

**Negotiating Intimacies: Gender, Rehabilitation and the Professionalisation
of Massage in Britain, c.1880-1920**

Submitted by Kayleigh Nias to the University of Exeter
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Abstract

Massage was professionalised in Britain in 1895 by the Society of Trained Masseuses (STM), a small group of nurses and midwives mainly concerned with giving general massage to neurasthenic women. By the end of the First World War the massage profession had been transformed - a key participant in the rehabilitation of the nation's wounded soldiers; publically, medically and politically acclaimed; and a specialism fully embryonic of physiotherapy. This thesis examines the professionalisation of massage from c.1880-1920. It argues that in order to fully understand the development of the profession in this period we have to move away from institutional teleologies, linear narratives of 'medical control' and embrace the myriad of socio-cultural, economic, political and professional forces driving and shaping this process. To explore these wider forces this thesis looks beyond internal institutional dynamics and examines a number of locations where massage was practised. Beginning with an examination of how massage was translated from a traditionally lay-treatment into the language of medical orthodoxy, this thesis considers its adoption into British medicine, its development as a practice and a profession, and its entry into the First World War.

Fiercely contested both medically and ethically throughout the period, the practice of massage offers a new lens through which to examine the complex socio-cultural and professional negotiations shaping the course of professionalisation. This thesis argues that debates about massage, gender and intimacy were intricately woven into the formulation of professional boundaries, conditioning the relationship between patient and masseuse as well as the masseuse and medical practitioner. Focus on practice also yields

insights into broader socio-economic and political concerns about disability, productivity and military efficiency. It situates the evolution of massage, practically and professionally, as part of the wider development of rehabilitation within society and medicine during this period. By contextualising the early professionalisation of massage in this way, this thesis offers new perspectives on the complex interplay between the development of physiotherapy, society and medicine.

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‘give God the glory; I’ll have none, I’ll have none, I’ll have none.’

William Dewsbury (1688)

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List of Abbreviations

AMS	Army Medical Services
APMC	Almeric Paget Massage Corps
BARP	British Association of the Advancement of Radiology and Physiotherapy
BMA	British Medical Association
BMJ	<i>British Medical Journal</i>
COS	Charity Organisation Society
CSMRG	Chartered Society of Massage and Remedial Gymnastics
CSP	Chartered Society of Physiotherapy
TK	The Keep, East Sussex
ICAA	Invalid Children's Aid Association
ISTM	Incorporated Society of Trained Masseuses
IWM	Imperial War Museum
JISTM	<i>Journal of the Incorporated Society of Trained Masseuses</i>
LMA	London Metropolitan Archives
MIRG	Manchester Institute of Massage and Remedial Gymnastics
MMS	Military Massage Service
NIB	National Institute of the Blind
NN	Nursing Notes
NNMC	Nursing Notes and Midwives' Chronicle
NVA	National Vigilance Association
RAMC	Royal Army Medical Corps
RCIG	Royal Central Institute of Gymnastics, Sweden
RCN	Royal College of Nursing (online archive)

RLHA	Royal London Hospital Archives
RJAHOH	Robert Jones and Agnes Hunt Orthopaedic Hospital
RNOH	Royal National Orthopaedic Hospital
SBC	Section of Balneology and Climatology of the Royal Society of Medicine
SRE	Swedish Remedial Exercise
STM	Society of Trained Masseuses
TNA	The National Archives
WL	Wellcome Library

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Introduction

“‘Massage’ to ‘physiotherapy’ is more than a change of name. It tells in brief the history of the growth of a profession’.¹

On 17th November 1943 the massage profession formally changed its name to physiotherapy, its members no longer masseuses and masseurs but physiotherapists. First professionalised in Britain in 1895 by the Society of Trained Masseuses (STM), a small group of nurses and midwives mainly concerned with giving general massage to neurasthenic women, by 1920 the profession had been completely transformed. Playing a key role in the First World War rehabilitating the nation’s wounded soldiers, by 1920 the profession had become embedded within Britain’s medical, public and political landscape and a specialism fully embryonic of modern physiotherapy. This thesis examines the professionalisation of massage from c.1880-1920. It argues that in order to fully understand the development of the profession we have to move away from institutional teleologies and linear narratives of ‘medical control’ and embrace the broad socio-cultural, economic, political and professional forces driving and shaping this process. To explore these wider forces this thesis looks beyond internal institutional dynamics of the STM and examines a number of different locations where massage was practised.

This thesis begins with an examination of how and why massage – a widespread, ancient and transcultural practice traditionally in the hands of lay-therapists – was translated into the language of medical orthodoxy and adopted into regular practice in Britain in the 1880s. Fiercely contested both medically and ethically throughout the period, this study considers the socio-cultural

¹ *Journal of the Chartered Society of Physiotherapy* (January 1944), p.71. This was the first journal issued under this title.

anxieties surrounding the intimacy of practice, and the gendered professional interests at play in the negotiation of professional boundaries. The thesis then moves to explore the development of massage practice in the context of rehabilitation before the war, highlighting broad socio-economic and political concerns about disability, productivity and military efficiency. It studies how the massage profession responded to shortcomings within medicine in the field of physical treatment and rehabilitation by carving out a multi-skilled specialism based on nursing and Swedish gymnastics. Finally, this thesis follows the entry of the massage profession into the First World War. It shows that it played a key role in the rehabilitation of the nation's wounded soldiers as a service in and of itself as well as a surgical auxiliary. It argues that by 1920, the professionalisation of massage had provided the practical and discursive parameters of physiotherapy as a modern specialism.

Historiography

The History of Physiotherapy

Little research has been done on the history of physiotherapy and the early professionalisation of massage in Britain. The two primary works on the topic recount the history of its main representative body, the Society of Trained Masseuses (STM). Founded in 1894, the STM became the Incorporated Society of Trained Masseuses (ISTM) in 1900, the Chartered Society of Massage and Remedial Gymnastics (CSMRG) in 1920, and the Chartered Society of Physiotherapy (CSP) in 1944, the changing names reflective of the profession's shifting dimensions.² Both texts are commemorative, commissioned by the Society to celebrate its jubilee and centenary

² While the name of the Society changed throughout the period examined in this thesis, this work will use the abbreviation 'STM' throughout for consistency.

anniversaries respectively. The first of the two works, *The Growth of a Profession* was written in 1944 by council member Jane Wicksteed, and the other, *In Good Hands*, was written in 1994 by Jean Barclay.³

These works synthesise a huge body of material and use the CSP's institutional records to chart the history of the STM over considerable time periods. These accounts are invaluable to anyone considering the history of physiotherapy and they highlight the role of the Society within the process of professionalisation. As with any commemorative text that focuses tightly upon an institution, however, these two accounts lack contextualisation and offer teleological accounts of the history of physiotherapy. While this thesis also highlights the agency of the STM and individual masseuses in the process of professionalisation, it breaks new ground in that it sets this within a broader narrative that gives agency to a wide range of forces. By looking at a shorter time period and expanding the scope of sources, this thesis differs in its approach and offers a contextualised investigation of the early development of the massage profession.

The history of physiotherapy has been of interest to other scholars. Sociologists have found physiotherapy a useful case study to investigate the power relations between different paramedical groups, the medical profession and the state. Physiotherapy is not the only allied profession to have received limited scholarly attention; the history of the paramedical professions in Britain more generally is an under-researched area, bar the work of a few, including

³ Jane H. Wicksteed, *The Growth of a Profession: Being the History of the Chartered Society of Physiotherapy, 1894-1945* (London: Edward Arnold & Co., 1948); Jean Barclay, *In Good Hands: The History of the Chartered Society of Physiotherapy 1894-1994* (Oxford: Butterworth-Heinemann Ltd, 1994).

sociologist Gerald Larkin.⁴ In his monograph *Occupational Monopoly and Modern Medicine*, Larkin offers a comparative analysis of the emergence of four paramedical groups: radiographers, chiropodists, ophthalmic opticians and physiotherapists. Larkin's work investigates how gender and power shaped the relationships and divisions of labour between these professions and medicine. One chapter concentrates on physiotherapy and analyses how certain external forces, particularly the medical profession and state, impacted upon professionalisation.⁵

Other scholars including Richard Hugman and Gwyneth Owen also look at the early years of physiotherapy from a sociological perspective, exploring ways in which the profession and its practices have been affected by social and cultural processes.⁶ Each of these studies offer sophisticated analysis and highlight the power relations that underpinned the professional strategies and divisions of labour between the massage and medical professions. The sociological approach provides a linear account of professionalisation, which is attuned to identifying important patterns and trends that can be used to inform the present. In contrast this thesis argues that a linear narrative cannot easily encapsulate the early professionalisation of massage. It moves away from a linear trajectory by limiting its investigation to one profession and basing its analysis on detailed archival research, which highlights the contingencies of professionalisation. Furthermore, the work of Larkin and Hugman, in particular,

⁴ G. Larkin, *Occupational Monopoly and Modern Medicine* (London; New York: Tavistock Publications, 1983); G. Larkin, 'The Emergence of the Paramedical Professions', in *Companion Encyclopaedia for the History of Medicine* Vol. 2, ed. by W.F. Bynum & R. Porter (London: Routledge, 1993), pp.1329-1349; G. Larkin, 'Health Workers', in *Companion Encyclopedia of Medicine in the Twentieth Century*, ed. by R. Cooter and J. Pickstone (Amsterdam: Harwood Academic Publishers, 2000), pp.531-543.

⁵ Larkin, *Occupational Monopoly*, p.92 (Chapter 4).

⁶ Richard Hugman, *Power in the Caring Professions* (Basingstoke: Macmillan, 1991); Gwyneth Owen, 'Becoming a Practice Profession: a Genealogy of Physiotherapy's Moving/ Touching Practices', (Unpublished doctoral thesis, Cardiff University, 2014).

explain the history of the early massage profession in terms of medical control and subordination. While this thesis shows that medical control and subordination were key features of early professionalisation, it argues that we have to consider the complex web of power relations through which these professional relationships were negotiated. Broadening the scope of research from a focus on professional relations offers new perspectives on how the professional boundaries of massage were inherently shaped by wider forces.

Historians have also been interested in the history of physiotherapy. Two critical moments for professionalisation, the 1894 massage scandals and the First World War, have received the most scholarly attention. Work that offers detailed analysis includes the 2006 article, 'Physiotherapy and the Shadow of Prostitution', by David Nicholls and Julianne Cheek.⁷ Using Foucauldian theory this study examines how discourses of power, professionalism and gender were at the heart of the formation of the STM in 1895. Like the sociological studies discussed above, however, this work has a present-centred aim for its analysis, seeking to 'critically analyse the continued relevance of the profession to contemporary healthcare'.⁸ While the Foucauldian approach is a valuable analytical tool to explore the power and gender dimensions at play, it lacks the historical context important for making balanced conclusions. For example in their 2010 article: 'The Body and Physiotherapy', David Nicholls and Barbara Gibson argue that physiotherapists first adopted a 'biomechanical view of the body' in response to the massage scandals in order to prove to the medical

⁷ David Nicholls and Julianne Cheek, 'Physiotherapy and the Shadow of Prostitution: The Society of Trained Masseuses and the Massage Scandals of 1894', *Social Science and Medicine*, 62 (2006), 2336-2348.

⁸ Nicholls and Cheek, 'Physiotherapy and the Shadow of Prostitution', 2336.

community and public that their work was legitimate.⁹ Within this explanation the adoption of a biomechanical view of massage treatment appears as an 'option' and sudden choice in 1895, rather than discourse reliant upon the translation of massage into the language of medical science throughout the nineteenth century. Using a different approach and starting with empirical research rather than a theoretical framework this thesis aims to contextualise the development of the massage profession.

Physiotherapy in the First World War has also received attention. The work of Ana Carden-Coyne and Fiona Reid in particular offer detailed analysis of the soldiers' experiences and perceptions of physiotherapy.¹⁰ Studying representations of massage and the masseuse in sources such as cartoons, poetry and jokes, these works examine how soldiers negotiated their experiences of pain, gender and intimacy. As these studies show, representations of massage and the masseuse provide rich insight into the culture of the hospital ward and the gendered politics underpinning rehabilitation in the First World War.¹¹ Building on this scholarship, this thesis examines how the politics of pain, gender and intimacy became embedded within the practical and professional boundaries of massage. It shows that these themes were central to the professionalisation of massage from the mid-nineteenth century throughout the First World War; and explores how they were negotiated and renegotiated in many different contexts.

⁹ David Nicholls and Barbara Gibson, 'The Body and Physiotherapy', *Physiotherapy Theory and Practice: An International Journal of Physiotherapy*, 26:8 (2010), 497-509, (p.499).

¹⁰ Ana Carden-Coyne, *The Politics of Wounds: Military Patients and Medical Power in the First World War* (Oxford: Oxford University Press, 2014); Ana Carden-Coyne, 'Painful Bodies and Brutal Women: Remedial Massage, Gender Relations and Cultural Agency in Military Hospitals, 1914-18', *Journal of War and Culture Studies*, 1:2 (2008), 139-158; Fiona Reid, *Medicine in First World War Europe: Soldiers, Medics, Pacifists* (New York: Bloomsbury Academic, 2017).

¹¹ The work of Ana Carden-Coyne is discussed again in the First World War section of this historiography.

Looking to another geographical location, the work of Beth Linker examining the history of physiotherapy in America is particularly valuable for this thesis. In her 2011 monograph *War's Waste*, Linker examines the importance of physiotherapy to the American rehabilitation movement.¹² Linker's work, including the articles 'Strength and Science', and 'The Business of Ethics', demonstrates the ways in which American physiotherapy was shaped by gender, militarism and medicine.¹³ There are many similarities and differences between the professionalisation of physiotherapy in Britain and America. In contrast to Britain, American physiotherapy was established during the First World War by female remedial gymnasts who carved their profession from altogether different circumstances than those bearing on British nurse-masseuses in the mid-1890s. While this thesis is focused upon the British context, it emulates Linker's approach by giving a broad contextual analysis of the transformation of the massage profession from the late-nineteenth century to 1920. The rest of this historiographical overview will discuss the broader historical framework of this thesis.

Medical Professionalisation

During the first half of the nineteenth century, the British medical profession was in a state of flux. As a result of the social and economic changes wrought by the industrial revolution, the medical market had expanded.¹⁴ Demands for health care services and the increased number of practitioners created a diverse

¹² Beth Linker, *War's Waste: Rehabilitation in World War I America* (Chicago; London: University of Chicago Press, 2011).

¹³ Beth Linker, 'The Business of Ethics: Gender, Medicine, and the Professional Codification of the American Physiotherapy Association, 1918-1935', *Journal of the History of Medicine and Allied Sciences*, 60:3 (2005), 320-354; Beth Linker, 'Strength and Science: Gender, Physiotherapy, and Medicine in Early-Twentieth-Century America', *Journal of Women's History*, 17:3 (Fall 2005), 105-132.

¹⁴ Iwan Morus, *Frankenstein's Children: Electricity, Exhibition, and Experiment in Early-Nineteenth Century London* (Princeton; New Jersey: Princeton University Press, 1998), p.231.

medical arena wherein there was no clearly defined 'orthodox' or 'alternative' practice.¹⁵ As Roberta Bivins has noted, these definitions within medicine are, in historical terms, fairly new. For any 'system, theory or practice' to be defined as 'alternative', she argues, there must exist a clearly recognisable orthodoxy to which it is opposed.¹⁶ Orthodoxy in Britain came to ascendancy following the 1858 Medical Act, which established a single register for practitioners holding specific medical qualifications.¹⁷ As historians have pointed out, however, even after this point, there was no discernibly monolithic medicine and the boundaries between regular and irregular practice were fluid.¹⁸

A considerable amount of scholarly attention has been paid to the shifting frontiers of medical orthodoxy. Monographs by Roberta Bivins and Mike Saks, and edited volumes such as William Bynum and Roy Porter's *Medical Fringe and Medical Orthodoxy* and Roger Cooter's *Studies in the History of Alternative Medicine*,¹⁹ show that the boundaries between 'regular' and 'irregular' medicine have been constituted in a myriad of different ways, in different contexts, throughout history. Detailed case studies that chart groups on the fringes of orthodoxy, such as hydropathy, herbalism, spiritual healing, mesmerism and homeopathy, highlight that relations between these groups and

¹⁵ Mike Saks, (ed.), *Alternative Medicine in Britain* (Oxford: Clarendon Press, 1992), p.9.

¹⁶ Roberta Bivins, *Alternative Medicine? A History* (Oxford: Oxford University Press, 2007), p.171; also see, Roberta Bivins, 'Histories of Heterodoxy', *Oxford Handbook of the History of Medicine*, ed. by Mark Jackson (Oxford: Oxford University Press, 2011), pp.578-597.

¹⁷ Joan Lane, *A Social History of Medicine: Health, Healing and Disease in England, 1750-1950* (London: Routledge, 2001), p.29.

¹⁸ W.F. Bynum and Roy Porter (eds.), *Medical Fringe and Medical Orthodoxy 1750-1850* (London: Croom Helm, 1987), p.1.

¹⁹ Mike Saks, *Orthodox and Alternative Medicine: Politics, Professionalization and Health Care* (London: Continuum, 2003); Mike Saks, *Professions and the Public Interest: Medical Power, Altruism and Alternative Medicine* (London: Routledge, 1995); Mike Saks, (ed.), *Alternative Medicine in Britain* (Oxford: Clarendon Press, 1992); Bynum and Porter (eds.), *Medical Fringe and Medical Orthodoxy*; Roger Cooter (ed.), *Studies in the History of Alternative Medicine* (Basingstoke: Macmillan Press, 1988). Although historians and sociologists have defined 'unqualified' practices and practitioners in a number of ways, using labels such as 'irregular', 'periphery', 'fringe', 'heterodox', 'unorthodox', 'paramedical' and 'auxiliary', distinct identities separate from the regular profession are often difficult to discern.

regular medicine ranged from amicable to hostile. Medical orthodoxy used a range of strategies to police its boundaries and assert its professional interests, ranging from adaption, adoption and absorption, to subordination, marginalisation and exclusion. By showing the ways in which medical boundaries and knowledge has been constructed, fluid and fiercely contested in different social contexts, this scholarship unsettles the privileged epistemological status of science and medicine as objective and 'independent of cultural or social constraints or meaning'.²⁰ While many of the more radical fringe groups have received scholarly attention, less notice has been paid to medical practices such as massage that were low-status and of little interest to the medical profession before the First World War. By examining the translation of massage, a traditionally lay-practice, into the language of medical orthodoxy, and its adoption into regular medicine, this thesis offers a case study to the wider scholarly field of medical professionalisation.

Throughout the second half of the nineteenth century, regular medicine developed an interest in the use of physical therapeutic agents, including massage, remedial gymnastics, mechano-, electro-, and hydro- therapy.²¹ While scholarship on these physical treatments in the late-nineteenth century is scarce, studies that look at bone-setting, hydropathy and electrotherapy elucidate the key forces driving the adoption of physical therapeutic agents into regular practice, as well as the ways in which they were adapted to suit the professional interests of medicine. These studies are also valuable to this thesis in that they give a background to practices other than massage that came to be

²⁰ Bivins, *Alternative Medicine?*, p.4.

²¹ Roger Cooter, 'Bones of Contention? Orthodox Medicine and the Mystery of the Bone-Setters Craft', in *Medical Fringe and Medical Orthodoxy 1750–1850*, ed. by W. F. Bynum and Roy Porter (London: Croom Helm, 1987), pp.158-173, (p.163); Roger Cooter, *Surgery and Society in Peace and War: Orthopaedics and the Organization of Modern Medicine, 1880-1948* (London: Macmillan Press, 1993), p.20.

a part of the physiotherapy specialism – but unfortunately beyond the scope of this thesis.

Hydrotherapy is a topic that has attracted considerable interest from scholars.²² Hydrotherapy as it emerged in the nineteenth century, diverged from earlier spa treatment, and was characterised by the application of clean, cold water both internally and externally.²³ While many hydrotherapeutic practitioners were medically qualified, it was also known as an anti-establishment therapeutic and occupied a tentative position on the margins of orthodoxy.²⁴ In *Social Context and Medical Theory*, P.S. Brown argues that 'hydrotherapy represented one of several forms of reaction to the unsatisfactory state of orthodox therapeutics'.²⁵ The Victorian period more broadly witnessed a turn away from 'heroic' medicine and surgery and what was regarded as the abuse of powerful, poisonous remedies and 'surgical butchery'.²⁶ This turn away from conventional treatments engendered a consumer demand for 'nature-centred' cures, and a shift within regular medicine and surgery towards conservative principles. Based on this philosophy, hydrotherapy offered an alternative mode of treatment, and a challenge to regular therapeutics.

The primary demand for hydrotherapy and other so-called natural therapies came from the middle and upper classes. They were motivated not only in their rejection of regular practice, but in their search for relief from the perceived

²² R. Price, 'Hydrotherapy in England, 1840-1870', *Medical History*, 25 (1981), 269-80; P.S. Brown, 'Social Context and Medical Theory in the Demarcation of Nineteenth Century Boundaries', in *Medical Fringe and Medical Orthodoxy, 1750-1850*, ed. by W.F. Bynum and R. Porter (London, 1987), pp.216-233; Hilary Marland and Jane Adams, 'Hydrotherapy at Home: The Water Cure and Domestic Healing in Mid-Nineteenth Century Britain', *Bull. Hist. Med.*, 83 (2009), 499-529; James Bradley and Marguerite Dupree, 'Opportunity on the Edge of Orthodoxy: Medically Qualified Hydrotherapists in the Era of Reform, 1840-60', *The Society for the Social History of Medicine*, 14:3 (2001), 417-137; K. Rees, 'Water as a Commodity: Hydrotherapy in Matlock', in *Studies in the History of Alternative Medicine*, ed. by R. Cooter (Macmillan, 1988), pp.27-44.

²³ Bradley and Dupree, 'Opportunity on the Edge of Orthodoxy', 417.

²⁴ Price, 'Hydrotherapy in England', 274; Brown, 'Social Context and Medical Theory', p.223.

²⁵ Brown, 'Social Context and Medical Theory', p.226.

²⁶ Price, 'Hydrotherapy in England', 269.

physical, mental and moral stresses of modern-day living. Brown shows that hydrotherapy was practised both by lay and regular practitioners for whom it offered a 'road to reform'.²⁷ Hydrotherapy offered a means by which regular medical practitioners were able to critique conventional treatments, but also retain their professional status. By adhering to orthodox concepts of disease and physiology, and translating the therapeutics of hydrotherapy into the discourse of orthodoxy, they were able to carve out a niche on the fringes of the profession where they could tap into a consumer demand while maintaining their medical status. The hydrotherapy movement provides one example of how a fringe practice was adopted into regular medicine, and also shows how physical therapies were a vehicle through which regular therapeutics expanded its scope and reformed its practices.

Many of the forces that drove the emergence of hydrotherapy can also be discerned in the relationship between medicine and bone-setting in the late-nineteenth century. Roger Cooter's study 'Bones of Contention?', argues that from the 1860s early orthopaedic surgeons sought to appropriate the bone-setters' therapeutic territory.²⁸ Bone-setters were lay practitioners who treated a wide variety of musculo-skeletal disorders, including sprains, fractures, stiff and ankylosed joints and dislocations, by manipulative techniques.²⁹ They were frequently used by the public, Cooter argues, because they provided a 'therapeutic for which the greater part of regular practice had neither the time nor the aptitude'.³⁰ The bone-setters' trade, then, represented shortcomings within regular medicine in the treatment of injuries and functional disabilities, as well as direct competition to regular medical practitioners. Cooter examines how

²⁷ Brown, 'Social Context and Medical Theory', p.226.

²⁸ Cooter, 'Bones of Contention?', p.163.

²⁹ Cooter, 'Bones of Contention?', p.163.

³⁰ Cooter, 'Bones of Contention?', p.169.

orthopaedic surgeons asserted their professional interests by marginalising bone-setters while assimilating their manipulative techniques. By arguing that manipulative expertise could only be possessed by those who were medically trained and that empirical practice was thoroughly dangerous, surgeons were able to legitimise a useful body of therapeutic while ostracising the lay practitioner.

Electrotherapy was another burgeoning practice throughout the nineteenth century. Iwan Morus argues that electricity became a therapeutic which offered a way of reversing the physical and mental damage caused by '[t]he pace of modern life, the mental stresses of modern culture, the sedentary occupations of the late Victorian middle classes'.³¹ In *The Age of Stress*, Mark Jackson has shown that fears of the physical and mental penalties of modernity were deeply entrenched in late-Victorian and Edwardian British culture.³² Likewise Ina Zweiniger-Bargeilwska's *Managing the Body*, argues that 'cultural pessimism' about modernity gave rise to growing fears of racial and national degeneration that permeated society and politics.³³ Alongside hydropathy, electrotherapy was one of a number of therapeutic regimes on offer at this time that promised to restore the natural order to bodies perceived unable to cope with the rigours of modern civilisation. Often practised by lay personnel it was another therapeutic that many regular practitioners wished to harness.

Electrotherapy held an ambiguous status amongst regular medical practitioners. Traditionally practised by laymen who presented themselves as

³¹ Iwan Morus, 'Bodily Disciplines and Disciplined Bodies: Instruments, Skills and Victorian Electrotherapeutics', *Social History of Medicine*, 19:2 (2006), 241-259, (p.255); also see Iwan Morus, 'Marketing the Machine: The Construction of Electrotherapeutics as Viable Medicine in Early Victorian England', *Medical History*, 36 (1992), 34-52; Morus, *Frankenstein's Children*.

³² Mark Jackson, *The Age of Stress: Science and the Search for Stability* (Oxford: Oxford University Press, 2016), pp.23-24.

³³ Ina Zweiniger-Bargeilwska, *Managing the Body: Beauty, Health, and Fitness in Britain, 1880-1939* (Oxford: Oxford University Press, 2010), p.17.

'medical electricians' or 'medical galvanists', it had a reputation as medical 'quackery' and empiricism. Furthermore, as Morus has argued, its technical and manual status threatened the clinical performance and gentlemanly culture of the medical elite.³⁴ In order for regular practitioners to market electrotherapy to the medical community, proponents presented the practice as having undergone a transformation. They dismissed lay practice as empiric and dangerous arguing that only trained medical professionals could rationally direct the treatment.³⁵ At the same time, however, they were also anxious to emphasise how little knowledge, skill and expertise was required to use the electrical apparatus. The mark of orthodox practice, they argued, was not in the application, but rather the diagnostic and managerial skill directing the treatment. In this way, the manual labour and technical skill of working with instruments could be devolved to those whose status made such work less of a problem.³⁶ The merger of electrotherapy into regular medical practice, then, occurred through a process of negotiating the professional and cultural interests of the medical profession.

This thesis argues that the professionalisation of massage was part of a wider process by which physical therapeutic techniques were assimilated into medical orthodoxy in the late-nineteenth century. It argues that like hydro-, electro-therapy and bone-setting, massage offered a therapeutic that addressed certain shortcomings within regular medicine. It looks at how massage was adopted into medicine through a division of labour in order to uphold the status of the medical practitioner.

³⁴ Morus, 'Bodily Disciplines', 247; Morus, *Frankenstein's Children*, p.254.

³⁵ Morus, *Frankenstein's Children*, p.236.

³⁶ Morus, 'Bodily Disciplines', 247.

Specialisation and Orthopaedics

Twentieth-century medicine has been characterised by the multiplication of medical and para-medical specialties.³⁷ While specialisation has often been viewed as an overdetermined process (an inevitable consequence of advancing scientific knowledge, modern technology and new skills), historians have been concerned to explain how and why specialisation took place. The history of medical specialisation is addressed in a number of well-known studies, including George Rosen's *The Specialization of Medicine*, Rosemary Stevens' *Medical Practice in Modern England*, and more recently George Weisz's *Divide and Conquer*.³⁸ Rosen's 1944 work signalled an important departure from traditional celebratory narratives of medical progress, by arguing that intellectual and social factors, as well as scientific and technological advances were involved in medical specialisation. In line with her argument that specialisation was not a marked feature of medicine before 1939 Stevens' 1966 work focuses on Britain during the twentieth century. Although her study does not trace the historical roots of specialisation, she suggests that the introduction of the National Health Service in 1948 exaggerated and formalised specialties that were already 'grafted onto accepted professional patterns'.³⁹ In both of these studies, however, primacy is placed on scientific advances and changing health care as drivers for change.

³⁷ Larkin, *Occupational Monopoly*, p.2. The term para-medical is used to refer to occupations organised as professions that support medical work but exclude doctors.

³⁸ George Rosen, *The Specialization of Medicine with Particular Reference to Ophthalmology* (New York: Froben Press, 1944); Rosemary Stevens, *Medical Practice in Modern England; the Impact of Specialization and State Medicine* (New Haven, Yale Univ. Press, 1966); George Weisz, *Divide and Conquer: A Comparative History of Medical Specialisation* (Oxford: Oxford University Press, 2006).

³⁹ Stevens, *Medical Practice in Modern England*, p.5.

Weisz's study *Divide and Conquer* offers a comparative study of medical specialisation in Britain, France, Germany and United States.⁴⁰ A comparative approach allows his study to demonstrate the national specificities of a common phenomenon. Furthermore, by analysing the historical roots and conditions determining specialisation, Weisz's work shows that this process did not occur in a historical vacuum, moving beyond the 'overdetermined' explanation.⁴¹ Many other valuable empirically based studies that examine the historical roots of medical specialisation have emerged in this field.⁴²

The development of certain medical specialisms opened up key arenas for massage and physiotherapy in the late-nineteenth and early-twentieth centuries. In particular this thesis shows how massage featured within gynaecology, orthopaedics and physical medicine. In contrast to gynaecology and orthopaedics, physical medicine is a specialism that has received relatively little scholarly attention. Referenced in her study, Rosemary Stevens argues that physical medicine only emerged during the interwar years, 'although it was more of a collection of individual methods of treatment than a unified discipline', that included hydrotherapy, actinotherapy (light treatment), electrotherapy, massage and exercise.⁴³ Cooter's study of orthopaedics notes that it was during the interwar period that physical medicine consolidated ground gained during the war.⁴⁴ The primary work written on physical medicine is Geoffrey

⁴⁰ Also see, George Weisz, 'Mapping Medical Specialization in Paris in the Nineteenth and Twentieth Centuries', *The Society for the Social History of Medicine*, 7:2 (1994), 177-211.

⁴¹ Weisz, *Divide and Conquer*, p.xii.

⁴² Pertinent for this thesis: Glenn Gritzer and Arnold Arluke, *The Making of Rehabilitation Medicine: A Political Economy of Medical Specialization, 1890-1980* (Berkeley: University of California Press, 1985); Ornella Moscucci, *The Science of Women: Gynaecology and Gender in England, 1800-1929* (Cambridge: Cambridge University Press, 1990); Cooter, *Surgery and Society*.

⁴³ Stevens, *Medical Practice in Modern England*, p.47.

⁴⁴ Roger Cooter, *Surgery and Society*, p.135.

Storey's *A History of Physical Medicine*,⁴⁵ a small survey that links the specialism to the institution of the British Association of Rheumatology and Rehabilitation. It traces its history to the Royal Society of Medicine, from which specialist sections, the British Balneology and Climatological Society (1895) and the Section of Electrotherapy (1907), emerged around the turn of the century.⁴⁶ While not a study of physical medicine, this thesis cuts across the history of this specialism by exploring how the interests of medical men in this field developed during the First World War and the impact that this had upon physiotherapy.

This thesis situates the development of massage in the context of orthopaedics, both before and during the First World War. Work by Leslie Klenerman, Frederick Watson, H. Osmond-Clarke, Roger Cooter, Anne Borsay, Julie Anderson and Heather Perry explores the historical roots of orthopaedics from the late-nineteenth century.⁴⁷ Watson, Osmond-Clarke and Leslie Klenerman's work describes the surgical advances and pioneering individuals key in the evolution of orthopaedics. They offer progressive accounts of the specialism that trace its origins to symbolic figures and institutions such as Robert Jones, Hugh Owen Thomas and Baschurch Surgical Home. In contrast the work of Cooter, Borsay, Anderson and Perry offer more critical analysis of

⁴⁵ Geoffrey Storey, *A History of Physical Medicine: The Story of the British Association of Rheumatology and Rehabilitation* (London: Royal Society of Medicine Services Limited, 1992).

⁴⁶ Storey, *A History of Physical Medicine*, pp.1-2.

