belief that health risks were to be endured as part

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<sup>737</sup> *Report of the Working Party on the Recruitment and Training of Nurses*, London: HMSO, 1947, p.60. Chaired by Sir Robert Wood and hereafter known as *The Majority Report*, p.1. Sir Robert Wood (1886-1963) entered the Board of Education in 1911 as school inspector. Subsequently he held a number of positions: private secretary to the President of the Board of Education, 1926-1928, Director of Establishments, 1928-1936, and Principal Assistant Secretary for technical education, 1936-1940. Rafferty, *The Politics of Nursing Knowledge*, p.249.

of a nurses' commitment to self sacrifice. Eva Luckes, Matron of The London Hospital, believed that the 'right' type of recruit had sufficient mental strength to cope with the military style discipline she favoured without complaining. Senior nurses continued to interpret ill health as an indication of a lack of vocation to nurse and this shaped the behaviour of ill junior nurses until the 1930s, according to chapter six (p.227). Nurses were deterred from seeking treatment for minor illnesses (considered important in the early detection of TB) because of senior nurses' claims that nurses' ill health was imagined. The traditional system of nurse discipline encouraged suspicion amongst senior nurses and fear amongst their juniors. In the late 1930s and 40s discipline began to be recognised for its detrimental effect on the physical and mental health of nurses, particularly as a cause of low morale.

Why was discipline still considered necessary in the 1930s? Abel-Smith suggests that many senior nurses believed it to be essential 'to ensure that patients got efficient treatment.' Probationers' lives bore remarkable similarities to their late nineteenth century counterparts consisting of 'petty restrictions, petty tyrannies and plenty of heavy domestic work.'<sup>738</sup> Hart argues there was considerable vested interest in its survival. The College of Nursing largely represented senior nurses, matrons who 'defended the traditional institutions of nursing' that now faced criticism.<sup>739</sup> It was not sympathetic to the 'liberalisation of student conditions' and consistently emphasised policies that drew the sharpest possible line between their members, and others employed in nursing.<sup>740</sup> Hart argues that some doctors supported a disciplined regime to preserve medical superiority and the continued subordination of nursing, a hospital based model of care the College condoned and colluded with, structuring recruitment, training and work around it.<sup>741</sup> Carpenter disagrees suggesting that 'modern doctors

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<sup>738</sup> Abel-Smith, *A History of the Nursing Profession*, p.140.

<sup>739</sup> Carpenter, *Working for Health*, p.204.

<sup>740</sup> Dingwall et al., *An Introduction to the Social History of Nursing*, p.100.

<sup>741</sup> Hart, *Behind the Mask*, p.56.

wanted a modern nurse with a degree of initiative rather than the handmaiden produced by the traditional system.’<sup>742</sup> Interestingly Starns suggests that nursing became more disciplined and militarised from 1939 in a move to elevate nurse status and compensate for the occupation’s lack of political power to determine policy during the Second World War and in the build up to the NHS.<sup>743</sup> Our discussion explores a different viewpoint suggesting that discipline became more relaxed in response to nursing’s recruitment problems and a bid to attract new recruits.

Nursing’s lack of political power resulted in a shift in the occupation’s gender identity, according to Starns. She suggests that the nursing ideology associated with nineteenth century middle class femininity (pp.20-21, 79-81) began to lose credibility during the Second World War. Nurses adopted qualities associated with the military and masculinity in order to gain status and professional power.<sup>744</sup> This chapter will suggest that psychologists also supported the idea that femininity alone was no longer a qualification to nurse; psychological research recommended that the ‘ideal’ nurse possessed a combination of masculine and feminine qualities.

Nurse leaders’ continued emphasis on a disciplined ideology as a necessary part of nurse training has been linked to notions of class. Chapter six noted how a shortage of recruits in the 1930s was related to an alleged decline in nursing’s appeal as a career for well-educated, middle class girls. Rafferty suggests that whilst it was acknowledged that nursing would always be considered a vocation governed by rigid regulations, some nurse leaders upheld the belief that if the ‘right’ type of probationer could be attracted, strict discipline would be unnecessary.<sup>745</sup> Investigations were shaped by the need to protect and enlarge nursing’s share of the market of well-qualified, middle class school

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<sup>742</sup> Carpenter, *Working for Health*, p.204.

<sup>743</sup> Rafferty, *The Politics of Nursing Knowledge*, p.173; Dingwall et al., *An Introduction to the Social History of Nursing*, p.109.

<sup>744</sup> P. Starns, *March of the Matrons*, Peterborough: DSM, 2000, p.44.

<sup>745</sup> ‘The Nurse’s Life’, *The Times*, 19 February 1932; Rafferty, *The Politics of Nursing Knowledge*, p.150.



leavers. These investigations were increasingly subjected to views and reports from outside the nursing profession, contributing to the idea that nurses had lost professional power and needed expert assistance. As already mentioned, experts from education and psychology were invited to join officials and nurses in solving the recruitment problems.<sup>746</sup>

In the 1940's intelligence tests 'were seized upon as the panacea for nurse selection and recruitment' because of their apparent capacity to discriminate between innate talent and educational background.<sup>747</sup> According to Nash, intelligence tests were not impartial to class background because they favoured the educated and this was generally accepted as the middle class because of the variability in class access to education. This variability was not seen as unfair but as a reflection of the intellectual differences between social classes caused by environmental and genetic factors.<sup>748</sup>

Did nurses resent the advice of non-nurses regarding the restructuring of their occupation? Starns believes they did: although nurses were called upon to give evidence, represented by the Royal College of Nursing, the General Nursing Council, the Association of Hospital Matrons and the College of Midwives, committee agendas often reflected the interest of its chairman and other members of the working party. From the mid 1940s, psychologists and psychological research played an influential role in inquiries although whether this changed the style of nurse management at the three case study institutions will be assessed. Before we consider whether psychology or the shortage of nurses shaped attitudes towards the recruitment, selection, discipline and welfare of nurses, we must examine the development of industrial psychology.

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<sup>746</sup> Dame E.Cockayne, Chief Nursing Officer at the Ministry of Health in 1948 quoted in Starns, *March of the Matrons*, p.56.

<sup>747</sup> Rafferty, *The Politics of Nurse Education*, p.170.

<sup>748</sup> R. Nash, 'Class, 'Ability' and Attainment: a problem for the sociology of education', *British Journal of Sociology of Education*, Vol. 22, No. 2, 2001, p.190.

## Industrial Psychology

In 1933 Charles Myers (1873 -1946), renowned psychologist and formerly Director of the Cambridge Psychological Laboratory, defined industrial psychology as a science concerned with the application of the ‘knowledge of mental processes to the conditions obtaining in modern industry.’ It was to deal with the human as opposed to the mechanical aspects of occupational life and aimed at not only reducing workers’ ‘effort’ and ‘irritation’ but also increasing interest and contentment in their employment. Myers suggested that industrial psychology could be extended to apply to commercial and professional employees as well as those from industry. It was to include study of psychological relations between labour and management, incentives to work, posture and movements of the worker, training and selection, distribution of periods of rest, physical environment and psychological factors influencing the distribution of products, for example in advertising.<sup>749</sup>

Industrial psychology developed during the second half of the nineteenth century shaped by physiology, nutrition and fatigue. It was the problem of fatigue, however, that became the focus of scientific work.<sup>750</sup> McIvor argues that a wide gap existed before the First World War between research findings and best practice and that British management (with some exceptions) grossly neglected the human element in production, ignored human physiological and psychological limitations and exacerbated problems of mental and physical fatigue.<sup>751</sup> Chapter five noted that research into workers’ health, fatigue and efficiency by the Health and Munition Workers’ Committee (HMWC) during the First World War led to the formation of the Industrial

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<sup>749</sup> C. Myers, *Industrial Psychology in Great Britain*, London: Jonathon Cape Ltd, 1933, p.13.

<sup>750</sup> L. Koppes, *Historical Perspectives in Industrial and Organisational Psychology*, London: Lawrence Erlbaum Associates, 2007, p.8.

<sup>751</sup> A.J. McIvor, ‘Employers, the government and industrial fatigue in Britain, 1890-1919’, *British Journal of Industrial Medicine*, Vol. 44 (11), November 1987, pp.724-732.

Fatigue Research Board (IFRB) in 1918. The IFRB carried out a number of studies in various industries into the relationship between hours of labour and conditions of work and fatigue.<sup>752</sup> In 1921, Charles Myers set up the National Institute of Industrial Psychology (NIIP) with Henry Welch. Its ambition was the promotion of systematic scientific methods to achieve a more effective application of human energy in occupational life and a correspondingly higher standard of comfort and welfare for workers. It invented a range of tests for vocational selection when it found that academic types of psychological tests were not suitable in the appointment of factory workers.

The selection of recruits during the First and Second World Wars also influenced the development of occupational psychology. According to Matthew Thomson, the desperate need for manpower in Britain during the First World War and the deskilled nature of trench warfare made quantity rather than quality of troops the overriding military concern. Circumstances were different in America where the cost of dispatching troops to Europe made authorities more ready to reject the mentally weak. Unlike Britain, American recruits underwent psychological testing with far more recruits rejected for mental or educational reasons.<sup>753</sup> Thompson argues that this led to much lower rates of mental disablement, ill discipline and suicide. By the end of the First World War, the inadequacy of British mental testing became apparent.

The Second World War saw extensive use of psychological selection methods with apparently successful results. At the outset of the conflict, partly in response to the growing technological complexity of warfare, psychologists from the Industrial Health Research Board and other organisations created new psychometric procedures.<sup>754</sup> In

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<sup>752</sup> Myers, *Industrial Psychology in Great Britain*, p.16.

<sup>753</sup> M. Thomson, 'Status, Manpower and Mental Fitness: Mental Deficiency in the First World War' in R. Cooter, M. Harrison & S. Sturdy, *War, Medicine and Modernity*, Stroud: Sutton Publishing Ltd, 1998, pp.151-159.

<sup>754</sup> L. Koppes (ed), *Historical Perspectives in Industrial and Organisational Psychology*, p.99.

1942, the War Office Selection Boards were established, initially for officer selection and later for all army recruits who were subjected to a series of intelligence and aptitude tests and interviews. Sir Robert Wood and John Cohen (authors of two important investigations into nurse recruitment problems in 1947 and 1949) suggested that the ‘*Report of the Expert Committee on the Work of Psychologists and Psychiatrists in the Services*’ had influenced their ideas about the selection of nurses.<sup>755</sup> Used in other areas of employment training, wastage was reduced from fifty per cent to fifteen per cent.<sup>756</sup>

It was not only ideas connected with occupational psychology that shaped conversations about discipline and nursing but also changing ideas about the nature of education. Supporters of the ‘progressive method’ of teaching considered it no longer appropriate to produce an atmosphere of fear and anxiety in the classroom. Pupils, it was argued, must be allowed to express ‘real character.’ A shift in emphasis from external control to self-discipline as an ideal can be traced in successive editions of the ‘*Board of Education’s Handbook for Teachers*’ between 1917 and 1937. Teachers were warned not to correct misbehaviour by punishment or repression but to search for its cause in the home or school environment and then help the child to readjust.<sup>757</sup> Educational methods now ‘insist[ed] on the importance of developing a student’s personality and tastes outside the range of daily work...which relied on arousing, instead of dampening, curiosity and initiative.’<sup>758</sup> These ideas, which had shaped many nurse recruits’ school education, sat uneasily with the 1930’s system of nurse training. Some senior nurses continued to believe that vocational spirit could be fostered by the

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<sup>755</sup> W. Jameson, *Report of an Expert Committee on the Work of Psychologists and Psychiatrists in the Services*, London: HMSO, 1947.

<sup>756</sup> *The Majority Report*, p.60.

<sup>757</sup> Bevington, *Nursing Life and Discipline*, pp.62-65.

<sup>758</sup> *The Lancet Commission on Nursing: appointed in December 1930, to inquire into the reasons for the shortage of candidates, trained and untrained, for nursing the sick in general and special hospitals throughout the country, and to offer suggestions for making the service more attractive to women suitable for this necessary work: Final Report*, London, 1932, p.29.

performance of routine work for nine to ten hours a day.<sup>759</sup> Domestic work formed a significant part of this routine and included the cleaning of brasses, dusting and polishing, scrubbing sinks and baths, washing paintwork and washing and ironing patients' clothes.<sup>760</sup> These senior nurses wished to continue a system which allowed them the freedom to impose their own disciplined regime on recruits and resented the introduction of a standard curriculum, refusing to give probationers time to study during the working day.

Having traced the development of a system of ideas that attached increasing importance to workers' psychological welfare, we will examine how ideas of freedom and self-discipline influenced inquiries into nursing and nurses' welfare at the case study institutions. To measure the extent to which attitudes towards discipline and welfare changed during the 1930s and 40s, we will examine the first inquiry of the period into nursing's recruitment problems, *The Lancet Commission*.

## **The Lancet Commission 1932**

In 1930 *The Lancet* launched a private initiative based on the model of its great investigations in the nineteenth century. Its terms of reference, discussed in chapter six (pp.212-214), were to 'inquire into the reasons for the shortage of candidates trained and untrained ... and to offer recommendations for making the service more attractive to women suitable of this necessary work.'<sup>761</sup> Competition from other occupations, 'which offered better salaries and better prospects with more freedom, more social amenities and without the restrictions and long hours of institutional life,' was identified as the main cause of the recruitment crisis.<sup>762</sup> Strict, disciplined styles of nurse management were also recognised as a source of mental distress amongst nurses.<sup>763</sup>

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<sup>759</sup> *The Lancet Commission on Nursing, Final Report*, p.29.

<sup>760</sup> *The Lancet Commission on Nursing, Final Report*, p.131.

<sup>761</sup> *The Lancet Commission on Nursing, Preface*.

<sup>762</sup> *Final Report of The Lancet Commission*, p.xxiv.

<sup>763</sup> *The Lancet Commission on Nursing, Final Report*.

The Commission, chaired by the Earl of Crawford, strongly represented voluntary hospitals' interests and included two hospital matrons, a girls' school headmistress, two doctors but no psychologist or other 'outside' experts.<sup>764</sup> Given voluntary hospitals' financial insecurities, its remit was to make non-monetary recommendations regarding nurses' work conditions.<sup>765</sup> It aimed to find solutions by adapting existing systems but this restricted remit meant that its report had little impact.<sup>766</sup>

The extent of the Commission's enquiry was also limited by the size of its sample of nurses. Although it included evidence from the major nursing organisations,<sup>767</sup> it received only 686 replies (sixty seven per cent) to the 1031 questionnaires sent to hospitals in England and Wales.<sup>768</sup> Only sixty probationers were questioned directly by interview, selected on the basis that they were 'personally known' to commission members 'or to their friends.' Fifty-seven nurses declared themselves 'essentially happy in their profession' although their evidence suggested a different picture, raising more points of objection about the system of nurse training than those in favour. Their objections included 'excessive restrictions and discipline in the nurses' home ... often treated as children ... favouritism and capriciousness among

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<sup>764</sup> Members were M.D. Brock, Headmistress, the Mary Datchelor Girls' School; L. Clark, Matron, Whipps Cross Hospital; Henry Clay, late Professor of Social Economics in the University of Manchester; R. Darbyshire, Matron, University College Hospital; F. R. Fraser, Professor of Medicine in the University of London; A. Lister-Harrison, Chairman, Committee of Management, Metropolitan Hospital; Dr. Robert Hutchinson, Physician to the London Hospital and to the Hospital for Sick Children, Great Ormond Street; Mrs Oliver Strachey, Chairman, Employment Committee, London and National Society for Women's Service; Miss E. Thompson, Member of Council, Bedford College, University of London; Sir Squire Sprigge, Editor of *The Lancet*; Dr. M. Kettle, assistant editor and honorary secretary. *The Lancet Commission on Nursing, Final Report*, p.7

<sup>765</sup> Dingwall et al., *An Introduction to the Social History of Nursing*, p.99.

<sup>766</sup> *The Lancet Commission on Nursing, Final Report*, p.11.

<sup>767</sup> Catholic Nurses Guild; The College of Nursing; Association of Hospital Matrons; International Council of Nurses; Mental Hospital Matrons Association; Queen Alexandra's Imperial Military Nursing Service; Queen Alexandra's Royal Naval Nursing Service; Queen's Institute of District Nursing.

<sup>768</sup> Bradford Hill, 'Statistical Analysis of the Questionnaire', *Final Report*, p.II.

the sisters ... nursing obliterated personality.’<sup>769</sup> Despite this evidence, the Commission concluded that it was a ‘myth’, perpetuated by teachers and parents, that training socially isolated nurses from ‘friends, games and social amusements’ or that the ‘probationers were always physically overtired.’

Discipline, the Commission agreed, needed to be relaxed although it felt that many hospitals would continue to maintain strict regimes ‘until a better type of candidate presents herself.’<sup>770</sup> Nursing’s failure to attract women of social quality validated continuation of a disciplined style of nurse management. Commentators interpreted the recruitment crisis not as a result of an expansion in acute hospital services prompting a need for more nurses but within a framework of social class. Although recent studies suggest that nursing was a socially mixed occupation, nurse leaders continued to focus on middle class women as important to the future status of the profession.<sup>771</sup> It is unclear whether The Commission held working class nurses’ background or changing lifestyles in all social classes as responsible for recruits’ lack of self-discipline both on and off duty. ‘It is not surprising’ the *Report* argued, ‘that the hospitals should continue to treat probationers as children, since many of them have not been trained to self-government before entering hospital.’ Thus, the Commission argued the necessity for an emphasis on discipline in training to continue.

In contrast to psychological thinking in the late 1940s, which emphasised freedom as a necessary criteria for the development of self-discipline, The Lancet Commission believed that only after undergoing a strict three year hospital training, was a nurse ‘fit to be trusted to regulate her own life in hospital outside working hours.’<sup>772</sup> Although the Commission’s stance on discipline appears conservative compared to

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<sup>769</sup> *The Lancet Commission on Nursing, Final Report*, pp.178-179.

<sup>770</sup> *The Lancet Commission on Nursing, Final Report*, pp.28-31.

<sup>771</sup> Abel-Smith, *A History of the Nursing Profession*, p.17; Maggs, *The Origins of General Nursing*, p.25; Dingwall et al., *An Introduction to the Social History of Nursing*, p.69.

<sup>772</sup> *The Lancet Commission on Nursing, Final Report*, p.32.

inquiries even five years later, it was willing to recommend small improvements i.e. that a trained nurse was capable of caring for herself off duty. It recommended that nurses' homes be 'run on informal lines as a hostel under a warden' and that probationers should no longer have to go to bed before 10.30 pm or put their lights out thirty minutes after retiring.<sup>773</sup> These recommendations failed to tackle the division between some senior nurses, and their adherence to traditional nursing values, and young women, many of who had received a progressive form of education. This division was identified as the reason why some probationers left.

Large sections of the nursing profession remained convinced of the value of a military style of discipline that included uncritical obedience, punctuality, and loyalty to superiors and to their training institution. Evidence to the Commission suggested such a system was the cause of 'physical strain', particularly because of the high speed nurses were expected to work at. The Commission recognised that improvements in work conditions often only served to incense senior nurses who felt that because they had endured a strict style of discipline then so should their juniors. Such attitudes were responsible for 'mental conflict' and 'worry' amongst probationers, the Commission argued, particularly those from 'good secondary schools.'<sup>774</sup> It is interesting to note that probationers from 'good' schools were identified as more likely to suffer from mental anxiety, implying that well-educated, middle class girls had different mental health needs to that of their less educated, working class counterparts. As was noted in chapter six (p.203), what was said about education 'may really have been a polite way of making statements about social class.'<sup>775</sup> The idea that social class influenced nurses' physical and mental health was suggested by Eva Luckes in the 1890s (chapter three pp.94-95) as rationale for improvements to living accommodation.

*The Lancet Commission's Final Report* marks the beginning of a movement

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<sup>773</sup> *The Lancet Commission on Nursing, Final Report*, p.170.

<sup>774</sup> *The Lancet Commission on Nursing, Final Report*, pp.29-31.

<sup>775</sup> Abel-Smith, *A History of the Nursing Profession*, p.153.



calling for a relaxation in nurse discipline. The Commission recommended the introduction of ‘small psychological concessions’ to nurses rather than material improvements. Nurses, it argued, ‘worried’ even in ‘luxurious nurses’ home and an excellent dietary’ because their limited freedom acted as ‘a more potent source of discontent than poor accommodation or badly served food.’ ‘Trivial regulations or concessions’, such as going for a summer walk, had ‘a psychological value altogether out of proportion to the difference they make in a normal day’s routine.’ It recognised that matrons needed to change but felt that most were willing to do so as long as discipline in duty hours remained the same. How a change in discipline was to be implemented, however, was left largely unaddressed; the practicalities of convincing senior staff that changes in nurses’ lives had not kept pace with the amount of personal freedom and independence given to women in other occupations was left for individual matrons to decide.<sup>776</sup>

Gertrude Littleboy, Matron at The London Hospital (1931-1938), met with the London Hospital Nursing Committee to discuss *The Lancet Commission on Nursing’s Final Report* in June 1932. A small concession was made which allowed nurses forty-five minutes for dinner instead of thirty and private staff nurses (but not hospital staff nurses or probationers) to keep their bedroom lights on after 10.30pm ‘provided they did not take advantage of the exception.’<sup>777</sup> This decision illustrates senior nurses’ reluctance to make any significant changes to existing systems of discipline. By comparing attitudes towards discipline in our case study institutions we can assess whether Littleboy’s attitude was typical.

### **Discipline in the case study hospitals in the 1930s**

Matron Lees’ response to a nurses’ letter of complaint about poor work conditions at the

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<sup>776</sup> *The Lancet Commission on Nursing, Final Report*, p.30, pp.100-101.

<sup>777</sup> RLH, The London Hospital Nursing Com and Sub- Com Mins, LH/A/9/63, 27 June 1932, p.37.

South Devon and East Cornwall Hospital in 1932 illustrates a similar determination to Littleboy to maintain a disciplined style of nurse management. Lees sacked the letter's ring leader, Probationer Van Unsworth, noting that she was a 'smart girl, ward work good but had no regard for hospital discipline.' The letter from twelve probationer nurses was published in the *Western Morning News* and, according to Lees (1931-1937), damaged the SDEC's reputation.<sup>778</sup> The nurses involved were asked to apologise or leave: all chose to apologise. What is interesting about this incident is that the Hospital Chairman, Sir Henry Lopes, and the House Committee blamed the probationer nurses and not the Matron. No thought was given to the possibility that these nurses feared Lees to the degree that they had been unable to approach her with their complaints. Lees' style of management received no criticism from the Board of Governors and was effectively endorsed by Van Unsworth's dismissal. Lees continued to reinforce her authority through a military style of discipline, unchallenged, throughout the 1930s. The House Committee's response to this letter of complaint stands in dramatic contrast to a very similar incident in 1942, which will be discussed later.

Lees' position as Matron gave her considerable authority over nurses' on and off duty lives. In 1933, Nurse Loan, one of those involved in the published letter, was dismissed for failing the preliminary state examination and Lillian C. for fraternising with the son of a hospital cleaner.<sup>779</sup> Lees seems to have regulated a set of written and unwritten rules including dictating who was suitable for romantic relationships with nurses. There is no evidence to suggest that Lillian was sacked because her relationship took place during working hours or that it affected her work. It was probably because Lees disapproved of the boy's working class background and may have considered that such a relationship would upset the Hospital's hierarchy. As mentioned in chapters

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<sup>778</sup> PWDRO, SDEC Nurses' Register, 1490/27, 1 November 1932.

<sup>779</sup> PWDRO, SDEC General Com Mins, 606/1/15, 1 November 1933, 5 November 1933.

two, three and five, nurse leaders had been determined to define a boundary between nursing and domestic work since the mid-nineteenth century when notions of discipline, class and gender were used to demark 'old' domestic style nurses from 'new' professional nurses. This determination continued after the Registration Act of 1919 when nurse leaders refused to participate in government legislation that bracketed nurses in the same class as domestic workers in 1920. The pursuit of professional status was about creating social boundaries as well as certificated.

Discipline at The London Hospital in the early 1930s appears to have been even stricter than the SDEC, on matters of nursing care and off duty rules. The idea that nurses could be moulded into shape by adhering to a strict set of regulations prevailed. In 1932 Matron Littleboy 'asked sister to speak to probationer Mary M. as the water for the patients' dinner was already in the tumblers on the trolley in the kitchen at 11.25am.'<sup>780</sup> This comment suggests that the Matron paid close attention to detail, controlling every aspect of nurses' working lives by a strict timetable. It is interesting to note that Matron Littleboy did not speak to Mary M. herself 'as she was in the middle of giving treatment to a patient' suggesting the role of matron included administering patient care.

Littleboy attached great importance to a nurse's ability to obey commands and respond to correction. 'From the beginning Betty W. was not an easy probationer to train, despite being educated and intelligent': Littleboy considered this was because her family had let her do as she wanted and as a result 'she found it difficult to conform to discipline.' She was disciplined twice about the untidiness of her room and later resigned because of the restrictions off duty.<sup>781</sup> Littleboy's disappointment that Betty failed to live up to her expectations associated with an educated, middle class background is clear. As mentioned earlier, The Lancet Commission rationalised the

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<sup>780</sup> RLH, The London Hospital, Official Ward Book, LH/N/6/58, 9 July 1932.

<sup>781</sup> RLH, The London Hospital, Register of Nurse Probationers, LH/N/1/36, November 1931- November 1932, 9 July 1932, p.9.

necessity for strict discipline on the basis of nursing's failure to attract middle class recruits. Middle class women were perceived as more self-disciplined than their working class counterparts although Betty's case challenges this perception. Despite her class background she was unwilling or unable to discipline herself, a fact Littleboy attributes to her family's lifestyle. Our discussion will show that some commentators suggested that it was smaller family sizes in the early twentieth century that were responsible for indulging children and producing a generation who lacked discipline.

Nurses' illness remained a sensitive issue at The London Hospital. It was surrounded by suspicion and sometimes interpreted as a lack of self-discipline. Ivy E., aged 23, was sacked because 'she was rather lazy, very feeble about her health and went off duty for the slightest ailment.' Despite a catalogue of illnesses including removal of ganglion, tonsillectomy and gastric symptoms that involved vomiting blood, Littleboy felt that 'Ivy E. tampered with the thermometer and exaggerated her symptoms all she could.'<sup>782</sup> As mentioned in chapters two (pp.58-64) and six, suspicion had characterised attitudes towards nurses' illness at The London Hospital from 1890 onwards and cannot be attributed to the personality of one particular matron.

Senior nurses at the Cornwall Mental Hospital continued to play little part in the management or discipline of nurses. Indeed there was little change from the pattern established in the late nineteenth century. Like Lees at the SDEC, Medical Superintendent Dr. W.G. Rivers (1931-1939) regulated staff relationships. Relationships between male and female attendants were banned and had been so since the late nineteenth century. It is difficult to know whether the ultimatum given to Attendant Garnett T. (aged 33) to either lose three years service or face dismissal unless he married pregnant Nurse Hannah F. within one month, arose because he had broken Hospital rules or Rivers was determined to instil a code of morality.<sup>783</sup>

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<sup>782</sup> RLH, The London Hospital, Register of Nurse Probationers, LH/N/1/36, 1932, p.124.