⁴⁷ Leslie Klenerman (ed.), *The Evolution of Orthopaedic Surgery* (London: Royal Society of Medicine Press, 2002), pp.1-9; Frederick Watson, *The Life of Sir Robert Jones* (London: Hodder & Stoughton, 1934); Frederick Watson, *Civilization and the Cripple* (London: John Bale, 1930); H. Osmond-Clarke, 'Half a Century of Orthopaedic Progress in Great Britain', *The Journal of Bone and Joint Surgery*, 4 (November, 1950), 620- 675; Cooter, *Surgery and Society*; Anne Borsay, *Disability and Social Policy in Britain Since 1750* (Basingstoke: Palgrave Macmillan, 2005); Anne Borsay, 'Disciplining Disabled Bodies: The Development of Orthopaedic Medicine in Britain, c.1800-1939', in *Social Histories of Disability and Deformity*, ed. by David M. Turner and Kevin Stagg (Abingdon: Routledge, 2006), pp.97-116; Julie Anderson and Heather Perry, 'Rehabilitation and Restoration: Orthopaedics and Disabled Soldiers in Germany and Britain in the First World War', *Medicine, Conflict and Survival*, 30:4 (2014), 227-251.

its development. They show that the history of orthopaedics has origins in a multitude of traditions and practices and challenge linear accounts.

Orthopaedics in the nineteenth century was a minor and low status branch of surgery that mostly dealt with the chronic diseases and congenital deformities of children. This traditional or 'pre-modern' orthopaedics had its origins in the work of William John Little (1810-1894) in the correction of club foot by the tenotomy operation, and the three London orthopaedic institutions that were founded upon this work. The first of these institutions, the Infirmary for the Correction of Club Foot and Other Contractions, was founded in Bloomsbury in 1838, changing its name to the Royal Orthopaedic Hospital in 1845.⁴⁸ The growing number of 'crippled poor' on the waiting list for treatment led to the foundation in 1851 of the City Orthopaedic Hospital in Hatton Garden for the 'surgical treatment of poor persons of every nation afflicted with club foot, contractions or distortions of the limbs, curvature of the spine or other bodily deformities'.⁴⁹ The third institution, the National Orthopaedic Hospital, was founded in 1864. While overwhelmed with patients, these hospitals faced marginalisation and continual financial and organisational challenges that were only alleviated in 1907 when they were amalgamated into one institution called the Royal National Orthopaedic Hospital (RNOH).⁵⁰

Cooter has argued that 'pre-modern' orthopaedics was characterised by the narrowness of its therapeutic focus and the surgical techniques that it deployed.⁵¹ The work of orthopaedics centred around the correction of the chronic congenital deformities of children. The emphasis on treating children

⁴⁸ Pat Starkey, 'Club Feet and Charity: Children at The House of Charity, Soho, 1848-1914', in *Disabled Children: Contested Caring, 1850-1979*, ed. by Anne Borsay and Pamela Dale (London: Pickering & Chatto, 2012), pp.15-28, (p.18).

⁴⁹ Starkey, 'Club Feet and Charity', pp.18-19.

⁵⁰ Cooter, *Surgery and Society*, p.17.

⁵¹ Cooter, *Surgery and Society*, p.17.

rather than adults came from the belief that younger patients were more amenable, physically and morally, to correction. Not only were deformities less chronic, bodies and bones more malleable, but they were also easier to manage as patients. Adults, by contrast, both men and women, were expected to be breadwinners and to raise children, meaning that only those who did not need a weekly wage and had help to manage the home, had the time or money to undertake prolonged and often uncomfortable orthopaedic treatment. Furthermore, only a minority of patients would have been admitted as in-patients; the majority would have attended out-patient clinics, which were often very difficult for the poor living outside of London to attend.⁵²

Traditional orthopaedic treatment was characteristically conservative, relying upon mechanical apparatus, massage, manipulation, exercise and rest, as well as some minor operative procedures. J.A. Cholmeley's work on the history of the RNOH suggests that this type of treatment remained conventional throughout the nineteenth century, little changing from 'tenotomies, manipulations [...] splinting and usually the ordering and fitting of surgical boots and instruments'.⁵³ This thesis examines how massage was used in orthopaedic treatment before the First World War. It highlights that techniques such as massage, while considered low-status by the contemporary surgical elite and eclipsed by surgical advances in the twentieth century, were important for the development of the early specialism.

The 'modern' orthopaedics that achieved ascendancy in the First World War differed in many ways to the specialism as it was understood throughout the nineteenth century. Under leading surgeon Robert Jones who became

⁵² Starkey, 'Club Feet and Charity', p.18.

⁵³ J.A. Cholmeley, *History of the Royal National Orthopaedic Hospital* (London: Chapman and Hall, 1985), p.31.

Military Director of Orthopaedics in March 1916, the therapeutic focus and surgical territory of orthopaedics was expanded to encompass chronic disabilities and acute trauma using a combination of physiotherapeutic and invasive surgical methods.⁵⁴ While Jones's wartime vision was a break with the past, however, it drew from pre-war orthopaedics as well as his personal and professional experiences from the late-nineteenth century. His uncle, Hugh Owen Thomas, who posthumously gained the reputation as the 'father' of modern orthopaedics was a qualified general practitioner from a family of bone-setters. He gained recognition for his work amongst the poor of the Liverpool docks and his commitment to conservative methods, most notably fresh air, prolonged rest and immobilisation by splinting, by which he treated both traumatic injuries and chronic deformities.⁵⁵ Thomas was a unique practitioner, however, and despite his advocacy of conservative principles, he was staunchly against the manipulative techniques used by his peers in orthopaedics and conservative surgery. This bias was linked both to his commitment to rest and splinting, but also to an effort to dissociate himself from his bone-setting ancestry. Tracing the history of orthopaedics to figures such as Thomas and Jones alone, therefore, can eclipse the wider historical roots that also underpin the modern specialism, including techniques such as massage.

Jones also drew from his own practical experience of treating trauma and chronic disability. His surgical approach advocated a mixture of invasive and conservative techniques according to the case; through a number of ventures, Jones was able to practice new technologies and operative techniques such as X-ray, asepsis and open surgery, osteotomy and arthroplasty, tendon

⁵⁴ Cooter, *Surgery and Society*, p.115.

⁵⁵ Thomas devised a number of splints for which he posthumously became famous, including the Thomas splint which Robert Jones introduced into the Army Medical Service in 1915.

transplantation and bone-grafting, alongside conservative methods.⁵⁶ Most famously he organised the accident and emergency services for the Manchester Ship Canal project (1888-1893), treated chronically disabled children (particularly tuberculosis of bones and joints) at Baschurch Surgical Home, in Oswestry (est.1904) and the Royal Liverpool Country Hospital for Children, at Heswall, (est.1909).⁵⁷ These provincial opportunities gave Jones a chance to showcase his ideas about orthopaedic treatment that required facilities for prolonged in-patient and after-care that were unavailable at the major voluntary hospitals. During the First World War Jones drew from his wide-ranging experiences defining orthopaedics as 'the treatment by manipulation, by operation, and re-education, of disabilities of the locomotor system, whether arising from disease or injury'.⁵⁸ This thesis is based upon archival research of the Baschurch surgical home and an investigation into the Britain's flagship military orthopaedic centre Shepherd's Bush during the war, in order to consider the relationship of massage to modern orthopaedics. It suggests that the role of massage shifted from a primary surgical tool in traditional orthopaedics, to surgical auxiliary in modern orthopaedics, and highlights that in both contexts massage played a key part.

Orthopaedics was not the only area of contemporary surgery concerned with conservative techniques and the correction of disabilities. By the late-nineteenth century the philosophy of conservatism was a leading principle within medicine and surgery. While little scholarship is dedicated to conservative surgery in Britain, historian Gert Brieger who examines the American context has argued that conservatism was not a rejection of operative

⁵⁶ Cooter, *Surgery and Society*, pp.51-52.

⁵⁷ Cooter, *Surgery and Society*, pp.100-103; pp.72-78; p.62.

⁵⁸ Robert Jones, 'Orthopaedic Surgery in its Relation to War', *Recalled to Life*, 1 (1917), 50-59, (p.51).

surgery, but rather the principle of effecting complete and radical cure whilst sacrificing as little of the body as possible.⁵⁹ Conservative surgery therefore could also be viewed as radical and progressive, diverging from 'heroic' surgery and medicine.⁶⁰

Conservatism had an impact upon surgical technique and thinking. Based on the teaching of John Hunter, there was a revival of trust in the healing power of nature whereby fresh air, rest, immobilisation as well as physical therapies were incorporated into general practice. Two arenas where conservative methods reformed general surgery, were firstly subcutaneous osteotomy, the technique for cutting and dividing bones under the skin, designed to prevent post-operative blood poisoning by avoiding the exposure of tissues,⁶¹ and, secondly, in the management of fractures, where rather than amputating broken limbs, methods such as splinting and bandaging were used.⁶² Alongside orthopaedic institutions, general hospitals also developed specialist and out-patient departments that began to offer treatment for disabilities and injuries.⁶³ Using archival research from the London and St Thomas' Hospitals this thesis explores how and why massage emerged in general hospitals. As historians have shown, there was relatively little provision within medicine for the treatment of disability before the war. Tracing the practice of massage in these institutions, however, offers insights into work being done in the arena of rehabilitation beyond orthopaedic institutions and the work of Robert Jones.

⁵⁹ Gert H. Brieger, 'From Conservative to Radical Surgery in Late Nineteenth-century America', in *Medical Theory, Surgical Practice*, ed. by Christopher Lawrence (London: Routledge, 1992), pp.216-231, (p.221). While Brieger looks at the American context, Cooter argues that conservatism was a broad movement comparable in USA and UK.

⁶⁰ Brieger, 'From Conservative to Radical Surgery', p.222.

⁶¹ Borsay, *Disability and Social Policy*, p.50.

⁶² Borsay, *Disability and Social Policy*, pp.50-51.

⁶³ Cooter, *Surgery and Society*, p.37.

As scholarship has tended to focus on what is considered to be ‘proper’ medicine, the history of paramedical specialisation has received relatively little attention.⁶⁴ This is, however, surprising in that the history of medical specialisation cannot be fully understood without reference to the supporting services that permitted its existence and development. Returning to the work of Gerald Larkin, his study represents one of few attempts to analyse the relationship between paramedical specialisation and the medical profession. Larkin argues that like medicine, the phenomenon of specialisation for the allied health professions has been viewed as an inevitable, overdetermined process.⁶⁵ His thesis shows that the formulation of medical and paramedical occupational boundaries was inherently interlinked in a ‘process of constructing, formalising and dividing skills and responsibilities’.⁶⁶ The medical profession, he suggests, ‘has fought the hardest’ in an effort ‘to retain control over the diagnosis and prescription of treatment’, shaping the development of allied occupations to correspond with its own professional aspirations and position within healthcare.⁶⁷ His work challenges the ‘aura of inevitable permanence’ attached to occupational boundaries and demonstrates the interdependence of the two respective arenas. Drawing from Larkin’s analysis, this thesis traces massage practice to analyse how occupational boundaries and divisions of

⁶⁴ For a history of radiography see, I. Moodie, *The Society of Radiographers: 50 years of History* (London: The Society of Radiographers, 1970); M. Jordan, *The Maturing Years: The History of the Society and College of Radiographers 1970-1995* (London: The Society of Radiographers, 1995). For a history of dietetics see, N.L. Blakestad, ‘King’s College of Household and Social Science and the Household Science Movement in English Higher Education, c. 1908-1939’, (Unpublished D. Phil. thesis: Oxford University, 1994). For a history of art therapy see, D. Waller, *Becoming a Profession: The history of Art Therapy in Britain 1940-82* (London: Routledge, 1991); S. Hogan, ‘The Intellectual Precursors of Art Therapy: A Cultural History’, (Unpublished Ph.D thesis, University of Aberdeen, 1997); S. Hogan, *Healing Arts: The History of Art Therapy* (London, Jessica Kingsley Publishers, 2001).

⁶⁵ Larkin, *Occupational Monopoly*, p.vi.

⁶⁶ Larkin, ‘The Emergence of the Paramedical Professions’, p.1335.

⁶⁷ Larkin, ‘The Emergence of the Paramedical Professions’, p.1335.

labour were constructed between the massage and the medical profession in a negotiation professional interests.

Nursing, Midwifery and Social Purity

In contrast to other allied health care professions, the history of nursing and midwifery has received extensive scholarly attention. Much of this scholarship examines professionalisation, analysing how class, gender and sexuality inflected these projects, shaping divisions of labour, professional identities, and knowledge. Nurse historian Christine Hallett argues that '[t]he nineteenth century can be seen as the "era of professionalization" in nursing'. It was also, she continues, 'the era in which nursing first began to specialize' and areas such as physiotherapy and occupational therapy split away.⁶⁸ Throughout the late-nineteenth century massage was part of nursing practice, and it remained so, becoming increasingly specialised, well into the First World War. The Society of Trained Masseuses (STM) who professionalised the practice in 1895, was a group of nurses and midwives who were trained in massage. The founding members, of whom there were twelve, were all closely linked to the Midwives' Institute and Trained Nurses Club, which was an association established in 1881 to campaign for midwifery reform and registration.

The topic of professionalisation has dominated scholarship on the history of nursing and midwifery. Two important studies, for nursing Brian Abel-Smith's *A History of the Nursing Profession*, and for midwifery Irvine Loudon's *Death In Childbirth*, offer empirical studies that depart from traditional progressive

⁶⁸ Christine Hallett, 'Nursing, 1830-1920: Forging a Profession', in *Nursing and Midwifery in Britain since 1700*, ed. by Anne Borsay and Billie Hunter (London: Palgrave Macmillan, 2012), pp.46-73, (p.65).

narratives.⁶⁹ Abel-Smith's work highlighted the many tensions, conflicts and fractures within the professionalisation movement, while Loudon analysed the link between maternal mortality rates and the obstetric techniques of midwives and medical men. Much scholarship has emerged building on these studies, including edited collections by Hilary Marland and Anne Marie Rafferty, *Midwives, Society and Childbirth*; Rafferty, Jane Robinson, and Ruth Elkan, *Nursing History and the Politics of Welfare*; and Anne Borsay and Billie Hunter's *Nursing and Midwifery in Britain*.⁷⁰ Within these collections, historians examine the complex social, cultural and political environments in which nurses and midwives worked and professionalised. This thesis draws extensively from these studies. It argues that the professionalisation of massage can be understood as part of the professionalisation movement of nursing and midwifery more broadly. It shows that during its formative years the massage profession closely aligned itself to these established female professions and emulated their professional strategies.

To first look at midwifery, the work of June Hannam and Alison Nuttall provides a particularly valuable context for this thesis as their research examines the Midwives' Institute. Hannam's work focuses on Rosalind Paget, who was a central figure in the Midwives' Institute from the 1880s to the First World War and a founding member of the STM.⁷¹ Hannam has argued that

⁶⁹ Brian Abel-Smith, *A History of the Nursing Profession* (London: Heinemann, 1960); Irvine Loudon, *Death in Childbirth: An International Study of Maternal Care and Maternal Mortality 1800-1950* (Oxford: Clarendon Press, 1992).

⁷⁰ Hilary Marland, and Anne Marie Rafferty (eds.), *Midwives, Society and Childbirth* (London: Routledge, 1997); Anne Marie Rafferty, Jane Robinson, and Ruth Elkan (eds.), *Nursing History and the Politics of Welfare* (London; New York: Routledge, 1996); Anne Borsay and Billie Hunter (eds.) *Nursing and Midwifery in Britain since 1700* (Basingstoke: Palgrave Macmillan, 2012).

⁷¹ June Hannam, 'Rosalind Paget: The Midwife, the Women's Reform Movement and Reform before 1914', in *Midwives, Society and Childbirth: Debates and Controversies in the Modern Period*, ed. by Hilary Marland and Anne Marie Rafferty (London: Routledge, 1997), pp.81-101, (p.83).

Rosalind Paget represents a group of female professional workers who were carving out a position for themselves amid a society reluctant to challenge notions of women's special qualities as wives and mothers.⁷² Hannam traces how the Midwives' Institute linked the professionalisation of midwifery to social reform in order to advance the professional interests of its members. At the turn of the century, maternal and child health gained political significance, ignited by the defeats of the Boer War, which put the spotlight on high rates of infant mortality and poor child health that appeared to indicate the decline of population's health and threaten Britain's imperial standing.⁷³ The Institute argued that the registration of midwives was essential to ensuring that even the poorest mothers received the best care in childbirth. By hitching their professional interests to that of the national community, they gained political cachet for their cause. It enabled them to present the campaign as motivated by public service rather than self-interest. This thesis draws upon Hannam's work and shows that the professionalisation of massage by the STM was an extension of the Institute's wider commitment to carving out professional roles for women. It argues that the leaders of the STM used a similar strategy, hitching their occupation to the ideology of rehabilitation in order to advance the profession as a public service rather than simply a means of income.

Nuttall's work on the ways in which class shaped the reformist aims of the Midwives' Institute adds nuance to Hannam's argument. Tracing midwifery reform throughout the second-half of the nineteenth century, Nuttall observes that the occupational basis shifted from predominantly working-class women drawn from the local community to women of higher social origins professionally

⁷² Hannam, 'Rosalind Paget', p.82.

⁷³ Hannam, 'Rosalind Paget', p.81.

trained in nursing.⁷⁴ Members of the Midwives' Institute, she argues, had little in common with ordinary practitioners. Based in London, these women represented the 'new type of midwife', mainly single women of upper, middle-class origins.⁷⁵ Midwives of the Institute were all well-educated, fully trained in nursing, and had the diploma of the London Obstetric Society, considered the 'gold standard' for midwifery, which became a pre-requisite for membership.⁷⁶ These women differentiated themselves as professionals through their education, seeking to restrict access to a career in midwifery to a limited circle of qualified women, marginalising other practitioners who had little or no formal education as 'untrained'.

The success of the Midwives' Institute's professional project was also linked to class. These women were in positions of social privilege with an ability to give both time and money to the reform project. For them midwifery was a voluntary pursuit as opposed to a necessary income, for example they were able to fund premises for a headquarters and publish a journal to promote their views.⁷⁷ The Institute was submerged within a culture of social and financial patronage, wherein they were able to gather support from connections among the medical and social elite.⁷⁸ Drawing from Nuttall's insights, this thesis shows that the STM sought to establish massage as a profession and differentiate themselves through education and used their advantaged social position to gather support their claims.

⁷⁴ Alison Nuttall, 'Midwifery, 1800-1920: The Journey to Registration', in *Nursing and Midwifery in Britain since 1700* ed. by Anne Borsay and Billie Hunter, (Basingstoke: Palgrave Macmillan, 2012), pp.128-143, (p.143).

⁷⁵ Nuttall, 'Midwifery, 1800-1920', p.137.

⁷⁶ Nuttall, 'Midwifery, 1800-1920', p.137.

⁷⁷ Nuttall, 'Midwifery, 1800-1920', p.138.

⁷⁸ Nuttall, 'Midwifery, 1800-1920', p.138.

Gender, as well as class, inflected the professionalisation of nursing and midwifery. In *Professions and Patriarchy* sociologist Anne Witz examines the ways in which the professional aspirations of the midwives' movement were constrained by gender.⁷⁹ The emergence of the female health-care professions more broadly, she argues, was challenged not only by the professional interests of a male dominated medical profession, but also by a deeply patriarchal society that challenged the movement of women into professional roles. The strategies that women used to establish themselves as professionals, and the resulting occupational boundaries, were therefore gendered constructions. Witz argues that the Midwives' Institute accepted a 'narrow knowledge base, and the limited, de-skilled sphere of competence prescribed for midwives by medical men of the Obstetrical Society'.⁸⁰ Within this scheme, midwives had a restricted role, permitted to attend natural labour only and duty-bound to send for medical assistance in any complication. By limiting the scope of their practice and subordinating their role, however, midwives achieved medical support for their professional status as well as a degree of autonomy to practice outside of medical supervision.

The professionalisation of massage was closely linked to that of nursing as well as midwifery. The majority of the first generation of professional masseuses were trained nurses, educated in the language and social etiquette of the medical profession. Emerging from a reformed nursing institution, the professional identity of massage drew from a bank of established nursing etiquette and imagery. The imagery of the reformed nurse was central to the success of the professional project. Beginning in the 1850s, the first wave of nurse reformers promoted the occupation as a 'new' and 'reformed' discipline.

⁷⁹ Anne Witz, *Professions and Patriarchy* (London: Routledge, 1992).

⁸⁰ Witz, *Professions and Patriarchy*, p.120.

Alison Bashford's *Purity and Pollution* examines the potency of cultural, literary and visual representations of the 'old' and 'new' nurse.⁸¹ The 'old' nurse, she argues, was portrayed as a 'morally and physically impure and filthy, ignorant, working-class hag', famously characterised by Charles Dickens's fictional character Sarah Gamp.⁸² This representation served as a contrast to the 'new' nurse, 'a middle-class figure of efficiency, neatness and whiteness', epitomised by the iconic Florence Nightingale.⁸³

The aim of nurse reformers was to transform nursing from a 'base occupation suitable only for the lowest orders' into 'a profession in which royal and aristocratic women took interest'.⁸⁴ In order to do so, these women had to work with, rather than against, powerful socio-cultural ideals of middle-class femininity. The imagery of the nursing reform movement fitted with the dominant middle-class ideology of the 'cult of domesticity', which idealised women as the spiritual centrepiece of home.⁸⁵ Within the domestic sphere women exercised dominance and control, in contrast to the man's sphere of the public world at large.⁸⁶ Drawing upon this ideology, women justified their entry into 'caring' professions as an extension of their domestic role. Christine Hallett argues that the first nurse reformers developed their professional identity around this ideology, claiming that the most important qualities of the nurse were domestic management and moral guardianship of the sick.⁸⁷ For them, she argues, femininity was a strength, 'the quality that permitted them to exercise authority in the "domestic sphere" of the hospital ward, and to excel in both the caring

⁸¹ Alison Bashford, *Purity and Pollution: Gender, Embodiment and Victorian Medicine* (Basingstoke: Palgrave Macmillan, 1998).

⁸² Bashford, *Purity and Pollution*, pp.21-22.

⁸³ Bashford, *Purity and Pollution*, p.22.

⁸⁴ Hallett, 'Nursing, 1830-1920', p.50.

⁸⁵ Martha Vicinus, *Independent Women: Work & Community for Single Women, 1850-1920* (Chicago; London: University of Chicago Press, 1985), p.2.

⁸⁶ Hallett, 'Nursing, 1830-1920', p.61.

⁸⁷ Hallett, 'Nursing, 1830-1920', p.62.

and managerial aspects of nursing work'.⁸⁸ The qualifications of the professional nurse therefore, defined through the social mores of the time, were based more on character than intellectual ability.

From the 1880s, however, a new generation of nurses began to challenge the narrowness of this professional ideal. Anne Marie Rafferty argues that nurses began to look towards medicine as a model to emulate.⁸⁹ This group of nurses, many of whom were prominent within the movement for nursing registration, argued that scientific and technical education were more important than character training for the professional nurse.⁹⁰ These women sought to be recognised as professionals and carve out a place for themselves in the male-medical-dominated world of nineteenth- and early-twentieth century health care.⁹¹ Scientific and technical training and qualifications offered a demarcation from the 'amateur nurse', while giving them the ability to move beyond a career reliant upon the hospital in which they trained. Rafferty's work argues, however, that far from being value-neutral, nursing knowledge and education were also shaped by wider social attitudes towards gender, and that this had an enduring impact upon the status of the nursing profession.⁹² While these reformers moved away from 'character training' and asserted their intellectual qualifications, the knowledge and skill base of nursing as a discipline remained limited by an anti-intellectual prejudice attached to the caring professions and women's work more broadly.

By the end of the century then, nursing had established itself as a profession based on a mixture of moral and intellectual qualities. Both phases

⁸⁸ Hallett, 'Nursing, 1830-1920', p.48.

⁸⁹ Anne Marie Rafferty, *The Politics of Nursing Knowledge* (London: Routledge, 1996), p.42.

⁹⁰ Rafferty, *Politics of Nursing Knowledge*, pp.61-62.

⁹¹ Hallett, 'Nursing, 1830-1920', p.66.

⁹² Rafferty, *Politics of Nursing Knowledge*, p.1.

of development had been necessary, first to carve out a respectable occupation for women, and second to promote the status of nursing as a profession. Both the nursing and midwifery reform project succeeded because they worked with dominant gender social conventions and upheld the professional interests of medicine. By analysing the formation of the STM, this thesis shows that professionalisation of nursing, midwifery and massage shared class and gender social relations that shaped their professional strategies and occupational boundaries.

This thesis places the professionalisation of massage within the wider social purity movement of the late-nineteenth century. The work of Judith Walkowitz, Lucy Bland and Stefan Petrow examines late-nineteenth century urban society and culture and shows that there were widespread anxieties surrounding the morality of the working class in this period.⁹³ The perceived rising levels of drunkenness, prostitution and crime among the urban 'residuum' captured the public imagination and were viewed as national concerns. Anxieties gave rise to increasingly interventionist campaigns, ranging from legislation and policing, to social purity pressure groups. Sexual morality, in particular, became a highly politicised topic and subject to increasing scrutiny and repression. Bland has argued that the action of female social purity campaigners who sought to repress brothels and clear the streets of prostitution cannot be simply explained as a disciplinary regime imposed upon working class women. Their efforts, she argues, were directed towards a wider feminist vision in which the public world was a safe and respectable environment,

⁹³ Judith Walkowitz, *City of Dreadful Delight: Narratives of Sexual Danger in Late-Victorian London* (Chicago: University of Chicago Press, 1992); Lucy Bland 'Feminist Vigilantes of Late-Victorian England', in *Regulating Womanhood: Historical Essays on Marriage, Motherhood, and Sexuality*, ed. by Carol Smart (London: Routledge, 1992), pp.33-52; Stefan Petrow, *Policing Morals: The Metropolitan Police and Home Office 1870-1914* (Oxford: Clarendon Press, 1994).

literally and symbolically, where all women had freedom of movement with impunity.⁹⁴

The work of Bashford highlights the way in which discourse on sexuality permeated the professional identity of nursing. For the late Victorians sexuality was highly gendered: whereas men were thought to have little self-will over 'animalistic' sexual instincts, women were considered to be able to exercise self-control.⁹⁵ For women sexuality was something always just submerged and dependent upon the character of the individual. This perceived instability and potential for immorality underpinned the late-nineteenth century obsession with regulating womanhood. Bashford looks at how this ambiguity surrounding female sexuality presented a challenge for nurses. The representation of the 'new' nurse, she argues, as moral and chaste was essentially at odds with interpretations of intimate physical contact with male bodies, which were linked to notions of sexuality.

The nurse's outdoor uniform offered another challenge. When nurses in the late-nineteenth and early-twentieth centuries walked out in public, they became 'public women'.⁹⁶ Prostitutes often disguised themselves in nurses' uniform as it gave them permission to walk alone in the street, as well as being an eroticised taboo.⁹⁷ This caused professional scandal as it threatened to damage the reputation of nursing and nurses feared they might be mistaken for prostitutes. The ease with which the nurses' identity could transition from a symbol of purity to one of 'immorality', reflects wider anxieties about female sexuality in this period, and highlights the importance of professional image to

⁹⁴ Bland, 'Feminist Vigilantes', p.51; for this argument also see Walkowitz, *City of Dreadful Delight*, pp.133-134.

⁹⁵ Bashford, *Purity and Pollution*, p.57.

⁹⁶ Bashford, *Purity and Pollution*, p.58.

⁹⁷ Bashford, *Purity and Pollution*, p.58.

the early female health professions. This thesis shows that negotiating sexuality and intimacy was at the heart of the STM's professionalisation project. It was a motivating factor in 1895 and continued to shape the practical and professional boundaries of the massage profession throughout the First World War.

Disability, Rehabilitation and War

Driving the development of massage in the late-nineteenth and early-twentieth centuries was a social context in which disability became increasingly problematised. The history of disability is a strong field and one of rich debate. Scholars including Henri Stiker, Deborah Stone, Helen Bolderson and Anne Borsay, offer broad studies into how understandings and treatment of disability have changed over time.⁹⁸ The work of Stone, Bolderson and Borsay examines the history of disability in Britain; they argue that a shift began to occur during the Industrial Revolution when economic productivity and efficiency became prioritised. From the 'New Disability History' perspective, David Turner and Kevin Stagg argue that the transformation in understandings of disability from the eighteenth century has been due to a number of interrelated factors, including industrialisation and the intensification of ideas of economic rationalism associated with capitalism; the development of notions of 'normality' and 'abnormality'; and the increasing medicalisation of 'deviant' bodies.⁹⁹

Directly relevant to this thesis was the problematisation and responses to disability, which emerged during the late-nineteenth and early-twentieth centuries. This work draws from scholars such as Julie Anderson, Anne Borsay,

⁹⁸ Henri-Jacques Stiker, *A History of Disability* (Ann Arbor: University of Michigan Press, c1999); Helen Bolderson, *Social Security, Disability and Rehabilitation: Conflicts in the Development of Social Policy 1914-1946* (London: Jessica Kingsley, 1991); Borsay, *Disability and Social Policy*.

⁹⁹ David M. Turner and Kevin Stagg, (eds.), *Social History of Disability and Deformity* (London; New York: 2006), p.6.

Roger Cooter, Steve Humphries and Pamela Gordon, Seth Koven and Meaghan Kowalski, who discuss the changing status of disability in this period.¹⁰⁰ Disease, disability and deformity were common amongst the Victorian and Edwardian population, especially the working class. Poverty, poor maternal health, malnutrition, insanitary living conditions and lack of health provision meant that the working class were vulnerable to diseases that could leave them disabled.¹⁰¹ Diseases such as rickets, poliomyelitis and tuberculosis of the bones and joints, were rife, causing high levels of chronic illness and impairment.¹⁰² Humphries and Gordon's investigation shows that disability was most concentrated amongst children. Between 1900 and 1950 the majority of the physically disabled were under fourteen, with more than half a million boys and girls suffering from rickets, polio, tuberculosis, cerebral palsy, impaired vision, deafness and other disabilities.¹⁰³ Adults were also at risk of disability through sickness, old age and military service, as well as urban and work related accidents.¹⁰⁴ With little provision for the disabled poor, individuals often depended upon a mixed economy of welfare, including the family, Poor Law, and a variety of hospitals and charitable initiatives.¹⁰⁵

While disability was not new in the late-nineteenth century, it was a moment that the disabled, and disabled children in particular, came into the

¹⁰⁰ Julie Anderson, *'Soul of a Nation': War, Disability and Rehabilitation in Britain* (Manchester: Manchester University Press, 2011); Julie Anderson, 'The Soul of a Nation: A Social History of Disabled People, Physical Therapy, Rehabilitation and Sport in Britain 1918-1970', (Unpublished doctoral thesis: De Montford University, May 2001); Meaghan Kowalski, 'Enabling the Great War: Ex-Servicemen, the Mixed Economy of Welfare and the Social Construction of Disability, 1899-1930', (Unpublished doctoral thesis, University of Leeds, 2007); Cooter, *Surgery and Society*; Borsay, *Disability and Social Policy*; Borsay, 'Disciplining Disabled Bodies'; Seth Koven, 'Remembering and Dismemberment: Crippled Children, Wounded Soldiers, and the Great War in Great Britain', *The American Historical Review*, 99:4 (October 1994), 1167-1202; Steve Humphries and Pamela Gordon, *Out of Sight: The Experience of Disability 1900-1950* (Plymouth: Northcote House, 1992).

¹⁰¹ Humphries and Gordon, *Out of Sight*, p.12.

¹⁰² Cooter, *Surgery and Society*, p.54.

¹⁰³ Humphries and Gordon, *Out of Sight*, p.12.

¹⁰⁴ Kowalski, 'Enabling the Great War', p.23.

¹⁰⁵ Kowalski, 'Enabling the Great War', p.24.

spotlight and wider social attitudes towards disability began to change. A number of interrelated factors were involved in this turn. Social investigations into slum life and advances in public health saw a shift from a hereditarian and moral explanation of disease and disability, to one of poverty and social consequence.¹⁰⁶ Furthermore, the Elementary Education Acts of 1870 and 1880, which brought universal education to children between five and thirteen, did not make provision for the mentally and physically impaired rendering their presence more visible.¹⁰⁷

In the context of Victorian economic ideology that linked citizenship and human value to productivity, disability, once viewed as an individualised incident, became a national concern. Not only were the disabled considered to be non-productive citizens but also dependants. It was feared that they represented an 'army of prospective paupers' who took recourse to charity, the workhouse and poor relief and threatened national resources and efficiency.¹⁰⁸ These fears were intensified in the wake of the Boer War, wherein more than 35 per cent of volunteers in Britain were rejected, unfit for military service.¹⁰⁹ Viewed as evidence of 'physical deterioration', individual and national decline became a national obsession, causing panic within the government, army, medical community and press.¹¹⁰ Convinced that state intervention was necessary for the greater good of the nation, the Liberal government instituted welfare reforms that included the provision of school meals (1906), the School Medical Act (1907), old age pensions (1908) and National Insurance Act (1911),

¹⁰⁶ Kowalski, 'Enabling the Great War', p.25; Cooter, *Surgery and Society*, p.57; D Pritchard, *Education and the Handicapped 1760-1980* (London, 1983), p.133. For example as early as 1888, Dr Francis Warner, an expert in child psychology, undertook an inquiry on behalf of a joint committee of the BMA and Charity Organisation Society into the physical and mental condition of 50,000 children in 106 schools.

¹⁰⁷ Cooter, *Surgery and Society*, p.55.

¹⁰⁸ Kowalski, 'Enabling the Great War', p.26.

¹⁰⁹ Anderson, *Soul of a Nation*, p.16.

¹¹⁰ Kowalski, 'Enabling the Great War', p.28.

which aimed to increase public health and prevent disease and disability. Keith Laybourne's work on the evolution of British social policy and the welfare state, has argued that the 'emergence of state intervention, through the medium of the Liberal welfare reforms of 1905-14, was the most important development in the decade before the First World War'.¹¹¹

It was against this backdrop that a broad movement to manage the 'problem' of the disabled emerged. A range of legislative, educational, voluntary, charitable and medical initiatives developed in this period to provide for the disabled in some way. Seth Koven has argued that many of these initiatives, including the development of child welfare provision in Britain before the First World War, were pioneered through voluntary action rather than central-state directives.¹¹² This also applied to welfare initiatives for disabled children. Initial provision for disabled children mainly came from a movement of middle-class, female dominated philanthropy, social reformers and educationalists.¹¹³ Two particularly influential organisations to emerge in London in the 1880s and 1890s were the Invalid Children's Aid Association (ICAA) and the Guild of the Brave Poor Things. The ICAA was an offshoot of the Charity Organisation Society (COS) whose ideology of 'scientific' charity aimed to replace outdoor relief with personal advice in order to deal with charity 'abuse'.¹¹⁴ In contrast, however, the ICAA contradicted the principles of its mother organisation and offered material assistance such as splints, carriages,

¹¹¹ Keith Laybourn, *The Evolution of British Social Policy and the Welfare State* (Keele: Keele University Press, 1995), p.151.

¹¹² Seth Koven, 'Borderlands: Women, Voluntary Action, and Child Welfare in Britain, 1840 to 1914', in *Mothers of a New World: Maternalist Politics and the Origins of the Welfare State*, ed. by Seth Koven and Sonya Michel (New York: Routledge, 1993), pp.94-135, (p.94).

¹¹³ Koven, 'Remembering and Dismemberment', 1173.

¹¹⁴ Cooter, *Surgery and Society*, pp.55-56.

home visits and even convalescent homes, to disabled children who they believed were not to blame for their need.

A number of pioneering initiatives for the disabled also grew out of the Settlement Movement. Started in Britain by a group of middle-class social reformers in 1884, the Settlement movement aimed to help the poor. Living and working within the poor community, middle-class 'settlers' aimed to establish educational and health provision at the same time as sharing knowledge and culture.¹¹⁵ Most famously, Mary Humphrey Ward (1851-1920) opened the first rate-supported school for disabled children exempt from ordinary school, at the Passmore-Edwards Settlement, London, in 1899.¹¹⁶ She also led the campaign for the first legislation that took responsibility for disabled children in 1899, the Elementary Education (Defective and Epileptic Children) Act.¹¹⁷

Another initiative growing from the Settlements was the Guild of the Brave Poor Things, established by Grace Kimmins (1870-1954) in 1893, at the West London Mission moving to the Bermondsey Settlement in 1895. The Bermondsey Guild aimed to provide meetings for the 'hundreds of maimed people swarming the waterside neighbourhoods of London',¹¹⁸ and soon inspired a nationwide network of Guilds offering social space, technical classes and lectures for members.¹¹⁹ The Guild's motto 'Laetus Sorte Mea', ('happy in my lot'), was described by Ada Vachell, leader of the Bristol branch, as a commitment to be 'brave and *laetus*' despite being 'crippled, or blind, or maimed

¹¹⁵ Katharine Bentley Beauman, *Women and the Settlement Movement* (London: Radcliffe Press, 1996), see introduction, pp.xiv-xxvi.

¹¹⁶ Pritchard, *Education and the Handicapped 1760-1980*, pp.156-157; for her campaigns see letters to *The Times* 26.09.1901, in her three column letter Ward gave a comprehensive account of the opening of the school and its development.

¹¹⁷ Cooter, *Surgery and Society*, p.59.

¹¹⁸ Anon., *The Coming of Age of the Heritage Craft Schools* (1924), The Keep (henceforth TK), BH 66061, p.9.

¹¹⁹ Michael Mantin, "'A Great Army of Suffering Ones": The Guild of the Brave Poor Things and Disability in the Late 19th and Early 20th Centuries', (Unpublished BA thesis: University of Bristol, 2009), p.11.

in some way'.¹²⁰ At the Guilds, military imagery was used to encourage the disabled to bear their impairments heroically and banish self-pity. The problem of disability, the Guilds believed, was not impairment but dependency. In this way individual impairment was linked to a collective socio-economic conscience. 'What could be worse', Kimmins wrote, 'to be a useless cripple, a burden upon the already overburdened, and with no outlook or hope of an independence ahead?'¹²¹

Inspired by the success of the Guilds, in 1903 Kimmins established a training school for disabled children called Chailey Heritage and Craft Schools, in Sussex. Described by Kimmins as 'the public school of crippledom',¹²² Chailey was a highly successful venture with patrons including Princess Louise, George Newman, the Bishop of London and Helen Keller.¹²³ Like Lord Treloar's Cripples Hospital at Alton, established in 1906, Chailey was a school for vocational training where children were taught 'the dignity of labour' and how to become self-sufficient and independent adults.¹²⁴ Occupational skills such as caning, leather work, weaving, cobbling, wood-carving and other handicrafts were taught in order to prepare students to compete in the labour market. These residential initiatives were not the first; the Cripples' Home and Industrial School for Girls at Marylebone, and the National Industrial School for Cripple Boys in Kensington, had been established in 1851 and 1865 respectively.¹²⁵ As historians such as Cooter and Borsay have argued, ultimately whether giving material assistance, education or training, each of these initiatives all had an

¹²⁰ Ada Vachell, 'The Guild and the Children', [c.1900s], pp.1-2, TK, HB146/3, p.2.

¹²¹ Anon., *The Coming of Age of the Heritage Craft Schools*, TK, BH 66061, p.9.

¹²² Koven, 'Remembering and Dismemberment', 1175.

¹²³ Anon., *History of the Heritage Craft Schools, The Guild of the Brave Poor Things and the Guild of Play*, (1914), TK, HB 130/1, pp.3-4.

¹²⁴ Cooter, *Surgery and Society*, p.56.

¹²⁵ Pritchard, *Education and the Handicapped 1760-1980*, p.63.

economic rationale. The majority of these projects were not concerned with providing medical or surgical treatment, rather they aimed to restore self-sufficiency. This thesis is based upon archival research at Chailey Heritage, which found that physical therapy was not a feature of Chailey's therapeutic regime until the inter-war years.¹²⁶ It gives an element of perspective to this thesis, and while it argues that massage and physical treatment played an important role in the development of rehabilitation within medicine before the war, that this was limited and stood alongside many other approaches that together constitute an emergent culture of rehabilitation.

While the majority of provision emerging to support the disabled in this period was aimed towards children, historians have shown that disabled workers and soldiers were also coming into the spotlight. War and industry were two significant causes of disability. In her study of disabled ex-servicemen before the First World War, Meaghan Kowalski argues that both the state and the army were beginning to recognise the long-term socio-economic consequences of disablement amongst this population.¹²⁷ The Boer War stimulated legislative reform that increased pensions for disabled ex-servicemen.¹²⁸ This state investment was motivated by the promise of long-term gain; improving chances of recovery and self-sufficiency rather than on-going support through the poor law. Associations such as the 1904 Soldiers and

¹²⁶ In 1922 Arctic explorer, Surgeon Commander Murray Levick was appointed 'Physio Therapist' by Robert Jones, who by this time had become Chairman of the Surgical Board. Levick deployed 'heliotherapy' or 'the sun cure' extensively at Chailey during the interwar period and encouraged the systematic use the Margaret Morris dance movement as physical therapy. Research has indicated, however, that medical treatment was not a prominent feature of the therapeutic regime at Chailey before the First World War. For details see, Anon., *Heritage Happenings* (November-December 1922), TK, HB/269/25, (item 294), p.14; Anon., *The Coming of Age of the Heritage Craft Schools*, TK, BH 66061, p.41; For Levick's treatment, with light, air and diet, of 'marasmic' babies mainly from London, from 1928 onwards see, George Murray Levick, *Results of the Experimental Treatment of Marasmic Babes*, [c.1932], TK, HB 130/3.

¹²⁷ Kowalski, 'Enabling the Great War', pp.34-35.

¹²⁸ Kowalski, 'Enabling the Great War', pp.35-36.

Sailors Help Society were also established, which set up the Lord Roberts' Memorial Workshops to train those disabled during the war in trades and handicrafts.¹²⁹

Industrial accidents were also a cause of severe hardship. In a labour market that relied upon skilled work, impairment could mean short term or permanent loss of employment. Poor medical treatment meant that simple injuries and fractures often resulted in long-term impairment such as shortened limbs, decreased mobility, stiffness and nerve pain. In order to relieve industrial impairment as a cause of destitution, a number of pieces of legislation were instituted. For example, the 1897 Workmen's Compensation Act made it easier for some workers to claim financial redress for their injuries, and the 1911 National Insurance Act enabled workers for the first time to insure themselves against unemployment.¹³⁰

There was also a strong voluntary movement amongst the industrial working class, especially in trades such as mining. In a study of industrial voluntarism in South Wales Coalfield, Ben Curtis and Steven Thompson show that from the 1890s working class organisations emerged to provide artificial limbs and other appliances to disabled workers and their families.¹³¹ Another organisation was the St John Ambulance Brigade, constituted in 1887 to provide transport and first aid to the sick and injured. By 1914, this organisation had over 23,000 volunteers, predominantly from the working class.¹³² The growth of legislative and voluntary provision suggests a growing awareness of

¹²⁹ G. Howson, (ed.), *Handbook for the Limbless* (London: The Disabled Society, 1922), p.108.

¹³⁰ Cooter, *Surgery and Society*, p.86; Anderson, 'The Soul of a Nation', p.43.

¹³¹ Ben Curtis and Steven Thompson, 'A Plentiful Crop of Cripples Made by All This Progress': Disability, Artificial Limbs and Working-Class Mutualism in the South Wales Coalfield, 1890-1948', *Social History of Medicine*, 27:4 (2014), 708-727, (pp.711-712).

¹³² Cooter, *Surgery and Society*, p.86, for a comparative analysis of lifesaving societies across Europe in this period see John F. Hutchinson, 'Civilian Ambulances and Lifesaving Societies: The European Experience, 1870- 1914', in *Accidents in History: Injuries, Fatalities and Social Relations*, ed. by Roger Cooter and Bill Luckin (Amsterdam: Rodopi, 1997), pp.158-179.

the socio-economic importance of accidents for the worker and national efficiency. Despite this, disability and rehabilitation was not a field that received sustained interest from the medical profession until the First World War.¹³³

Whilst scholarship has shown that medical provision for the disabled was limited in this period, broad socio-economic and political concerns about disability did have an impact upon medicine and surgery. As suggested, studies that examine medical provision for the disabled before the First World War tend to focus upon orthopaedic surgery and figures such as Robert Jones and Hugh Owen Thomas. Accounts such as Watson's *Civilization and the Cripple* and *The Life of Sir Robert Jones*, Alan Malkin's 'The Conquest of Disability', and E.M. Macdonald's *World-wide Conquest of Disabilities*, offer progressive accounts of the development of rehabilitation through the lens of such figures and institutions.¹³⁴ More recent studies, however, including those by Roger Cooter, Anne Borsay and edited volumes by Cooter and Bill Luckin *Accidents in History*, and Pamela Dale and Borsay *Disabled Children*, identify other areas in which rehabilitation within medicine was developed before the war.¹³⁵

As suggested earlier, however, it is important not to overstate the impact of medicine and surgery in the treatment of the disabled in the period before the war. Those who received treatment were the exception rather than the rule;

¹³³ Roger Cooter, 'The Moment of the Accident: Culture, Militarism and Modernity in Late-Victorian Britain', in *Accidents in History: Injuries, Fatalities and Social Relations*, ed. by Roger Cooter and Bill Luckin (Amsterdam: Rodopi, 1997), pp.107-146, (p.114).

¹³⁴ Frederick Watson, *Civilization and the Cripple* (London: John Bale, 1930); Frederick Watson, *The Life of Sir Robert Jones* (London: Hodder & Stoughton, 1934); Alan S. Malkin, 'The Conquest of Disability', Robert Jones Lecture delivered at the Royal College of Surgeons of England, (8 November 1956).

¹³⁵ Cooter, *Surgery and Society*; Borsay, 'Disciplining Disabled Bodies'; Borsay, *Disability and Social Policy*; Roger Cooter and Bill Luckin, (eds.) *Accidents in History: Injuries, Fatalities and Social Relations* (Amsterdam: Rodopi, 1997); Starkey, 'Club Feet and Charity'; Steven Thompson, 'The Mixed Economy of Welfare and the Care of Sick and Disabled Children in the South Wales Coalfield, c. 1850-1950', in *Disabled Children: Contested Caring, 1850-1979*, ed. by Anne Borsay and Pamela Dale (London: Pickering & Chatto, 2012), pp.43-58; Anne Borsay, 'From Representation to Experience: Disability in the British Advice Literature for Parents, 1890-1980', in *Disabled Children: Contested Caring, 1850-1979*, ed. by Anne Borsay and Pamela Dale (London: Pickering & Chatto, 2012), pp.87-101.

most disabled children received custodial rather than medical care and many had little option but the workhouse, along with others such as the blind and insane.¹³⁶ A number of interlinking factors worked against the development of rehabilitation within medicine before 1914. Firstly, was the widespread belief that certain disabilities were not amenable to treatment and therefore not a medical problem. Cooter argues that surgeons shared this view, 'many of them admitting to a large class of 'stationary cripples' who, as a result of congenital malformations, accidents of childbirth, infantile paralysis or long-standing rickets, were beyond the surgical pale' and could only be helped through educational and training facilities.¹³⁷ Furthermore, because disability and industrial accidents tended to be the lot of the working class, specialisation in the treatment of disability lacked the prestige and potential for private practice that general practitioners and surgeons relied upon.¹³⁸

Another factor inhibiting the development of rehabilitation within British medicine was the organisation of voluntary hospitals in this period. Since the eighteenth century, institutions reliant upon charitable subscriptions had privileged acute over chronic patients. Chronic patients were not viewed as medically challenging clinical material for teaching hospitals, nor likely to fully recover. Furthermore their requirements for prolonged in-patient care reduced the patient turnover rate, which was how institutions measured their success and gained subscriptions.¹³⁹ Consequently, patients were only admitted when their conditions became acute, as was common with the infectious swelling of tubercular bones and joints. As soon as acute symptoms were relieved, however, patients were discharged to out-patient clinics where they were often

¹³⁶ Starkey, 'Club Feet and Charity', p.22.

¹³⁷ Cooter, *Surgery and Society*, p.60.

¹³⁸ Cooter, *Surgery and Society*, p.84.

¹³⁹ Cooter, *Surgery and Society*, p.62.

lost sight of. Consequently, the majority of patients never saw full recovery and slipped into cycles of relapse and ill health. Furthermore, in comparison to the well-managed in-patient wards of voluntary hospitals, out-patient clinics were low-status, uncoordinated and supervised haphazardly by surgical dressers and junior staff.¹⁴⁰ Most patients, however, unless living within close proximity of the hospital, would not have been able to attend appointments regularly and therefore the prolonged treatment necessary to treat chronic conditions was rarely accomplished.¹⁴¹

The many obstacles restricting the treatment of the disabled in metropolitan hospitals were critiqued by a number of surgeons. Most famously, the frustrations of Robert Jones and his colleagues led to a number of provincial projects that allowed them to experiment with treatment. The first initiative was based at the Children's Convalescent Home, West Kirby, Liverpool, in which 22 beds were rented to provide long-term in-patient facilities for children with surgical tuberculosis. This small project evolved in 1900 to become the Royal Liverpool Country Hospital at Heswall, where the principles of prolonged in-patient accommodation and the 'trinity of rest, surgical treatment and fresh air' were observed.¹⁴² Most famously, however, was the development of the Baschurch Home in Oswestry, Shropshire. Opening in 1900, the Baschurch home would later be described by its founder Agnes Hunt as the 'first open-air orthopaedic hospital in the world'.¹⁴³ Beginning as a small convalescent home for women and children, open-air facilities were first initiated there as an economic exigency rather than therapeutic innovation, as they found it easier to

¹⁴⁰ Cooter, *Surgery and Society*, p.84.

¹⁴¹ Starkey, 'Club Feet and Charity', p.22.

¹⁴² H. Osmond-Clark, 'Half a Century of Orthopaedic Progress in Great Britain', *The Journal of Bone and Joint Surgery*, 32B (November 1950), 620-675, (p.623).

¹⁴³ Osmond-Clark, 'Half a Century of Orthopaedic Progress', 623.

accommodate ambulant patients in outdoor sheds than to carry them up the stairs of the home.¹⁴⁴ Jones became involved in the venture as visiting surgeon in 1904 after Hunt had attended his Nelson Street clinic for her own hip condition. It was at Baschurch that Jones and Hunt had the opportunity to demonstrate that disabled children could be cured under certain conditions. The home became famous before the war, and celebrated long after as the 'spiritual home and show-piece of the self-consciously styled Liverpool school of orthopaedics, a reference to Thomas's and Jones's brand of conservative surgery'.¹⁴⁵

Scholarship on the history of disability in the late-nineteenth century demonstrates that by 1914 social, cultural, medical and political attitudes towards disability were changing. Now a topic of national interest, increasingly disability was something to be addressed through social reform, educational provision and medicine. This thesis situates the professionalisation of massage in the late-nineteenth and early-twentieth centuries within this broader culture of rehabilitation surfacing within British society in this period. By exploring how massage was used and developed in the context of disability, trauma and rehabilitation before the war, this thesis breaks new ground. It argues that massage treatment was a key mode of rehabilitation within medicine before 1914, which explains why the profession became an important part of the medico-military apparatus during the First World War.

The First World War has been identified by historians as a watershed in military medicine and a turning point in the history of disability and rehabilitation. Whereas in the late-nineteenth century disability had been confined to the margins of medicine and society, as men returned home from the Western

¹⁴⁴ Agnes Hunt, *This is my Life* (London: Blackie & Son, Ltd, 1940), pp.128-129.

¹⁴⁵ Cooter, *Surgery and Society*, p.76.

Front with severe impairments public awareness of disabled people rapidly increased.¹⁴⁶ Unparalleled in terms of casualties, weaponry and medicine, the number of men who returned home disabled was unprecedented: one-quarter of battle casualties were orthopaedic cases, and over 41,000 men had limbs amputated.¹⁴⁷ In 1914 the military medical services were unprepared for the scale of the conflict, variety of foreign theatres and types of wounding with which they were confronted. Jagged shrapnel, rushed and insanitary medical treatment and widespread infection were amongst the conditions that forced medicine and surgery to develop rapidly.

A strong field of scholarship examines the relationship between war and medicine. Two edited volumes by Roger Cooter, Mark Harrison and Steve Sturdy offer a broad range of studies that investigate different aspects of medicine and modern warfare.¹⁴⁸ Monographs that focus on the First World War in particular include Mark Harrison's *The Medical War*, Ana Carden-Coyne's *Politics of Wounds*, and Fiona Reid's *Medicine in First World War Europe*.¹⁴⁹ Mark Harrison's work offers a detailed study of the British medical services and how it responded to warfare on the Western Front, Middle East and East Africa. Harrison argues that as a result of the war, medicine became a military resource and gained significant political and symbolic importance for its role in maintaining manpower and morale. Taking a different approach, Ana Carden-Coyne's study uses a variety of sources to reconstruct how wounded soldiers experienced the medical services and medical treatment. Fiona Reid's work

¹⁴⁶ Anderson, 'Soul of a Nation', p.42.

¹⁴⁷ Joanna Bourke, *Dismembering the Male: Men's Bodies, Britain and the Great War* (London: Reaktion Books, 1996), p.33.

¹⁴⁸ Roger Cooter, Mark Harrison and Steve Sturdy (eds.), *War, Medicine and Modernity* (Stroud: Sutton, 1998); Roger Cooter, Mark Harrison and Steve Sturdy (eds.), *Medicine and Modern Warfare* (Amsterdam: Rodopi, 1999).

¹⁴⁹ Mark Harrison, *The Medical War: British Military Medicine in the First World War* (Oxford: Oxford University Press, 2010); Carden-Coyne, *The Politics of Wounds*; Fiona Reid, *Medicine in First World War Europe*.

takes a similar approach, using a wide range of source material to examine how the work of doctors and nurses was shaped by military and civilian social, cultural and political concerns, and how this impacted upon the soldiers' experience of wounding and rehabilitation.

Under the demands of total war, all manpower, industrial and medical resources were quickly directed towards maintaining the British war machine. While histories of rehabilitation have traditionally focused on medical developments, surgical advances, and individual figures, more recent historiography has viewed rehabilitation more broadly as an overarching concept expressed throughout medicine, society, politics and culture. Such studies include Jeffrey Reznick's *Healing the Nation* and Julie Anderson's '*Soul of a Nation*': *War, Disability and Rehabilitation in Britain*.¹⁵⁰ Reznick's work explores the 'culture of caregiving' that developed within British society during the war. Using a variety of sources, he offers insight into the politics of healing and the culture of rehabilitation developed in rest huts, military hospitals and orthopaedic centres.

Julie Anderson's work expands the scope of study to look at how war and rehabilitation shaped disability during the first half of the twentieth century. Tracing the experience of and provision for disability from 1900 her work shows that wartime rehabilitation was a product of both new and existing therapies, underpinned by the military need for a manpower supply. She argues that while it was during the Second World War that a 'modern, organised system of rehabilitation came into being',¹⁵¹ this system drew extensively from provision developed in the late-nineteenth century and First World War. Using the

¹⁵⁰ Jeffrey Reznick, *Healing the Nation: Soldiers and the Culture of Caregiving in Britain during the Great War* (Manchester: Manchester University Press, 2004); Anderson, '*Soul of a Nation*'.

¹⁵¹ Anderson, '*Soul of a Nation*', p.44.

institutional case studies of St Dunstan's and the Star and Garter Home, Anderson's work offers insight into the culture of rehabilitation, and how it worked in practice. This thesis aims to contribute to this field by showing that the development of massage as a practice and profession was part of the broader culture of rehabilitation emergent in this period. It argues that massage and physical therapy in the First World War can be traced from the late-nineteenth century.

One example of where First World War rehabilitation drew from the late-Victorian and Edwardian period was at Chailey Heritage and Craft Schools. In the war Chailey became a headquarters for the rehabilitation of wounded soldiers, where students encouraged soldiers to 'forget' their wounds and avoid self-pity. Thus, as Koven has argued, children, the traditional objects of rehabilitation, became agents.¹⁵² During the war Chailey pioneered the idea of 'educative convalescence' whereby the soldier became a student. The aim, according to educational psychologist Cyril Burt, was to make sure '[t]he long tedious weeks of convalescence are put to good service', and men undergoing prolonged periods of hospital treatment were encouraged to train in a trade most suitable to his injury.¹⁵³ The 'entire scheme', Burt continued, was based upon 'twenty-three years' intimate experience with cripples' at the Guilds of the Brave Poor Things and Chailey.¹⁵⁴ Although not widely acknowledged, Chailey's scheme of 'educative convalescence' was approved by the War Office in August 1914 and a model upon which the orthopaedic curative workshops of

¹⁵² Seth Koven, 'Remembering and Dismemberment', 1182.

¹⁵³ Cyril Burt, *Soldier Students: A Scheme of Educative Convalescence for the Wounded. Princess Louise Military Orthopaedic Hospital (in Connection with the Military Orthopaedic Hospital, Shepherd's Bush) The Heritage Craft Schools Chailey, Sussex*, (1917), TK, HB 130/7, p.6.

¹⁵⁴ Burt, *Soldier Students: A Scheme of Educative Convalescence*, TK, HB 130/7, p.9.

the First World War were based.¹⁵⁵ At the end of the war the War Office issued an official statement noting that ‘the fact is fully appreciated at Headquarters that your scheme of educative convalescence for the wounded was the earliest laid before the Military Authorities and recommended and approved by them on 31st August 1914’, and that ‘your hospital set an example which others have been quick to recognise and imitate throughout the various Commands’.¹⁵⁶ As studies have shown, it was the success of the curative workshops that ultimately convinced the military to invest in orthopaedics.¹⁵⁷

Chapters by Reznick and Deborah Cohen in David Gerber’s edited volume, *Disabled Veterans in History*, focus on the theme of work.¹⁵⁸ These studies show that during the First World War, notions of rehabilitation, masculinity and citizenship were intimately linked to economic ideology - the capacity for men to work and be self-sufficient. Cohen’s work is a comparative analysis of the effort to reintegrate disabled veterans into the workforce in post-war Britain and Germany. Reznick looks at how the ideology of work expressed itself in wartime Britain, using Shepherd’s Bush Military Hospital, Britain’s flagship orthopaedic centre opened in 1916, as a case study. He argues that by combining both physical therapy and vocational retraining in one programme,

¹⁵⁵ Cyril Burt, ‘The Ex-Service Man’s Crippled Child’, *Spectator* (3 December 1921), TK, HB 269/25, (item 279x). ‘Chailey, in virtue of its long experience, was ready with a tried and tested plan. A few weeks after the outbreak of the War a scheme of Educative Convalescence was worked out for Soldier Students. In an incredibly short space of time the first batch of wounded men were received from the London Hospital; and the plan which was worked out at Chailey became a model for the whole nation’.

¹⁵⁶ Anon., ‘Booklet’, [c.1921], pp.1-4, TK, HB 269/25, (item 255), p.2. (The title page of this booklet is unknown as it is stuck into a scrapbook).

¹⁵⁷ Cooter, *Surgery and Society*, p.118.

¹⁵⁸ Jeffrey Reznick, ‘Work Therapy and the Disabled British Soldier in Great Britain in the First World War: The Case of Shepherd’s Bush Military Hospital in London’, in *Disabled Veterans in History*, ed. by David Gerber (Ann Arbor: University of Michigan Press, 2012), pp.185-203; D. Cohen, ‘The Will to Work: Disabled Ex-servicemen in Britain and Germany after the First World War’, in *Disabled Veterans in History*, ed. by David Gerber (Ann Arbor: University of Michigan Press, 2012), pp. 295-321. Also see Deborah Cohen, *The War Come Home: Disabled Veterans in Britain and Germany, 1914-1939* (Berkeley: University of California Press, 2001) for comparative analysis of post-war welfare provision for disabled veterans in Britain and Germany.

Shepherd's Bush reflects the close connection between rehabilitation and official socio-economic concerns, situating the culture of rehabilitation within the wider context of the British war machine.¹⁵⁹ These studies show that the aim of rehabilitation was not only to reconstitute men physically as healthy individuals, but also as breadwinners and productive citizens.¹⁶⁰ They indicate that the drive for rehabilitation was not simply a consequence of progress in medicine, surgery, and humanitarian efforts, but also the state's positive economic and political valuation of restoring the disabled.¹⁶¹ It highlights that economic ideology was a driving force behind rehabilitation and that wartime medical developments, including orthopaedics and physical therapy, were part of a broader historical movement.

As suggested, the First World War saw much progress in medicine and surgery, with the coming together of specialisms such as plastic surgery, psychiatry and orthopaedics. In particular, this thesis examines how the development of military orthopaedics was a key setting for the evolution of physical therapy.¹⁶² Two particularly important studies that examine military orthopaedics are by Cooter and a more recent article by Julie Anderson and Heather Perry.¹⁶³ Anderson and Perry's work offers a comparative analysis of the development of orthopaedics in Britain and Germany highlighting the national contingency of rehabilitative provision. Entering the war as a 'medical backwater' and 'the butt of medical jokes', by 1918 with over 20,000 designated

¹⁵⁹ Reznick, 'Work Therapy', pp.186-187.

¹⁶⁰ Reznick, *Healing the Nation*, p.117.

¹⁶¹ Cooter, *Surgery and Society*, p.116.

¹⁶² Such as, Frederick Watson, *Civilization and the Cripple* (London: John Bale, 1930); Frederick Watson, *The Life of Sir Robert Jones* (London: Hodder & Stoughton, 1934); T. Scotland, 'The First World War and its Influence on the Development of Orthopaedic Surgery', *J R Coll Physicians Edinb.*, 44:1 (2014), 163-9; Arul Ramasamy, W.G.P. Eardley, D.S. Edwards, *et al.* 'Surgical Advances during the Great War (1914-1918): the Birth of Modern Orthopaedics', *J R Army Med Corps* (2014), 1-5.

¹⁶³ Cooter, *Surgery and Society*; Anderson and Perry, 'Rehabilitation and Restoration'.

beds and twenty specially designed centres (most of which equipped with curative workshops), orthopaedics had been transformed and was at the heart of Britain's rehabilitation effort, returning soldiers to the battlefield and workplace with military efficiency.¹⁶⁴ The work of Cooter, Anderson and Perry highlights that while military orthopaedics drew from developments in the late-nineteenth century, it cannot be explained simply as an extension of traditional pre-war orthopaedics. Rather, it was a model that encompassed both trauma and the correction of disability, inherently shaped by the exigencies of war. The modern specialism was constituted from a range of surgical procedures, conservative and physio-therapeutic practices. It can be traced to traditional orthopaedics, general surgery, Hugh Owen Thomas, as well as the work of Robert Jones who became Military Director of Orthopaedics in March 1916.

These investigations highlight the link between the evolution of military orthopaedics and Britain's increasingly pressing manpower needs.¹⁶⁵ One of the keys to the development of military orthopaedics was the curative workshop, which tapped into the state's military concerns. Orthopaedic hospitals became special rehabilitation 'centres' bringing together orthopaedic, physio-therapeutic expertise and vocational training to restore injured soldiers to productivity. The first of these centres opened in 1916 at Shepherd's Bush, which became a model for other centres and a national symbol of the state's commitment to the disabled. The fortunes of orthopaedics then, was inherently linked to the state's commitment to rehabilitation during the war, which gave it an opportunity to flourish. This thesis situates the wartime professionalisation of massage within this broader ideological context. It shows that the evolution of the massage

¹⁶⁴ Cooter, *Surgery and Society*, p.106.

¹⁶⁵ For in depth discussion of military orthopaedics see Cooter's chapter 'The Great War', in Cooter, *Surgery and Society*.

profession was inherently linked to the military and political drive for rehabilitation.

Beside medical and surgical specialisms, an array of allied professionals and auxiliary workers emerged as part of the First World War medical services. Increasingly historians have started to examine the significance of personnel such as nurses, orderlies, stretcher-bearers, VAD's, occupational- and physical-therapists.¹⁶⁶ While on the periphery of many studies, detailed research into how and why massage came into and was shaped, practically and professionally by the First World War in Britain is lacking. In contrast, however, Beth Linker's work offers a detailed study into the emergence of American physiotherapy during the war.¹⁶⁷ As previously noted, the American physiotherapy service was established specifically by the US Army Surgeon General's office and wartime Orthopaedic Advisory Council, which sought to emulate Jones's rehabilitation programme in Britain.¹⁶⁸ As there are no detailed studies of the use and professionalisation of massage during the First World War in Britain, this thesis contributes new insights to the field.

The First World War was unique in the level of destruction wrought upon the male body; compound fractures and amputation, shell shock and hysteria, maiming and disfigurement, blindness and paralysis, were all common injuries. Koven's *Remembering and Dismemberment*, Joanna Bourke's *Dismembering the Male*, and Wendy Gagen's unpublished thesis and article 'Remastering the

¹⁶⁶ Christine Hallett, *Containing Trauma: Nursing Work in the First World War* (Manchester: Manchester University Press, 2009); Emily Mayhew, *Wounded: from Battlefield to Blighty, 1914-1918* (London: The Bodley Head, 2013); Alison Fell and Christine Hallett (eds.), *First World War Nursing: New Perspectives* (New York: Routledge, 2013); Sharon Ouditt, *Fighting Forces, Writing Women: Identity and Ideology in the First World War* (London: Routledge, 1994); Catherine F. Paterson, 'The Development of Occupational Therapy in Scotland, 1900-1960', (Unpublished doctoral thesis, University of Aberdeen, 2002); Carden-Coyne, *The Politics of Wounds*.

¹⁶⁷ Linker, *War's Waste*; Linker, 'The Business of Ethics'; Linker, 'Strength and Science'.

¹⁶⁸ Linker, *War's Waste*, p.63.