<sup>783</sup> CRO, CMHVC Mins, HC1/1/1/30, 27 July 1936, p.337.

The Lancet Commission identified female asylum nurses as responsible for mental hospitals' problems with staff relationships. The employment of men and women, the Commission argued, attracted 'a group of girls' solely interested in 'their masculine friendships.' This group, labelled 'drifters', were neither interested in education nor training and deterred more suitable candidates. With the aim of broadening mental nurses' outlook and fostering 'a spirit of inquiry and self-expression' the Commission recommended that debates on nursing and 'other matters' be introduced into mental nurses' off duty time. The CMH introduced such a series of talks, thirteen years later, in 1945.<sup>784</sup>

The key points raised in this section are that matrons, supported by hospital management committees, used disciplined styles of management to control nurses' on and off duty lives in the early 1930s. Regulations at the SDEC and the CMH incorporated staff relationships but each institution practiced these rules with different aims. At the SDEC, it was an attempt to raise nurses' status by drawing a boundary between nurses' class background and other groups of workers in contrast to the CMH where such rules attempted to instil a code of morality. Having considered the relationship between discipline, class, The Lancet Commission and the case study institutions in the early 1930s, we must now examine the effect of preparations for the Second World War.

### **Self-Discipline, Freedom and Preparations for War**

The prospect of providing nursing services for military and civilian populations under wartime conditions provided an additional stimulus to government action to resolve increasing recruitment problems.<sup>785</sup> The Government commissioned the Inter-departmental Committee on Nursing Services (Athlone Committee) in 1937 to identify

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<sup>784</sup> *The Lancet Commission on Nursing, Final Report*, pp.149-160.

<sup>785</sup> Rafferty, *The Politics of Nursing Knowledge*, p.160.

recruitment and training needs in relation to projected demands on health services. In the same year, an eruption of militant trade union activity among nurses ‘dwarfed anything that had gone before, witnessing the formation of breakaway unions and intense political activity’, according to Hart. Chapter four noted general hospital nurses’ lack of enthusiasm for trade union membership at the end of the First World War but by 1937 attitudes had begun to change. Significant numbers of nurses were beginning ‘to believe that things could be different and were not accepting the discipline and socialisation processes of their profession.’ The impetus to change was related to nurses’ basic pay and work conditions. Nurses’ cited poor pay, long hours, the performance of menial tasks and last minute changes to off duty as responsible for the increased uptake in membership of the National Association of Local Government Officers (NALGO) and the National Union of Public Employees (NUPE). The Guild of Nurses, a branch of the National Union of County Officers (NUCO), organised a march of masked nurses (to avoid victimisation) through central London in protest of poor conditions, calling for a forty-eight hour week and more pay.<sup>786</sup>

Why did attitudes towards trade union membership change? One could argue that it was partly as a result of the College of Nursing’s perceived failure to address the need for improvements to pay and hours of work. Critics claimed that its continued support for the traditional notions of self-sacrifice and vocation had a detrimental effect on nurses’ health. In 1939, G. B. Carter, a nurse, midwife and formerly organising secretary of the Midwives’ Institute, complained that ‘the old idea of endurance for endurance sake is by no means dead and probably explains why nurses are not taught that their own health is the greatest asset to the patients as well as to themselves.’ She claimed that hospitals frequently ‘neglect[ed] the health of nurses because of staff shortages, lack of funds and ‘the ever ready tendency to rationalise what it is

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<sup>786</sup> Hart, *Behind the Mask*, pp.57-64.

inexpedient to alter.<sup>787</sup> In language reminiscent of late nineteenth century debates about workers' health, Carter claimed that nurses' conditions and clothes would not be tolerated in factories and workshops. The College was condemned as unrepresentative and as 'an organisation of Voluntary Hospital snobs.'<sup>788</sup> Its attachment to a strict style of discipline as part of nurse training was branded outdated. In *A Criticism of Nursing Education*, Dr Harold Balme, Medical Superintendent at Pinderfields Emergency Hospital, argued:

In days like the present, when education and discipline have found to be entirely compatible with freedom for self-expression and initiative, the type of authority which is still imposed in the great majority of nursing schools seems altogether out of place.<sup>789</sup>

He suggested that the traditional system of nurse education underestimated the 'importance of the psychological and cultural sides of a nurse's training' making nurses 'terribly dull and boring as companions.'<sup>790</sup> It is interesting to note that individuals other than psychologists promoted psychology as a solution to nursing's problems. Balme was a qualified surgeon and physician but not a psychiatrist.<sup>791</sup> Carter and he both suggested that self-discipline and freedom to make decisions would help develop a nurse's character. Character training was still considered an important aspect of nurse education but in contrast to the nineteenth century when strict discipline was considered an essential part of the process, now a relaxation in rules was emphasised. Nurses at liberty to stay out late would, Carter argued, be determined to go to bed early on six nights out of seven in the knowledge that a 'nursing career demand[ed] health and

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<sup>787</sup> G.B. Carter, *A New Deal for Nurses*, pp.136-153.

<sup>788</sup> *The Nursing Mirror*, 23 October 1937.

<sup>789</sup> H. Balme, *A Criticism of Nursing Education with suggestions for constructive reform*, London: Humphrey Milford, 1937, p.21.

<sup>790</sup> Balme, *A Criticism of Nursing Education*, p.21.

<sup>791</sup> 'Obituary for Dr. H. Balme', *The Times*, 28 February 1953, p.511.

freshness.<sup>792</sup> She was convinced that given more responsibility about their health, nurses would make wise choices.

The Association of Headmistresses suggested to the Athlone Committee that hospitals gave ‘too little consideration to the trend of modern psychology.’

Nurse training failed to recognise that young people today will often loyally adhere to principles, the reasonableness of which has been proved, while they are goaded into rebellion by prohibitions for which they can see no good reason.<sup>793</sup>

Freedom, the Association argued, engendered a higher degree of loyalty amongst the workforce than restraint. Military style discipline, according to one nurse, produced a fear so great ‘that a mere look from a sister completely reduce[d] them to such a state of nerves that they will behave abnormally.’<sup>794</sup> Balme held matrons’ autocratic power responsible for ‘many of the physical and mental breakdowns which occur among young nurses.’<sup>795</sup> Hospital hierarchy was condemned as an outdated way of instilling discipline and according to Carter, resulted in bullying:

autocracies are suspect, and modern psychologists frank about the motives of matrons and sisters who feel the need to hedge themselves round with forms and ceremonies in order to gain respect.

Carter recommended that hospitals scrap the title of matron on the grounds that it hindered ‘psychological progress’ and replace it with Miss or Mrs and that all nurses on duty be called ‘sister.’<sup>796</sup> Early twentieth century understandings of nurses’ anxiety, discussed in chapter two (pp.106-107), identified the pace of modern life and the nature

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<sup>792</sup> G.B. Carter, *A New Deal for Nurses*, London: Victor Gollancz Ltd, 1939, pp.136-153.

<sup>793</sup> Ministry of Health, Board of Education and Department of Health for Scotland, *Interim Report of the Inter-departmental Committee on Nursing Services*, London: HMSO, 1939, hereafter known as the *Athlone Report*, p.55

<sup>794</sup> *Athlone Report*, pp.55-56.

<sup>795</sup> Balme, *A Criticism of Nursing Education*, p.24.

<sup>796</sup> G. B. Carter, *A New Deal for Nurses*, pp.141-174.



of work as possible causes. By the 1930s, however, understandings had shifted towards the notion that hierarchical relationships within nursing were mainly responsible.

The Athlone Committee found that recruitment problems had adversely affected nurses' health. Many hospitals were so desperate to fill staff vacancies that they failed to perform a medical examination of new recruits. Sisters in charge of nurses' homes passed nurses fit for duty with colds, septic conditions and other minor ailments. 'All nursing staff', the Committee concluded, 'from matrons to first year probationers [were] enduring a strain which cannot be paralleled in any other profession.' This strain was attributed to the fact that nurses had increased their working hours to compensate for the shortage of staff. Despite this evidence, the Committee argued that nurses' hours should remain unregulated by statute. This idea was similar to that put forward by nurse leaders nineteen years earlier when making a case to opt out of government legislation in the early 1920s (see chapter five, pp.169-180). The idea that 'the nursing of the sick [was] not comparable to a trade or industry where the hours of work can be fixed within reasonable limits' continued to hold sway in the late 1930s.<sup>797</sup>

The Lancet Commission's conclusions were now considered 'out of step with the different service demands of an expanding municipal and domiciliary nursing service'.<sup>798</sup> Attitudes towards discipline had changed significantly since 1932, the Athlone Committee argued, because 'the social and industrial structure of the nation had undergone such radical changes.' These changes meant that 'the nursing profession [could] no longer rely upon the "sense of vocation" as the chief stimulus to recruitment.'<sup>799</sup> It is interesting to note that *social* and *industrial* factors were identified as responsible for change. Our discussion will examine these points in turn.

Evelyn Sharp, a feminist journalist, writing in *The Labour Woman*, linked women's position in society with changing social attitudes towards discipline:

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<sup>797</sup> *Athlone Report*, pp.51-60.

<sup>798</sup> Rafferty, *The Politics of Nursing Knowledge*, p.160.

<sup>799</sup> *Athlone Report*, p.8.

the change in our ideas as to what young girls and young women may do with their lives is mainly responsible for the reluctance shown by the modern girl to take up nursing... New regard for personal freedom has sprung from the improvement in the whole position of women. Women no longer required supervision in their leisure hours.<sup>800</sup>

The increasing number of women receiving secondary and further or higher education and an expanding number of career options meant that many women had choices other than nursing. Increased freedom in leisure pursuits plus enfranchisement in 1928 as the same terms as men gave women a sense of confidence that changed attitudes towards discipline. In the late nineteenth century women had fewer career opportunities and were therefore more prepared to tolerate the military style discipline associated with nursing. Indeed, nursing may have provided some women with a means of escape from the confines of family life. Families were reassured for the safety of their daughters by the disciplined hospital environment and nurses' home. As women's options expanded, the incentive to tolerate strict off duty rules decreased.

Changes in the 'industrial structure' of society were also identified as responsible for nursing's declining popularity. The growth of female trade union membership, generally since the First World War, and amongst nurses in the 1930s, may have contributed to the belief that pay and work conditions mattered more than the intangible rewards of a vocation. *The Athlone Report* was keen to remind nurses that trade unionism did not fit well with the vocational nature of nursing: 'from the very nature of her calling, there must of necessity be demands, and at times heavy demands, made on her for self-sacrifice and physical and mental endurance.'<sup>801</sup> 'Emergencies are always arising which may demand some personal sacrifice.'<sup>802</sup> It is interesting how the *Report* captures a sense of conflicting ideals: on the one hand, commentators wanted

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<sup>800</sup> E. Sharp, *The Labour Woman*, April 1932, p.53.

<sup>801</sup> *Athlone Report*, p.9.

<sup>802</sup> *Athlone Report*, p.51.

nurses to aspire to similar ideals to those set by late nineteenth century nurse leaders, particularly notions of self-sacrifice, but at the same time demands for a relaxation in discipline cited the 1930s 'modern' woman as a role model for nurses.

Industrial psychology may have also played a part in changing the industrial structure of society. Certainly a psychological approach to discipline influenced the Athlone Committee's recommendations. With the aim of bringing hospitals in line 'with the best psychological knowledge', *The Athlone Report* cited the practice of the London County Council which allowed nurses freedom to leave the hospital in their off duty hours and to smoke in bedrooms and sitting rooms.<sup>803</sup> *The Athlone Report* also recommended that nurses form councils, based on those recommended for industry in *The Whitley Report*. The aims of the Whitley Councils were to secure co-operation between administration and staff, to promote the well being of employees and to provide machinery for dealing with grievances.

In summary, demands to change the traditional system of discipline to one incorporating new ideas of self-discipline and freedom attracted increasing attention during the late 1930s. Commentators cited psychology as one of the reasons for change as well as social and industrial changes to society. The recruitment problems and the prospect of providing nursing services under war-time conditions elevated nursing into an issue of high priority. Dissatisfaction with poor pay, long working hours and strict discipline prompted an uptake in union membership amongst nurses who perceived the College of Nursing as failing to address their need for material improvements.

## **The War Years**

This next section will argue that the shortage of nurses during the Second World War prompted matrons to consider psychology as a framework on which to organise their nursing departments. In August 1939, an Emergency Medical Service was created to

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<sup>803</sup> *Athlone Report*, p.57.

prepare the health services to cope with the expected effects of the bombing of civilians. Central government commandeered the public and voluntary hospitals and made finance available to improve equipment and buildings. A Civilian Nursing Reserve was set up and for the first time, standardised rates of pay were identified for employers to follow.<sup>804</sup> Despite the improvements in pay (which were no greater in real terms due to the rising cost of living than nurses had received before the War) the shortage of nurses continued.

Psychologists gained increasing prominence during the War Years as critics of nurse training. They recognised the detrimental effects military styles of discipline had on nurses' health and recruitment. One of the most influential was Dr. Sheila Bevington, investigator at the National Institute of Industrial Psychology and specialist teacher at the London School of Economics, whose study of *Nursing Life and Discipline* based on 500 interviews with nurses in five hospitals was cited by the King Edward's Hospital Fund for London *Memorandum on the Supervision of Nurses' Health* (1945) and Wood's *Majority Report* (1946). Charles Myers, the renowned psychologist (discussed earlier, pp.248-249), wrote the preface to Bevington's book. The contemporary probationer, Bevington argued, was 'more sensitive to fatigue and censure than her 'tougher' predecessor' because of the 'decay in walking and the softening influence of membership of smaller families'.<sup>805</sup> This comment is interesting because it suggests that each generation of nurses was viewed more fragile than their predecessor. Chapter three noted that the 'new' middle class nurse of the 1890s was perceived as more susceptible to ill health than the 'old' working class nurse of the early nineteenth century. Whereas class was identified as the factor responsible then, a change in lifestyles was believed to be the principal cause in the 1940s, particularly a

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<sup>804</sup> Rafferty, *The Politics of Nursing Knowledge*, p.167; Carpenter, *Working for Health*, pp.224-225.

<sup>805</sup> S. Bevington, *Nursing Life and Discipline: a study based on over 500 hundred interviews. With a preface by C.S. Myers and a foreward by F. Horsburgh*, London: Lewis, 1943, p.11.

reduction in family size. The early twentieth century witnessed a revolution in contraceptive behaviour as the large Victorian family disappeared.<sup>806</sup> Bevington implies that children from smaller families were less hardy either because they received more care and attention or that smaller families had money to improve their children's lifestyles and they were therefore less tolerant of hardship .

Bevington suggested three reasons why nursing had fallen behind industry in its methods of selecting, dismissing and training staff. Firstly, hospitals lacked the influence of ad hoc societies whose job was to initiate reform and support the appointment of officials with progressive views. Secondly, nursing suffered from a lack of scientific research and thirdly, hospitals had paid less attention to psychology and more to material factors, such as diet and accommodation, as a result of the recommendations of The Lancet Commission and *The Athlone Report*. Interestingly, Bevington did not interpret the division in the pace of reform as public versus private sector: some sections of the public sector were, she argued, apace with industry, particularly prisons and schools.

The notion that nurses' physical and mental health was closely related continued to shape recommendations to improve nurses' welfare. In 1945, Bevington recommended the appointment of welfare supervisors who would be responsible for nurses' 'cultural and social development' as well as physical wellbeing. She suggested that the role involved assisting matrons with recruitment and 'the humanisation of staff relations.'<sup>807</sup> The idea that close links existed between nurses' physical and mental health was not new. In 1911, Dr Geheimerat Hecker identified mental illness as a symptom of nurses' physical 'overstrain'(pp.106-109). Nurses' mental wellbeing was advocated by Bedford Fenwick in 1920 in support of a reduction in working hours, arguing that nurses needed time to maintain their 'spiritual' health by participating in

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<sup>806</sup> K. Fisher, *Birth Control, Sex and Marriage in Britain, 1918-1960*, Oxford: Oxford University Press, 2006.

<sup>807</sup> Bevington, *Nursing Life and Discipline*, p.27.

cultural and social activities (pp.172-173).

Some matrons resented the idea of welfare supervisors on the grounds that they would restrict their authority over nurses. Matron Littleboy of The London Hospital did not want 'a Welfare Officer acting as a go-between between her and the nursing staff'. Instead, she advocated the appointment of a:

social secretary to assist with the various activities *she* (the Matron) felt were desirable for the Nursing Staff ... she had seen these arrangements carried out in the United States of America<sup>808</sup>

This suggests that some senior nurses were more willing to adopt an international framework of ideas about the welfare of nurses than take up psychologists' recommendations. Littleboy appointed a 'lady' herself, paying their salary from her own 'special' fund. She limited the role to arranging 'educational and social visits' and booking entertainment and travel tickets. By doing so, she effectively eliminated any threats to her authority.<sup>809</sup>

Evidence from the SDEC and its linked hospitals suggests that its shift towards a more relaxed style of nurse management was a pragmatic response to recruitment problems during the Second World War rather than the influence of psychology. The Prince of Wales Hospital (originally called the Homeopathic and General Hospital) had combined with the South Devon and East Cornwall Hospital, Lockyer Street Hospital and the Royal Albert Hospital in 1934. The hospitals were situated in the centre of Plymouth, an area that suffered considerable damage during the Blitz, causing a further fall in recruitment. In 1943, the Prince of Wales Hospital was short of two trained nurses and five probationers. Each hospital in the group retained their own matron who attended a joint nursing committee each month.<sup>810</sup> To illustrate the change in

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<sup>808</sup> RLH, The London Hospital, Nursing Com Mins, LH/A/12/41, 27 June 1949, p.8.

<sup>809</sup> RLH, The London Hospital, Nursing Com Mins, LH/A/12/41, 27 June 1949, p.8.

<sup>810</sup> An article in the *Nursing Times*, 19 March 1938, p.306, discussed matrons' lack of

management styles our discussion will compare and contrast hospital management's response to the nurses' letter of complaint of 1932, discussed earlier (pp.256-257), with that of a similar letter written in 1942. In 1932 SDEC management blamed complaining nurses for bringing the hospital into disrepute but supported Matron Lees disciplined style of management despite evidence suggesting that nurses feared her unapproachable attitude and that she ignored their complaints. This reaction contrasted with the management's response a decade later.

In 1942, a group of trained nurses and probationers at the Prince of Wales Hospital complained to Plymouth's *Evening Herald*, of long working hours, a lack of lectures, poor diet and too much domestic work:

We have been told that we belong to a noble profession and that we are doing a great bit in the war effort. Are we supposed to be so noble that we require neither salary nor respectable food to carry on our work? ... This is written by a group of nurses who are utterly worn out, overworked, underfed, underpaid.<sup>811</sup>

Monica O., the letter's principal author, claimed to have had only four lectures between April 1941 and August 1942, and (unsurprisingly) none during the Blitz!<sup>812</sup> She also resented working sixty-three hours a week and even alleged that the doctors and matron were given better food than that given to the nurses.<sup>813</sup> It seems that these nurses considered neither a sense of vocation nor the notion of contributing to the war effort compensation for their poor work conditions.

The Prince of Wales Hospital was much smaller than the SDEC with only two representation in the management of hospitals. 'All too often she (the Matron) is not a member of the Committee of Management or any Sub-Committee and may not have direct access to them. Even if she is a member, there are always several doctors on the committee to one nurse, and their opinions and their votes will have very great weight in any discussion on nursing matters.' The Joint Nursing Committee at the SDEC and linked hospitals was chaired by Dr. Lindsay with Colonel Browne Seaife, Dr Wilmot, Dr. Pierson, Mr Law and Mr. Riddell as members.

<sup>811</sup> *Evening Herald*, 27 July 1942.

<sup>812</sup> PWDRO, Prince of Wales Hospital Sub-Com Mins, 606/7/10, 4 August 1942.

<sup>813</sup> *Evening Herald*, 27 July 1942.

wards (one male and one female) employing nine trained nurses and twenty-three probationers. Each ward was constantly 'on take' meaning it was always open to new admissions rather than admitting patients in a rota system, as happened in larger hospitals. The rota system allowed nurses some respite from emergencies. The Nursing Committee recognised the detrimental effect this system had on nurses' health suggesting it forced nurses to work 'at too high a pressure making them ill.'<sup>814</sup>

The Joint Hospitals' Nursing Committee interpreted the letter of complaint as an indication of Matron Kenwell's unapproachable and unfair attitude towards her nursing staff. The fact that the nurses had resorted to the press to air their grievances was taken as a measure of Kenwell's failure. The ex-Sister Tutor and Deputy Matron, Miss Lamont, claimed to have frequently told Kenwell of nurses' complaints which she had apparently ignored.<sup>815</sup> Lamont claimed she had resigned from her job because of the Matron's unapproachable attitude. Although Kenwell suspended the principal author of the letter, Monica O., the Nursing Committee chose to reinstate her. It was Kenwell's ability to perform her job that came under intense scrutiny.

Criticism suggested that Kenwell lacked the fibre for her job. Her frequent absences from work because of 'sickness, accident and other causes' were no excuse, the Nursing Committee argued. Her ill health and her 'lackadaisical' attitude were blamed for her inefficiency in performing her duties. Unsympathetic to the notion that Kenwell's failure to manage the nurses successfully might be as the result of her own ill health, the Nursing Committee reiterated their high expectations of the Matron's role. She 'should be competent and thoroughly familiar with all the detailed routine of the hospital, must be so observant and comprehending that she is able to visualise what is going on, not only in her presence but in her absence.' The nurses 'had cause for complaint as regards too few lectures, food, hours of duty although the causes were

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<sup>814</sup> PWDRO, Prince of Wales Hospital Sub-Com Mins, 606/7/10, 4 August 1942.

<sup>815</sup> PWDRO, Prince of Wales Hospital Sub-Com Mins, 606/7/10, 4 August 1942; 2 September 1942; 27 August 1942; *The Evening Herald*, 27 July 1942.



such as could have been easily removed by any comprehending, understanding and efficient matron.’ The Chairman of the Committee, Dr Pierson, thought that the absence of Mr Pine, a hospital administrator, had contributed to the unrest: ‘when he was at the hospital, he handled complaints tactfully and immediately they came to knowledge.’ The Nursing Committee decided not to dismiss Kenwell because of the detrimental effect this would have on the Hospital’s reputation but to assess her efficiency at three-month intervals. This restriction, however, failed to prevent Kenwell enforcing her authority: three months later she dismissed Monica O. for breaching the 10pm curfew on more than three occasions.<sup>816</sup>

The need to attract recruits had already prompted Kenwell to make a small concession towards a relaxation in discipline by letting student nurses attend lectures out of uniform eight months prior to the nurses’ letter of complaint in August 1942. This move failed to improve recruitment, perhaps unsurprisingly given the local press’ publicity to nurses’ poor work conditions. In 1944, the Prince of Wales and the SDEC came under pressure from both the Ministry of Labour and Ministry of Health to tackle its shortage of nurses. The Ministry of Labour assumed responsibility for the direction and control of nurse labour in September 1943.<sup>817</sup> The SDEC reported to the Ministry that one of its difficulties stemmed from its shortage of domestic staff. The Government had been unwilling to improve the pay and conditions of hospital domestics so that by 1943 there were an estimated 8,000 vacancies nationally.<sup>818</sup> This meant that SDEC student nurses had to take on more domestic duties ‘which in normal times would be considered unenlightened and wasteful as well as damaging to recruitment.’ This continued until 1945 when ‘student nurses were doing more domestic work and getting less training.’<sup>819</sup>

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<sup>816</sup> PWDRO, Prince of Wales Hospital Sub-Com Mins, 606/7/10, 28 January 1942; 4 August 1942; 7 August 1942; 2 September 1942; October 1942.

<sup>817</sup> Rafferty, *The Politics of Nursing Knowledge*, p.172.

<sup>818</sup> Carpenter, *Working for Health*, p.228.

<sup>819</sup> PWDRO, Prince of Wales Hospital Sub-Com Mins, 606/7/10, 24 September 1943,

A survey of the SDEC's nursing staff by the Ministry of Labour and National Service in November 1945 seems to have acted as an incentive to improve nurses' quality of life. The Chairman of the SDEC House Committee declared the Ministry's recommendations as those 'made by the Royal College of Nursing and the General Nursing Council for many years.' This point is interesting because it suggests that the College had indeed had some impact in improving provincial nurses' lives. However, whether the College's recommendations were acted upon is doubtful. The SDEC management were spurred into action when forced by the Ministry of Labour's enquiry. The House Committee sought to portray itself as interested in the freedom of its nurses:

In this hospital nurses are allowed to smoke without question in their bedrooms and in the sitting rooms, they have their own telephone, and tea and a snack are provided for those who come in late at night. They have a day off a week; one month's holiday a year and a representative council. All the recommendations of the Ministry cannot be put into practice until more staff is obtained.<sup>820</sup>

The Hospital declared itself unable to provide individual bedrooms, a visitors' room, shampoo room, an adequate number of bathrooms or a recreation room because of limited finances. As a compromise, the House Committee provided one study room in each nursing house. Despite these shortcomings, the SDEC invited the press to inspect its facilities available for training nurses before advertising for recruits. With little response, further measures were taken to stimulate recruitment: trained nurses were allowed to live out and free bath towels and a table tennis table provided. Two years later, again in response to recruitment problems, nurses were issued with keys to their bedrooms.<sup>821</sup>

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p.11; 15 December 1944; 16 March 1945, p.82.

<sup>820</sup> PWDRO, SDEC House Com Mins, 606/1/17, 18 May 1945, p.92; 23 November 1945 p.116.

<sup>821</sup> PWDRO, SDEC House Com Mins, 606/1/17, 9 September 1943; 23 November 1945; p.116; 19 September 1947, p.180.

The CMH also suffered from acute recruitment problems during the Second World War. In 1942, the Hospital employed fifty-five whole time and thirteen part-time female nurses out of a complement of ninety-nine. Despite the Minister of Health's 'standstill order' of 1941, which ruled that any person employed as a nurse in a mental hospital must continue their service until his or her services were no longer required, nine nurses left between 1941-42, of whom eight had under one year's service. As a result all nurses had to do overtime and two ward maids did nursing duties. To improve recruitment and because petrol was in very short supply, Medical Superintendent Coleman arranged for a car to take nurses to Bugle, a neighbouring town, at 7pm each evening and also on alternative Sundays. Coleman identified the geographically isolated position of the Hospital as part of its recruitment problems. In contrast to the late nineteenth and early twentieth centuries when nurses lived at the end of their wards, eighty per cent of male staff now lived out.<sup>822</sup> Staff dances were held regularly and a badminton club resurrected. These pragmatic changes had little effect and by 1943 the number of female nurses had dropped to fifty. Desperate for staff, nurses were recruited from the Labour Exchange but were often considered unsuitable: temporary nurse W. H. Ford. 'entered the service on March 8<sup>th</sup> and was discharged on March 17<sup>th</sup> on account of unsuitability.'<sup>823</sup> Such short periods of service suggest that the Hospital's regime may have been too difficult even for suitable nurses. In 1946, a nurse on duty was expected to be 'in charge of fifty to sixty difficult cases.'<sup>824</sup>

Nurses at the local emergency hospital were asked to volunteer at the CMH. In 1944 and 1945 Coleman wrote to Ernest Bevin MP to ask for more nurses. In 1945, social activities were extended to include staff membership of the local library and social evenings but only 'by arrangement with and under the supervision of the Medical

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<sup>822</sup> Andrews, *The Dark Awakening*, p.246.