Body', examines the experience of wounding, and its effect on the body and masculinity.¹⁶⁹ Building on this cultural analysis, Carden-Coyne offers insight into patient experience of British physiotherapy during the First World War.¹⁷⁰ By using a range of cultural sources such as cartoons, poetry and patient narratives, Carden-Coyne gives a detailed analysis of how soldiers experienced and perceived massage treatment. Physical therapy, she argues, was underpinned by a re-gendering process by which the male body was slowly reactivated and masculine self-control restored.¹⁷¹ Starting as a passive body, the aim of physical therapy was to progress the soldier-patient from passive to active treatments, reflecting his recovery and representing the restoration of masculinity.

Carden-Coyne's exploration of pain and intimacy in the context of physiotherapy is particularly important for this thesis. Massage could be a painful treatment, and was used for highly sensitive conditions such as open wounds, sprains, fractures, amputations and stiff joints. The expectation that patients should bear pain, Carden-Coyne argues, was built into the fabric of massage treatment and rehabilitation.¹⁷² Furthermore, the First World War military hospital was an unprecedented arena where Victorian gender roles were reversed. Masseuses occupied a position of power and elicited pain upon passive male bodies, which contrasted sharply with traditional notions of women as carers and nurturers. At the same time, massage was a highly intimate and

¹⁶⁹ Koven, 'Remembering and Dismemberment'; Joanna Bourke, *Dismembering the Male: Men's Bodies, Britain and the Great War* (London: Reaktion Books, 1996); Wendy Gagen, 'Disabling Masculinity: Ex-servicemen, Disability and Gender Identity, 1914-1930', (Unpublished doctoral thesis, University of Essex, 2004); Wendy Gagen, 'Remastering the Body, Renegotiating Gender: Physical Disability and Masculinity during the First World War, the Case of J.B. Middlebrook', *European Review of History*, 14:4 (December, 2007), 525-541.

¹⁷⁰ Carden-Coyne, *The Politics of Wounds*; Carden-Coyne, 'Painful Bodies'; Reid also discusses these themes in *Medicine in First World War Europe*.

¹⁷¹ Carden-Coyne, 'Painful Bodies', 144.

¹⁷² Carden-Coyne, 'Painful Bodies', 145.

sensitive treatment, often humiliating and potentially emasculating for patients dealing with serious injuries, as well as painful to bear. Carden-Coyne's work looks at how the experience of pain, intimacy and vulnerability was managed by soldiers through humour and sexual mythology. The characterisation of the masseuse as sexualised or a masculine tormenter was a way of making sense of and dealing with the pain and unfamiliar gender dynamic of the encounter. Whereas Carden-Coyne's study investigates the patient's experience, this thesis draws from her analysis to explore how pain, gender and intimacy built into the rehabilitative process shaped the practice and professional identity of the masseuse during the war.

As with all studies that examine medicine during the war, this thesis cuts across the debate surrounding whether or not war is 'good' for medicine. In 'Medicine and the Goodness of War', Cooter challenges the causal relationship between war and medicine, and the perception of them as distinct states from the rest of history.¹⁷³ By tracing the historical roots and examining the multitude of forces and drivers involved, this thesis shows that the development of the massage profession during the First World War was intricately connected to wider social, cultural, economic and political factors running through society and medicine in the late-nineteenth and early-twentieth centuries.

Sources and Method

This thesis examines the forces bearing upon the practical and professional development of massage during the late-nineteenth and early-twentieth centuries. Influenced by social constructionist approaches that understand medical knowledge, practices and divisions of labour as socially fashioned, this

¹⁷³ Roger Cooter, 'Medicine and the Goodness of War', *Canadian Bulletin of Medical History*, 7 (1990), 147-59.

thesis combines close textual analysis and broad contextual evaluation to explore the history of massage on multiple levels.¹⁷⁴ This project uses a wide range of published and archival material to trace the practice of massage to a number of different locations, illustrating that professionalisation was a process embedded within a range of historical events, forces, social and professional relations.

At the heart of this study are the institutional records of the Chartered Society of Physiotherapy (CSP), located at the Wellcome Library, London.¹⁷⁵ Early records of the Society include council minutes (that run uninterrupted from 1894 throughout the First World War), correspondences, reports of sub-committees, medical advisory boards and disciplinary procedures. These sources offer insight into the internal dynamics of the British massage profession. They highlight the debates and challenges faced by the Society and how they were resolved. Another central resource is the Society's journal. Initially appearing in 1894 as a section titled 'massage notes' in the journal of the Midwives' Institute and Trained Nurses' Club, *Nursing Notes*, it branched off in July 1915, becoming *The Journal of the Incorporated Society of Trained Masseuses*.¹⁷⁶ The Society's journal was an organ through which the Council communicated the boundaries and practical dimensions of the profession. It contains a wide range of information about massage treatment, the role of the masseuse, education, etiquette and events. It includes articles, letters,

¹⁷⁴ Ludmilla Jordanova, 'The Social Construction of Medical Knowledge', *Social History of Medicine*, 7:3 (1995), 361-381.

¹⁷⁵ The institutional records of the Chartered Society of Physiotherapy from 1894-2011 are held at the Wellcome Library (henceforth WL), London, catalogued under the reference SA/CSP.

¹⁷⁶ 'Massage Notes' first appeared in *Nursing Notes: A Practical Journal for Nurses*, in October 1894, p.135; the first issue of the *Journal of the Incorporated Society of Trained Masseuses* appeared in August 1915. The Wellcome Library holds *Nursing Notes*, volumes 1-20, (1887-1907). *Nursing Notes* changed its name in 1908 to *Nursing Notes and Midwives' Chronicle: A Practical Journal for Midwives and Nurses*, and the journals in the period 1908-1915 can be found at Oxford, Bodleian Library, University of Oxford. The Wellcome Library holds the *Journal of the Incorporated Society of Trained Masseuses*, volumes 1-5, (1915-1920).

photographs and advertisements from the Council, STM members and medical men, providing a rich resource for anyone investigating the profession.

To consider the profession within its wider historical setting, this research traces the practice of massage beyond the Society's institutional sources. Monographs and medical articles from the late-nineteenth century to 1920 have been used extensively in order to consider how massage was adopted into regular medicine and the professional relationships between massage and medical profession. This study has relied upon digital search tools as well as manual sampling techniques to identify source material. Searching for 'massage' in online repositories, however, can be problematic in that historically it has been widely practised. Journal databases frequently offered thousands of results, many of which were brief references and it was necessary to identify more detailed accounts to be examined in depth. From these broad searches, however, it has been possible to identify pertinent themes and figures, although necessarily much has been omitted.

Historians such as Peter Bartrip have shown that medical journals in this period, particularly the *British Medical Journal* and *The Lancet*, were medico-political tools through which the boundaries of orthodoxy were established.¹⁷⁷ These journals reveal heated debates about massage and show the multiplicity of understandings, interests and conflicts surrounding its practice. This project also uses nursing journals to examine the changing relationship between massage and nursing. The digitalised archives of the Royal College of Nursing allowed this research to consider how massage was viewed from the perspective of the nursing profession.

¹⁷⁷ Peter Bartrip, *Mirror of Medicine: A History of the British Medical Journal* (Oxford: Clarendon Press, 1990), pp.41-42; also see W.F. Bynum, Stephen Lock and Roy Porter (eds.), *Medical Journals and Medical Knowledge: Historical Essays* (London: Routledge, 1992).

This thesis is also based on extensive unpublished archival material. To examine how massage developed practically in an institutional setting, a range of hospital archives have been consulted. In particular, this research is based on records of St Thomas' Hospital, held in the London Metropolitan Archives; the London Hospital, held at the Royal London Hospital archive, Prescot Street; Baschurch Hospital, held at The Robert Jones and Agnes Hunt Orthopaedic Hospital archives, Oswestry; and Chailey Heritage and Craft Schools, held at The Keep, East Sussex. In contrast to online databases, searching for massage in archival repositories is more challenging and yielded mixed results. One challenge is that many institutions recorded very little about massage and physical therapy before the First World War; another is that, subject to certain cataloguing techniques, where they do exist, these records often prove difficult to find. However, analysis of records such as committee minutes, hospital reports, photographs, staff registers and qualifications, has offered unique insight into the evolution of massage departments before and during the First World War. Institutional case studies have a number of strengths and weaknesses. While they offer unique insight into how massage was incorporated into specific medical and social spaces, their explanatory value is necessarily limited. Massage and physical therapy operated in a multitude of different arenas throughout this period and this thesis argues that generalised assumptions about how it was used are difficult to make.

In order to explore the relationship between the profession and the state, a number of official sources have been examined. This thesis examines where massage appeared in records from the Metropolitan Police, Ministries of Pensions, Health, Board of Trade, Home Office and War Office, located in the National Archives and the Imperial War Museum, London. These records

highlight points at which massage became an 'official' concern, and show the ways in which the practice was shaped by social, political and economic concerns more broadly.

Finally, through newspaper articles, advertisements, trench journals, personal accounts and memoirs, this study investigates how and when massage came to personal and public attention. By providing a window into the primary experience and popular perception of massage treatment, these sources give insight into the social relations and cultural dimensions of professionalisation. By mobilising a wide variety of material, this thesis aims to offer a more granular understanding of the evolution of the massage profession.

Chapter Outline

This thesis has a chronological and thematic structure. Each chapter can be viewed singly or as part of a pair. The first chapters in each pair explore massage in uncharted territory and as such synthesise large amounts of empirical material. Based on new research, these chapters investigate the development of massage practice in late-nineteenth and early-twentieth century medicine. This research explores why – broad socio-economic, political, medical and military drivers – and how – by whom, divisions of labour, expertise, combination with other therapies – massage was adopted into regular medical practice in this period. These chapters provide the contextual backdrop that this study argues is essential for analysis of the professionalisation of massage. The second chapter in each pair shifts the focus to professionalisation, considering the socio-cultural concerns, social relations and professional interests at play in the negotiation of the occupational boundaries and development of the massage profession.

Chapters 1 and 2 examine the professionalisation of massage in 1895 and the conditions upon which it was contingent. Chapter 1 examines the adoption of massage into medical orthodoxy and its revival in Britain. It traces the influence of Swedish gymnastics upon the status of massage, how it was reformulated into medical discourse, and the significance of the Weir Mitchell rest cure to the growth of massage as a practice and occupation in late-nineteenth century Britain. It argues that these conditions were prerequisite for the professionalisation of massage in the mid-1890s. Chapter 2 explores the 1894 'massage scandals' and the formation of the Society of Trained Masseuses (STM). It investigates the ways in which the professionalisation of massage was a negotiation of socio-cultural discourses, professional interests and gender-power relations.

Chapters 3 and 4 move away from the 'massage scandals', to examine another set of contexts that, although less explored, were also key to the professionalisation of massage before the First World War. Chapter 3 traces the use of massage in the context of orthopaedic conditions and rehabilitation before 1914. It shows how massage was used to treat conditions such as deformity, paralysis and pain, which defied conventional medical practice, and how massage was at the centre of a medical debate about the reform of injury and fracture treatment at the turn of the century. This chapter uses massage practice as a lens through which to examine how socio-economic concerns about disability and productivity, and therapeutic shortcomings within conventional medical practice, were drivers for the incorporation of massage into medicine. It shows that the treatment of disability and injuries were key sites for the professionalisation of massage and the cultivation of a multi-skilled specialism embryonic of physiotherapy. It argues that massage played a role in

the development of early rehabilitation within medicine, which was later extended in the First World War. Chapter 4 shifts the focus from practice to professionalisation. Building on the context outlined in Chapters 1 to 3, it investigates the significance of nursing and Swedish gymnastics for the early massage profession, and how its relationship to medicine changed before the war.

Chapters 5 and 6 examine the impact of the First World War upon the massage profession. Chapter 5 traces how and why massage came to be used as a treatment during the war. It situates the militarisation of the massage profession within the broader medico-political drive for rehabilitation. It shows how masseuses adapted therapeutic principles and practices developed in the late-nineteenth century to the restoration of injured soldiers during the war. The chapter argues that the massage profession played an important part in the development of rehabilitation during World War One, both as a medical service in and of itself, as well as a surgical auxiliary that supported the development of orthopaedics. Finally, Chapter 6 concludes by considering how war work transformed the profession. It looks at how the massage profession adapted to working under military conditions, analysing the ways in which on-going disputes and debates surrounding professionalisation from the late-nineteenth century were renegotiated in a new context. It argues that while the war was a platform for the profession to achieve unprecedented recognition and independence, this cannot be understood as a simple process of ascendancy.

Chapter 1

Massage, Medicine and Revival in Britain

The remarkable revival in the use of massage which has taken place within the last decade, though it has affected this country, has yet attained much larger proportions on the Continent [...] Though too much has perhaps been claimed for the method by some of its most ardent advocates, yet a very short experience will convince any impartial observer that in it we possess a very valuable means of treating certain forms of disease. Every practitioner ought to make him-self acquainted with the general principles of the manipulations employed, and with the results which may be obtained.¹

Increasingly throughout the nineteenth century, physio-therapeutic techniques such as massage, remedial gymnastics, mechanotherapy, hydrotherapy and electrotherapy, previously the domain of lay practitioners or so-called 'ignorant charlatans', entered into orthodox medicine.² By 1900 massage was a burgeoning medical practice in Britain. Used for a range of medical and surgical conditions, general hospitals established 'massage departments' and independent practitioners flourished serving the latest therapeutic 'fashion' for the middle and upper classes. The aim of this chapter is to consider how and why a traditionally lay practice was translated into medical orthodoxy, and the terms on which it was adopted into British medical practice in the late-nineteenth century.

To explore the medicalisation of massage and its adoption in Britain, this chapter focuses on four themes. Firstly, it looks at the influence of Swedish remedial gymnastics on the spread of massage. It then moves to examine the international dialogue through which massage was translated into the language

¹ 'Reviews and Notices', *BMJ* (10 November 1888), 1050-1051, (p.1050).

² Roger Cooter, *Surgery and Society in Peace and War: Orthopaedics and the Organization of Modern Medicine, 1880-1948* (London: Macmillan Press, 1993), p.20.

of medical orthodoxy. Thirdly, it assesses the significance of the Weir Mitchell treatment for the revival of massage in Britain. Finally, it explores how massage was incorporated into Britain as a division of labour, and debates surrounding its practice and expertise. To investigate these issues, this chapter draws extensively from the discourses of medical men and others interested in massage, analysing treatise, articles and pamphlets. The chapter argues that the international movement of Swedish gymnastics, the theoretical reformulation of massage into medical discourse, and the Weir Mitchell rest cure were prerequisite conditions leading to the professionalisation of massage in the mid-1890s. It offers insights into the complex processes by which physical therapy was adopted into regular medicine and shows that massage offered an avenue of reform and an opportunity to widen the scope of medical and surgical practice.

Swedish Remedial Gymnastics

Interest in people's lack of physical strength was a nationalist concern that permeated Europe from the late-eighteenth century and intensified throughout the nineteenth.³ It was a climate that saw the emergence of so-called 'gymnasiarchs', who developed and marketed different systems of exercise and gymnastics.⁴ One of the most influential systems across Europe was Swedish remedial gymnastics, which had a profound impact upon pedagogical and medical thinking. Swedish gymnastics was first developed by Swedish nationalist, physiologist and fencing instructor, Pehr Henrik Ling (1776-1837), in the early nineteenth century. It was through curing himself of rheumatism in his

³ Anders Ottoson, 'The Manipulated History of Manipulations of Spines and Joints? Rethinking Orthopaedic Medicine Through the 19th Century Discourse of European Mechanical Medicine', *Medicine Studies*, 3 (2011), 83-116, (p.89).

⁴ Ottoson, 'Manipulated History', 90.

arm by fencing practice that Ling first became interested in the use of exercise to treat the body and mind.⁵

Lingian gymnastics was widely acclaimed as a 'modern system' and differentiated itself from other contemporary regimes by its scientific basis. While not a physician, Ling based his system upon orthodox principles and claimed that 'the dearest source of knowledge for the gymnast' was anatomy and physiology.⁶ The success of Lingian doctrine lay in its scientific status, whereby it claimed that rational use involved clearly intentioned systematised movements, which produced known physiological effects. It was through science that Swedish gymnasts and other advocates claimed a special expertise over 'unsystematic' and 'empiric' uses of exercise. As Morus's study of Victorian electrotherapeutics has argued:

"Empiricism" as used by early nineteenth medical commentators invariably had derogatory connotations. An empirical therapy was one that was not based on a rational understanding of the method whereby the therapy affected the human body.⁷

Writing in 1909 eminent French surgeon Just Lucas-Championnière (1843-1913) described that, '[i]t must not be supposed that the fundamental difference between the system of gymnastics known as Swedish and other systems lies in any actual difference in the movements'. Rather, he asserted, the 'merit' of the system lie in its 'methodization' and 'in the application of scientific rules and of a definite method'.⁸

⁵ Joseph Schreiber, *A Manual of Treatment by Massage and Methodical Muscle Exercise*, trans. by Walter Mendelson (Edinburgh: Young J. Pentylend, 1887), p.21.

⁶ Pehr Henrik Ling, *Gymnastiken Almännna Grunder*, (Uppsala, 1834/1840), in 'Manipulated History', 90.

⁷ Iwan Morus, *Frankenstein's Children: Electricity, Exhibition, and Experiment in Early-Nineteenth Century London* (Princeton; New Jersey: Princeton University Press, 1998), p.236.

⁸ Just Lucas-Championnière, 'An Address on The Modern Treatment of Fractures', *BMJ* (12 June 1909),1397-1400, (p.1398).

Ling outlined the method in *The Basic Principles of Gymnastics*, which described principles that could be adapted to what he classified as educational, medicinal, aesthetic and military purposes.⁹ Ling used terminology such as 'passive', 'active' and 'resistive' to systematise bodily movements, defining them through the relationship between the patient and the gymnast.¹⁰ Massage was a central component of Swedish remedial gymnastics and received systematisation and status within it. Describing the gymnastic movements, Austrian physician and Lingian disciple Mathias Roth (1818-1891) wrote that 'active' exercises were those 'executed by the patient alone, or with the help of the assistant'. In contrast, 'passive' movements were 'executed by the assistant only on the patient' and included massage techniques such as frictions, kneading, pressure, vibration, percussion, sawing and fulling. 'Resistive' or 'compound' movements, were a combination of the two, wherein the gymnast 'resists the patient's effort'.¹¹ The Lingian systematisation of bodily movement aimed towards restoration and 'perfection' of physical fitness, and would become a central conceptual underpinning for remedial massage and rehabilitation in the First World War.

The cradle of the movement was Ling's state-sanctioned Royal Central Institute of Gymnastics (RCIG), established in 1814.¹² The Institute was instigated by an 'upbringing committee' in 1812 to train 'gymnastic directors' to

⁹ Ling, *Gymnastiken Almännna Grunder*, in Ottoson, 'Manipulated History', 90. This was his largest treatise, which he worked on from 1834 until the time of his death and was completed by two of his pupils 'Liedbeck and Georgii', see Schreiber, *A Manual of Treatment*, p.23.

¹⁰ Resisted movements were also known under other terms such as 'semi-active', see Donald Baynes, *Auxiliary Methods of Cure* (London: Simpkin, Marshall & Co., 1888), p.45; 'Compound movements', see Friedrich Busch, *General Orthopaedics, Gymnastics and Massage*, trans. by Eldred Noble Smith (London: Smith, Elder, & Co., 1886), p.38. 'Duplicate movements', see Anders Wide, *Hand-book of Medical and Orthopaedic Gymnastics*, 2nd edn. (London: Funk & Wagnalls Company, 1903), p.11.

¹¹ Mathias Roth, *Notes on the Movement-Cure, or Rational Medical Gymnastics, the Diseases in Which it is Used, and on Scientific Educational Gymnastics* (London: Groombridge & Sons, 1860), pp.6-7.

¹² Robert Tait McKenzie, *Exercise in Education and Medicine*, 2nd edn. (Philadelphia; London: W.B. Saunders Company, 1915), p.109.

teach Lingian gymnastics in schools and the military, with the aim of restoring physical splendour to the Scandinavian race.¹³ In order to qualify as a gymnast, students had to undertake a three-year course at the Institute where they were instructed in educational and medical gymnastics.¹⁴ RCIG graduates had a strong professional identity and became an internationally influential diaspora. The prestige of the profession was based not only on its scientific training, but also its high social status, which was elevated because gymnastic directors often belonged to the upper classes and the RCIG was a state sanctioned institution.¹⁵ As Anders Ottoson argues, the gymnastic director and field of mechanical medicine were not seen as separate from or subordinate to orthodox medical practice on the Continent.¹⁶ They were viewed as a separate branch of medical science requiring specialist training and expertise. There was a one-year course at the RCIG for trained physicians to qualify as specialists in mechanical medicine and in Sweden this was an official prerequisite for practice in this area.¹⁷ Many physicians from across Europe went to Sweden to train at the RCIG and similar state sponsored institutions in order to receive a prestigious qualification in a territory not covered within conventional medical education. Many of those who went from Britain became prominent figures specialising in massage and remedial gymnastics.¹⁸ As the medical profession became increasingly interested in manipulative and mechanical expertise

¹³ Ottoson, 'Manipulated History', 89.

¹⁴ Anders Wide, *Hand-Book of Medical Gymnastics* (London: Sampson Low, Marston & Company Ltd., 1899), p.9. Women were not permitted to train at the Institute until 1864 when they undertook a two year course rather than three as not instructed in military gymnastics.

¹⁵ Ottoson, 'Manipulated History', 97.

¹⁶ Ottoson, 'Manipulated History', 96. Mechanical expertise was a term widely used to denote the field of massage and gymnastics, referring to the mobilisation and mechanical action of the body. It was also a term to describe the use of apparatus for mobilising the body, for example 'mechano-therapeutics'.

¹⁷ Wide, *Hand-book of Medical Gymnastics*, p.10.

¹⁸ See qualification 'G.D. Stockholm'. For example, Richard Timberg was a physician and gymnastic director who headed the Physical Exercise Department at St Thomas' Hospital, from its establishment in 1898-1911 with two Swedish gymnasts.

across the late-nineteenth and early-twentieth centuries, the claims of Swedish remedial gymnasts to privileged status, autonomy and expertise became a cause of friction across Europe.¹⁹

The relationship between massage and remedial gymnastics was a topic of debate. As noted above, within the system of Swedish remedial gymnastics massage and exercise were intricately linked. Such was the belief of 'Ling-physician' and director of the state founded Gymnastic Orthopaedic Institute (1827), Anders Wide.²⁰ In his *Hand-book of Medical and Orthopaedic Gymnastics*, published in multiple languages and editions, Wide argued that it was 'almost impossible to make any clear distinction between Medical Gymnastics and Massage', especially in the treatment of orthopaedic conditions.²¹ Massage and exercise, he argued, were inseparable within a holistic treatment of disability. According to Wide, passive movement included the gymnasts' mobilisation of a patient's limbs and joints, as well as their manipulations upon the body. Wide argued that '[s]ome authors have lately tried to set up a distinct limit between Medical Gymnastics and Massage' based on the distinction 'that movements *on* the patient should be assigned to massage, because no movement *with* the patient is made'.²² Such claims, he continued, not only 'shows ignorance of Swedish Gymnastics' but was a professional strategy and an attempt to seize massage 'at the cost of Gymnastics'.²³

In contrast, Swedish physician Emil Kleen (1847-1923) claimed a 'sharp distinction' between the two methods of treatment. Like Wide's treatise, Kleen's

¹⁹ 'Swedes come here and practise, doubtless with skill, but also on their own authority and diagnosis. This danger is guarded against by the definite law of the Incorporated Society, and to disregard it involves loss of membership', see 'A masseuse since 1888', 'Correspondence', *Journal of the Society of Trained Masseuses* (July 1919), 16.

²⁰ Ottoson, 'Manipulated History', 95.

²¹ Wide, *Hand-Book of Medical and Orthopaedic Gymnastics*, p.4.

²² Wide, *Hand-Book of Medical and Orthopaedic Gymnastics*, pp.10-11.

²³ Wide, *Hand-Book of Medical and Orthopaedic Gymnastics*, p.11.

1892 *Handbook of Massage* was a popular text published in multiple editions and languages. Kleen's work was intended specifically for medical students, to educate them in massage, 'which is rightly coming to occupy a more and more prominent place in modern therapy'.²⁴ Massage, he wrote, was mechanical action performed on the soft tissues, for a therapeutic purpose 'by means of certain manipulations, namely, stroking, rubbing, kneading and striking,' whereas gymnastics was the 'exercise of the organs of motion'.²⁵ While both 'have many points in common [...] often employed simultaneously in medical practice', it was of 'paramount necessity' he argued, to discriminate between the two.²⁶

For Kleen, the difficulty of separating massage from gymnastics was due to the professionalising strategies of remedial gymnasts who sought to monopolise the expertise. Gymnasts, he wrote:

in their zeal to secure all possible recognitions for medical gymnastics - and in their not unusual confusion of ideas as to their office, will have it, perforce, that massage is "only a part of gymnastics," and declare that the "passive movements" of the latter include the former.²⁷

The relationship between massage and gymnastics, then, was more than a technical debate, it was a site of conflicting professional interests. By arguing there was a distinction between massage and gymnastics, physicians such as Kleen were contesting the monopoly of gymnasts over the practice while carving it out as an arena of specialist expertise. While massage did gain an identity separate to that of remedial gymnastics, the close link, especially in the

²⁴ Emil Kleen, *Handbook of Massage*, trans. by Edward Mussey Hartwell (Philadelphia: P. Blakiston, Son & Co., 1892), p.ix.

²⁵ Kleen, *Handbook of Massage*, p.17.

²⁶ Kleen, *Handbook of Massage*, p.17.

²⁷ Kleen, *Handbook of Massage*, p.18.

treatment of orthopaedic conditions, was one that endured throughout the period examined in this thesis. The historical connections between massage and other physical therapies, such as hydrotherapy, remains an area to be fully explored.

Gymnastics was a transatlantic movement and Ling's was not the only system to have an international impact.²⁸ Preceding the Swedish gymnastic movement was the German system known as 'Turnen' ('movement'), inaugurated by Friedrich Ludwig Jahn (1778-1852).²⁹ Like Ling's, Jahn's system grew out of nationalist sentiment; living through the Napoleonic period, he aimed to strengthen Germany through the physical fitness of the population, devising a 'plan of rescuing youths from the weakening effects of a life of luxury by means of energetic scholastic gymnastics, and the raising of them to such a degree of strength and energy that later on they might be in a condition to throw off the yoke of foreign power'.³⁰ Jahn opened his first gymnastic ground in Berlin in 1811 and the movement spread throughout Europe and North America.³¹

In Britain, Scottish Archibald Maclaren (1819[?]-1884) transformed physical training in the military after he was asked to develop a new system for the army in 1860.³² Maclaren's system included dumb-bells, bar-bells, climbing ropes and walls, vaulting horses, as well as running and free-standing drill

²⁸ Gertrud Pfister, (ed.), *Gymnastics, A Transatlantic Movement: From Europe to America* (London: Routledge, 2011).

²⁹ Ottoson, 'Manipulated History', 90.

³⁰ Busch, *General Orthopaedics*, p.32.

³¹ Roland Naul and March Krotee, 'German Legacy: From German Gymnastics to Physical Education in Modern Unified Germany', in *Turnen and Sport: Transatlantic Transfers*, ed. by Annette Hoffman (Münster: Waxman, 2004), pp.69-87, (p.69).

³² Peter C. McIntosh, 'Maclaren, Archibald (1819?-1884)', *Oxford Dictionary of National Biography*, (henceforth *ODNB*), (Oxford University Press, 2004; Online edn., October 2009), [<http://www.oxforddnb.com/view/article/50298>, last accessed 13 Oct 2016].

exercises.³³ Maclaren criticised Swedish gymnastics arguing that while it was suitable as remedial therapy for restoring the weak and delicate, it was not appropriate for strengthening healthy individuals, 'soldier or civilian, child or man'.³⁴ 'Chicken broth', he wrote in 1863, 'may yield ample nutriment to the invalid, but the soldier would make but a poor day's march upon it; you must give *him* the chicken too'.³⁵

Lingian doctrine had an impact throughout Europe through the emigration of Swedish gymnasts.³⁶ Starting in the 1830s, Lingian 'disciples' and other 'zealous advocates' settled in almost every major European city and North America, taking with them and adapting Lingian ideas to a variety of settings.³⁷ Pehr Ling's son, Hjalmar Ling, developed his father's work, organising gymnastic lessons into systematic 'tables' of exercises that were devised from a wider vocabulary of Swedish movements.³⁸ In this way, Swedish exercise regimes could be custom designed and adapted to a variety of educational and remedial settings. Designing the table and instructing the class was the responsibility of the gymnast, whose expertise was deemed necessary to ensure that exercises were balanced to work the body evenly, and pitched at the right level of difficulty for the class or individual.³⁹ While scholarship has tended to focus on Swedish gymnasts as educators, they were also physical therapists. Their work had a significant impact upon medical thinking about physical therapy and rehabilitation, and while little is recorded of them, they were a notable presence in Britain throughout the period discussed in this

³³ McIntosh, 'Maclaren', *ODNB*.

³⁴ Archibald Maclaren, 'National Systems of Bodily Exercise', *Macmillan's Magazine* (1863), 277-286, (p.280).

³⁵ Maclaren, 'National Systems', p.280.

³⁶ Ottoson, 'Manipulated History', 97.

³⁷ Roth, *Notes on the Movement-Cure*, p.7.

³⁸ Steve Bailey and Wray Vamplew, *100 Years of Physical Education, 1899-1999* (Warwick: Warwick Printing Company Limited, 1999), p.4.

³⁹ Bailey and Vamplew, *100 Years of Physical Education*, p.4.

thesis. Gymnasts emigrated and established clinics where curative gymnastics was practised.⁴⁰ They worked in spas, health resorts and hospitals, and they treated a wide range of medical and surgical ailments from emphysema, tuberculosis and heart conditions to rheumatism, scoliosis and club foot.⁴¹

A considerable number of Swedish gymnasts migrated to Britain.

Describing this movement in 1945 Jane Wicksteed wrote that:

This revival of massage and medical rubbing was largely due to the migration to this country of a considerable number of Swedish men and women trained in massage and education and remedial gymnastics at the Central Institute of Stockholm. These Swedes were usually well trained, well educated, competent, robust and vigorous, and not lacking in that particular charm and freshness which characterise the Scandinavian races.⁴²

By the end of the century, Swedish gymnasts were a familiar presence on the public and medical landscape; they ran lucrative private practices and were frequently employed in general hospitals.⁴³ One particularly influential Swedish gymnast in Britain was Austrian physician and homeopath Mathias Roth (1818-1891). After graduating from the RCIG, Roth emigrated to Britain in 1849 and established a private clinic called the Institute for the Treatment of Chronic Diseases and Deformities, in 1850.⁴⁴ Roth's Institute offered the 'movement cure' by Lingian medical gymnastics, a 'Russian bath' of his own invention, and

⁴⁰ Busch, *General Orthopaedics*, p.38.

⁴¹ Ottoson, 'Manipulated History', 92. Ottoson notes that thousands of records kept by Swedish gymnasts report undertaking such treatments and patients cured or health improved, (National Archives of Sweden).

⁴² Jane H. Wicksteed, *The Growth of a Profession: Being the History of the Chartered Society of Physiotherapy, 1894-1945* (London: Edward Arnold & Co., 1948), p.19.

⁴³ See Chapter 3, highlighting this point, Swedish gymnast Dr Koch and his wife were employed by the London Hospital in 1905 to give Swedish massage, his appointment came on recommendation from the Queen with whom they had a personal connection.

⁴⁴ Roth, *Notes on the Movement-Cure*, title page; Judit Brody, 'Roth, Mathias (1818-1891)', *ODNB*, (Oxford University Press, 2004), [<http://www.oxforddnb.com/view/article/56050>, last accessed 13 Oct 2016]. Mathias Roth's son was surgeon Bernard Roth (1852-1915).

the 'water cure'.⁴⁵ Underpinning his advocacy of the movement cure was a criticism of conventional medical and surgical practice. An alternative to allopathic medications and surgery, Roth presented movement and massage as a radical treatment, curing chronic diseases and deformities where regular practice failed. He claimed success with internal 'ailments from which many persons labour', such as tuberculosis, asthma, nervous diseases, headache and constipation, that were 'only palliatively treated' and 'temporarily relieved by medicines', whereas 'permanently removed by the method under consideration and suitable regimen'.⁴⁶ Paralysis, he wrote, was another 'class of disease[s] in which the usual remedies have, in general, no prominent effect'; furthermore, he complained, in the majority of cases 'nothing is even attempted for restoring the patient's power of movement'.⁴⁷ By contrast massage and passive movements 'by acting on the part which cannot be moved by the patient himself, improve a large number of cases, and the instances of radical cure are also not rare'.⁴⁸

Roth believed that movement particularly benefited chronic deformities and functional disabilities such as 'contractions of the limbs, stiffness and other affections of the joints of chronic nature'.⁴⁹ Foreshadowing medical debates at the turn of the century as to the most effective treatment for spinal deformity, Roth criticised conventional methods of treatment by rest and splinting deployed in 'so-called orthopaedic institutions', arguing that movement should replace such methods altogether:

This mode of treatment by Movements will be hailed as the greatest of blessings by those afflicted by spinal disease, who have undergone the tedious process of lying in bed for years, and whose

⁴⁵ Roth, *Notes on the Movement-Cure*, end-matter.