<sup>823</sup> CRO, CMHVC Mins, HC1/1/1/34, 29 June 1942; 22 February 1943, p.439.

<sup>824</sup> CRO, CMHVC Mins, HC1/1/1/34, 27 November 1944; 24 September 1945; 29 October 1945; 24 June 1946, p.358.

Superintendent.’ Although nurses were given more freedom to socialise, Coleman retained a high degree of control over nurses’ off-duty lives. Discipline at work also remained strict. Nurse Elsie R. was dismissed for taking a day off work without permission and Charge Nurse W., found asleep on duty in charge of suicidal and other special patients, was downgraded to staff nurse despite appeals from her trade union.<sup>825</sup>

In summary, recruitment problems during the War prompted some changes to the SDEC matron’s style of management. Although Kenwell’s military style of management was criticised and held responsible for nurses’ problems, she continued to exert considerable authority despite hospital management’s recommendation that she adopt a more tactful and less disciplined approach. Discipline remained strict at both the SDEC and the CMH although small concessions were made to attract new recruits.

### **Preparations for a National Health Service 1946 -1948**

The post-war shortage of nurses threatened the viability of the National Health Service (NHS). In a publicity campaign launched jointly by the Ministry of Health and Labour and the Secretary of State for Scotland in 1945, a brochure on staffing hospitals listed details of recommended conditions of service. These included removal of the marriage bar, employment of part-time staff, hours of duty, supervision of health and the formation of representative bodies.<sup>826</sup> The establishment of the NHS and the anticipated expansion in facilities and increase in demand for labour suggested a comprehensive review of nursing was required. In 1946, the Ministry of Health set up The Working Party on Nurse Recruitment and Training under the chairmanship of Sir Robert Wood and consisting of a doctor, psychologist (Dr John Cohen) and two nurses.<sup>827</sup> Nurse

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<sup>825</sup> CRO, CMHVC Mins, HC1/1/1/31, 25 August 1941, p.124; 26 February 1945, p.134.

<sup>826</sup> Ministry of Health, Ministry of Labour and National Service and Department of Health for Scotland, *Staffing the Hospitals: An Urgent National Need*, London: HMSO, 1945; Rafferty, *The Politics of Nursing Knowledge*, p.173.

<sup>827</sup> Abel-Smith, *A History of the Nursing Profession*, p.182. The two nurses were Katherine Watt, Chief Nursing Officer at the Ministry of Health and Elizabeth Cockayne, Matron of the Royal Free Hospital.

organisations were neither consulted about the Working Party's composition nor represented on its body. The Working Party proposed that nurse training should reflect principles established in industrial psychology, particularly work simplification on the grounds that it reduced fatigue. Its task was to assess the nursing force required for the future health service.

Cohen was a quantitative psychologist at the Psychological Laboratory, University College London. His research interests reflected the eugenic orientation of inter-war psychology and 'its confidence in the application of scientific methods of measurement to the solution of social problems.'<sup>828</sup> Drawing on research methods common in education and operational research, the Working Party undertook job analyses and surveys of the causes of student wastage, nurses' ability and selection procedures. Psychometric testing, questionnaires and interviews obtained further information.

The Working Party was not without controversy; dissension split it into two uneven camps, leading to the production of majority and minority reports. According to Rafferty, 'what had originally been conceived of as an efficient task-force inquiry was converted into an embarrassing expose of the government's incapacity to perform vital planning functions.'<sup>829</sup> Cohen refused to sign *The Majority Report* objecting to its focus on material recommendations, particularly the three shift system and student status. His divergence was also partly political, implying that the Working Party had toned down their representation of the negative aspects of nursing conditions. Cohen prepared a *Minority Report* with assistance from Geoffrey Pyke, a journalist and educationalist. Cohen believed the answer to nursing's problems was not to be found in repeated committees composed of doctors, nurses, administrators and members of the public but by scientific research and placing conclusions and solutions in the context of wider

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<sup>828</sup> Rafferty, *The Politics of Nursing Knowledge*, p.178.

<sup>829</sup> Rafferty, *The Politics of Nursing Knowledge*, p.177.

health service developments. He was the first to measure the effectiveness of nursing care by studying the relationship between lengths of patient stay and nursing skill. His theorising on productivity in nursing reflected the wider research tradition of industrial psychology.<sup>830</sup> By analogy with industry, Cohen argued that improving human relations in hospitals would enhance productivity as it had in factories. Francis Goodall, general secretary to the Royal College of Nursing supported Cohen's scientific approach to the recruitment problems:

A job analysis of the present trained nurses' duties will not give the answer. We have to know what her duties ought to be and to what extent she can hope to meet them, taking into account the manpower situation. To do this we must analyse the total care required from all members of the health team ... Research is necessary on ... work simplification, improved selection of candidates for the various tasks involved and experiments as to the best preparation of those subsidiary grades whose integration in the health team enables us to economise nurse power.<sup>831</sup>

This suggests that the College supported a scientific approach to management to justify the adoption of task allocation for subsidiary grades of nurses. It realised that such an approach could give greater control and autonomy over nursing work to the trained nurse.

Having examined the background to the *Majority* and *Minority Reports*, we will focus firstly on the findings of Wood's *Majority Report*, particularly its recommendations regarding discipline and nurse selection. Strict military styles of discipline were found in the majority of nurse training schools and identified as the most important cause of wastage.<sup>832</sup> Ex-student nurses complained about the lack of help, co-operation, encouragement or sympathy from senior staff who begrudged better

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<sup>830</sup> Rafferty, *The Politics of Nursing Knowledge*, p.179.

<sup>831</sup> F. Goodall, letter to Editor, *The Times*, 1 March 1948, p.5.

<sup>832</sup> Bevington, *Nursing Life and Discipline*, p.84.

training and greater freedom.<sup>833</sup> *The Majority Report* recommended that discipline no longer be used to reinforce status and etiquette and that hospitals' hierarchies be based on recognition of experience and ability. To reduce the wastage rate improvements in the selection procedures of both senior and junior nurses were recommended.

The idea that only members of the nursing profession had the knowledge and experience to decide on candidates' suitability was no longer considered viable. Matrons, it was argued, perpetuated a narrow, authoritarian regime by selecting staff with similar attitudes to themselves regarding discipline and giving preference to candidates from their own hospital, a system that caused low morale and psychological damage to junior staff. Many matrons, *The Majority Report* argued, were 'unfitted on grounds of personality to assume the responsibilities of student and staff management.' It recommended the introduction of staff selection boards, modelled on the War Office Selection Boards, and specified the inclusion of a qualified psychologist and psychometric testing. *The Majority Report* also suggested that the selection of senior nurses included a biographical and personal questionnaire (a psychiatric 'screening' device for detecting unsuitable individuals), verbal and non-verbal intelligence tests, group discussion, test of teaching skills, written views of questions of nursing life and discipline and 'sociometric and projective devices.'<sup>834</sup> *The Majority Report* used the term 'sociometric devices' to refer to ways of studying interpersonal relationships within social groups. Such devices can be used to identify and track behaviour within groups, with a view to improving relationships. The term 'projective' devices referred to personality tests designed to yield information on the basis of an unrestricted response to ambiguous objects or situations. As far as the selection of student nurses was concerned, *The Majority Report* recommended an interview by a personnel selection officer, a questionnaire analysing occupational preferences and health and

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<sup>833</sup> *Majority Report*, 1947, p.36.

<sup>834</sup> *Majority Report*, 1947, Appendix IV, pp.93-95.

standardised intelligence testing.<sup>835</sup>

Prompted by these recommendations, the Ministry of Health approached a number of London Hospitals to investigate their selection procedures. The Matron of the London Hospital, Claire Alexander, was asked if interviewers, trained by the National Institute of Industrial Psychology, could interview candidates in addition to their interview with her and the Sister Tutors. The Ministry's research project proposed to follow up these candidates throughout their nursing careers. Alexander was willing to co-operate but reassured the Nursing Committee that the status quo of the hospital would be maintained and 'there was no suggestion that the Interviewers were going to try and influence her in the selection of candidate.'<sup>836</sup> This suggests that she had no intention of relinquishing her authority to psychologists and her Committee supported her.

With the aim of improving nurse selection, The Working Party assessed qualities senior nurses considered most desirable in probationers in a survey of 132 London County Council General Hospitals. It found that the personality traits most valued by ward sisters were 'kind to patients' and 'interest in work.'<sup>837</sup> *The Majority Report* recommended that these qualities form the basis of psychological methods of selection. Whether senior nurses at The London Hospital considered such qualities the most important is doubtful. A brief survey of The London Hospital Ward Books suggest that the probationer's response to discipline was considered more important than whether she was kind to patients, which was rarely mentioned. The most frequent compliments included 'took correction well' and 'sensible' whilst common criticisms were 'requires a lot of supervision', 'a slow worker' and 'inclined to resent correction.'<sup>838</sup> Clearly obedience remained a valuable quality in London Hospital

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<sup>835</sup> *Majority Report*, 1947, p.60.

<sup>836</sup> RLH, The London Hospital Nursing Com Mins, 1947, LH/A/12/41, 7 June 1948.

<sup>837</sup> *Majority Report*, 1947, p.58.

<sup>838</sup> RLH, The London Hospital Official Ward Book, LH/N/6/77, 31 December 1944-31 August 1945.



probationers who were expected to conform to Alexander's strict style of management.

Alexander took some measures towards relaxing her style of management but these were limited. For example, she encouraged nurses to confide in her with their problems by holding twice daily clinics. In 1945 she recorded her hope 'that every member of the nursing staff [would] always feel that she [could] come to her personally for help and advice on any matter.' However, her advice often reflected the traditional message that nurses must endure hardship. In July 1945 student nurse Hazel R. asked to see Alexander:

Hazel reported that she felt very tired, nervy and also that she felt that she could not do anything right. She was told to try and make a little more effort and to go to the nurses' sick room for a tonic.<sup>839</sup>

Likewise, student nurse Mary G. was told that 'she must make up her mind to do better work and not resent correction.' Although Alexander's response seems to be limited to telling nurses to get on with their job, she was, at least, listening to individual complaints. This marks an important change from the end of the nineteenth century when complaining nurses were considered unsuitable and often instructed to leave. Indeed, in 1945, many nurses held Alexander in affection; student nurse Mabel P. was typical of several who left but returned within the next few weeks to say good-bye to her.

Some off duty rules were relaxed at The London in 1945; nurses were allowed to smoke in their bedrooms and were given two midnight passes per calendar month in addition to an 11pm pass each week. The relaxation in discipline in the student nurses' home led to complaints from trained staff concerning an increase in the level of noise. In response, Alexander reintroduced the stricter regime of rules causing several nurses

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<sup>839</sup> RLH, The London Hospital Official Ward Book, 30 December 1944- 31 August 1945, LH/N/6/77, 21 July 1945, p.1035.

to write to *The Daily Express* threatening to go on strike.<sup>840</sup> This response is interesting because it is the first evidence that London Hospital nurses were prepared to take industrial action to improve their work conditions and suggests that the notion of self-sacrifice had lost some of their influence over nurses' behaviour.

Alexander's response to the publication of *The Daily Express* letter is noteworthy. Unlike Matron Dickson of the South Devon and East Cornwall Hospital, in 1932, she did not sack the letter's authors. Nor did the London Hospital Nursing Committee interpret the letter as evidence of Alexander's poor management style, as at The Prince of Wales Hospital in 1942. Instead, Alexander chose to do nothing on the understanding that 'anything they wrote to the press would be distorted and utterly misrepresented so that no useful purpose would be served.'<sup>841</sup> This pragmatic response suggests a shift towards a less severe and more flexible style of management.

By 1947, several commentators including *The Majority* and *Minority Reports* recommended sexual equality in nursing.<sup>842</sup> 'Experience in the Services' during the Second World War had 'shown that there [was] no valid reason for sex distinctions.' 'Suitable personality' and 'necessary qualifications' were recommended as the deciding factors regarding the employability of a nurse rather than gender.<sup>843</sup> The War's effect on gender roles has been the subject of historical debate. Women's activities on the Home Front, it is claimed, established their right to full citizenship within the post-welfare state. Efficiency in the workforce combined with management of domestic responsibilities during the War proved that women's place was not necessarily limited to the home.<sup>844</sup> Summerfield argues that the popular construction of women's war work

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<sup>840</sup> RLH, *The London Hospital Official Ward Book*, 30 December 1944-31 August 1945, LH/N/6/77, 21 July 1945, p.1035; 28 July 1945; 30 October 1945, p.1325; 31 October 1945; 6 December 1945.

<sup>841</sup> RLH, *The London Hospital Official Ward Book*, 30 December 1944 - 31 August 1945, LH/N/6/77, October 1945, p.1319.

<sup>842</sup> *Majority Report*, p.73.

<sup>843</sup> *Majority Report*, pp.73-74.