⁴⁶ Roth, *Notes on the Movement-Cure*, pp.8-9.

⁴⁷ Roth, *Notes on the Movement-Cure*, p.10.

⁴⁸ Roth, *Notes on the Movement-Cure*, p.10.

⁴⁹ Roth, *Notes on the Movement-Cure*, p.10.

general health has thus been more or less undermined - to say nothing of the tortures of pitch plasters, issues, setons, [sic] moxas, [sic] etc., applied from one end of the backbone to the other [...] A cure of spinal deformity by Movements is a gradual one; because the parts which contribute to hold the spine upright are made strong, in order to obtain support from the increased strength of these parts, and not from an external mechanical contrivance.⁵⁰

While movement and massage were conservative methods in the conventional sense of the term, they were also radical because they represented a criticism of regular medical and surgical practice and a departure from conventional modes of treatment. As Marland, Adam's and other scholarship has shown, hydropathy, homeopathy, anti-vaccination and spiritualism⁵¹ alike represent radical therapeutic movements that were part of wider social reactions to shortcomings within orthodox therapeutics. The development of gymnastics and massage in this period can be seen as part of this broader movement within society and medicine.

While making radical and reformist claims, Roth was anxious to defend his position within the medical profession. A homeopathist and gymnast, Roth was also a physician and did not reject orthodoxy. Like many other reforming systems, Roth advocated the movement cure as a rational and orthodox treatment. Firstly he asserted the scientific and rational basis of Lingian gymnastics, differentiating it from gymnastics used by orthopaedics:

The Movements of Ling differ entirely from those generally used in our gymnastic and orthopaedic institutions, to which they have scarcely any resemblance; they are based on the most accurate

⁵⁰ Roth, *Notes on the Movement-Cure*, p.9. 'Spinal curvatures belong to those complaints which are not admitted to general hospitals, yet require special attention for their treatment', in Mathias Roth, *The Prevention of Spinal Deformities Especially of Lateral Curvatures, with Notes on the Causes, the Artificial Production & the Injurious Modes of Treatment of these Complaints* (London: Groombridge, 1861), p.iii.

⁵¹ Hilary Marland and Jane Adams, 'Hydropathy at Home: The Water Cure and Domestic Healing in Mid-Nineteenth Century Britain', *Bull. Hist. Med.*, 83 (2009), 499-529, (p.503).

knowledge of anatomy, physiology, and pathology, and are used wither for the prevention or cure of disease.⁵²

He did not reject regular treatment and his claim that 'no rational mode of treatment which can contribute to the cure of deformities and chronic diseases [was] excluded' from his treatment, was a way of showing that massage and gymnastics should be considered as part of regular medicine.⁵³ While 'I am very zealous in my advocacy of the treatment by Movements', he noted, 'I wish it clearly to be understood that I do not recommend it as a panacea'.⁵⁴ Rather, he saw it as a 'branch of medical science' and 'undoubtedly a very important addition to our other curative means'.⁵⁵

According to Roth, there was only a 'small number of unprejudiced practitioners' receptive to curative movements and medical gymnastics in Britain in 1861.⁵⁶ He encouraged regular practitioners and gymnasts to learn from each other in order to advance the field:

The physician, the surgeon, the orthopaedist, and other medical specialists, will find the Movements a most valuable accessory in the treatment of many diseases, and the man who is engaged in the treatment by Movements as a specialty, must not neglect to make himself acquainted with the progress of all other medical sciences, if he would not be reckoned among those empirics who profess to cure all diseases by the same means.⁵⁷

By maintaining the scientific basis of massage and gymnastics, Roth was able to present a radical critique of medical and surgical treatment, while offering a road to reform. In this way he was able assert his own professional interest in

⁵² Roth, *Notes on the Movement-Cure*, p.5.

⁵³ Roth, *Notes on the Movement-Cure*, (endmatter).

⁵⁴ Mathias Roth, *Hand-book of the Movement Cure: A Description of the Positions, Movements, and Manipulations, Used for Preventive and Curative Purposes, According to the System of Long & the Works of Rothstein, Neumann, & Others* (London: Groombridge, 1856), p.vi.

⁵⁵ Roth, *Hand-book of the Movement Cure*, p.vi.

⁵⁶ Roth, *The Prevention of Spinal Deformities*, p.iv.

⁵⁷ Roth, *Hand-book of the Movement Cure*, p.vi-vii.

the increasingly niche market for movement, while maintaining his reputation within the medical profession.

Roth was also responsible for establishing the first Zander Institute in London, Soho Square in 1882.⁵⁸ The Institute was based on the work of Swedish physician and gymnast Gustav Zander (1835-1920).⁵⁹ In the 1860s Zander invented apparatus based upon a system of levers to provide resistance matching the strength of the patient.⁶⁰ Zander modified Lingian ideas, addressing what he believed to be shortcomings in the method. Zander's 'medico-gymnastic' machinery was intended primarily for 'invalids' and those 'ladies, young girls, elderly men, and weakly persons of all ages and of either sex', whose poor physical condition limited their ability to conduct regular free-standing movements.⁶¹ Zander's machinery also aimed to replace human agency. Apparatus could regulate the force administered during passive and resistive movements more accurately than the therapist and ensure that treatments were graduated slowly.⁶² At the same time, it removed the physical contact of 'handling and rubbing',⁶³ circumventing intimate encounters considered distasteful and availing 'those who disliked being handled by a professional shampooer' to the therapeutic value of movement cure.⁶⁴

⁵⁸ Jean Barclay, *In Good Hands: The History of the Chartered Society of Physiotherapy 1894-1994* (Oxford: Butterworth-Heinemann Ltd, 1994), p.6.

⁵⁹ S. Elsaesser and A.R. Butler, 'Nineteenth Century Exercise Clinics for the Treatment of Scoliosis', *Journal of the Royal College of Physicians Edinburgh*, 44 (2014), 240-246, (p.244).

⁶⁰ Elsaesser and Butler, 'Exercise Clinics', 244.

⁶¹ Anon., *Mechanical Exercise as a Means of Cure: Being a Description of the Zander Institute, London (7 Soho Square), its History, Appliances, Scope, and Object* (London: J & A. Churchill, 1883), p.v. While no author is named, it states 'Edited by the Medical Officer to the Institution', who is cited as 'Mr Oxley' in, 'Mechanico-Therapeutics', *The Lancet* (17 December 1881), 1059.

⁶² Anon., *Mechanical Exercise*, p.3.

⁶³ Anon., *Mechanical Exercise*, p.2.

⁶⁴ Anon., *Mechanical Exercise*, p.4.

There was a certain amount of prejudice against manual therapy amongst the British medical profession.⁶⁵ In 1882, the *BMJ* noted that Ling's movement cure, involving as it did 'passive movements' and 'manual frictions', 'doubtless effected much good' but needed to be 'employed with discretion, and kept within its legitimate bounds'.⁶⁶ The *BMJ* argued that 'in England it has not met with a great deal of favour, because its pretensions have been considered to simulate very closely those of empiricism.'⁶⁷ While acknowledging the benefits of the movement cure, then, the medical profession feared that if it was undertaken by specialists it threatened to lose perspective of its position within the broader medical hierarchy. In contrast, however, the Zander Institute, which removed the need for specialist operators, was 'highly approved of by the medical profession'.⁶⁸ Managed by a medical officer, orthopaedic surgeon Eldred Noble Smith noted that, the Institute offered an 'excellent substitute for Ling's system of gymnastics' and promised to be 'free from that empiricism, or, to say the least, extravagant and costly enthusiasm with which the 'movement cure' is so often surrounded'.⁶⁹ By using machinery, the *BMJ* wrote, 'to effect the movements which were otherwise carried out manually', the Ling system, was 'more likely to be approved by the medical profession in this country'.⁷⁰

The medical profession became interested in this field of treatment because it offered a way of treating a variety of medical and surgical ailments that challenged regular therapeutics.⁷¹ By offering Ling's movement cure in a

⁶⁵ Anon., *Mechanical Exercise*, p.1.

⁶⁶ 'The Zander Medico-Gymnastic Machines', *BMJ* (4 March 1882), 310.

⁶⁷ 'The Zander Medico-Gymnastic Machines', 310.

⁶⁸ Eldred Noble Smith, 'note 1', in Busch, *General Orthopaedics*, p.41.

⁶⁹ Noble Smith, 'note 1', p.41.

⁷⁰ 'The Zander Medico-Gymnastic Machines', 310.

⁷¹ Anon., *Mechanical Exercise*, p.6.

way that was acceptable to, and under the direction of, the medical profession, the Zander Institute promised to advance existing treatments:

The necessity for some means of carefully exercising, or bringing into active play, stiff joints and enfeebled muscles, has long been made evident to medical men, who have often seen a case [...] come to an unfortunate standstill, or even degenerate, for the simple reason that mechanical means to further carry out the desirable exercise of joint or muscle did not exist. This is no uncommon result of fractures, dislocation of joints, deformities of joints, club foot, infantile paralysis.⁷²

The support of the Institute represents the wider move to assimilate mechanical expertise into orthodoxy and marginalise the gymnast or 'rubber'. Mechano-therapeutics offered an opportunity for the medical profession to harness the therapeutic benefits of massage, mobilisation and exercise, without engaging with a low-status and labour-intensive manual practice, or employing a lay practitioner with questionable professional loyalty.

Mathias Roth was not only critical of medicine; as part of his twenty-year campaign to advance Swedish gymnastics in Britain, he rallied the government for sanitary and educational reform.⁷³ He critiqued regular physical education in schools, predominantly taught by 'drill sergeants, teachers of calisthenic movements and of common gymnastics, and dancing and fencing masters'.⁷⁴ According to Roth, regular physical education in elementary schools, taught by

⁷² Anon., *Mechanical Exercise*, p.6.

⁷³ Roth wrote prolifically, see: Mathias Roth, *The Prevention and Cure of Many Chronic Diseases by Movements: An Exposition of the Principles and Practice by these Movements for the Correction of the Tendencies to Disease in Infancy, Childhood, and Youth, and for the Cure of Many Morbid Affections of Adults* (London: Churchill, 1851); Mathias Roth, *On the Neglect of Physical Education & Hygiene by Parliament and by the Educational Department* (London, 1879); Roth also produced a number of pamphlets to this end including: Mathias Roth, *A Letter... On the Importance of Rational Gymnastics as a Branch of National Education* (1854); Mathias Roth, *A Plea for the Compulsory Teaching of the Elements of Physical Education in our National Elementary Schools* (1870). Roth's wife, Anna Maria Roth, (n.d.–1907), founded the Women's Sanitary Association in 1857, in Bailey and Vamplew, *100 Years of Physical Education* (Warwick: Warwick Printing Company Limited, 1999), pp.4-5.

⁷⁴ Roth, *Notes on the Movement-Cure*, p.11; for an account of the development of physical education in Britain see Bailey and Vamplew, *100 Years of Physical Education*, p.19.

such personnel, lacked a rational basis and should be replaced by 'scientific' physical education taught by trained Swedish gymnasts.⁷⁵ Physical education, he believed, was a serious matter, closely linked to national fitness and therefore should only be entrusted to those trained to prevent and cure deformity and strengthen physique generally. According to Roth, mismanagement was the principal cause of the 'progressing degeneration of the physique of the population' and had military and socio-economic consequences. '[I]gnorance and neglect' of physical education he wrote, led to:

great infantile and general mortality, to the increase of scrofulous, consumptive, and many school diseases, to the larger number of spinal and other deformities, even to the necessity of lowering the standard of height for recruits, and to the greater expenditure of training them during a much longer period further, to the increased expenses for hospitals, workhouses, and higher poor- and police-rates.⁷⁶

Roth's advocacy of the movement cure and physical education demonstrates that the development of this field was linked to broad fears about the decline of the British population, which predate the national panic engendered by the Boer and First World Wars.

As historians such as Cooter have noted, the 1870 Education Act that brought universal education in Britain also highlighted the poor health of school children.⁷⁷ This context was particularly receptive to Roth's campaigns to introduce Swedish gymnastics into the school curriculum and resulted in the London School Board's appointment of RCIG-trained Swedish gymnast Concordia Löfving as first Lady Superintendent of Physical Exercises in 1878.⁷⁸

⁷⁵ Roth, *On the Neglect of Physical Education*, p.5.

⁷⁶ Roth, *On the Neglect of Physical Education*, pp.v-vi.

⁷⁷ Cooter, *Surgery and Society*, p.55.

⁷⁸ Bailey and Vamplew, *100 Years of Physical Education*, p.5. The 1870 Education Act legislated 'universal education,' but physical education was not a compulsory subject. The Act

Physical education for both boys and girls was directed towards national strength. For boys it aimed to produce strong workers and soldiers through games, military drill and gymnastics often taught by ex-servicemen, while for girls physical fitness developed them as mothers.⁷⁹ Löfving's role was to introduce Swedish gymnastics into girls' elementary schools and within three years she had trained over 80 teachers in the theory and practice of gymnastics.⁸⁰ The appointment of a woman to such an esteemed post reflects the political significance and the prestige attached to Swedish gymnastics at this time.

Löfving was succeeded in 1881 by another Swedish graduate of the RCIG Martina Bergman-Österberg (1849-1915). During her engagement, Bergman-Österberg trained 1312 female gymnasts and introduced Swedish gymnastics to almost 300 elementary schools.⁸¹ Highlighting the influence of Swedish doctrine in Britain as carried through its practitioners, Kathleen McCrone argues that Bergman-Österberg's work 'laid the foundations of a national system of physical training by introducing Ling gymnastics into all board girls' schools and departments' and helped 'awaken public interest in physical education'.⁸² Deciding to leave her post at the London School Board in 1887 to work with girls from higher-class backgrounds, she launched her own school, the Hamstead Physical Training College, to prepare well-educated

did allow ratepayers to elect local school boards that had permissive powers to add to the government's basic outline. It was in this context that Roth was able to campaign to the London School Board.

⁷⁹ Beth Linker, *War's Waste: Rehabilitation in World War I America* (Chicago; London: University of Chicago Press, 2011), p.70; Barclay, *In Good Hands*, p.8.

⁸⁰ Barclay, *In Good Hands*, p.6. In 1888 the London School Board appointed the Swedish trained Allan Broman as Organising Master of Physical Training to introduce Swedish gymnastics to boy's elementary schools.

⁸¹ Jennifer Hargreaves, *Sporting Females: Critical Issues in the History and Sociology of Women's Sports*, 3rd edn. (London: Routledge, 1997), p.69; Kathleen E. McCrone, *Sport and the Physical Emancipation of English Women* (London: Routledge, 1988), p.105.

⁸² McCrone, *Sport and Physical Emancipation*, p.105.

women as gymnasts to teach in the new girls' secondary schools.⁸³ Swedish gymnasts flourished and by 1905, amid apprehensions of national decline, five other physical training colleges had been established to meet the demand, two of them launched by Bergman-Österberg's graduates of Hamstead.⁸⁴ Swedish gymnastics was adopted by the Navy in 1903 and by the Army in 1906 which had physical training schools in Portsmouth and Aldershot respectively.⁸⁵

Like graduates of the RCIG, the graduates of the British physical training colleges had a strong professional identity. In 1899 a group of alumni founded the Ling Physical Education Association (Ling Association):

with the intention of placing physical education on a higher basis than before; of ultimately obtaining a registered list of those qualified to teach Swedish gymnastics and to give massage in a thoroughly trained manner.⁸⁶

As the quote above demonstrates, the remedial gymnast had a similar expertise to the physical therapist. As the following chapters will show, by the First World War there was a distinct overlap between the gymnast and the masseuse, which became the source of a turbulent professional relationship.⁸⁷ Linker's study identifies how physiotherapy in America grew out of physical education rather than nursing, further highlighting the gymnasts' expertise in rehabilitation.

⁸³ Sheila Fletcher, 'Österberg, Martina Sofia Helena Bergman (1849–1915)', *ODNB*, (Oxford University Press, 2004; Online edn., October 2007), [<http://www.oxforddnb.com/view/article/47656>, last accessed 13 Oct 2016].

⁸⁴ Fletcher, 'Österberg', *ODNB*.

⁸⁵ Allan Broman, 'The London Central Institute for Swedish Gymnastics, Physical Training College for Men Students', (c.1911) The National Archives (henceforth TNA), LAB 2/1505/AD/1426/2/1919.

⁸⁶ Ling Physical Education Association, 'Minutes of First Meeting.' (1899), in Bailey and Vamplew, *100 Years of Physical Education*, p.1.

⁸⁷ See negotiations that broke down during the war to apply for state registration, March-June 1917, see Chartered Society of Physiotherapy: Council Minutes, (16 March 1917-16 March 1918), Wellcome Library (henceforth WL), SA/CSP/B.1/1/12.

Physical education was a system whose aims and methods were based on sex segregation.⁸⁸ Sex segregation applied not only to practice - female gymnasts instructing female students - but also to the training of gymnasts. This principle became problematic because while female gymnasts were trained at the physical training colleges, training facilities for men were lacking. This meant that during the Edwardian period there was a notable shortage of male gymnastic instructors,⁸⁹ and often physical education teachers in boy's schools were ex-drill sergeants.⁹⁰

Medicalisation

As Cooter has observed, during the second half of the nineteenth century practices such as medical gymnastics, massage, mechanotherapy, electrotherapy and hydrotherapy were 'put upon a scientific basis and entered orthodox medicine as physiotherapeutic procedures'.⁹¹ This section explores how massage was worked into orthodox medicine and reformulated as a medical science and expertise. Scholarship on electro- and hydro- therapy has traced this process by looking at the texts of various actors as constructions. Morus has written that 'rather than thinking about such images as descriptions of actual mores or attitudes we should think of them as constructions, as active efforts to persuade others to regard themselves in a particular way'.⁹² Focusing

⁸⁸ Linker, *War's Waste*, p.70.

⁸⁹ Barclay, *In Good Hands*, p.8. The Board of Education issued a syllabus of Swedish gymnastics in 1909, but there was a dearth training institutions for men, many of whom had to train in Sweden. Allan Broman opened 'The London Central Institute for Swedish Gymnastics, Physical Training College for Men Students', in 1911, to train male gymnastics teachers, which was opened by physician Sir Thomas Lauder Brunton, in Broman, 'The London Central Institute for Swedish Gymnastics', TNA, LAB 2/1505/AD/1426/2/1919.

⁹⁰ Barclay, *In Good Hands*, p.8.

⁹¹ Cooter, *Surgery and Society*, p.20.

⁹² Iwan Morus, 'Bodily Disciplines and Disciplined Bodies: Instruments, Skills and Victorian Electrotherapeutics', *Social History of Medicine*, 19:2 (2006), 241-259, (p.245).

on a number of medical texts, this section examines some of the strategies used to transform the status of massage and justify its practice within medicine.

While carried through the spread of remedial gymnastics, from 1870 massage as a distinct practice began to receive attention from the medical community. The medicalisation of massage was a transatlantic discourse, many physicians across Europe and America were interested in the subject, and by 1890 British physician William Murrell noted that the literature 'is now so extensive that it is not possible [...] to refer to even a tithe of the able works and articles'.⁹³ Well-known 'authorities' in the subject included Austrian Joseph Schreiber (1835-1908), Swedish Emil Kleen (1847-1923) and Anders Wide (1854-1938), Americans Douglas Graham (1848-?), Silas Weir Mitchell (1829-1914) and John Harvey Kellogg (1852-1943), and British Herbert Tibbits (1838-1907), Thomas Stretch Dowse, William Playfair (1835-1903), Arthur Symons Eccles (1855-1900) and William Murrell (1853-1912). These men wrote texts to educate physicians in massage as a mode of treatment, in an age, as one text wrote, where '[t]he growing tendency of modern therapeutics' was 'to do away as far as possible with the use of drugs'.⁹⁴

The translation of massage into medical discourse, and the strategies used to do so, were directly linked to its historical status. In an address to the STM in 1902, British surgeon Sir William Bennett (1852-1931) reflected on the traditional 'rubber' in Britain:

⁹³ William Murrell, *Massotherapy, or, Massage as a Mode of Treatment*, 5th edn. (London: H.K.Lewis, 1890), p.15.

⁹⁴ Walter Mendelson, 'Preface to the American Edition', in Schreiber, *A Manual of Treatment*. Also see Herbert Tibbits, *Massage and Allied Methods of Treatment: An Abstract of Lectures delivered to Trained Nurses and Masseuses at School of Electricity and Massage, in Connection with the West-End Hospital for Diseases of the Nervous System*, 2nd edn. (London: Central Medical Book Stores, 1888), p.2, who wrote massage was 'what may be called the "local treatment" of disease, as distinguished from mere physic drinking'.

My first recollection of anything connected with Massage, or of those who practised it, was the old fashioned rubber, who was generally a woman, although there were also men rubbers [...] These women rubbers were very respectable people, rather portly in figure as a rule, strictly honest according to their lights, their main purpose seemed to be the rubbing away of knots in muscles, which were not apparent, and the dispersing of curious conditions of the veins, which were also of doubtful existence. In addition, they were much concerned in the removal of humours from all parts of the body, which lay more in the imagination of the rubber than in the person of the patient.⁹⁵

Traditionally the domain of lay practitioners called 'rubbers' or 'shampooers' who worked independently or in establishments such as 'Turkish baths', massage was generally accepted as a standard prescription for musculo-skeletal ailments such as stiff joints and muscles. Until the late-nineteenth century these practitioners did not seem to generate any significant medical resistance, primarily because their sphere of operations did not impinge on or threaten regular medical practice, and they provided a convenient place to refer inconvenient patients.

Bennett's description, however, also highlights aspects of the reputation of massage that were problematic for the adoption of massage into medical practice. Massage had strong associations as an empirical and unsystematised treatment, based on anecdotal evidence and non-orthodox notions of the human body 'more in the imagination of the rubber than in the person' who rubbed away conditions 'of doubtful existence'. Another problem was that the manual work of massage was a radical departure from traditional medical practice. As historians have shown, the medical elite professed intellectual rather than practical qualifications and based their identity upon 'scientific'

⁹⁵ William Bennett, 'Some Points Relating to Massage', delivered to the STM (21 March 1902), in Wicksteed, *The Growth of a Profession*, pp.19-20; also see William Bennett, 'Some Points Relating to Massage', *The Lancet* (3 May 1902), 1262-1263, (p.1262).

knowledge and skill.⁹⁶ 'Doing' massage not only threatened the intellectual status of the physician, but also his clinical performance. Manual work was time-consuming and threatened the income of the general practitioner who relied upon private practice. Not only were the practical aspects of manual work a problem. Roy Porter's work has shown that touch and intimate physical contact between doctors and patients had long been viewed with distaste and 'recognized as posing severe problems'.⁹⁷ In the late-nineteenth century, then, massage represented a radical departure from traditional medical practice, and neither appealed to the professional and economic interests of the majority of medical practitioners.

In order for practitioners interested in massage to exempt themselves from charges of empiricism and to market the practice to the medical community more widely, they had to present it as having transformed. One way of doing this was to present massage as a systematic treatment; indeed the word 'massage' itself, along with other terms such as 'medical rubbing' and 'massotherapeutics', were adopted in this period to differentiate it from 'shampooing' and 'rubbing'. Medical men defined massage as a technical field and used a new lexicon to describe its application. It was the Dutch physician Johan Metzger (1839-1909), who famously treated the Danish prince for a joint condition in the 1860s with massage, who first introduced the French terms 'effleurage', 'petrissage', 'tapotement' and 'friction' to classify techniques.⁹⁸ Advocates discussed massage in an increasingly technical way; for example, in

⁹⁶ Anne Marie Rafferty, *The Politics of Nursing Knowledge* (London: Routledge, 1996), p.60.

⁹⁷ Roy Porter, 'The Rise of the Physical Examination', in *Medicine and the Five Senses*, ed. by W.F. Bynum and Roy Porter (Cambridge: CUP, 1993), pp.179-198, (p.194).

⁹⁸ Busch, *General Orthopaedics*, p.42; Kleen, *Handbook of Massage*, pp.27-28; Murrell, *Massotherapeutics*, p.11; According to Murrell, Metzger did not produce any large work on the subject aside from a thesis in 1868, and his reputation rested upon his work with private patients which included Danish royalty. Also see Margaret Palmer, *Lessons on Massage* (London, Ballière, Tindall and Cox., 1901), p.3.

his 1887 work on massage American George Taylor wrote that, '[m]assage implies some source from which the pressure-motion is derived and involves the production of physiological consequence'.⁹⁹ Accounts of massage varied widely, however, and medical men defined the practice in a multitude of different ways. In his 1892 *A Primer of the Art of Massage (For Learners)*, British physician Thomas Stretch Dowse wrote that:

I speak of massage manipulations as "The application of sentient living matter to sentient living matter in divers ways, with varying degrees of energy, according to the resistances in the living tissues which have to be encountered and overcome." [...] The question of energy *versus* resistance is at the bottom of all massage manipulations.¹⁰⁰

Above all, medical advocates such as Murrell were anxious to stress, 'there is much more in it than at first sight appears. It is essential for success that the various processes should be carried out systematically'.¹⁰¹

The technical status of massage did not go unchallenged amongst the medical community, least of all in Britain. In 1883 the *BMJ* complained that 'rubbing', 'shampooing' and 'kneading the muscles' were basic 'survival practices associated with the use of baths with which we are all familiar', and the new terminology was unnecessary. The 'clumsy French word "massage,"' they continued:

has of late years acquired a place in our language to express these mechanical processes, and the still more objectionable terms "masseurs" and "masseuses" have been applied to the male and female operators respectively. The affection of foreign words will, it is

⁹⁹ George Taylor, *Massage: Principles and Practice of Remedial Treatment by Imparted Motion* (New York: John B. Alden, 1887), p.7.

¹⁰⁰ Thomas Stretch Dowse, *A Primer of the Art of Massage (For Learners)* (Bristol: John Wright & Co., 1892), pp.1-2.

¹⁰¹ William Murrell, 'Massage as a Therapeutic Agent', *BMJ* (15 May 1886), 926-927, (p.926).

to be feared, relegate to the category of vulgar expressions the good old English words rubbing and rubbers.¹⁰²

Criticisms were heard again in 1888 when the *BMJ* objected to the increasing use of 'French terms', writing that '[t]he multiplication of terms used in a technical sense by writers on massage is an evil'.¹⁰³ These complaints demonstrate that the medicalisation of massage was a contested process, and faced on-going resistance.

Alongside new terminology, massage was presented as a scientific and rational treatment. In contrast to lay practice that relied on anecdotal evidence and indiscriminate use, rational application, they argued, depended upon an orthodox understanding of the body, disease and physiological effects of massage. Massage became a subject of clinical studies and experimentation, which aimed at proving its rational basis. Most often cited in texts was the famous work of German 'Professor Von Mosengeil' whose 'accurate and painstaking experiments' placed massage on 'a sound scientific basis'.¹⁰⁴ According to Schreiber, it was Von Mosengeil who offered the first treatise on massage, 'physiologically considered', in 1876.¹⁰⁵ In his experiments, Von Mosengeil injected ink into the knee-joints of a number of rabbits, and while '[m]assage was performed at intervals on the right knee', the left was untouched. After twenty-four hours the animals were killed and dissected, showing 'that massage promoted absorption by the lymphatics'.¹⁰⁶

An important feature of experiments like Von Mosengeil's was that they offered a scientific explanation for treatments and effects long understood

¹⁰² 'Revived Therapeutic Agents', *BMJ* (13 October 1883), 732-733, (p.733).

¹⁰³ 'Reviews and Notices', 1050.

¹⁰⁴ Murrell, 'Massage as a Therapeutic Agent', 926.

¹⁰⁵ Schreiber, *A Manual of Treatment*, p.29.

¹⁰⁶ Murrell, *Massotherapy*, pp.78-79. But the majority of early works describe this experiment, see Schreiber, *A Manual of Treatment*, pp.42-43.

anecdotally. Experimental evidence was used to articulate the long-known effects of massage upon swelling and inflammation, muscular fatigue, circulation and temperature in scientific discourse. Many experiments took place across Europe and North America in this period. John Harvey Kellogg conducted research into massage from the 1870s in his 'physiological laboratory' at the Battle Creek Sanitarium.¹⁰⁷ He published results in his 1895 *The Art of Massage*, which linked his findings to 'numerous investigations by able physiologists for the purpose of determining with exactness the physiological effects of various procedures included under the general term *massage*, and thus obtaining a correct basis for their therapeutic use'.¹⁰⁸ 'These investigations', he argued, 'established beyond all possibility of question, that massage affords one of the most effective means of influencing the functions of the human body'.¹⁰⁹ British physician, massage advocate and experimenter, Arthur Symons Eccles (1854-1900) produced a number of works detailing the 'physiological effects and therapeutic uses' of massage.¹¹⁰ He detailed experiments including those by Professor of Massage at the University of Berlin, J.B Zabludowski 'on the muscles of an uninjured frog and on the forearms of human beings, showing the restorative effects of massage on fatigued muscles'.¹¹¹ Other investigations included those on temperature by Silas Weir

¹⁰⁷ John Harvey Kellogg, *The Art of Massage: its Physiological Effects and Therapeutic Applications*, (Battle Creek, Mich.: Modern Medicine Publishing, 1895), p.20.

¹⁰⁸ Kellogg, *The Art of Massage*, p.20.

¹⁰⁹ Kellogg, *The Art of Massage*, p.20.

¹¹⁰ Arthur Symons Eccles, 'The Physiological Effects of Massage', ([publisher not identified]: c.1899), pp.1-12; Arthur Symons Eccles, *The Practice of Massage: Its Physiological Effects and Therapeutic Uses* (London: Macmillan and Co., 1895); Arthur Symons Eccles, 'The Internal and External Temperature of the Human Body as Modified by Muscle- Kneading: With Sphygmographic and Sphygmonano-metric Records', *BMJ* (1 December 1888), 1211-1215.

¹¹¹ Symons Eccles, *The Practice of Massage*, p.44. Unsurprisingly in the context of the popularity of the Weir Mitchell rest cure, a lot of interest was directed towards the use of massage to treat fatigue and exhaustion, particularly in Britain and America, for examples see Douglas Graham, *Recent Developments in Massage: Historical, Physiological, Medical and Surgical*, 2nd edn. (Detroit, Michigan: George S. Davis, 1893), p.5; Thomas Stretch Dowse, *The Modern Treatment of Disease by the System of Massage: Three Lectures on this Subject*

Mitchell, on vascular nutrition by John Mitchell, on bodyweight by F. Gopadze and on circulation by Douglas Graham.¹¹² In 1894 British Thomas Lauder Brunton and F.W. Tunncliffe undertook experiments on rabbits and dogs to determine the effects of massage on blood pressure and circulation.¹¹³ Those interested in using massage frequently cited experiments such as these to support their claims that massage had a rational basis and could be used to treat a variety of medical and surgical conditions.¹¹⁴

Presenting a scientifically verified anatomical and physiological basis for massage was the aim of advocates who undertook experiments and described them in their texts. For these writers, defining massage as a medical science was a way of legitimising the practice and avoiding accusations of empiricism. Differentiating 'scientific' from empirical practice was a rhetorical strategy used by many writers for professional uplift. For example in 1889, British physician Thomas Stretch Dowse, who lectured and produced many texts on massage, clearly discerned this difference:

When people say that massage is as old if not older than any other form of treatment they are wrong. Medical rubbing and anointing with unguents and slapping and thumping the body, were (if we read the history of medicine) common modes of treatment; but we claim something more for massage than this: we say that massage consists of a series of movements classified and arranged in order to produce certain well-known physiological effects.¹¹⁵

Delivered at the West End Hospitals for Nervous Diseases, Paralysis, and Epilepsy, Welbeck Street, London (London: Griffith, Farren, Okeden & Welsh, 1887), pp.3-4. Information on Zabudowski from Graham, *Recent Developments in Massage*, p.38.

¹¹² Symons Eccles, 'The Physiological Effects of Massage', pp.1-12.

¹¹³ T. Lauder Brunton, and F.W. Tunncliffe, 'On the Effects of Kneading of Muscles upon the Circulation, Local and General', *Journal of Physiology* (15 December 1894), 364-377, (p.364). Also see Thomas Lauder Brunton, 'An Address on the Clinical Measurement of Diastolic Blood Pressure and Cardiac Strength', *BMJ* (5 November 1910), 1389-1393.

¹¹⁴ 'Reviews and Notices', 1050; The pattern in early massage texts was first to discuss the history of massage, its scientific basis and progress, and then give its therapeutic uses.