<sup>844</sup> J. Hinton, *Women, Social Leadership and the Second World War, continuities of class*, Oxford: Oxford University Press, 2002.

was that it was men's work taken on by women to help in an emergency. The shift in representations of women and work, however, was temporary and following the War the majority of women returned to their traditional, domestic role.<sup>845</sup>

New psychological approaches suggested that a combination of feminine and masculine qualities were now needed to nurse successfully. *The Majority Report* recommended that a scale for assessing masculinity and femininity, developed by L.M. Terman of Stanford University, be adapted for assessing student nurses. Terman's study showed that practicing nurses in America achieved more "masculine" scores than any female occupational group except secondary school teachers.<sup>846</sup>

The task of a trained nurse involves a certain firmness and authority or leadership in handling patients and "controlling" a ward, and also a certain "toughness" in being unshaken by the sight of blood, wounds, surgical operations or death. ... This masculine quality can be, and often is, combined in the same person with a gentleness of disposition stressed in the LCC reports.<sup>847</sup>

Terman's interpretation of the qualities of leadership and ward management as masculine were the very qualities late nineteenth century nurse leaders perceived as feminine. Then nurse leaders argued that the management of late Victorian households equipped women with the necessary skills to nurse. Domesticity, considered a qualification to nurse in the 1880/90s, was not a desirable quality in 1947. Terman's scale of masculine and feminine qualities of personality found that domestics stood at the feminine and opposite end of the personality scale to practicing nurses. This explained why 'the attempt to burden student nurses with nursing and domestic tasks calling, apparently, for diametrically opposed qualities, breaks down in the form of

<sup>845</sup> P. Summerfield, "They didn't want women back in the job!", *The Second World War and the construction of gendered work histories*, *Labour History Review*, Vol. 63, No. 1, 1998, pp.83-104.

<sup>846</sup> *Majority Report*, p.62.

<sup>847</sup> *Majority Report*, p.62.

wastage during training.<sup>848</sup> A drive to remove domestic tasks from nurses' remit also reflected Cohen's attempt to reshape the division of labour as part of a movement towards 'efficiency.' This movement legitimised psychologists' authority to measure, design and determine nursing work.<sup>849</sup> Psychological research supported nurse leaders' case for drawing distinct boundaries between nursing and domestic work.

Recommendations of where male nurses would work in the new nationalised service reflected the traditional idea that their employment was based on physical strength and not equality. The numbers of male nurses had increased dramatically from 3.9 million in 1931 to seventeen million in 1946, largely as a result of the Second World War.<sup>850</sup>

The employment of large numbers of men as nursing orderlies in the services during the war has stimulated interest in civilian nursing as a suitable male occupation both in hospitals and in the public health field.<sup>851</sup>

Men's role in the NHS became one of central concerns of both *The Majority* and *Minority Reports*. *The Majority Report* suggested that men could 'fill the gaps ... in the scarcity fields' of tuberculosis nursing and the care of the chronic sick, 'the type of "heavy case" requiring great physical strength as well as nursing skill.'<sup>852</sup> Masculinity was constructed in a similar way to the late nineteenth century, noted in chapter three. Men were perceived as unsuited to the type of caring work required in acute, voluntary hospitals. The idea that their physical strength qualified them for certain roles was used to encourage men towards the more unpopular areas of nursing, suffering acute shortages and away from the more prestigious posts in voluntary hospitals.

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<sup>848</sup> *Majority Report*, p.62.

<sup>849</sup> Rafferty, *The Politics of Nursing Knowledge*, p.179.

<sup>850</sup> *Minority Report*, 1949.

<sup>851</sup> *Minority Report*, 1949.

<sup>852</sup> *Majority Report*, p.74.

Drawing on Professor F. C. Bartlett's research<sup>853</sup> studying the relationship between sex difference and occupation as criteria in determining the occupational suitability of the sexes for nursing, Cohen suggested a wider role for the male nurse than that envisaged by *The Majority Report*. He argued that the male nurse was 'of considerable importance for the future of nursing in all fields and not simply in mental and public assistance hospitals and institutions where the vast majority of male nurses are now employed.' Prejudice against men in nursing was rife, according to Cohen, because some doctors, nurses and administrators believed that the scope of male nurses was limited and feared that the reaction of female patients would be unfavourable.<sup>854</sup>

Matron Alexander's attitude to male attendants at The London Hospital is an example of how such prejudice manifested itself. Despite the fact that the term 'attendant' was dropped in 1919 and replaced by 'nurse', as part of the National Programme adopted by the NAWU, Alexander continued to refer to male nurses as attendants.<sup>855</sup> This term may have carried the negative connotations associated with male asylum attendants in the late nineteenth century who, as discussed in chapter three, had little training. Female probationers at The London were now referred to as student nurses. The contrast between the term 'attendant' and 'student nurse' and its implications of difference in education and professional status emphasised a distinct boundary between male and female groups. Fearing that male attendants would encroach on the work of female student nurses and medical students, Alexander introduced a new set of rules in June 1948 'to curtail' male nurses' 'nursing activities.' She realised that the rules would 'discourage certain men with ambition from continuing this work.' By October 1948 all but one had left; medical students were

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<sup>853</sup> Frederick Bartlett succeeded Charles Myers as Director of the Cambridge Psychological Laboratory in 1922 and became Professor of experimental psychology in 1931. See A. Collins, 'The Embodiment of Reconciliation: Order and Change in the works of Frederick Bartlett', *History of Psychology*, 2006, Vol. 4, pp.290-312.

<sup>854</sup> *Minority Report*, 1949.

<sup>855</sup> Carpenter, *Working for Health*, p.76.

allocated the attendants' duties. The remaining attendant, Mr Adams, resigned in July 1950 because 'he found the work too much for him.'<sup>856</sup> Which aspect of the work caused Adams difficulties is unclear although the restrictions surrounding male nurses at The London did not encourage a career in nursing.

## Conclusion

In conclusion, it was the shortage of nurses and dissatisfaction with pay and work conditions that began to erode the traditional system of discipline. Financial insecurities and the Government's assumption of responsibility for health services during the War meant that hospitals had a limited capacity to tackle these problems. Ideas of freedom and self-discipline were an inexpensive solution to both the shortage and wastage of nurses. Certainly, psychological ideas were an increasing feature of conversations and inquiries about nursing between 1932 and 1948 but their influence on styles of nurse management at our case study institutions was limited. Changes often preceded the publication of similar ideas put forward by psychologists and nurse inquiries. A relaxation in discipline and an extension in social and recreational facilities was more often a pragmatic response to labour problems than influenced by psychologists' recommendations.

Psychologists' influence at national level was also limited: Cohen's report was, after all, a *minority* report and, according to Starns, provoked 'extreme anger' from the nursing establishment who continued to adhere rigidly to its own body of traditions.<sup>857</sup> *The Majority Report* also met with opposition from senior nurses who objected to its radical proposals. Although the initial drafting of The Nurses Act of 1949 was based on its recommendations, by the time it had reached the statute books, there was very little evidence of this fact.

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<sup>856</sup> RLH, The London Hospital Nursing Com Mins, 1947, LH/A/12/41, 7 June 1948; 25 October 1948; 24 July 1950, p.11.

<sup>857</sup> P. Starns, *March of the Matrons*, p.55.

Our study shows ideas connected with industrial psychology were met with a mixed response at The London Hospital, the only case study institution to make direct reference to psychological recommendations in its Minutes. Fear that psychological recommendations would weaken the hierarchical structure of nursing prompted Matron Alexander to adapt the recommendation to appoint nurse welfare officers to the appointment of a social secretary, a post that was subordinate to her and presented no threat to her authority. She also encouraged nurses to consider her as an approachable confidante, as psychologists suggested, but used this relationship to reinforce the importance she attached to qualities of obedience and endurance.

As nurses' discontent about poor pay and work conditions grew, prompting an increase in trade union membership, so ideas that nurses' regime should be less militarised gained attention. Despite a shift towards the introduction of nationally determined pay and conditions, the rising cost of living meant that nurses were no better off. In contrast to The Lancet Commission's conservative recommendation, in 1932, that senior nurses make 'small' psychological concessions by relaxing discipline, enquiries began to suggest more radical changes to the occupation's hierarchical structure and the selection and promotion of staff, the use of welfare officers and the adoption of representative committees.

Psychologists and other commentators identified disciplined styles of management as responsible for nurses' mental ill health and a cause of recruitment problems. A growing body of opinion called for a relaxation in nurses' rules. Evidence from our case study institutions suggests that other practical factors were also responsible for the nursing shortage including the geographical isolation of the CMH and recruits' expense of purchasing uniform and textbooks at the SDEC.

Nursing's failure to attract women of social quality in the early 1930s validated the continuation of a disciplined style of management. Our evidence challenges the

notion that only middle class women were capable of exerting self-discipline. Matron Littleboy of The London Hospital considered a nurses' 'lifestyle' as important as class in shaping her ability to obey rules. Psychologist Sheila Bevington identified lifestyle rather than class as an explanation of nurses' vulnerability to ill health. The term 'lifestyle' was used broadly by several commentators and referred to a multitude of social factors including changes in family sizes. The notion of lifestyle did not replace 'class' but added an extra dimension to understandings of nurses' ill health. By the 1940s, conversations shifted from referring to the 'right type of girl' to the need for the 'intelligent' girl. Intelligence was connected with social status. Psychologists recommended the use of intelligence tests as the answer to nursing's recruitment problems. Such tests favoured the middle classes because of their access to education.

This chapter also identified an important change in ideas related to nurses' gender. Psychological research challenged the late nineteenth century notion that the ideal nurse was feminine, domesticated and thus qualified to care. Reflecting culturally accepted ideas of late Victorian middle class femininity, late nineteenth century nurse leaders suggested that women's domestic skills, learnt from household management, entitled them to manage departments of nursing. In the 1940s, the ideal nurse was considered a combination of feminine and masculine qualities. This shift in gender identity reflected a wartime trend when qualities associated with masculinity were afforded higher status and access to power. Psychologists labelled the qualities of leadership and management as masculine and suggested that the domesticity was no longer a desirable quality in nurses.

New psychological approaches in the 1940s recommended sexual equality in nursing. Men's work as orderlies in the services during the War and women's work on the Home Front temporarily shifted the construction of gender related to work. The construction of masculinity, however, reflected the traditional idea that male nurses'



employment was based on physical strength. *The Majority Report* encouraged male nurses to work in unpopular areas of nursing that valued the physical strength to lift heavily dependent patients. Ideas about sexual equality and the expansion of the male nurse's role met with some resistance at The London Hospital where its Matron devised a set of rules to limit men's role in nursing.

Why did nurse enquiries move away from the traditional approach of a committee of doctors and nurses towards a panel of experts? Nurse organisations lost political power because they were unable to resolve recruitment problems. A shift in the style of school education towards a more 'progressive' approach, the development of industrial psychology and improvements in the selection of recruits during the Second World War contributed to a growing body of ideas which supported a need for change to the organisation of nursing. As preparations for the NHS gathered pace, so the need for 'outside experts' increased to provide solutions to recruitment and wastage problems.

## CHAPTER EIGHT

### Conclusion

This thesis set out to explore the neglected field of nurses' occupational health. Evidence from the three case study hospitals confirms that attitudes toward nurses' health changed in significant ways in the years between 1888 and 1948. The health of nurses was an issue that was always taken seriously at each of the hospitals but each institution approached the problem differently and responses showed much variation over time. There were good reasons for this but the failure to adopt a coherent and consistent policy worked to the detriment of nurse health. This difficulty, noticeable at all the case study hospitals, helps explain the ambiguous treatment of occupational health within wider histories of nursing. This can lead to the erroneous conclusion that occupational health was somehow neglected by contemporary actors, thereby facilitating the omission of the subject from historical studies concentrating on professional projects and the wider politics of nursing.<sup>858</sup> This study takes a different approach. The thesis has shown that occupational health issues were inexorably connected to these nursing debates. Occupational health cannot be understood without reference to professional projects. This conclusion can be taken further to argue that assessment of professional projects and the goals of nursing will be incomplete without appropriate discussion of occupational health concerns. This is as true in debates where occupational health was obscured as it was in cases of overt concern.<sup>859</sup> Contemporary interest in the problem of nurse health is evidenced by the number of enquires held in the study period.<sup>860</sup>

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<sup>858</sup> Abel-Smith, *A History of the Nursing Profession*; Rafferty, *The Politics of Nursing Knowledge*, Dingwall et al., *An Introduction to the Social History of Nursing*.

<sup>859</sup> For example, this thesis has drawn attention to the way Luckes promoted the professionalisation of London Hospital nurses by linking their image with that of 'new women'. This implied a physical strength and immunity to illness that helped to obscure nurse health issues, see p.87.

<sup>860</sup> *The Lancet Commission on Nursing, 1932; Athlone Report*.

In the late nineteenth century the main occupational health difficulties were risk of infection and the chronic problem of overwork in understaffed wards. These problems were common to a variety of institutions but to date the historiography has been most concerned with the treatment of general nurses in voluntary hospitals.<sup>861</sup> This is because the 1880s marked a crucial phase in the campaign to both reform and professionalise nursing.<sup>862</sup> Leading nurses and their lay and medical supporters were keen to attract more middle class recruits.<sup>863</sup> It was therefore the special attributes and also vulnerabilities of middle class women that framed these discourses. Over time however, it became apparent that a focus on poor working conditions was repelling the very recruits that nurse reformers most hoped to attract. This encouraged a new relationship between the promotion of professional projects and health concerns. Increasingly poor working conditions were either denied or the professional nurse was presented as a superior person equipped with sufficient physical and/or mental strength to transcend them. This was particularly noticeable in the most elite London institutions.

Chapters two and three give a detailed account of the way health impacted on professional projects at The London. Eva Luckes used a notion of health to promote good discipline by stressing that the nurse was responsible for her own health and should in no way be discouraged by the everyday sights and sounds she encountered on the wards. Luckes expected nurses to tolerate ill health in order to demonstrate their vocation to nurse at an institution determined to mark itself as a beacon of the highest professional standards. These included the notion that nurses should ignore occupational health hazards and any symptoms of illness and continue to work; those

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<sup>861</sup> Rafferty, *The Politics of Nursing Knowledge*; Abel-Smith, *A History of the Nursing Profession*.