¹¹⁵ Thomas Stretch Dowse, *Lectures on Massage & Electricity in the Treatment of Disease, (Masso-Electrotherapeutics)* (Bristol: John Wright & Co., 1889), p.xi. For other writings by Stretch Dowse, see: Stretch Dowse, *The Modern Treatment of Disease by the System of Massage*; Stretch Dowse, *A Primer of the Art of Massage*; Thomas Stretch Dowse, *The Treatment of Disease by Physical Methods* (Bristol: John Wright & Co., 1898).

Likewise, British authority Murrell, whose popular *Massotherapeutics* had been published in five editions by 1890, argued that massage was 'a scientific method of treating disease by means of systematic manipulation', in contrast to 'medical rubbing' where the conditions 'essential to Massage are considered to be of no importance, and the operator simply rubs or pummels the patient, without any regard to the anatomical arrangement of the parts, and usually without any very definite object'.¹¹⁶ According to Murrell, 'there is as much difference between Massage and shampooing as there is between playing a difficult piece of music and striking the keys of the pianoforte at random'.¹¹⁷ Medical knowledge, he argued, was essential to undertake 'Massage', whereas for ordinary 'rubbing' and 'shampooing', only 'physical strength', 'endurance' and a 'certain knack' was necessary.¹¹⁸ Similarly, another British physician Abraham Colles complained to the *BMJ* in 1888 that lay practitioners were 'simply persons who would rub or knead you - for a consideration - but who knew nothing about massage proper'.¹¹⁹ 'It has been truly said', he continued, that "[t]here is as much difference between Metzger's massage and the so-called English massage, as there is between Champagne and gooseberry".¹²⁰

By elevating massage as a medical science, these medical men sought to legitimise its use to their medical peers, and claim ownership over the territory. The anxiety to define and differentiate scientific massage also suggests the stronghold of lay practitioners and the threat that their continued existence posed to medical interests. Writers sought to present massage as a

¹¹⁶ Murrell, *Massotherapeutics*, pp.17-18.

¹¹⁷ Murrell, *Massotherapeutics*, p.18.

¹¹⁸ Murrell, *Massotherapeutics*, p.18.

¹¹⁹ Abraham Colles, 'On Massage', *BMJ* (28 July 1888), 175-176, (p.175), it is a quote from, Murrell, *Massotherapeutics*, p.23.

¹²⁰ Colles, 'On Massage', 175.

powerful therapeutic that needed to be under the supervision of the medically trained. Writing in 1883 British obstetrician William Playfair warned that:

massage is a thoroughly scientific remedy based on good physiology and sound common sense, the value of which in properly stated cases, no one who knows anything of the matter can possibly question and which doubtless, when improperly applied, is capable of doing as much injury, as any other powerful treatment, such as mercury or opium.¹²¹

By presenting massage as ‘one of a number of therapeutic agents at the disposal of every physician’, writers aimed to normalise it as a regular mode of treatment.¹²² By emphasising the ‘incalculable harm’ that it could do in the hands of the ‘ignorant’, they attempted to marginalise lay practitioners.¹²³ In 1882 the founder of the London School of Massage, physician J. Fletcher Little, wrote that ‘[m]edical rubbing, when skilfully done, is one of the most effective and powerful remedies that we possess. If it is done by ignorant or untrained hands it is capable of doing immense injury’.¹²⁴

The scientific reformulation of massage, then, was a key part of appropriating the practice into British medicine. Its scientific basis served to divorce the practice from ‘empiricism’ and underpinned medical claims for control. Murrell for example, wrote that ‘if carried out under the direction of a scientific physician [...] it yields excellent results’ but ‘if allowed to drift into the hands of an ignorant empiric it soon degenerates into the most arrant quackery’.¹²⁵ For many writers, the troubled reputation of massage and the success of lay practitioners was partially down to the ignorance and prejudice of fellow medical men who refused to inform themselves of the therapeutic

¹²¹ William Playfair, ‘The Risks of “Massage”’, *BMJ* (30 June 1883), 1306-1307, (p.1306).

¹²² Murrell, *Massotherapy*, p.vi.

¹²³ Murrell, *Massotherapy*, p.vi.

¹²⁴ J. Fletcher Little, ‘Medical Rubbing’, *BMJ* (26 August 1882), 351.

¹²⁵ Murrell, *Massotherapy*, p.3.

potential of massage, and 'relegated' it to untrained personnel.¹²⁶ 'If the physiological effects of massage are to be rendered serviceable in the treatment of disease', Symons Eccles wrote, the practice 'must not be entrusted to the hands of unskilled and ignorant performers'.¹²⁷ Through medical science, these writers aimed to uplift the reputation of massage amongst their peers.

Scientific discourse was not the only strategy deployed by writers; these texts also used history to support their claims. The use of history writing as a tool for aspirant professional groups has been widely acknowledged by sociologists and historians. Historians Warwick Anderson, Myles Jackson, and Barbara Gutmann Rosenkrantz for example have explored the importance of 'invented history' for the specialty of immunology in America.¹²⁸ They argue that '[t]o position oneself at the end of history is no casual exercise it is a powerful (if unwitting) means of defining the boundaries of one's discipline, and of securing the legitimacy of one's knowledge'. Furthermore, they show that the construction of a narrative by those in power can become stabilised as the 'collective memory' of a discipline, protected against the diverse range of 'alternative histories'.¹²⁹ As many historians have demonstrated, the construction of a historical narrative was an important part of the process of medical professionalisation in the nineteenth century. Within this narrative, science, medicine and physicians were cast as heroes, fighting against quackery, empiricism and superstition.¹³⁰

Massage texts in the late-nineteenth and early-twentieth century often discussed the history of massage within this framework of progress and

¹²⁶ Murrell, *Massoherapeutics*, p.65.

¹²⁷ Symons Eccles, 'The Physiological Effects of Massage', p.12.

¹²⁸ Warwick Anderson, Myles Jackson, and Barbara Rosenkrantz, 'Toward an Unnatural History of Immunology', *Journal of the History of Biology*, 27:3 (Fall 1994), 575-594.

¹²⁹ Anderson, Jackson, and Rosenkrantz, 'Unnatural History of Immunology', 576.

¹³⁰ Ottoson, 'Manipulated History', 86.

enlightenment. These writers did not deny the ancient use of massage for therapeutic purposes. In his *Handbook of Massage*, Emil Kleen wrote that:

The History of Massage is certainly as old as that of man; since its technique is so simple, the indications for it, to some extent, so much a matter of every-day occurrence, its effects so obvious, that, even in the lowest stages of development, men instinctively resort to it, the more so as, in a double sense, it is always "at hand."¹³¹

Past practice, however, was dismissed as empirical and unscientific. As physician at the West-End Hospital for Diseases of the Nervous System, Paralysis and Epilepsy, Herbert Tibbits described in 1887:

Unscientific massage was practiced long ago. The Chinese used it. The Greek Fathers of Medicine advocated it to restore health to the sick. The Egyptians employed it [...] Next the Roman's adopted it: and after the fall of the Roman Empire, the Arabs, those inheritors of most of the ancient arts, kept it from oblivion, and so it descended to us.¹³²

Describing traditional massage practice as unscientific, 'primitive' or 'oriental', was another way that writers were able to distinguish themselves.¹³³

Writers not only used history to differentiate themselves in the present, but also to situate massage within the history of medical progress more broadly. Austrian Schreiber emphasised that massage had been used by a list of celebrated physicians: 'Hippocrates extended on a scientific basis the principles laid down by his master, [Herodicos] and his doctrines on bodily exercise were accepted by the most celebrated physicians of Greece and Rome, such as Antillos, Orisabius Asclepiades, Athenaeus, Celsus and Galen; the latter

¹³¹ Kleen, *Handbook of Massage*, p.19.

¹³² Herbert Tibbits, *Massage and its Applications: a Concluding Lecture delivered to Nurses and Masseuses, at the School of Electricity and Massage in Connection with the West-End Hospital for Diseases of the Nervous System, Paralysis, and Epilepsy, 73, Welbeck Street, London, W.* (London: Published at the School of Massage & Electricity, 1887), p.7.

¹³³ Murrell, *Massotherapy*, p.5.

teaching nine different kinds of massage'.¹³⁴ By linking massage to the history of medical enlightenment, these authors sought to vindicate massage and identify themselves as forward-thinking practitioners in a lineage of great figures. As Kleen proudly announced, '[i]t gives me especial pleasure to introduce to the reader a well-known and "highly esteemed colleague," from ancient Hellenic times no less a person than Hippocrates'.¹³⁵

While it was generally accepted that massage was a medical practice, whether medical men should undertake it themselves was a topic of debate. On the Continent where mechano-therapy had a higher status it was more common for medical practitioners to give manipulative treatment. According to Murrell, 'on the continent the physician or surgeon is usually his own operator, it being considered inexpedient to employ, even as an assistant, anyone who has not been thoroughly and systematically trained'.¹³⁶ Kleen argued that '[w]e must *everywhere* come to the point of providing instruction in mechano-therapy in our medical schools, and exacting the same guarantee for the physician's knowledge in this as in the other branches of medicine'.¹³⁷ For Kleen, it was the ignorance of the profession that was responsible for 'the numerous guild of charlatans' who practised massage with impunity beyond professional boundaries.¹³⁸

Not until the physicians themselves, *in corpore*, adopt massage, will it be found practicable for the public to secure as good treatment in mechano-therapy as in all other forms of treatment; and not till then shall we be able to exercise control over the work of others and to attack vigorously and uproot the ignorant, impudent, and dangerous

¹³⁴ Schreiber, *A Manual of Treatment*, p.19.

¹³⁵ Kleen, *Handbook of Massage*, p.20.

¹³⁶ Murrell, 'Massage as a Therapeutic Agent', 926.

¹³⁷ Kleen, *Handbook of Massage*, p.32.

¹³⁸ Kleen, *Handbook of Massage*, p.32.

practices which we denounce so often, and for whose existence we are largely to blame.¹³⁹

Similarly, in Britain, Symons Eccles encouraged physicians to be conversant with the practice. In many cases, he wrote, 'success will depend very greatly upon its performance by the physician himself; for it is almost impossible to convey correctly to another the duration, force, and extent of manipulation desirable in a given case for the production of a particular effect'.¹⁴⁰

It was, however, generally accepted that '[m]assage could never come into general use so long as its exercise depended solely on the medical man'.¹⁴¹ Describing why 'the world of scientific medicine' was unlikely to embrace massage, Kleen wrote that the labour-intensive practice was 'always more troublesome than writing prescriptions, and almost always less remunerative'. Furthermore, he argued '[v]ery many physicians are still so ignorant of mechano-therapy that they are alike unable to undertake it or teach it to others'. 'Finally', he wrote, 'there is a class of men in our profession affected with what I should call intellectual snobbery, who will, on general principles, have nothing to do with a method of treatment that calls for mechanical labour'.¹⁴² Likewise, Tibbits argued, it was 'not possible on account of time' for medical men to engage in massage treatment.¹⁴³ Economic interests, unfamiliarity with the mode of treatment, and prejudice, then, were all factors deterring medical practitioners from taking on massage themselves.

One way of avoiding these professional dilemmas was to pass the work onto others. The answer, wrote Colles in Britain, was for physicians to 'have the

¹³⁹ Kleen, *Handbook of Massage*, p.32.

¹⁴⁰ Symons Eccles, *The Practice of Massage*, pp.33-34.

¹⁴¹ Colles, 'On Massage', 175-176.

¹⁴² Kleen, *Handbook of Massage*, p.32.

¹⁴³ Tibbits, *Massage and Allied Methods of Treatment*, pp.v-vi.

assistance of skilled manipulators, who would faithfully carry out his directions in his absence, just as a good nurse did in her own province'.¹⁴⁴ For these writers, the division of labour was organised along a distinction between hand and brain, manual and intellectual work. Defining this clearly, Murrell wrote:

A Massotherapeutist, I take it, is one who studies the art and science of Massotherapy. He must know in what cases Massage is likely to do good, and should be able to give precise directions for carrying out the requisite manipulations. He need not of necessity be a practical *Masseur*, and the *Masseur* on the other hand may have no real knowledge of Massotherapeutics. There is the same difference between them as there is between a composer and an instrumentalist.¹⁴⁵

The scientific reformulation of massage, then, which underpinned medical claims to control over the treatment, also underpinned the division of labour between doctor and therapist. The division of labour was constructed to support the professional interests of medical practitioners. It offered a channel for devalued work while enabling the medical profession to harness and retain authority over a valuable therapeutic.

By the end of the century, then, massage had been translated into a medical science, a process that was prerequisite to its adoption into regular medical practice and composition as a division of labour. Implicit and explicit in these texts, however, was that this process was fiercely contested. While the use of massage and mechanical medicine was becoming routine on the Continent,¹⁴⁶ it was slower to be adopted in Britain. Nonetheless massage was gaining an increasing presence on the medical landscape and by 1888 Tibbits could write that '[r]egarded at first by the medical profession with aversion, it

¹⁴⁴ Colles, 'On Massage', 176.

¹⁴⁵ Murrell, *Massotherapeutics*, p.4.

¹⁴⁶ Roger Cooter, 'Bones of Contention? Orthodox Medicine and the Mystery of the Bone-Setters Craft', in *Medical Fringe and Medical Orthodoxy 1750–1850*, ed. by W. F. Bynum and Roy Porter (London: Croom Helm, 1987), pp.158-173, (p.163).

has gradually but surely made its way' with 'leading physicians and surgeons [...] amongst its warmest advocates'.¹⁴⁷

The Rest Cure and Massage in Britain

By the end of the 1880s massage was used in the treatment of a multitude of medical and surgical complaints, including writers' cramp, constipation, infantile paralysis, arthritis and a range of chronic deformities. It was, however, the introduction of the rest cure to Britain that brought massage most prominently into the medical and public spotlight. The rest cure was a treatment developed by American physiologist and physician Silas Weir Mitchell (1829-1914), 'as a means of restoring weight and energy to, and imposing "order and control" on neurasthenic patients'.¹⁴⁸ The treatment was variably received in different locations, and most notably promoted in Britain by London gynaecologist and obstetrician William Playfair (1835-1903). As historians have identified, medical accounts of neurasthenia and its treatment varied widely across the late-nineteenth and early-twentieth centuries.¹⁴⁹ In *The Age of Stress*, Mark Jackson argues, however, that there were a number of persistent themes including the prominence of fatigue as a pivotal symptom, and the perceived role that a combination of inherited instability, and external stresses and strains, had in triggering nervous exhaustion.¹⁵⁰

Neurasthenia and nervous exhaustion were believed to be a result of the worries, overwork and pace of modern civilisation, and by the end of the century it was a common diagnosis, especially amongst the middle and upper class.

¹⁴⁷ Tibbits, *Massage and Allied Methods of Treatment*, p.2.

¹⁴⁸ Mark Jackson, *The Age of Stress: Science and the Search for Stability* (Oxford: Oxford University Press, 2016), p.28.

¹⁴⁹ Jackson, *Age of Stress*, pp.24-37.

¹⁵⁰ Jackson, *Age of Stress*, p.30.

The work of Hilary Marland has shown that for Playfair in Britain, neurasthenia had powerful class and cultural dimensions and it was a condition that mainly 'affected ladies of standing and great delicacy of feeling'.¹⁵¹ According to Playfair, the neurasthenic was one 'whose nervous system, from some cause or other, shock, overwork, mental strain' had 'broken down, and who has thus become a complete invalid, and is incapable of fulfilling the ordinary duties of life'.¹⁵² Chiefly a 'disease of the cultured classes' and 'not found [...] in the patients of our large hospitals', Playfair's neurasthenic was a lucrative private case.¹⁵³ He noted that his patients suffered from an 'assemblage of symptoms',¹⁵⁴ including wasting, sleeplessness, hysteria, anaemia, loss of appetite and dyspepsia. He argued that neurasthenia had become endemic and that such 'invalids' had were 'widely scattered' across the country.¹⁵⁵ According to Playfair, neurasthenic patients frequently resisted conventional treatments and that medical men were 'in the habit of abandoning' cases in 'despair'.¹⁵⁶ It was amid a miscellany of treatments developed to treat neurasthenia, including radical surgical procedures such as the 'Battey's operation' and 'oöphorectomy' used for gynaecological and nervous disorders, that the rest cure emerged.

Although adapted by physicians in different ways, characteristically the rest cure was based upon a combination of rest, systematic feeding, passive exercise and seclusion.¹⁵⁷ The principal curative agent was rest, commonly a

¹⁵¹ Hilary Marland, "Uterine Mischief": W.S. Playfair and his neurasthenic patients', in *Cultures of Neurasthenia: from Beard to the First World War*, ed. by Marijke Gijswijt-Hofstra and Roy Porter (Amsterdam: Rodopi, 2001), pp.117-39, (pp.118-119).

¹⁵² W.S. Playfair, 'Some Observations Concerning What Is Called Neurasthenia', *BMJ* (6 November 1886), 853-855, (p.854).

¹⁵³ Playfair, 'Observations Concerning Neurasthenia', 854.

¹⁵⁴ Playfair, 'Observations Concerning Neurasthenia', 854.

¹⁵⁵ William Playfair, *The Systematic Treatment of Nerve Prostration and Hysteria* (London: Smith Elder & Co., 1883), pp.1-2.

¹⁵⁶ Playfair, *The Systematic Treatment of Nerve Prostration*, p.1.

¹⁵⁷ Silas Weir Mitchell, *Fat and Blood and How to Make Them* (Philadelphia: J.B. Lippincott & Co., 1877), p.7.

period of six weeks, which, combined with systematic feeding, aimed to renew the mental and physical vitality of the patient. Seclusion aimed to remove the patient from any 'unwholesome moral atmosphere'¹⁵⁸ and 'injudicious sympathy'¹⁵⁹ believed to reinforce symptoms.¹⁶⁰ 'Passive exercise' was the term used to denote massage and electricity, which facilitated prolonged bed rest. As Weir Mitchell himself noted, the originality of the rest cure was not the components themselves but rather in their combination and systematic application.¹⁶¹

In his work *Fat and Blood and How to Make Them*, Weir Mitchell dedicated a chapter to each of the individual components explaining their purpose and method. To introduce the chapter on massage he wrote '[h]ow to deprive rest of its evils is the title with which I might very well have labelled this chapter',¹⁶² demonstrating that he used massage to counter the negative effects of rest. As the work of Gert Brieger has shown, conservatism had a profound effect on medical and surgical thinking in the nineteenth century.¹⁶³ Conservatism emerged in the late-eighteenth century out of the teachings of John Hunter and was a reaction to 'heroic' medications and surgery.¹⁶⁴ Linked to conservatism was a belief in the healing power of nature, and the curative properties of agents such as fresh air, sunlight, rest and immobilisation. Rest and immobilisation were used to treat a range of conditions in this period including fractures, tuberculosis, deformity and nervous diseases, and was a

¹⁵⁸ Playfair, *The Systematic Treatment of Nerve Prostration*, p.14.

¹⁵⁹ Playfair, *The Systematic Treatment of Nerve Prostration*, p.15.

¹⁶⁰ Weir Mitchell, *Fat and Blood*, p.35.

¹⁶¹ Weir Mitchell, *Fat and Blood*, p.8.

¹⁶² Silas Weir Mitchell, *Fat and Blood: An Essay on the Treatment of Certain Forms of Neurasthenia and Hysteria*, 8th edn. (Philadelphia: J.B. Lippincott Company, 1902), p.80.

¹⁶³ Gert H. Brieger, 'From Conservative to Radical Surgery in Late Nineteenth-century America', in *Medical Theory, Surgical Practice*, ed. by Christopher Lawrence (London: Routledge, 1992), pp.216-231, (p.218).

¹⁶⁴ Cooter, *Surgery and Society*, p.20.

key feature of taking 'convalescence'. Medicine and surgery, however, were less well equipped to deal with the residual problems that prolonged rest produced and this was a key context in which massage developed.

In 1875, Weir Mitchell described the positive and negative effects of rest.¹⁶⁵ 'It is well to recall', he wrote, 'that in our attempts to help we may sometimes do harm, and we must make sure that in causing the largest share of good we do the least possible evil'.¹⁶⁶ Weir Mitchell observed that:

When we put the entire body at rest we create certain evils while doing some share of good, and it is therefore our part to use such means as shall, in every case, lessen and limit the ills we cannot wholly avoid.¹⁶⁷

He enjoined the profession to give this point 'the most thoughtful attention', because managing the side effects of rest was key to harnessing its full therapeutic potential.¹⁶⁸ In the case of prolonged bed rest, he wrote:

We are lessening the heart-beats some twenty a minute, nearly a third [...] we are causing the tardy blood to linger in the by-ways of the blood-round [...] rest in bed binds the bowels, and tends to destroy the desire to eat; and that muscles at rest too long get to be unhealthy and shrunken in substance. Bear these ills in mind, and be ready to meet them, and we shall have answered the hard question of how to help by rest without hurt to the patient.¹⁶⁹

It was with the aim to harness the therapeutic properties of rest that Weir Mitchell came to use physical therapy as part of his rest cure. 'The two aids', he

¹⁶⁵ Reference to: 'Rest in the Treatment of Nervous Disease', *Séguin's Series of American Clinical Lectures*, Vol. I. No. IV, (1975), in Weir Mitchell, *Fat and Blood*, 8th edn., pp.9-10.

¹⁶⁶ Weir Mitchell, *Fat and Blood*, 8th edn., p.73.

¹⁶⁷ 'Rest in the Treatment of Nervous Disease', p.74.

¹⁶⁸ 'Rest in the Treatment of Nervous Disease', p.75.

¹⁶⁹ 'Rest in the Treatment of Nervous Disease', p.77.

wrote, 'which by degrees I learnt to call up with confidence to enable time to rest without doing harm are massage and electricity'.¹⁷⁰

Weir Mitchell prescribed general massage each day. Massage was used to simulate physical exercise, to keep skin healthy and reduce muscular atrophy.¹⁷¹

The muscles are by these means exercised without the use of volition or the aid of the nervous centres, and at the same time the alternate grasp and relaxation of the manipulator's hands squeezes out the blood and allows it to flow back anew, thus healthfully exciting the vessels and increasing, mechanically, the flow of blood to the tissues which they feed. The visible results as regards the surface circulation are sufficiently obvious, and most remarkably so in persons who, besides being anaemic and thin, have been long unused to exercise.¹⁷²

Massage maintained the health of the body while exacting no physical or nervous exertion on the part of the patient. After a six-week period of rest and massage Weir Mitchell progressed patients to Swedish movements. 'I direct the rubber to spend half of the hour in exercising the limbs as preparation for walking. This is done after the Swedish plan, by making movements of flexion and extension, which the patient is taught to resist'.¹⁷³ While physical therapy was not the primary curative agent in the rest cure it was an essential component for its success. Weir Mitchell applied massage not only in the rest cure but to a range of conditions that were treated by rest including fractures and paralysis.

The rest cure was not the first time that Weir Mitchell had worked with massage; in fact he was considered by many to be an authority on the subject.

¹⁷⁰ Weir Mitchell, *Fat and Blood*, 8th edn., p.80.

¹⁷¹ Weir Mitchell, *Fat and Blood*, p.60.

¹⁷² Weir Mitchell, *Fat and Blood*, pp.60-61. For Playfair massage and electricity was essential for the assimilation of food and weight gain. See William Playfair, 'The Systematic Treatment of Aggravated Hysteria', *BMJ* (19 August 1882), 309-310, (p.310).

¹⁷³ Weir Mitchell, *Fat and Blood*, p.55.

He was described by Tibbits as the 'Father of Modern Massage';¹⁷⁴ wrote the introduction to the American edition of Kleen's 1892 *Handbook of Massage*,¹⁷⁵ and was frequently cited in texts for his work on massage, not only for the rest cure but also clinical experimentations, which included 'thermometric observations'.¹⁷⁶ Describing his first encounter with massage, Weir Mitchell wrote that he first observed its successful practice by a lay practitioner:

It is many years since I first saw in this city systematic massage used by a charlatan in a case of progressive paralysis. The temporary results he obtained were so remarkable that I began soon after to learn what I could of its employment and to train some of the nurses I had in charge of cases to make use of it. Somewhat later I employed it in the earlier cases which I treated by rest, and I very soon found that I had in it an agent little understood and of singular utility.¹⁷⁷

Weir Mitchell had the opportunity to develop his use of massage during the American Civil War in the 1860s, in which he was asked by the Surgeon General of the U.S. Army to head an army hospital for nerve injuries.¹⁷⁸ He presented his clinical findings at the U.S.A. Hospital for Injuries and Diseases of the Nervous System in his 1872 text *Injuries of Nerves and their Consequences*.¹⁷⁹ He explained that a specialist institution devoted to nerve injuries was unprecedented and a unique opportunity to advance medical and surgical treatment.¹⁸⁰ As was noted by Roth in 1860, at this time medicine and surgery experienced an unsettling degree of powerlessness in its ability to treat nerve injuries and paralysis and as these conditions were thought to be rarely

¹⁷⁴ Tibbits, *Massage and Allied Methods of Treatment*, p.5.

¹⁷⁵ Silas Weir Mitchell, 'Introduction to the American Edition', in Kleen, *Handbook of Massage*, preface.

¹⁷⁶ Douglas Graham, *Massage, Manual Treatment, Remedial Movements: History, Mode of Application and Effects; Indications and Contraindications*, 4th edn. (J.P.Lippincott, 1913), p.36.

¹⁷⁷ Weir Mitchell, *Fat and Blood*, pp.51-52.

¹⁷⁸ Silas Weir Mitchell, *Injuries of Nerves and their Consequences* (Philadelphia: J.B. Lippincott & Co. 1872), p.9.

¹⁷⁹ Weir Mitchell, *Injuries of Nerves*.

¹⁸⁰ Weir Mitchell, *Injuries of Nerves*, p.9.

amenable to hospital treatment very little was attempted for the majority of patients.¹⁸¹ In his work, Weir Mitchell described the treatments pioneered for nerve injuries at the hospital.¹⁸²

Among the cases received 'was a vast collection of wounds and contusions of the nerves, including all the rarest forms of nerve lesion of almost every great nerve in the human body'.¹⁸³ When nerves were damaged or severed, 'the muscles, thus set at rest, undergo atrophy, and, in some cases, shorten, while their sensibility to pain is lost, and the supply of blood diminishes, as it is sure to do in tissues which are no longer in a condition of functional activity'.¹⁸⁴ Whereas convention understood any form of treatment to be 'useless', 'until many months have elapsed and the nerve has had time to undergo a process of repair and reunion', Weir Mitchell and his colleagues developed a different approach.¹⁸⁵ Physical therapy, '[e]lectricity, in some form, manipulation, and alternate hot and cold douches' was used from the earliest date to relieve atrophy and muscular paralysis, on the grounds that it was wiser 'in all cases' to stimulate the muscle passively, 'rather than to leave it to itself'.¹⁸⁶ Massage and deep kneading was used daily and considered a valuable therapeutic tool:¹⁸⁷

For want of a better name I have here styled manipulation what is known as shampooing, rubbing, massage, etc. Its value in the treatment of all forms of traumatic, and, indeed, of some other palsies, is very great, and the results which I have seen obtained by

¹⁸¹ Roth, *Notes on the Movement-Cure*, p.10.

¹⁸² He wrote that there 'contains no complete treatise on injuries of nerves and the diseases consequent upon them' in English medical literature at this time, Weir Mitchell, *Injuries of Nerves*, p.9.

¹⁸³ Weir Mitchell, *Injuries of Nerves*, p.10.

¹⁸⁴ Weir Mitchell, *Injuries of Nerves*, p.245.

¹⁸⁵ Weir Mitchell, *Injuries of Nerves*, p.245.

¹⁸⁶ Weir Mitchell, *Injuries of Nerves*, pp.245.

¹⁸⁷ Weir Mitchell, *Injuries of Nerves*, p.245.

practiced rubbers were certainly to be gained by no other equally rapid treatment.¹⁸⁸

Using massage and physical therapy for nerve injuries and paralysis broke new ground and radically altered the prognosis for cases of nerve injuries. It became a principle adopted more broadly in medical and surgical practice.

Examining the reception of the rest cure in Britain offers insight into contemporary debates about massage, and the socio-medical context in which it was professionalised. Introduced by Playfair in May and June 1881, the rest cure was met with resistance from the British medical community. As Hilary Marland's study has shown, despite his efforts to popularise the treatment many of his colleagues were sceptical and none seem to have advocated it as enthusiastically as Playfair.¹⁸⁹ Reflecting in 1886, he wrote:

I had to undergo an amount of obloquy which was quite surprising. Some of my professional friends did not hesitate to tell me that I had descended to the level of a charlatan, and other criticisms were made on me which would have been amusing had they not been painful.¹⁹⁰

Criticisms of the treatment were based upon its use of physical therapy, and many refused to employ massage calling it 'quackery'.¹⁹¹ 'When my original paper was written', Playfair remarked, 'there were many members of the profession who were inclined to doubt the statements made in it, and who looked with suspicion on the methods employed as something heterodox, and so different from the old-established mode of medication as to be almost

¹⁸⁸ Weir Mitchell, *Injuries of Nerves*, p.249.

¹⁸⁹ Marland, "Uterine Mischief", p.122.

¹⁹⁰ William Playfair, 'Treatment by Massage', *The Lancet* (23 October 1886), 794-795, (p.794).

¹⁹¹ William Playfair, 'Further Notes on the Systematic Treatment of Nerve Prostration,' *The Lancet* (17 December 1881), 1029-1030, (p.1030), this is part two, also see *The Lancet* (10 December 1881).

reprehensible'.¹⁹² Like other contemporary advocates of massage, Playfair defended his use of the treatment arguing that 'quackery does not consist in the thing that is done, so much as in the spirit in which it is done':¹⁹³

That we should be debarred from the use of such potent therapeutic agents as shampooing, massage, or systematic muscular exercise, whichever we may choose to call it, or electricity, or hydrotherapeutics, and the like, because in unworthy hands they have been abused, seems to me almost worse than an absurdity.¹⁹⁴

For Playfair, massage was not quackery when applied rationally by a medical practitioner; the only 'true scientific position', he argued, was 'to rescue such means of treatment from abuse, and lay down rational rules for their employment'.¹⁹⁵

In association with the Weir Mitchell rest cure, however, the medical and social status of massage soon changed. As the rest cure was a high-profile treatment for the 'civilised' and 'cultured' classes, the reputation of massage was socially elevated. As the *BMJ* remarked in October 1883, massage had been 'put on a respectable footing, as a therapeutic agent, by the weighty authority of Dr. Weir Mitchell'.¹⁹⁶ Playfair noted that until 1881 when he introduced the rest cure to Britain massage was 'practically unknown in this country',¹⁹⁷ it rapidly gained ground, however, becoming a familiar and fashionable treatment. By 1883 physician Julius Althaus (1833-1900) observed that:

¹⁹² William Playfair, 'On the Limitations of the So-Called "Weir Mitchell Treatment"', *The Lancet*, (7 January 1888), 8-9, (p.8).

¹⁹³ Playfair, 'Further Notes', (17 December 1881), 1030.

¹⁹⁴ Playfair, 'Further Notes', (17 December 1881), 1030.

¹⁹⁵ Playfair, 'Further Notes', (17 December 1881), 1030.

¹⁹⁶ 'Revived Therapeutic Agents', 733.

¹⁹⁷ Playfair, 'Limitations', 8.

"Massage," which has for a long time been the Cinderella of therapeutics, has recently seen a considerable change in its fortunes, and become as thoroughly fashionable as mesmerism and homeopathy have been at previous periods in the history of medicine.¹⁹⁸

The boom for massage treatment evident in the 1880s and 1890s was directly linked to the introduction of the rest cure in Britain, As Playfair lamented in 1886, 'I feel that I am unwittingly in some degree responsible for this epidemic of massage'.¹⁹⁹ The rest cure was instrumental for the revival of massage in Britain and they were so closely associated in the public and medical imagination that some complained that 'it is often supposed that Dr. Weir Mitchell was the inventor or originator of massage'.²⁰⁰

The demand for massage engendered by the rest cure, however, was not limited to the rest cure. By raising the profile and status of massage, the rest cure sparked demand for massage as a treatment in and of itself. The craze for massage caused members of the medical profession to criticise that it was 'being indiscriminately applied'.²⁰¹ Julius Althaus, for example, complained to *The Lancet* in 1883 that, it is 'time that we should say, "Hands off!" lest a procedure - which does good in a limited class of cases should suffer by the excessive praises of injudicious partisans'.²⁰² Similarly Playfair wrote that he was 'anxious to avoid the imputation of riding a hobby too hard' and that widespread use would bring massage discredit:

If I may judge by numerous instances I have lately seen, massage now runs the risk of being employed in cases for which it is perfectly

¹⁹⁸ Julius Althaus, 'The Risks of Massage', *BMJ* (23 June 1883), 1223-1224, (p.1223).

¹⁹⁹ Playfair, 'Treatment by Massage', 795.

²⁰⁰ Murrell, *Massotherapy*, pp.175-176; also see, Douglas Graham, *A Treatise on Massage: its History, Mode of Application and Effects*, 2nd edn. (New York: J.H. Vail & Company, 1890), p.33.

²⁰¹ Althaus, 'The Risks of Massage', 1223.

²⁰² Althaus, 'The Risks of Massage', 1223.

unsuitable, and in which it can do nothing but harm. As a means of depriving rest, voluntary or enforced, of its evils it is invaluable; as a panacea for all the ills which flesh is heir to, like all such panacea, it is sure to lead to failure and disappointment.²⁰³

The demand led to it becoming a standard treatment for a range of therapeutic and cosmetic purposes.²⁰⁴

One consequence of the increasing demand for massage was a corresponding proliferation of practitioners. As the status of massage treatment was socially and medically elevated so was the reputation of massage as an occupation. As one letter to *The Lancet* observed, '[n]o newspaper appears without half a dozen advertisements about massage, schools for massage have been started, every hospital has one or two nurses or sisters who practise it, and massage threatens to become the prevailing medical fashion, if not the prevailing folly, of the day'.²⁰⁵ Increasingly 'massage', medically and socially reconstituted, was losing its associations with the 'old fashioned rubber' and became a fashionable occupation for ladies to undertake. As Playfair commented in 1888, 'it is quite astonishing to see the number of women who are seeking to earn a livelihood by practising it. I hear of them in shoals, and such a supply seems to indicate a great demand'.²⁰⁶ It was in this context of burgeoning demand for massage as a treatment and occupation that debates about massage expertise emerged.

²⁰³ William Playfair, 'Treatment by Massage', 795.

²⁰⁴ A search for 'massage' in the *BMJ* and *The Lancet* in this period returns thousands of results and highlights the broad range of applications massage was used for. For references to its cosmetic uses see, 'Profits of Flesh-Pounding: My Experiences as a Masseur', *Cassell's Weekly* (8 August, 1894); 'The Massage Scandals: Aristocratic Bagnios', *Reynolds Weekly* (12 August, 1894), Massage Scandal Press Cutting Album, WL, SA/CSP/P.1/1.

²⁰⁵ Playfair, 'Limitations', 8.

²⁰⁶ Playfair, 'Limitations', 8.

Massage Expertise

As noted earlier in this chapter, while massage as a division of labour was widely accepted by the medical community in Britain, the knowledge and expertise necessary to undertake the practice was a topic of debate. Examining this debate highlights how definitions of massage expertise were linked to understandings of massage and professional interests. In October 1886, senior physician to Westminster Hospital, Octavius Sturges (1833-1894), argued against the opinion of some who influenced by the Swedish understanding that the field of massage and gymnastics was a specialist expertise, believed that to learn massage required a prolonged period training. In contrast, he wrote, massage 'does not need two years to learn, nor two months, nor, with an apt scholar, two weeks'.²⁰⁷ By the end of the 1880s massage was used in many large hospitals and frequently practised by nurses who, as Sturges noted, learnt the skill in a few lessons. Sturges described massage as an art and trade as opposed to an intellectual occupation or profession, writing that 'as with other skilled exercise - as with fly-fishing and cricket and tennis', 'some pick it up very readily, even from the mere observation', while others 'can never learn massage at all'.²⁰⁸

Playfair agreed with Sturges opinion and wrote to *The Lancet* that when he first brought the rest cure to Britain in 1881, 'there was, so far as I knew, no such thing as a "masseur" in this country'.²⁰⁹ In order to obtain staff to give the treatment, he commented, he had to instruct a nurse himself with directions

²⁰⁷ Octavius Sturges, 'Treatment by Massage', *The Lancet*, (9 October 1886), 702-703, (p.703). For the full debate see: Octavius Sturges, 'Treatment by Massage', *The Lancet*, (9 October 1886), 702-703; William Murrell, 'Treatment by Massage', *The Lancet* (16 October 1886), 749-750; Thomas Easton, 'Treatment by Massage', *The Lancet* (16 October 1886), 750; William Playfair, 'Treatment by Massage', (23 October 1886), 794-795; Octavius Sturges, 'Treatment by Massage', *The Lancet* (23 October 1886), 795; William Murrell, 'Treatment by Massage', *The Lancet* (30 October 1886), 845.

²⁰⁸ Sturges, 'Treatment by Massage', (9 October 1886), 703.

²⁰⁹ Playfair, 'Treatment by Massage', 794.

given in Weir Mitchell's *Fat and Blood*. This nurse, he wrote, then 'taught another, in a few lessons only, and from this origin I have obtained a staff of competent masseuses sufficient for my own purposes'.²¹⁰ For Playfair massage was not a qualification, 'I have myself never seen massage employed and do not care how it is done', 'whether this is done by "pétrissage," or "effleurage," or anything else, is a matter of indifference to me'.²¹¹ Rather he judged massage by its results; if a patient was not improving, Playfair wrote, the masseuse 'knows very well I consider the fault hers, and that she will not be allowed to continue her work'.²¹² Playfair believed that massage was a matter of natural aptitude and skill rather than training and specialist expertise: 'no one who cannot learn the knack of massage sufficiently to start with in six lessons will learn it in two years or twenty, since the thing requires a natural aptitude which very few possess'.²¹³

The opinions expressed by Sturges and Playfair were common amongst medical practitioners and were linked to understandings of massage as a practical occupation akin to an art or trade rather than a professional, intellectual or technical qualification. Reinforcing this view was the opinion that massage was a harmless treatment. As Weir Mitchell put it, '[i]t is not, perhaps putting it too strongly to say that bad massage is better than none in those cases in which manipulation is needed. Very little harm can result from its use even by unskilled hands'.²¹⁴ The opinion that massage could do no harm and that 'any intelligent attendant' could be taught rubbing, meant that massage was often prescribed by medical men when they could do little else and was carried

²¹⁰ Playfair, 'Treatment by Massage', 794.

²¹¹ Playfair, 'Treatment by Massage', 795.

²¹² Playfair, 'Treatment by Massage', 795.

²¹³ Playfair, 'Treatment by Massage', 795.

²¹⁴ Weir Mitchell, *Fat and Blood*, 8th edn., p.107.

out by a range of personnel whose training was unspecified. While those with some medical training practised massage such as nurses and medical orderlies, it was not uncommon for medical practitioners to advise that a patient's family members or servants give them treatment.²¹⁵ The argument of these men was not that massage was unscientific but rather that the intellectual and practical aspects of treatment were two different responsibilities. For these practitioners it was the trained medical professional's carefully honed managerial and diagnostic skills that mattered rather than the application.

By emphasising that very little training was required for proficiency, doctors undermined its status as a profession. Writers such as Weir Mitchell, Playfair and Sturges criticised the 'professional rubber' and warned that specialist knowledge claims threatened to usurp the position and authority of the medical man. As Sturges warned, assertions that massage was a specialist expertise would lead massage to 'ultimately fall into the hands of a few "professors," who will make of it a "speciality"'.²¹⁶ According to Playfair, specialist 'rubbers' were too 'presuming' of their knowledge and challenged conventional doctor - auxiliary professional relations: '[t]he so-called professional rubbers of whom I have tried several [...] have their own preconceived notions, which it is impossible to break them of, and they are unwilling, so far as my experience goes, to learn afresh'.²¹⁷ Similarly Weir Mitchell wrote that it was the 'professional rubber' who was partly responsible for the 'great deal of nonsense [...] talked and written as to the use and the usefulness of massage'.²¹⁸ Professional rubbers had 'not unnaturally' made a

²¹⁵ Weir Mitchell, *Injuries of Nerves*, p.250, 272; Bernard Roth, 'The Early Treatment of Flat-Foot', *BMJ* (18 November 1882), 989.

²¹⁶ Sturges, 'Treatment by Massage', (9 October 1886), 703.

²¹⁷ Playfair, 'Further Notes', (17 December 1881), 1030.

²¹⁸ Weir Mitchell, *Fat and Blood*, 8th edn., p.106.

'mystery' of massage, he argued, for their own professional interest.²¹⁹ For these men, claims that massage was a specialist field of expertise and profession in and of itself threatened their diagnostic authority and their assertion that massage was a division of labour for them to manage. It was a professional strategy to uphold the position of the medical practitioner.

While practitioners agreed that an extended technical training was unnecessary, opinion as to what skills and qualities were necessary for the massage operator were varied. While Sturges noted that nurses were considered good massage personnel, Playfair and Weir Mitchell both agreed that employing a nurse who did not devote all her time to massage was not the best option. They believed, in contrast, that the best massage workers dedicated their time to massage alone. For example, in Weir Mitchell's opinion 'no one could use massage well who was not continually engaged in doing it'.²²⁰ Similarly, Playfair wrote, 'it requires an amount of physical strength, combined with a certain knack, which many otherwise excellent nurses are entirely deficient in'. 'Moreover', he added, 'the nurse has so much to do in other ways, that to carry out the massage properly requires from her an amount of work that it is really unfair to exact'.²²¹ For these men, more important than a medical or technical training were qualities such as '[k]indness', 'firmness', 'physical strength', 'a certain knack', 'a strong, warm, soft hand' and 'ordinary intelligence'.²²²

The division of labour articulated by these medical men was highly gendered. This was partly because the revival of massage in Britain was closely

²¹⁹ Weir Mitchell, *Fat and Blood*, 8th edn., p.106.

²²⁰ Weir Mitchell, *Fat and Blood*, 8th edn., p.81.

²²¹ Playfair, 'Further Notes', (17 December 1881), 1030.

²²² Playfair, 'Further Notes', (17 December 1881), 1029-1030; Weir Mitchell, *Fat and Blood*, 8th edn., pp.106-107.

associated with the rest cure and the use of nurses to massage female patients in this treatment. It was also because of a gendering of skills more broadly in society whereby a distinction between hand and brain, manual and intellectual work, organised male and female roles. For Tibbits, who organised classes in the rudiments of massage and electrotherapy at his West-End School of Massage and Electricity, massage was best suited to 'educated women, possessing some aptitude for nursing'.²²³ He considered that 'for its most perfect application, the qualities possessed by women rather than the qualities possessed by men are required; the *sensitive* rather than the *strong* hand, and patience, kindness, tact and sympathy'.²²⁴ Women were also thought to be able to better understand their role as an auxiliary than men. As Playfair wrote, women needed only enough education to 'appreciate and second the object of the medical attendant'.²²⁵ Playfair considered class just as important as intelligence for the masseuse. This was particularly the case as a large portion of clientele were middle and upper class women, 'it is obvious', he wrote, 'that a vulgar, underbred woman, even if sufficiently intelligent, is likely to do harm to a class of patients who are often of high culture and refinement'.²²⁶

Standing in contrast to these medical men, however, was another view that considered massage a profession and both technical and scientific training to be essential qualifications. They based their argument upon a distinction between the type of general massage used for the rest cure treatment and what they understood as 'scientific' massage. In response to Sturges and Playfair's

²²³ Tibbits, *Massage and its Applications*, p.5.

²²⁴ Tibbits, *Massage and its Applications*, p.11.

²²⁵ Playfair, 'Further Notes', (17 December 1881), 1029.

²²⁶ Playfair, 'Further Notes', (17 December 1881), 1029.

correspondence in *The Lancet*, William Murrell wrote that these men made ‘the curious error of confounding massage with the Weir Mitchell treatment’:²²⁷

Shampooing or medical rubbing, which is very useful in its way, can be acquired by anyone “in a few lessons,” but the true massage, as practiced by Professor Von Mosengeil and others on the Continent, depending as it does on a knowledge of anatomy and physiology, certainly cannot be mastered in less than two years.²²⁸

Professional masseur Thomas Easton also wrote in complaining that ‘[t]he whole system of massage and manual treatment is of very much wider area than that covered by Dr. Weir Mitchell’s method’ and argued that ‘it seems utterly unreasonable that a method of treatment which requires delicate manipulations of different kinds, and a considerable knowledge of physiology and anatomy, can be sufficiently acquired in a week’.²²⁹ In order to undertake ‘proper’ massage, then, an amount of medical knowledge and technical training were essential. As Murrell summed up, ‘we cannot take John from the stable, or Biddy from the wash tub, and in one easy lesson convert either into a safe, reliable, or efficient manipulator. Massage is an art, and, as such, must be acquired by study and patient practice under competent guidance’.²³⁰

For these men, invested within the notion of massage as an expertise was its status as a scientifically based treatment, on which their own specialist interests were based. As demonstrated earlier in this chapter, claims that massage treatment required scientific and technical knowledge enabled those interested in professionalising massage to differentiate themselves from ordinary lay practitioners. Easton wrote that, unless ‘we have careful observers and trained manipulators [...] the practise itself will fall into the region of

²²⁷ Murrell, ‘Treatment by Massage’, (16 October 1886), 749.

²²⁸ Murrell, ‘Treatment by Massage’, (16 October 1886), 750.

²²⁹ Easton, ‘Treatment by Massage’, (16 October 1886), 750.

²³⁰ Murrell, *Massotherapy*, p.65.

empiricism and quackery'.²³¹ Similarly, without training to regulate its use, Abraham Colles complained that massage was becoming 'a system of treatment under which a fresh body of charlatans seemed to take refuge'. He blamed the ignorance of his peers for allowing the untrained rubber to flourish: 'much of the success of these quacks being due to the apathy of orthodox practitioners on the subject'.²³²

Defining massage as a field of expertise, and the operator as an expert, however, did not necessarily mean relinquishing massage as a division of labour. In contrast to Weir Mitchell and Playfair who believed that increased expertise led workers to be more presuming and usurp the authority of the medical practitioner, Murrell argued that training was essential in order for the operator to obey 'the instructions of the physician intelligently'.²³³ Ultimately for both parties, the definition of skills and knowledge was linked to professional interests and exerting authority over the practice and the practitioner.

Concluding the debate of October 1888, Sturges wrote that he had not 'confounded' Weir Mitchellism with 'scientific' massage. Rather, he pointed out, Weir Mitchell-style massage was the only type of massage to be practised in Britain:

there is no other form of massage whatever which has taken root or is commonly practised in this country, save and except that which Dr Weir Mitchell describes. For years that method and that method only, has been largely employed in our hospitals and nursing establishments, and always under the name of massage.²³⁴

This demonstrates that understandings of massage as a practice and a profession were highly varied and closely associated with the rest cure in Britain

²³¹ Easton, 'Treatment by Massage', (16 October 1886), 750.

²³² Colles, 'On Massage', 175.

²³³ Murrell, *Masso-therapeutics*, p.63.

²³⁴ Sturges, 'Treatment by Massage', (23 October 1886), 795.

during the 1880s and 1890s. Fiercely contested, the qualifications and expertise of the massage operator was a site of a number of competing professional interests.

Conclusion

By the 1890s massage was a burgeoning medical practice and the latest therapeutic 'fashion' in Britain. The revival in massage was not unique to Britain; this chapter has shown that it was part of a broader international interest in the field of mechanical therapy, including massage, gymnastics and mechano-therapy, which was fuelled by a movement of Swedish gymnastics. In order for massage to be adopted into medical practice it first had to be translated into the language of science and medical orthodoxy. This chapter has shown how medical men claimed ownership of massage – an ancient and traditionally lay practice – through their writings. The medicalisation of massage was a key process that underpinned all further developments of massage within medicine, including the division of labour. This chapter has shown that the adoption of massage into medicine was driven by shortcomings within conventional practices such as prolonged rest and immobilisation and that massage enabled medicine and surgery to advance in areas in which it was weak, for example in the treatment of conditions such as paralysis and nerve injuries.

While part of a wider phenomenon the revival of massage in Britain was also unique. This chapter has shown that the introduction of the Weir Mitchell rest cure to Britain was pivotal for the growth of massage as a practice and occupation in the 1880s and 1890s. It raised the social and medical status of massage and inherently shaped understandings of expertise. Debates about massage highlighted throughout this chapter show that it was a contested

territory and the site of a number of competing interests. This was the context in which the professionalisation of massage took place in the mid-1890s. Chapter 2 moves on to explore how nurses engaged in this debate and the way in which the new medical status of massage offered an opportunity for professional advancement.

Chapter 2

The 1894 'Massage Scandals' and the Society of Trained Masseuses

It is exceedingly hard for the respectable and competent masseuse that the innocent term massage should be taken to cloak a vile trade; it is also hard on the trained nurse to have to discard her out-door uniform because disreputable women chose to masquerade as nurses. Let us hope there will some time be an end to both these abuses.¹

The revival in massage in late-nineteenth century Britain stimulated a rise in the number of practitioners, massage houses and training schools, and exposed a new therapeutic encounter without clear guidelines or professional boundaries. Amid late-Victorian anxiety to police social purity, the use of massage parlours as a disguise for brothels brought the practice into the public spotlight in the 1894 'massage scandals'. It was in this context that the regulation of massage became a matter of social, moral and medical importance. This chapter explores how massage practice was contested ethically and professionally and intersected a number of socio-cultural and professional interests. It examines the ways in which these broader forces stimulated and shaped the professionalisation of massage by the Society of Trained Masseuses (STM) in 1895.

To investigate these issues, this chapter focuses on three areas. First it traces the context in which massage parlours became an expedient disguise for brothels. It then explores the 1894 massage scandals in order to examine why and how massage was contested ethically and professionally. Lastly it considers the ways in which the formation of the STM in 1895 was stimulated and shaped by these socio-cultural and medical concerns. Using reports from

¹ 'Massage Notes', *Nursing Notes* (henceforth *NM*) (November 1898), 155.

the metropolitan police, the *BMJ*'s 'massage scandal' articles and media reactions, as well as records from the STM, this chapter aims to reconstruct some of the discourses bearing upon the professionalisation of massage in 1895. It argues that this professional project was the product of a negotiation of intimacy and professional interests. As a case study it offers an opportunity to examine how socio-cultural discourses impacted female professional projects in the late-Victorian period and the contingent nature of professionalisation.

Disguising Prostitution

As Chapter 1 indicated, by the end of the nineteenth century massage had become a regular medical treatment. It was also used, however, for a range of recreational, sporting and cosmetic reasons for which the market was the wealthy classes. As one 'Masseur' wrote for the *Cassells Weekly* in 1894, 'I know a great number of society men and women who undergo massage for the purpose of removing wrinkles; and many ladies will even visit a masseuse before every important ball, in order that they may be fortified against the excitement and fatigue'.² 'On the other hand', he continued:

Some people undergo the treatment for pleasure only - that is to say, they become accustomed to, and are willing to pay for, the glorious feeling of exhilaration which follows it. In this connection it may be mentioned that I myself have attended a wealthy banker (massage is practically unknown among the lower classes) for over three years, though he had no ailment whatever. Again, one of our leading masseurs has operated daily upon the person of a certain noble earl for more than eighteen years, yet he is one of the healthiest men alive.³

² 'Profits of Flesh-Pounding', *Cassells Weekly* (8 August 1894), Wellcome Library (henceforth WL), SA/CSP/P.1/1. Clippings from some of the local, tabloid and foreign newspapers were collected together in a scrapbook, perhaps by one of the founding members of the STM, which is now kept at WL, SA/CSP/P.1/1-2, (SA/CSP/P.1/1, represents the scrapbook; SA/CSP/P.1/2, represents other articles collected kept separately and not in scrapbook form), page numbers are referenced when known.

³ 'Profits of Flesh-Pounding', WL, SA/CSP/P.1/1.

He listed treating 'professional oarsmen', footballers, gymnasts and jockeys before a 'big event', and that the 'Princess of Wales, Lady Burton, Lady Decies, and many well-known personages have expert masseuses always resident with them'.⁴ Combined with its new 'scientific' status, its reputation as a popular treatment with the upper and aristocratic classes significantly boosted its social status and professional interest in its use.

As its reputation improved it became an attractive career opportunity. Contemporary socialite Lady Janetta Manners, who wrote an article on massage in the popular *Nineteenth Century* magazine in December 1886, was often cited as enhancing its popularity and reputation.⁵ Describing it as a 'healing art' she wrote that:

Women might, after being properly instructed, find the practice of massage a useful and profitable employment [...] would gladly practise this healing art for moderate remuneration, and find much happiness in soothing pain and relieving weariness.⁶

While both men and women became practitioners in the late-nineteenth century, increasing numbers of middle-class women seeking employment chose to take it up. As historians have shown, expanding employment opportunities for women provided entry into the public arena from which they had formerly

⁴ 'Profits of Flesh-Pounding', WL, SA/CSP/P.1/1.

⁵ For a positive view of Manners' influence see, T.S. Dowse, *The Modern Treatment of Disease by the System of Massage: Three Lectures on this Subject Delivered at the West End Hospitals for Nervous Diseases, Paralysis, and Epilepsy, Welbeck Street, London* (London: Griffith, Farren, Okeden & Welsh, 1887), p. vii-viii. For a negative view of her influence, see Anon., *Astounding Revelations Concerning Supposed Massage Houses or Pandemoniums of Vice, Frequented by Both Sexes, Being a Complete Exposé of the Ways of Professed Masseurs and Masseuses* (London: T Skeats, 1894), WL, SA/CSP/P.1/2, p.4.

⁶ Janetta Manners, *Nineteenth Century*, (December 1886), in Jean Barclay, *In Good Hands: The History of the Chartered Society of Physiotherapy 1894-1994* (Oxford: Butterworth-Heinemann Ltd, 1994), p.14.

been excluded.⁷ Martha Vicinus has shown that by the end of the nineteenth century a generation of 'new women' passionately sought meaningful employment and to gain respect for their work.⁸ Remedial gymnasts, taught at the Lingian physical training colleges (discussed in the previous chapter), and masseuses are two examples of assertive female professional groups that fit into this trend.

While massage offered paid employment for many it was also taken up by a number of well-to-do women who were able to give their services voluntarily.⁹ In a lecture to the STM in 1902, surgeon at St George's hospital Sir William Bennett described that:

A good deal of enthusiasm was excited among the public generally in the matter [...] indeed, it became at one time almost a matter of honour for any lady of position in society to have a course in massage, and to be visited by her masseur or masseuse, generally once in the day before she commenced her other occupations [...] Hence people began to crowd into this calling with extraordinary avidity.¹⁰

As one massage school, the Harley Institute of Swedish Massage, wrote in its prospectus, 'a really clever masseur or masseuse is always in demand' and 'as the treatment incurs little or no exertion on the patient's part and often gives relief from the commencement, it is one that appeals to the wealthier class of

⁷ Martha Vicinus, *Independent Women: Work & Community for Single Women, 1850-1920* (Chicago; London: University of Chicago Press, 1985); Lucy Bland, *Banishing the Beast: Feminism, Sex and Morality* (London: Tauris Parke, 2001); Lucy Bland 'Feminist Vigilantes of Late-Victorian England', in *Regulating Womanhood: Historical Essays on Marriage, Motherhood, and Sexuality*, ed. by Carol Smart (London: Routledge, 1992), pp.33-52; Judith Walkowitz, *City of Dreadful Delight: Narratives of Sexual Danger in Late-Victorian London* (Chicago: University of Chicago Press, 1992).

⁸ Vicinus, *Independent Women*, pp.1-2.

⁹ William Bennett, 'Some Points Relating to Massage', *The Lancet* (3 May 1902), 1262-1263, (p.1262).

¹⁰ William Bennett, 'Some Points Relating to Massage', speech delivered to the ISTM, Strand, London (21 March, 1902), in Jane H. Wicksteed, *The Growth of a Profession: Being the History of the Chartered Society of Physiotherapy, 1894-1945* (London: Edward Arnold & Co., 1948), p.22.

patients, and a medical specialist or doctor in a high class practice can always be relied upon for cases'.¹¹

The burgeoning popularity of massage led to anxieties that it was serving as a front for prostitution. While associations between massage, bathing, and prostitution were historic, they were heightened in the context of campaigns and legislation to eradicate brothel keeping and soliciting in the late-nineteenth century. As Stefan Petrow's work has shown, there was widespread concern to regulate morality in this period.¹² The perceived rising levels of drunkenness, prostitution and crime among the 'urban residuum' were viewed as national concerns and captured the public imagination. Anxieties gave rise to increasingly interventionist strategies, from legislation and policing to social purity pressure groups. Sexual morality in particular was a highly politicised topic and subject to increasing scrutiny. The 1885 Criminal Law Amendment Act that raised the age of consent from thirteen to sixteen also outlawed brothel keeping and the procurement of women for prostitution. Prosecutions increased significantly: while from 1875-1885 an average of 86 brothels were prosecuted in England and Wales each year, in the years between 1885-1914 the average number rose to more than 1,200.¹³

As Petrow has argued, rather than eradicating prostitution, however, the Act had the effect of driving many to operate underground where they 'disguised their true purposes and made it less easy for police or private watchers to obtain evidence against them'.¹⁴ Such 'disguises' included

¹¹ 'Harley Institute School of Swedish Massage and Medical Electricity', (c.1912-1914), pp.1-12, Harley Institute, School of Swedish Exercises, WL, SA/CSP/P.1/3, p.9.

¹² Stefan Petrow, *Policing Morals: The Metropolitan Police and Home Office 1870-1914* (Oxford: Clarendon Press, 1994), p.3.

¹³ Bland, *Banishing the Beast*, p.101.

¹⁴ Petrow, *Policing Morals*, p.154.

manicure, chiropody, bathing and massage establishments.¹⁵ The 'massage parlour' increasingly attracted complaints from the 1890s and Petrow argues that 'few people doubted that most massage parlours were brothels or that 'the nurses' were prostitutes':¹⁶

Parlour proprietors camouflaged their activities by catering for many 'respectable people really in need of a massage'. Distinguishing genuine massage parlours from others was therefore difficult.¹⁷

The records of the Metropolitan Police show that the 'massage parlour' question continually troubled the police throughout the late-nineteenth and early-twentieth centuries.¹⁸ They suggest that while the police had increased authority to prosecute brothels they felt powerless in other ways. For example, because publically they disguised their activities, police found it difficult to obtain evidence against them and it was considered inappropriate for police officers to gather evidence through undercover investigations. As one report wrote 'it is not a duty which should be undertaken by the Police':

[i]t is extremely improbable that the Police could obtain any adequate evidence without playing the part of agents provocateurs by endeavouring to entrap the inmates into impropriety; as even at the worst of these houses a man would probably receive only legitimate massage treatment unless he made overtures to the female operators.¹⁹

Police dossiers on massage establishments in this period, however, contain numerous complaints and investigations from the public. They show that women working in these establishments often presented themselves as nurses.

¹⁵ Petrow, *Policing Morals*, p.155.

¹⁶ Petrow, *Policing Morals*, p.154.

¹⁷ Petrow, *Policing Morals*, p.154.

¹⁸ 'Disorderly Houses: Massage Establishments', (1895-1915), The National Archives, (henceforth TNA), MEPO 2/460.

¹⁹ 'Report 16122', (c.1897), TNA, MEPO 2/460.

One report wrote that: 'the women seen to attend at the various addresses bear little resemblance to trained nurses although they are advertised as such', dressing 'themselves in this manner in order to deceive the unwary'.²⁰

Conducting private investigations and 'watching' brothels became a prominent mission of social purity campaigners, vigilance committees and church vestries in the late-nineteenth century. The National Vigilance Association (NVA) was an organisation set up by social purists to ensure the enforcement of the Criminal Law Amendment Act of 1885.²¹ Committed to 'the enforcement and improvement of the laws for the repression of criminal vice and public immorality',²² the NVA and social purists were increasingly concerned that action should be taken against massage establishments. As one letter from the 'social purity department' of The National British Women's Temperance Association wrote, 'we are feeling extremely anxious about the matter. It is a new and horrible force of vice, because done under cloak of a legitimate object'. 'Begging' for the 'help and sympathy' of the Police, they complained that massage disguised 'a new development of prostitution' and was a 'refinement of cruelty', noting 'the number of young girls' who came to them for assistance.²³ It was amid these broader socio-cultural anxieties that the 1894 'massage scandals' erupted.

²⁰ 'Report - Pelican Advertisements', (9 December 1912), TNA, MEPO 2/460.

²¹ Bland, 'Feminist Vigilantes', p.37.

²² <http://discovery.nationalarchives.gov.uk/details/rd/b2aa2b6c-d248-48d1-9787-d3acca2a38e9> last accessed 20/5/17.

²³ 'Letter to Edward Bradford, from The National British Women's Temperance Association', (30 April 1897), TNA, MEPO 2/460.

The Massage Scandals

The massage scandals offer a means to investigate the ways in which massage was conceptualised and contested ethically and professionally in the late-nineteenth century. Articles published both by the *BMJ* and the national press offer insights into the beliefs and concerns that motivated the actions of those who sought to regulate and professionalise massage. Initiating the scandal on 14 June 1894 in an article entitled 'Immoral "Massage" Establishments', the *BMJ* wrote that, '[w]e understand that a good many "massage shops," the advertisements of which are frequently inserted in one or two of the fashionable daily papers, are very little more than houses of accommodation'.²⁴ Responding to a request that a register be established 'for those who have gone through a proper course of instruction in massage', the *BMJ* stated that this could not be done. This was because 'in many cases', they argued, the recognition of a certificate 'would mean neither more nor less than a recognition of prostitution'.²⁵ Subsequently, the journal produced a four-part report of investigations into massage establishments undertaken by their 'Special Commissioners'. The story captured the public imagination and was further taken up by tabloid newspapers throughout Britain.

For the *BMJ* the massage scandal was not only a social and moral issue, but also one in which a number of professional interests were also embedded. 'That under the cloak of a useful form of medical treatment the grossest immorality should be practised', they wrote, was not only a matter of 'public

²⁴ 'Immoral "Massage" Establishments', *BMJ* (14 July 1894), 88. The *BMJ*'s 1894 massage scandal consisted of seven articles investigated in this Chapter, 'Immoral "Massage" Establishments', *BMJ* (14 July 1894), 88; 'Immoral Massage', *BMJ* (21 July 1894), 145-146; 'Immoral "Massage" Establishments', *BMJ* (21 July 1894), 148; 'The Scandals of Massage', *BMJ* (3 November 1894), 1003-1004; 'The Scandals of Massage II', *BMJ* (10 November 1894), 1069-1070; 'The Scandals of Massage III', *BMJ* (17 November 1894), 1140-1141; 'The Scandals of Massage IV', *BMJ* (24 November 1894), 1199-1201.

²⁵ 'Immoral "Massage" Establishments', (14 July 1894), 88.

importance well worthy of the attention of our police and our magistrates', but there was also 'a professional and medical side to this question of massage to which it is our duty to refer'.²⁶ The massage scandal was part of a broader concern to police the boundaries of the medical profession. It sought to regulate those 'who thus abuse the pretence of medical treatment', whether that be for 'immoral' purposes or as irregular practitioners. At stake was the 'injury' to the legitimate practice of massage, which was becoming increasingly valuable to British medicine.²⁷ While they called for action by the Home Office and Police to repress 'immoral massage establishments', to deal with the root of the problem they also sought to 'draw a sharp dividing line between the sheep and the goats, between those who merely make a cloak of massage and those who practise it honestly as a means of cure'.²⁸

This was not the first time the *BMJ* had published on a controversial topic and the massage scandal is inseparable from the *BMJ*'s wider involvement in a number of different socio-medical topics. As the official organ of the British Medical Association (BMA), the *BMJ* was a platform for medical practitioners to debate their collective identity and the future of medical orthodoxy and an instrument to promote the status and reputation of the profession.²⁹ Surgeon Ernest Hart (1835-1898) assumed editorship of the *BMJ* in January 1867, a position he held for over thirty years,³⁰ and was appointed chairman of the BMA's Parliamentary Bills Committee in 1872.³¹ Peter Bartrip argues that Hart

²⁶ 'Immoral Massage', (21 July 1894), 145.

²⁷ 'The Scandals of Massage IV', 1200.

²⁸ 'Immoral Massage', (21 July 1894), 145.

²⁹ By the Edwardian period the BMA represented approximately 40 percent of the thirty-five to forty thousand practitioners on the Medical Register. See Roger Cooter, 'The Rise and Decline of the Medical Member: Doctors and Parliament in Edwardian and Interwar Britain', *Bull. Hist. Med.*, 78 (2004), 59-107, (p.65).

³⁰ Peter Bartrip, *Mirror of Medicine: A History of the British Medical Journal* (Oxford: Clarendon Press, 1990), p.63.