<sup>862</sup> Abel-Smith, *A History of the Nursing Profession*, p.61; Rafferty, *The Politics of Nursing Knowledge*, p.94.

<sup>863</sup> Dingwall et al., *An Introduction to the Social History of Nursing*, p.69; Abel-Smith, *A History of the Nursing Profession*, p.17.

that were unable to achieve this were often regarded as self-centred and dismissed. As a result, some nurses were reluctant to report sick for fear that they would not achieve qualification.

The way Luckes treated nurse health was distinctive and led to a particular set of practices at The London. Since Luckes was a major national figure it might be expected that such a model was replicated elsewhere.<sup>864</sup> My study confirms that this was not necessarily the case. Even within her own institution some rank and file nurses registered opposition to the denial of their health concerns.<sup>865</sup> Other institutions facing similar issues approached the problem completely differently. I have demonstrated this point through a case study of the SDEC. This hospital lacked the resources of The London, making it unlikely that policies could simply be replicated. More fundamental however was an apparently explicit rejection of the strong matron model. Matron Hopkins was a less powerful figure than Eva Luckes making her more open to negotiation and compromise. Crucially Matron Hopkins treated health and disciplinary issues as entirely separate. With significant variations in the practices adopted at two voluntary hospitals, it becomes important to look wider and explore how health was treated in other institutional settings. Here reference to the CLA is important.

The CLA was different to the voluntary hospitals for a number of reasons. It had an almost equal ratio of male to female nurses and its system of discipline was led by a doctor, the Medical Superintendent, rather than the matrons. Nurse discipline was strict but was not applied to occupational health. Episodes of illness were treated as a separate entity and not as an indication of a lack of vocation to nurse.<sup>866</sup> The Visiting Committee considered its financial responsibility towards its employees' ill health as paramount and this turned on its accountability towards the cause of illness. Formal

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<sup>864</sup> Baly, *Nursing and Social Change*, pp.148-149.

<sup>865</sup> See earlier discussion on nurses' complaints about their health treatment, p.48; pp.56-57.

<sup>866</sup> Chatterton, 'Women in mental health nursing', pp.11-19.

nurse training was introduced thirty years later than the two voluntary hospitals. Unqualified, senior asylum nurses attached little importance to the value of self-sacrifice or nurse education. However, CLA nursing staff did try to endure ill health but this was to accrue long periods of service in order to qualify for a pension. Furthermore, in contrast to The London and SDEC nurses, CLA nurses considered trade union membership and strike action necessary to improve work and health issues.

This thesis is the first to consider mental nurses alongside general nurses. The points of similarity and also difference tell us much about both sectors. This reveals the inadequacy of studies concentrating on just one area. It is also important with a topic like occupational health to look beyond the narrow confines of nursing history and more generally at the regulation of women's work, men's work and trades perceived to be dangerous. Following Barbara Harrison it is possible to argue that the traditional association of women and care work led to a misunderstanding of the real nature of the hazards all workers would need to confront in the changing world of the hospital.<sup>867</sup> It is also true that it suited nurse leaders to downplay and even deny that a specific occupational risk existed. These points are explored in relation to physical health in chapters two and three. More generally, chapter seven reveals how nursing was both drawn into and excluded from debates about the psychology of work. By the end of my period the physical and mental health of nurses were both under scrutiny. However, the attention given to these issues suffered from the priority given to a post war recruitment drive and the transfer of power away from nurse leaders to all manner of experts. At this time the nursing workforce was acknowledged to be more diverse and this led to new discourses about the special vulnerabilities of working class recruits and different types of worker. The ideal nurse was considered to have masculine and feminine traits.<sup>868</sup>

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<sup>867</sup> Harrison, *'Not only the 'Dangerous Trades'*.

<sup>868</sup> See earlier discussion on the relationship between psychological research and gender, p.281.

The discussion above highlights the contested role of occupational health in relation to nurses. This conclusion is as relevant to the situation today as it is to the study period. Some of the parallels between past and present are explored in the introduction. The introduction also set out six questions that are vital to our understanding of occupational health issues at particular moments in time and how perceptions of health and illness changed over time. Many actors within and outside of nursing contributed to these debates. Chapter six highlighted that the special hazards faced by nurses need to be contextualised with references to changing theories of contagion and ideas about who was vulnerable and in what circumstances.

Class and gender emerge as key organising points in these debates. This connects work on occupational health to the more familiar professionalisation debates that, in the historiography, are framed by these concerns.<sup>869</sup> This study is however underpinned by new research that has drawn attention to the diversity of the nursing workforce even within the elite general hospitals.<sup>870</sup> Nursing leaders, preoccupied with an idealised image of the nurse, were perhaps less aware of the day-to-day concerns of rank and file members of the profession. The opportunity to explore how staff health was managed at the Cornwall Lunatic Asylum provides a useful point of contrast. However, while working conditions were different they were not necessarily more conducive to the promotion of staff health. The absence of the all powerful matron, usually seen as a barrier to reform, did not seem to aid the identification of health problems. Gender was also a complicating factor. The female attendants were not idealised in the same way as general hospital nurses but the presence of male staff drew attention to the necessary strength and fitness required for the work. There is no mention of how the female nurses should cope with these demands. On the other hand,

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<sup>869</sup> See Summers, *Angels and Citizens*, pp.1-9; Rafferty, *The Politics of Nursing Knowledge*, p.25; Davies, *Gender and the Professional Predicament in Nursing*, p.58; D'Antonio, 'Rethinking the Rewriting of Nursing History', p.271.

<sup>870</sup> S. Hawkins, *Nursing and Women's Labour in the Nineteenth Century The Quest for Independence*, London: Routledge, 2010.

some aspects of nursing that originated in the asylum sector were potentially helpful to the discussion of health issues and improved working conditions. This study has identified that trade union activity could win significant concessions from employers although the impact of this was only really felt after the First World War. A significant problem in the asylum sector was lack of resources and the strong suspicion that concessions could only be granted to staff at the expense of patient care. These pressures were felt even more acutely in the voluntary hospital sector where patients were seen as more deserving and public good will depended on the efficient use of charitable funds. One of the difficulties at the end of the study period was that the first sustained period of concern with nurses' occupational health at a national level coincided with the financial and organisational difficulties of setting up the National Health Service.

### **Understanding Nurses' Sickness**

Nurses' sickness was one of the many aspects of nursing left invisible by the politics of professionalisation.<sup>871</sup> The construction of nurses' health reflected wider debates about disease in society, focussing on themes of gender, class and discipline rather than identifying exactly what it was about the work that produced a risk of ill health. As ideas about gender and class shifted over time so too did understandings of nurses' occupational health. In 1890 middle class nurses were considered most susceptible to sickness but by 1947 society's ideas about the relationship between social class and illness had changed, in part because of research on the factors contributing to tuberculosis.<sup>872</sup> The focus on gender and class helped to obscure nurses' health problems which were also confused by a lack of clarity as to how disease was spread.<sup>873</sup>

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<sup>871</sup> Harrison, *Not only the 'Dangerous Trades'*, p.124.

<sup>872</sup> For full discussion of the relationship between social class and tuberculosis see pp.200-201; pp.232-234.

<sup>873</sup> Worboys, *Spreading Germs*, pp.231-234.

Understandings of nurses' sickness at The London Hospital during the late nineteenth century were set within the context of the professionalisation debate. Evidence suggesting nurses' sickness had rapidly increased between 1888-1890 was understood as a result of the changing class background of recruits and the 'new' nurses' role. Evidence given to the Select Committee on Metropolitan Hospitals (1890) describing London Hospital nurses' fatigue from their poor work conditions was largely ignored by Luckes and the medical staff. The ability to endure the arduous nature of nursing was seen as a test of dedication beyond that of the ordinary worker and medical staff supported Luckes in her view that regulating nurses' sickness was a necessary part of nurse training. Matron Luckes and the medical staff understood that close links existed between physical and mental illness; nervous disorders were often attributed to a recent physical illness or as a sign of a weak physical constitution. However, no exception was made for nurses of nervous dispositions within the strict, military style of discipline. In the 1930s London Hospital doctors were sensitive to the idea that high nurse sickness rates may be interpreted as an indication of the hospital's failure to adequately care for its staff and this may have shaped their treatment of tuberculosis. Despite a proliferation of publications confirming nurses' vulnerability to TB, doctors were reluctant to diagnose nurses with the disease preferring to dismiss those with suspected TB. This reluctance can be explained by the difficulties in TB diagnosis but also suggests an unwillingness to risk The London's reputation by associating its nurses with TB's stigma.

Late nineteenth and early twentieth century understandings of nurses' sickness at the SDEC were different to The London. This was largely due to Matron Hopkins' disinterest in the political organisation of nursing or nurse education and training. In contrast to The London, sickness was understood as a separate entity apart from nurse discipline or training. As a result a flexible, tolerant understanding of nurses' sickness



prevailed until 1919. Because the SDEC system of health care was not part of the rules governing nurses, sick nurses were unafraid to admit ill health and were, in most cases, sent home to recover. Nurses were allowed long periods of sick leave and returned to work with an unblemished character. Attitudes became less sympathetic after 1919 when a recurrent shortage of nurses meant that sickness absence had more impact on managing the hospital. In contrast to the CLA, understandings of SDEC' nurse sickness were not challenged by mounting evidence of ill health during the First World War. Indeed, the number of episodes and causes of SDEC nurse sickness remained consistent with the preceding decade. The hospital's doctors understood that infectious diseases posed the greatest risk to nurses' and patients' health and employed a comprehensive infection control policy. Despite this policy, cases of open TB continued to be nursed on open wards until the late 1940s and nurses complained that this posed a significant risk to their health.<sup>874</sup> The hospital's lack of an effective policy regarding TB is surprising considering its wide-ranging infection control policy during the First World War. A reluctance to diagnose nurses with TB may have been influenced by a concern to keep the hospital adequately staffed during a period characterised by recruitment crises. A diagnosis of 'query' or 'suspected' TB meant that sick nurses could be sent home to recover, at no financial outlay to the SDEC, and reemployed when recovered. It is not clear why this policy changed during the 1940s but may be due to the increasing publicity given to nurses' risk to TB at this time.<sup>875</sup> Nurses understood that not only TB posed a health risk but also that understaffed wards during the Second World War and a shortage of domestics produced fatigue. Nurses continued to complain that they were 'utterly worn out' and 'overworked' with little effect.<sup>876</sup>

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<sup>874</sup> PWDRO, Prince of Wales Hospital House Com Mins and Joint Meeting of House Committee and Medical Board Mins, 606/1/17, 14 May 1948.

<sup>875</sup> Daniels et al., *Tuberculosis in young adults*; King Edwards Hospital Fund for London, *Memorandum on the Supervision of Nurses' Health*, 1945; Bevington, *Nursing Life and Discipline*, 1943.

<sup>876</sup> *Evening Herald*, 27 July 1942.

Understandings of nurses' sickness at the CLA in the late nineteenth century are difficult to gauge because of the lack of material evidence regarding nurses' health. This may explain why the historiography on asylum nursing has failed to include nurse health issues. At management level, there was very little broad discussion by the Medical Superintendent or the Visiting Committee as to what caused nurses' illnesses apart from the conversations regarding the Asylum's financial responsibility towards its employees. All sick nurses were sent home to recover until the First World War. This does not necessarily mean that health issues were misunderstood but implies that they were neglected. Certainly the nurses and attendants understood that the disruptive, deluded patient posed a risk to their physical health and that long hours in close proximity to the mentally ill threatened their mental welfare.<sup>877</sup> Nursing staff may have been unwilling to raise health problems because they recognised that that sickness was antithetical to the qualities believed necessary to perform their job well. In contrast to The London, CLA nurse sickness was not understood as part of the professionalisation of nursing debate and was treated by the Medical Superintendent as a separate entity from discipline. Nurses were treated as employees and not members of a profession. Understandings of occupational health risk changed during the First World War when the infectious patient replaced the violent patient as the greatest risk to nurses' health.<sup>878</sup> A deterioration in work conditions as a result of an increased workload, diet rations and a depleted staff was believed to have reduced nurses' resistance to disease. The rise in nurse sickness between 1915-1918 contributed to an uptake in union membership in 1918. How clearly CLA asylum doctors understood nurses' risk to TB in the 1930s is difficult to tell. Like the voluntary hospitals, the Asylum did not protect its nurses by isolating tuberculous patients but did implement a limited vaccination programme of

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<sup>877</sup> CRO, Letter from Attendants to the Visiting Committee, CLAVC Mins, HC1/1/1/6, 27 December 1894.

<sup>878</sup> For full discussion of the health risk infections posed to CLA staff during the First World War see p.125.

horse serum to some nurses. Whether all nurses received this vaccination is doubtful because their treatment of TB varied depending on their personal wealth and seniority.

Understandings of nurse sickness in the case study institutions shared similarities but also differences. It is difficult to separate understandings of nurse health at The London Hospital from the debate on the professional nurse. This debate did not influence perceptions of nurses' health at the SDEC or the CLA. At both these institutions nurses' health was understood as a separate and independent entity although there were significant differences in how each institution approached nurses' sickness. The SDEC policy regarding nurses' health was primarily influenced by its recurrent shortage of nurses whilst the CLA limited its understanding of nurse sickness to its financial obligations.

### **Professional Battles and Management Strategies**

The key to understanding nurses' health in the late nineteenth century is its relationship to the battle for professionalism, particularly the question of nurse registration. As nurse leaders and doctors sought to redefine nurses' work and place within the hospital hierarchy, commentators supported their arguments for and against change with reference to nurses' health. It was used as a barometer to measure the extent to which change was possible within the existing power structures of nineteenth century hospitals. By citing nurses' health, arguments supporting the necessity for improvements to work and living conditions gained credibility.<sup>879</sup> On the other hand, it was also used to limit change by suggesting that middle class, educated professional women lacked the physical and mental strength of their working class predecessors and were unable to perform the onerous, menial tasks implicit to nineteenth century nursing.<sup>880</sup>

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<sup>879</sup> See p.95 for discussion of the way Eva Luckes justified her agenda for improvements to work conditions by citing nurses' social background.

<sup>880</sup> For full discussion of the relationship between the role of the middle class nurse and

The theme of power, integral to the debate on professionalism, is fundamental to understanding why institutions differed in their treatment of nurses' sickness. National enquiries into nurses' work conditions in the 1890s focussed on the relationship between the matron's role and nurses' health.<sup>881</sup> Whilst critics of nurse registration argued that the rapid increase in matron's power had a detrimental effect on the way nurses' health was treated, its supporters hoped that such power would facilitate health benefits to nurses.<sup>882</sup> Certainly some matrons influenced improvements to work and living conditions but such power also had negative consequences highlighted by enquiries during the 1940s.<sup>883</sup> Complaints of hierarchical bullying, intimidation and unapproachable attitudes that discouraged nurses from reporting sick were held up as evidence why the organisation of nursing needed restructuring.<sup>884</sup> Institutional variations in the balance of power between doctors, nurses and lay managers also account for differences in the way nurses' health was treated. Finally, the power accorded to nurse organisations influenced occupational health policy. Competing nurse factions during the campaign for registration had a detrimental effect on nurse organisations' influence, which was weak and unable to force improvements to work conditions in the Registration Act of 1919.<sup>885</sup> Their powerless position had long-term repercussions for nurses' health: indeed it received little attention from government until the Athlone Committee in 1939. Nurse organisations' power was further

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her health see pp.97-99.

<sup>881</sup> The Select Committee on Metropolitan Hospitals were concerned with allegations that Luckes powerful role had a detrimental effect on nurses' health see p.62; *Sandhurst Report*, p.319.

<sup>882</sup> *Sandhurst Report*, p.318; RLH, *Report of the House Committee on the allegations which have been recently made against the Nursing Department*, LH/A/17/49, 3 December 1890.

<sup>883</sup> In 1947, ex-student nurses complained about bullying and the lack of help from senior staff who begrudged better training and greater freedom, see pp.276-277; *The Majority Report*, Appendix IV, pp.93-95; *Minority Report*.

<sup>884</sup> Bevington and *Majority Report* recommended a less hierarchical structure to the organisation of nursing see pp. 225-226, p.277; Bevington, *Nursing Life and Discipline*, p.19. King Edward's Hospital Fund for London, *Memorandum on the Supervision of Nurses' Health*, 1945.

<sup>885</sup> Rafferty, *The Politics of Nursing Knowledge*, pp.77-87.

undermined by their inability to resolve the recurrent recruitment crises of the 1930s and government turned to educational and psychological experts to provide solutions to improve nurse welfare.

One of the ways the matron successfully exerted power was by enforcing a strict system of nurse discipline and this incorporated nurse sickness in some institutions. A pattern has emerged in this study suggesting that the more power accorded to the matron, the more regulated health issues were. The historiography examining the professionalisation of nurses links strict discipline with nurse leaders bid for professional status and this study shows how systems of discipline varied between institutions according to its matron's involvement with the registration campaign.<sup>886</sup>

The idea that discipline would elevate nursing's status to that of a 'calling' was strongest at the metropolitan teaching hospital studied. Luckes' and her senior medical colleagues' opposition to registration placed The London Hospital in the political spotlight. In order to demonstrate that individual hospitals were capable of setting high standards of professional behaviour without state regulation, a militarised system of discipline was enforced which incorporated the care of sick nurses. Expectations that London Hospital nurses would endure ill health were intended to show that disciplined training produced a superior type of nurse who did not need state registration to prove her quality. Matron Luckes accrued power by developing good management skills, implementing a comprehensive system of nurse training, publishing nursing textbooks and building a strong relationship with medical staff. The London Hospital matron's role retained its power until at least the 1940s when Matron Alexander manipulated expert recommendations regarding a less disciplined style of nurse management to reinforce the traditional message of obedience and endurance. Whilst evidence from The London supports Witz' and Abel-Smith's argument that voluntary hospital matrons

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<sup>886</sup> Maggs, *The Origins of General Nursing*, p.15; Starns, *The March of the Matrons*, p.18.

had established themselves as head of independent nursing departments by the end of the nineteenth century, SDEC and CLA case studies suggest that there were significant variations in the matron's influence.<sup>887</sup>

Hopkins' lack of interest in registration and education contributed to her lack of overall authority within the SDEC. Nurse discipline was comparatively relaxed and, as a result, ill health amongst nurses tolerated. Crowther's argument that a power struggle arose between 1870 and 1900 because doctors felt threatened by the status of the new 'lady' matrons applies to the SDEC but not The London.<sup>888</sup> Doctors acted as Luckes' ally and supported disciplinary ideology as part of nurses' health care. In contrast, doctors at the SDEC successfully challenged Matron Hopkins' position in 1904 and imposed their own regime of nurse education which disregarded the disciplined nursing ideology favoured at The London. CLA matrons exerted less influence on nursing policy than their voluntary hospital counterparts. They did not participate in the registration debate nor implement any form of nurse education programme. Asylum nurses were subject to a disciplined system of rules and regulations but these were more concerned with containing a large number of disturbed patients than elevating nurses' professional status. Senior nurses' conceptions of professionalism varied and this accounts in part why attitudes towards and understandings of nurses' occupational health changed between institutions. Differences were also underpinned by notions of gender and their relationship in shaping ideas about both nurses' bodies and the qualities perceived necessary to become a professional nurse.

## **Gender**

Historiography regarding gender and nursing highlights nurse leaders' use of gender

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<sup>887</sup> Abel-Smith, *The Hospitals 1848-1948*, p.68; Witz, *Professions and Patriarchy*, p.140.

<sup>888</sup> Crowther, 'Why women should be nurses and not doctors', unpaginated.

ideologies and imagery to promote their case for professional status.<sup>889</sup> This study goes one step further by examining the impact this relationship of gender ideologies and professional status had on nurses' occupational health. Nurse leaders claimed that women's right to nurse derived from their biological capacity for motherhood and their management skills learnt from organising domestic households.<sup>890</sup> This study shows that such arguments were problematic and whilst a source of strength also created a boundary around health issues. It became difficult for nurse leaders to identify health hazards or demand a reduction in their working hours when the model of motherhood as a framework for nursing implied a twenty-four hour commitment and a duty of self-sacrifice. Those nurses demanding a reduction in working hours were accused of undermining the case for professional status. The ideology of motherhood as a model for nursing continued to carry some weight until the mid 1930s despite criticism by the NCW that nursing carried a potential risk to motherhood in 1919.<sup>891</sup>

Ideas about gender and the 'ideal' professional nurse changed during the 1940s. Starns argues that a transformation occurred as a result of the Second World War when nurses adopted many of the qualities associated with masculinity in order to gain higher status.<sup>892</sup> This study adds a new dimension to this argument by showing how psychological research supported the notion that the ideal nurse was a combination of feminine and masculine qualities, largely because psychologists now considered leadership and an ability to tolerate harrowing sights masculine.<sup>893</sup> At the same time notions of femininity lost some of their potency in conversations about nurses' risk to

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<sup>889</sup> See Summers, *Angels and Citizens*, pp.1-9; Rafferty, *The Politics of Nursing Knowledge*, p.25; Davies, *Gender and the Professional Predicament in Nursing*, p.58; D'Antonio, 'Rethinking the Rewriting of Nursing History', p.271.

<sup>890</sup> For full discussion of the way nineteenth century nurses drew on their domestic experience to manage nurses see p.81; Summers, *Angels and Citizens*, p.3; RLH, *Report of the House-Committee on the Allegations which have been recently made against the Nursing Department*, LH/N/17/49, 3 December 1890.

<sup>891</sup> NCW, 'Report of the Special Committee on the Economic Position of Nurses', *BJN*, 27 September 1919, pp. 189-194.

<sup>892</sup> Starns, *March of the Matrons*, p.44.

<sup>893</sup> *The Majority Report*, p.62.

illness. Commentators continued to draw on gendered vulnerability when discussing TB but more importance was attached to nurses' social class as an explanation of susceptibility.<sup>894</sup> An understanding of the changing relationship between notions of gender and the qualities associated with the professional nurse may help explain female voluntary hospital nurses' resistance to male nurses. The fact that nurse leadership qualities were now considered masculine may have raised fears that if male nurses gained admission to voluntary hospitals they would quickly dominate senior management positions.

This study aimed to redress the balance of a nursing historiography written predominately about a female occupation by including male nurses. It supports recent historical studies into masculinity that adopt a more nuanced approach than the assumption of a single masculinity.<sup>895</sup> In contrast to feminist writers in the 1980s who characterised the relationship between men and women as between a dominant self and a subordinate 'other', this study suggests that as far as nursing was concerned the position was reversed with women seeking to dominate an occupation by excluding men on the grounds of their 'otherness'.<sup>896</sup> Although the question of registration was concerned with male and female asylum nursing staff, it was male attendants and their qualification to nurse that received most attention. In a debate that manipulated ideas and ideals of gender, male nurses were portrayed both as physical brutes and as effeminate. These negative images sought to define male nurses as 'the other' to the ideal female carer.

It was the Second World War and the dramatic increase in the number of male nurses that challenged some nurse leaders' prejudice against men. Men's role in the

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<sup>894</sup> Daniels et al., *Tuberculosis in young adults*, pp.205-213.

<sup>895</sup> D.E. Hall, 'The End of Masculinity Studies', *Victorian Literature and Culture*, 28, 2000, pp.227-236; J. Pettegrew, 'Deepening the History of Masculinity', *Reviews in American History*, 31, No. 1, March 2003, pp.135-142.

<sup>896</sup> J. Purvis and A. Weatherill, 'Playing the Gender History Game: A Reply to Penelope J. Corfield', *Rethinking History*, No. 3, 1999, pp.333-338.



NHS became one of the central concerns of both the *Majority* and *Minority Reports* although their recommendations suggested that men were unsuited to acute care work.<sup>897</sup> The traditional idea that their physical strength qualified men to work in long stay wards with heavily dependent, chronic patients or in mental hospitals continued to encourage male nurses towards the more unpopular areas of nursing.

Notions of gender were, however, less influential on nurses' choice of occupational representation than Carpenter suggests.<sup>898</sup> Case studies of the CLA and SDEC refute his argument that women were more likely to reject unionism because of their adherence to professional and vocational values. Female CLA nurses played a leading role in the rapid upsurge of union membership and strike action in 1918 suggesting that women were just as likely as men to reject professional ideology.<sup>899</sup> Whether the SDEC nurses' disinterest in trade unionism stemmed from a lack of male nurse leadership is highly unlikely. Indeed, SDEC nurses were not interested in any form of occupational representation. During the First World War, most SDEC nurses were drawn from upper and middle class backgrounds and so were unlikely to sympathise with working class movements.<sup>900</sup> Maggs' argument that the choice of a college route was influenced by professional ideology is also disputed here.<sup>901</sup> SDEC nurses were quick to complain about minor problems during the First World War suggesting the notion of self-sacrifice as a model of behaviour carried little weight at this provincial hospital.<sup>902</sup> The SDEC management's eagerness to provide favourable resolutions to appease the type of middle class nurse considered favourable to the hospital's reputation and the fact that nurses' levels of occupational ill health had not

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<sup>897</sup> *Majority Report*, p.74; *Minority Report*, 1949.

<sup>898</sup> Carpenter, 'Asylum Nursing Before 1914', pp.142-143.

<sup>899</sup> For full discussion of the leading role CLA female nurses took in the 1918 industrial action see pp.135-141.

<sup>900</sup> Abel-Smith, *A History of the Nursing Profession*, p.132.

<sup>901</sup> Maggs, *The Origins of General Nursing*, p.84-88; Carpenter, *Working for Health*, p.166.

<sup>902</sup> See p.143 for discussion of the SDEC nurses' complaints; PWDRO SDEC House Com Mins, 606/1/22, 19 November 1915; 606/1/11 27 September 1918.

deteriorated during the War explains why SDEC nurses felt they had no need for occupational representation.

The case study of The London Hospital illustrates the way gender issues obscured nurses' health problems. Despite her support of a scientific based system of nurse education, Luckes advocated qualities associated with motherhood as characteristic of The London Hospital nurse. She used the idea of motherhood as a vocational commitment to support her argument against state registration and a national set of regulations governing work conditions. She refuted allegations that middle class women lacked the physical strength to nurse by associating them with a superior type of women represented in the image of the 'new woman'. Luckes supported her view of how nursing should attain professional status by highlighting feminine qualities of physical strength and commitment, thus promoting an image of nurses that could not accommodate ill health. Thus this case study reveals how notions of gender and professionalism underpinned understandings of nurses' health.

The history of the occupational health of nurses is important. It offers a new perspective on many of the themes that are central to nursing history, particularly class, gender and the question of professionalisation. The focus on these themes helps understand why attitudes towards the care of sick nurses changed over time and varied between different types of institutions. By concentrating on individual nurses' experiences we reveal something new about the way national conversations affected ordinary nurses' lives. Recognition that nursing presents a serious occupational health risk is a relatively recent phenomenon; it was not until the 1990s that most nurses had access to occupational health units. This study not only sheds light on why nurses' health attracted little attention before the Second World War but also explains why this situation began to change from the 1940s. The reform process was always likely to be tortuous because the identification of occupational health problems did nothing to

resolve the class, gender and professional complications that had already tended to obscure the hazards and make them more difficult to address.

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