³¹ Bartrip, *Mirror of Medicine*, p.103.

transformed the *BMJ* from a comparatively obscure and low circulation medical weekly into a mass-circulation, actively campaigning journal 'on the success of which the BMA rose to national and international prominence as a professional body'.³² Between the late 1860s and the end of the century, Bartrip argues, 'few subjects of socio-medical importance escaped the penetrating gaze of Hart and his contributors'.³³ The massage scandal was one controversial campaign amongst many, which included the Contagious Diseases Acts, baby farming, compulsory vaccination and vivisection. Importantly, 'the journal sought not only to inform its readers of developments relating to these subjects but often to influence those developments and initiate public debate'.³⁴

The massage scandal was reported widely in the national press; many of the tabloids intensifying the story further. As Judith Walkowitz has shown, scandal, sensationalism and melodrama were familiar aspects of late-nineteenth century journalistic culture.³⁵ Within prevailing laissez faire ideology, these journalistic strategies intended to rouse public attention and galvanise government action. This culture was catalysed by the public furore stimulated by William Stead's (1849-1912) 1885 exposé, 'The Maiden Tribute of Modern Babylon', in the *Pall Mall Gazette*. The highly controversial report of child prostitution and trafficking led to public demonstrations in excess of 250,000 and had a number of significant political effects.³⁶ In the wake of the scandal, the 1885 Criminal Law Amendment Act was passed, raising the age-of-consent

³² Peter Bartrip, 'Hart, Ernest Abraham (1835-1898)', *Oxford Dictionary of National Biography*, (henceforth *ODNB*), Oxford University Press, 2004, [<http://www.oxforddnb.com/view/article/12475>, last accessed 2 Nov 2016].

³³ Bartrip, *Mirror of Medicine*, p.93.

³⁴ Bartrip, *Mirror of Medicine*, p.93.

³⁵ Judith Walkowitz, *City of Dreadful Delight: Narratives of Sexual Danger in Late-Victorian London* (Chicago: University of Chicago Press, 1992), p.5.

³⁶ Walkowitz, *City of Dreadful Delight*, p.82.

from thirteen to sixteen, outlawing homosexuality, and as noted earlier increasing police power to prosecute brothel-keeping and prostitution.³⁷

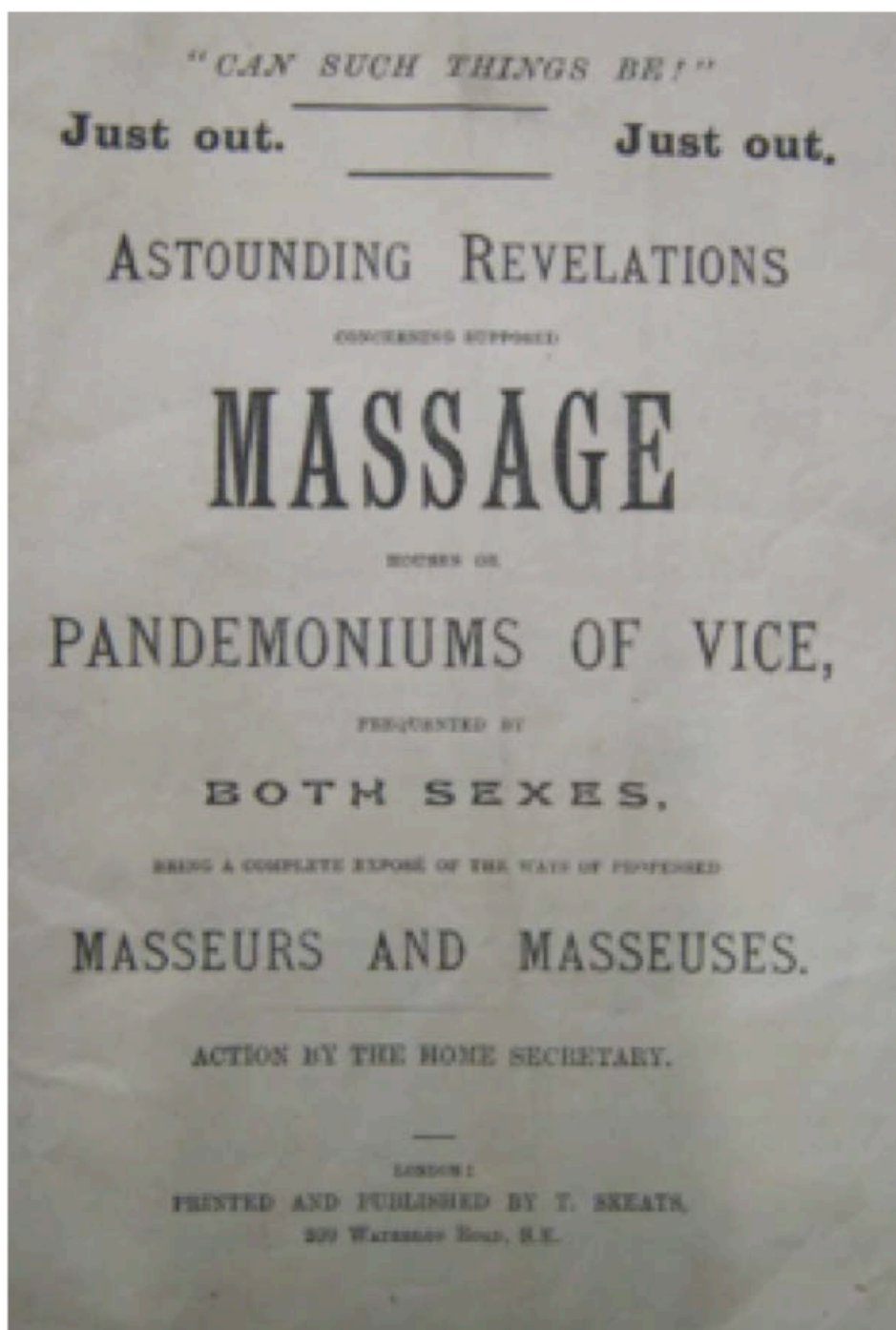


Figure 1 - Anon., *Astounding Revelations* (London: T Skeats, 1894), WL, SA/CSP/P.1/2.

³⁷ Walkowitz, *City of Dreadful Delight*, p.82.

Walkowitz argues that popular interest in sexual crime and scandal, reflected in the coverage of stories such as the Maiden Tribute and 'Jack the Ripper', was a manifestation of broader socio-cultural anxieties surrounding the emancipation of women.³⁸ As women increasingly moved into work and public roles they transgressed established gender boundaries that confined women to the private and domestic sphere. Sexual scandal, social purity campaigns and 'morality' legislation were all part of the same effort to make sense of and regulate the changing place of women. The massage scandals fit into this broader journalistic pattern in terms of its rhetoric, narrative and aims. Furthermore, the professionalisation of massage by the STM can be viewed as part of the wider rationalisation and regulation of women in this period.

There were clear similarities between the massage scandals and the 'Maiden Tribute' articles. Both scandals used the narrative of 'white slavery' to discuss the economy of prostitution. Petrow's work shows that white slavery meant the exploitation of women for money, and from 1870s became closely associated with the procurement of girls and women for prostitution.³⁹ Within this white slavery narrative, women were presented as the victims of their circumstances, lured, trapped and ruined by brothel-keepers. Whereas Stead's 'Maiden Tribute' documented how 'poor daughters of the people' were 'snared, trapped, and outraged, either when under the influence of drugs or after a prolonged struggle in a locked room',⁴⁰ the massage scandal described how 'young women', 'almost penniless', were 'victims' of the 'worst passions' of man.⁴¹ Invoking this narrative the *BMJ* wrote that '[m]any of these girls have certificates, but they, as a rule, have spent their last penny in getting instruction,

³⁸ Walkowitz, *City of Dreadful Delight*, p.3.

³⁹ Petrow, *Policing Morals*, p.158.

⁴⁰ Walkowitz, *City of Dreadful Delight*, p.81.

⁴¹ Anon., *Astounding Revelations*, WL, SA/CSP/P.1/2, p.6, p.9.

and, little by little, drift into a mode of life which is often most distasteful to them'.⁴² 'These women', they argued, were 'unfortunate victims', 'told that they can make a good income, but as soon as they are squeezed dry they are turned out to shift for themselves'.⁴³

The story was further intensified in the press. Using melodramatic rhetoric one fifteen paged pamphlet entitled *Astounding Revelations Concerning Supposed Massage Houses or Pandemoniums of Vice, Frequented by Both Sexes, Being a Complete Exposé of the Ways of Professed Masseurs and Masseuses* (Figure 1), wrote that '[i]n these so-styled massage institutions the most diabolically inclined people are the most courted', 'creatures sunk so deep in debasement that one finds it hard to admit them within the pale of humanity'.⁴⁴ Detailing '[h]ow the masseuse victim [was] obtained', the pamphlet described that the 'young lady', hoping to gain legitimate work as a masseuse 'haplessly' applied for a post where the principal qualification was 'agreeableness':

Perhaps, some of the unfortunate young ladies, after a few days residence at the supposed "institutions" will run from the dwelling as from a house of pestilence. Some, strongly agitated in mind, and not knowing whither to turn, will fall into the deep pit of "agreeableness," and, becoming a slave of Madame, leave hope and honour behind, living on in a lurid glare of ignominy and shame. Then the stricken deer weeps and breaks her panting heart.⁴⁵

Lucy Bland shows that the trope of the prostitute as a 'victim' of circumstances was part of a wider social purity discourse on 'saving' 'fallen women'.⁴⁶ By framing prostitution within an economy of entrapment, differentiating 'victims'

⁴² 'Immoral "Massage" Establishments', (14 July 1894), 88.

⁴³ 'Immoral "Massage" Establishments', (14 July 1894), 88.

⁴⁴ Anon., *Astounding Revelations*, WL, SA/CSP/P.1/2, p.6.

⁴⁵ Anon., *Astounding Revelations*, WL, SA/CSP/P.1/2, p.9.

⁴⁶ Bland, 'Feminist Vigilantes', pp.48-49.

from those who intentionally engaged in prostitution made women reclaimable and justified intervention. The massage scandals were part of this social purity discourse and drew from well-established narratives and language to tap into popular moral anxieties.

Not all commentators were convinced by the massage scandal story, however; the nursing press in particular voiced disapproval. *The Nurse or Hygieia in Homespun*, for example, felt that the matter had been overdramatized writing that ‘we venture to state that there are not more than half a dozen such wretches engaged in the nefarious traffic in the whole of the Metropolis’.⁴⁷ They criticised the *BMJ* for its articles, writing ‘we greatly question whether there is much, if any, reason for the public pronouncements which have been, and are still, being made on this nasty subject’.⁴⁸ While ‘[i]t may be enterprising from a journalistic point of view’, they continued, ‘there are grossnesses, moral decays, and sources of filth like open sewers, which it is safer for all that they should be immediately bricked over, hidden from sight, and flushed clean by competent persons’.⁴⁹ Likewise the nursing journal *Nursing Notes* also expressed scepticism:

The recent abominable statements that have flooded some of the newspapers during the recent silly season require to be taken with many grains of salt. All who have had much to do with massage are quite aware that there are a certain number of people who misuse the name, but there is very little danger of anyone getting mixed up with such people unintentionally [...] We have not much pity for “the young innocent girl from the country” of whom we have heard a good deal lately, who pays a large fee for training and then finds she has been entrapped. She had better apply to the nearest magistrate if

⁴⁷ ‘The Massage “Scandal”’, *The Nurse or Hygieia in Homespun* (August 1894), WL, SA/CSP/P.1/1.

⁴⁸ ‘The Massage “Scandal”’, *The Nurse or Hygieia in Homespun*, WL, SA/CSP/P.1/1.

⁴⁹ ‘The Massage “Scandal”’, *The Nurse or Hygieia in Homespun*, WL, SA/CSP/P.1/1. This idea that explicit material should not be made public was expressed in other articles, see, *Today* (21 July 1894); ‘The Massage Scandal’, *Truth* (19 July 1894), 139-140, WL, SA/CSP/P.1/1.

she really exists, when if her story is proved true she will get redress.⁵⁰

Sheryl Root has questioned the veracity of the white slavery narrative in the massage scandals. She points out that it is doubtful that all massage accused of being 'immoral' was prostitution and when it was, it was more likely to be due to economic necessity than forcible entrapment.⁵¹ While individuals may have been misled or confused, the records of the Metropolitan Police do not support a narrative of entrapment.

Fears of national decline were also evident within the massage scandals. The scandal was presented as evidence of the wider moral decline of the British population. Press reports described the 'metropolis' as a centre of corruption and 'vice' that promoted immorality.⁵² The *Aspinall's Neigeline Society*, for example, wrote '[t]hat such indecencies should be allowed to exist in the Metropolis is disgraceful':

Massage under such circumstances is grossly indecent and must irreparably tarnish the honour and purity of the masseuses, who imperceptibly will drift down the slope of degradation to their ruin [...] Heaven grant that society may be purged of the unhallowed leaven that has crept into it; that every woman may raise a higher standard for herself through life than to pander man's vile passions; that she may resist successfully the temptations of the Modern Babylon and the dastardly attempts of cowardly villains, who, to satisfy their lust, would take advantage of defenceless woman in her courageous struggle through life.⁵³

Accounts often blamed the aristocracy for the massage scandal, as the *Reynolds Weekly* wrote '[i]n a word, the profession of massage has been

⁵⁰ 'Massage Notes', *NN* (October 1895), 135.

⁵¹ Sheryl Root, 'The Healing Touch: Spiritual Healing in England, c. 1870-1955', (Unpublished doctoral thesis: University of Warwick, 2005), pp.160-161.

⁵² 'The Last State of the Massage Scandal', *Truth* (14 March 1895), 647-648, WL, SA/CSP/P.1/2, p.648.

⁵³ *Aspinall's Neigeline Society*, Vol. 18, No. 901 (20 April 1895), WL, SA/CSP/P.1/2, p.311.

largely made a cloak for unbridled sexual intercourse on the part of the rich and aristocratic classes in “Christian England”⁵⁴.

The massage scandals also often drew links, explicitly and implicitly, between the British Empire and ancient Rome. Kate Fisher and Rebecca Langlands have shown that the history of the Roman Empire has often been used as a point of reference around which debates about sexuality have pivoted.⁵⁵ Associations between sexual immorality and the decline of the Roman Empire allowed press articles to transition from the massage scandals to British decline. ‘There is an abundance of reflective matter in these last exposures of aristocratic English vices’, *Astounding Revelations* wrote:

The Romans became effeminate and the Empire City crumbled and collapsed almost lifeless. “Suicide and murder were then hourly occurrences, just as they are to-day in London. Then, as now, life was a huge organised lie, and Society gangrened with corruption. Men lived in ostentatious luxury and sensual indulgence on the labours of the masses just as the ‘gentlemen of England’ do to-day”. “The hoarse paeans over our ‘glorious civilization’ have scarcely yet died away ere we discover the old vices and corruption reappearing in our modern world. The grand structure of progressive morality we are rearing, will have to be revised.”⁵⁶

Within these narratives was a call for government intervention and the policing of morals to stop the ‘immorality’ perceived to be the root cause of national degeneration. As *Astounding Revelations* wrote, ‘little notice was taken’ of ‘the declining days’ of Rome, ‘so feeble had Roman government become’.⁵⁷

Underpinning the massage scandals were certain assumptions about human nature and sexuality. As Bland and Bashford have indicated, Victorian

⁵⁴ ‘Massage and Aristocracy’, *Reynolds Weekly* (22 July 1894), WL, SA/CSP/P.1/1.

⁵⁵ Kate Fisher and Rebecca Langlands, ‘The Censorship Myth and the Secret Museum’, in *Pompeii in the Public Imagination: From its Rediscovery to Today*, ed. by Shelley Hales and Joanna Paul (Oxford: Oxford University Press, 2011), pp.301-315, (p.311).

⁵⁶ Anon., *Astounding Revelations*, WL, SA/CSP/P.1/2, p.13.

⁵⁷ Anon., *Astounding Revelations*, WL, SA/CSP/P.1/2, p.13.

discussions on sexuality were inherently gendered. While masculine sexuality was presented in narratives of sexual danger as 'untameable', feminine sexuality was thought to be controllable, and therefore 'purity' and 'modesty' deemed as qualities to be exercised.⁵⁸ Female sexuality was believed to be something always below the surface, as Bland argues '[b]ehind the veneer of the dominant nineteenth-century ideal woman, the domestic 'angel in the house', lurked the earlier representation of sexualized femininity: 'the Magdalene behind the Madonna'.⁵⁹ Many reports drew upon this understanding of sexuality to articulate opinions about the massage scandal. As the *Whitehall Review* expressed, '[w]e know full well that so long as human beings have passions and human infirmities, the relations of the sexes especially in great cities, will always occasion immorality more or less heinous'.⁶⁰ 'It is as hopeless', they continued, 'to expect to exterminate immorality as death'.⁶¹ Similarly, *Today* wrote that resolving the massage scandal was a futile attempt at 'abolishing the unabolishable', and that '[y]ou can no more do away with evil in human nature than you can abolish a river'.⁶² The Victorian construction of sexuality, the masculine potential to corrupt and feminine vulnerability to corruption, shaped understandings of medical touch and physical contact in this period. It made touch and intimacy highly charged socio-medical issues and shaped professional conventions established to regulate such encounters.

For the *BMJ* and many other commentators the massage-parlour brothel scandal was a symptom of a more general problem with the ethics and organisation of the massage profession as it emerged in the late-nineteenth

⁵⁸ Alison Bashford, *Purity and Pollution: Gender, Embodiment and Victorian Medicine* (Basingstoke: Palgrave Macmillan, 1998), pp.57-58; Bland, *Banishing the Beast*, p.58.

⁵⁹ Bland, *Banishing the Beast*, p.58.

⁶⁰ 'Immoral Massage', *Whitehall Review* (28 July 1894), WL, SA/CSP/P.1/1.

⁶¹ 'Immoral Massage', *Whitehall Review*, WL, SA/CSP/P.1/1.

⁶² *Today* (21 July 1894), WL, SA/CSP/P.1/1.

century. While the *BMJ* acknowledged that not all massage establishments were illegitimate, they implicated all by arguing that the conditions under which massage was practised were inherently dangerous. '[W]e repeat' they said:

that it would be most unjust to suggest that all the establishments which are advertised [...] are otherwise than honestly intentioned establishments. But in almost all those which we have investigated it is beyond question that the method in which the business is carried on is dangerous to the last degree, and that the customary arrangements are of such a nature that it would be hardly rational to expect that scandals should not arise.⁶³

When describing these 'customary arrangements', the *BMJ* reflected the Victorian problematisation of intimacy. Mixed sex physical contact, physical exposure and privacy were all conditions that contradicted traditional notions of female purity, modesty, and the asexual medical touch:

not only is the client treated by the so-called nurse in a condition of nudity, but the two are left deliberately alone for as long a period as the gentleman chooses to pay for [...] We ask the Home Office and the profession, not to speak of the general public, whether this is not a state of things which involves the most obvious risk?⁶⁴

As the conditions under which massage was practised were charged with sexual associations, both legitimate and illegitimate masseuses and the reputation of massage as a whole were overshadowed with doubt.

The massage scandals suggest that at this moment, mixed-sex massage practice was irreconcilable with socio-culturally dominant notions of chaste womanhood and the respectable female professional. One of the primary concerns for the *BMJ* was that this therapeutic encounter was unregulated. They compared the intimate contact involved in massage with nursing, writing that '[n]othing is more honourable than the profession of a genuine nurse, and

⁶³ 'The Scandals of Massage II', 1069.

⁶⁴ 'The Scandals of Massage II', 1069.

certainly no one would suggest in this Journal that mere questions of necessary exposure in the difficult and delicate business of nursing could be stigmatised as indecent'.⁶⁵ Massage work however, they argued, was not governed by the same principles as nursing, '[t]he clients who attend are not persons reduced by illness to a hospital bed [...] They come upon no kind of medical prescription, and, indeed, with no pretence that their object is genuine medical treatment or that they are suffering from any complaint which requires it'.⁶⁶ The respectability of the nurse and her authority to handle the male body with impunity, then, was connected to the medical status and surveillance of her work. By contrast, massage practised independently of medical direction was open to accusations.

For the *BMJ* and many press commentators, the only way to resolve the massage scandal was to clearly define 'legitimate' practice. Mixed-sex massage was considered by many to be altogether too 'dangerous' to be sanctioned.⁶⁷ The *BMJ* wrote that the "general" massage of a man by a woman, involving as it does massage of the trunk and limbs, is an abomination' and '[s]o far as the medical uses of massage are concerned, woman can do all that is necessary for woman, and man for man'.⁶⁸ For the *BMJ*, mixed-sex general massage (massage of the whole body as opposed to a specific area) was beyond the limits of ethical practice. They argued that it compromised the reputation of the masseuse even if under medical prescription:

young women of modesty and proper feeling have found it necessary to sever their connection with otherwise respectable institutions simply because, under medical prescription, they have been detailed to apply "general" massage to men. This is a real evil, and tends to

⁶⁵ 'The Scandals of Massage II', 1069.

⁶⁶ 'The Scandals of Massage II', 1069.

⁶⁷ 'The Scandals of Massage II', 1069.

⁶⁸ 'Immoral Massage', (21 July 1894), 146.

whittle away the boundary line between propriety and impropriety, if not immorality.⁶⁹

Shaping the *BMJ*'s understanding of ethical practice were the broader anxieties surrounding the instability of female sexuality, the sexual interpretation of therapeutic intimacy and the threat of women moving into new professional roles. Embedded within the *BMJ*'s belief that for 'a woman to apply "general" massage to man' was 'to neglect that element of sex which is present in human affairs [...] which refuses to be ignored',⁷⁰ was the wider understanding that you could not 'abolish the unabolishable'⁷¹ nor 'exterminate immorality as death'.⁷² The view that 'the mistaken practice of women or men massing the opposite sex' was the root cause of the 'complaint against the employment of massage' was also widely echoed amongst social purity and nursing commentators.⁷³

The *BMJ* was not only concerned with the ethics of massage practice but the system of training and qualifications upon which the profession was based. Massage training varied widely in both content and duration. Mrs Creighton Hale, for example, who trained at the London Hospital and claimed to be 'the longest established teacher in England', advertised 'Massage and Electricity (Weir Mitchell System) scientifically taught in a Fortnight'.⁷⁴ At Herbert Tibbits' West End School of Massage and Electricity, and John Fletcher Little's School of Massage, training occupied from four to six months.⁷⁵ Another masseur however noted that a certificate was not needed at all:

⁶⁹ 'Immoral Massage', (21 July 1894), 146.

⁷⁰ 'Immoral Massage', (21 July 1894), 146.

⁷¹ *Today* (21 July 1894), WL, SA/CSP/P.1/1.

⁷² 'Immoral Massage', *Whitehall Review*, WL, SA/CSP/P.1/1.

⁷³ 'Massage Notes', *NN* (December 1895), 161.

⁷⁴ *NN* (1 May 1895), 70.

⁷⁵ Barclay, *In Good Hands*, p.18.

the most profitable field open to a qualified masseur, who can readily impart the details of his profession to others, however, is undoubtedly the coaching of valets and ladies' maids, who can command astonishingly high wages when they have had a few lessons from a good masseur.⁷⁶

The *BMJ* discredited all massage qualifications arguing that 'we regret to say that we cannot ourselves place any confidence in any of the certificates which are in circulation'. 'It may be', they continued, 'that some of the persons concerned have had a serious training in massage, but the public has no guarantee that in any individual instance this is to be assumed'.⁷⁷

The diverse qualifications of the massage profession as it emerged organically in the late-nineteenth century corresponded to the varied understandings of massage expertise, demonstrated in Chapter 1. Writing to *The Nursing Record & Hospital World*, orthopaedic surgeon to the Birmingham Royal Orthopaedic and Spinal Hospital, E. Luke Freer, warned that the public could not rely on certificates given from 'private schools of instruction'. For Freer, the common view amongst the medical community that massage was a skill to be acquired in a 'few lessons' was responsible for a general neglect of training:⁷⁸

In his article on Massage in "Health's Dictionary of Surgery," Mr. Bernard Roth states that "an intelligent Nurse can be readily taught in one or two séances." My experience is diametrically opposed to this assertion, but as one is continually seeing advertisements of the "Massage-taught-while-you-wait, with-a-certificate-on-leaving" type, in these journals, evidently Mr Roth's ideas of the amount of instruction necessary are being propounded generally, with the natural unsatisfactory results.⁷⁹

⁷⁶ 'Profits of Flesh-Pounding', WL, SA/CSP/P.1/1.

⁷⁷ 'The Scandals of Massage III', 1141.

⁷⁸ E. Luke Freer, 'Massage', *The Nursing Record & Hospital World* (7 April 1894), 239-240, Royal College of Nursing online archive (henceforth RCN), 239.

⁷⁹ Luke Freer, 'Massage', RCN, 239.

Similarly, in 1897, Swedish gymnast Theodora Johnson complained that the belief that the *only* thing really required is knack',⁸⁰ was due to ignorance which tarnished the professional reputation of massage:

When we find that a doctor gives any man or woman *six lessons*, in which to acquire the requisite knowledge of anatomy, physiology, disease and its treatment by manipulation; and grants forsooth, a certificate by means of which such person trades upon the ignorance of a gullible public, causing pain and exhaustion, if not serious injury, and so brings "Massage" into sorry disrepute.⁸¹

This demonstrates how the contested status of massage expertise had direct implications for the training, qualifications and ultimately the reputation of massage as a practice and profession.

The *BMJ* brought this problem to the fore; 'it is one' they argued, 'which seriously demands the attention of the medical profession'.⁸² 'Some of the best operators do not appear to refer to any certificate at all, and, from the result of our investigations, we do not suppose that they are the less competent on that account.'⁸³ It concerned the *BMJ* that the ambiguity of the massage market offered not only a veil for 'immoral' practice, but also made it difficult to guarantee 'any sort of knowledge or efficiency':

One lady describes herself as a "nurse" holding the "highest English medical certificates" – whatever that may mean. Another, who also calls herself a "nurse," is described as "a certificated London hospital masseuse." Another nurse is said to be "hospital trained and certificated," whereas her principal advertises a "medical certificate," and proposes to *teach* massage and give certificates herself when her pupils are proficient. Another lady advertises a "physician's certificate."⁸⁴

⁸⁰ Theodora Johnson, *The Swedish System of Physical Education: Its Medical and General Aspects* (London: Simpkin, Marshall, Hamilton, Kent & Co., Ltd, 1897), p.39.

⁸¹ Johnson, *The Swedish System of Physical Education*, p.38.

⁸² 'The Scandals of Massage III', 1140.

⁸³ 'The Scandals of Massage III', 1140.

⁸⁴ 'The Scandals of Massage III', 1140.

The desire of many massage practitioners to present themselves with a 'medical status' intersected broader concerns of the medical profession to police its borders and stop the 'abuse' of medical titles.⁸⁵ By defining legitimate and illegitimate practice, then, the *BMJ* sought not only to eliminate 'immorality' but also to marginalise 'quacks' and regulate those who practised massage outside of medical direction. As matters stood, there was no way of differentiating legitimate from illegitimate practice and the public had no assurance of the competency of therapists. Furthermore, the presence of unregulated massage practitioners threatened the authority of medical men over an increasingly valuable therapeutic and subsequently their economic interests. As the *BMJ* complained, massage threatened to become a 'treatment from which quacks reap a rich harvest', and the reputation of 'what may be a most valuable therapeutic measure' at stake.⁸⁶

Nurse-masseuses also voiced their professional concerns about the vagaries of the massage market. *The Nurse* wrote that, 'as apart entirely from the moral aspect of the matter, there are so many bogus certificates and so many bogus practitioners about that this reiterated caution is absolutely necessary'.⁸⁷ In December 1894, nurse-masseuse Lucy Robinson wrote that:

I fear the habit of undertaking a case because someone has a fancy for massage and asks a masseuse to rub, and of suggesting that massage is likely to do good to some ailment or pain, has more to do with the discredit thrown on massage and masseuses, than any outside and temporary scandal is ever likely to do. Add to this the

⁸⁵ Work by Iwan Morus and P.S. Brown shows that throughout the nineteenth century, a range of different practitioners wished to be identified with regular medicine and used medical titles - including electrotherapists, hydropathists and patent medicine vendors - and this was a major subject of professional antagonism and conflict. See Brown, 'Social Context and Medical Theory', p.217, and Iwan Morus, *Frankenstein's Children: Electricity, Exhibition, and Experiment in Early-Nineteenth Century London* (Princeton; New Jersey: Princeton University Press, 1998), p.249.

⁸⁶ Bennett, 'Some Points Relating to Massage', 1262.

⁸⁷ 'The Massage "Scandal"', *The Nurse or Hygieia in Homespun*, WL, SA/CSP/P.1/1.

mistaken practice of women or men massing the opposite sex, and I think we have the true causes of complaint.⁸⁸

The ambiguous image and status of the massage profession at this time was highlighted in accounts that described masseuses being mixed up in or associated with, what they considered to be unprofessional practice. As Lucy Robinson continued:

It was only this morning that in beginning a new case, and while rolling up my white sleeves ready for work, my patient looked at me in a puzzled way, and said, "Are you a nurse? The last masseuse I had always wore a silk gown and long lace and jet ruffles; she did worry me so, and was always in a hurry to go to some party or 'At Home'!" So long as such things are possible, massage will suffer in repute.⁸⁹

In her private notes, Rosalind Paget recalled the early uncertainty surrounding massage:

A young pretty masseuse was sent for to a nursing home [...] she was waiting in the sitting room, where a man was waiting - he looked at her and asked her what she was there for, she told she was come to do some massage. He said be advised by me and go out of this place at once it is not a place for you.⁹⁰

Instances such as those described above, Rosalind Paget noted, where massage was not used in a medical context and therefore 'questionable', meant that circumscribing massage practice to a doctors' orders 'was a desirable rule'.⁹¹ The massage scandals highlight that many parties, not only the medical profession, were interested in getting massage into the open and making the practice transparent.

⁸⁸ Lucy Robinson, 'Massage Notes', *NN* (December 1894), 161.

⁸⁹ Robinson, 'Massage Notes', (December 1894), 161.

⁹⁰ 'Historical Notes by Dame Rosalind Paget, c.1936', WL, SA/CSP/P.2/3/1.

⁹¹ 'Historical Notes by Dame Rosalind Paget', WL, SA/CSP/P.2/3/1.

Calls for massage establishments to be dealt with by the police and Home Office were largely unsuccessful. After questioning in the House of Commons on 23 July 1894, the Home Secretary Henry Asquith replied that 'I have read the article referred to' and deprived the matter of any sensationalism:

Except by the statement in that article the attention of the police has not been called to the subject. There is no truth in the statement that the police have raided and stopped one of these places. The matter has been and is being carefully investigated, but up to the present no sufficient evidence has been forthcoming to warrant police action, or to show the necessity for an amendment of the law.⁹²

After its series of further investigations, the *BMJ* informed readers in November 1894 that a deputation to the Home Office by the BMA's Parliamentary Bills Committee would deal with the matter.⁹³ As Roger Cooter shows, the medical profession frequently engaged in parliamentary politics during the Edwardian period more broadly.⁹⁴ One of the BMA's sub-committees, the Parliamentary Bills Committee, was established in 1872 in order to make direct appeals to the government and lobby parliament on the profession's behalf.⁹⁵ One of these issues was the regulation of massage establishments, and the Parliamentary Bills Committee proposed a Bill named 'The Massage and Hypnotism [and Electro-Therapeutics] Act, 1895', prepared by the chairman Ernest Hart, in May 1895.⁹⁶ The Bill suggested that all massage establishments not managed by a medical practitioner should be registered and regularly inspected, and that:

it should be unlawful to keep open or assist in conducting any establishment for the purposes of massage or other similar

⁹² 'Massage Establishments', *Daily Chronicle: House of Commons* (24 July 1894), WL, SA/CSP/P.1/1. This quote from Asquith featured widely in the press on 24th July, and also in 'Short Notes', *NN* (August 1894), 105.

⁹³ 'The Scandals of Massage IV', 1200.

⁹⁴ Cooter, 'The Rise and Decline of the Medical Member', 63.

⁹⁵ Cooter, 'The Rise and Decline of the Medical Member', 65.

⁹⁶ 'Parliamentary Bills Committee', *BMJ* (4 May 1895), 991- 992, (p.991).

processes in which men were treated by women, or women by men, otherwise than under the direct sanction of a written medical prescription.⁹⁷

Although unsuccessful, the effort highlights that by forwarding their professional interests in parliament the *BMJ* sought governmental backing for the regulation of massage and medical authority over practice. The framing of the Bill with hypnotism and electrotherapy also suggests that anxiety to regulate massage was part of a wider effort to police the borders of the medical profession.⁹⁸

The BMA was not the only party to push for legislation against massage. It was increasingly the opinion of social purity campaigners that amending the law was the only way to deal with brothel-keeping and prostitution more broadly.⁹⁹ Echoing the BMA, in May 1898 the vestry of St James sent a deputation to the Home Office calling for 'legislation which will directly control establishments in which massage is practiced', they complained that it was 'well nigh impossible' to prosecute under the existing Criminal Law Amendment Act.¹⁰⁰ They argued for the registration and inspection of massage establishments and the ruling that only qualified and certificated persons be allowed to practice. 'On the other hand', they wrote, 'it may be deemed advisable to take a different course, and really strike at the root of the evil by making it an illegal act for any person [...] to apply massage or similar treatment to any person of the opposite sex'.¹⁰¹ For social purity, as for the *BMJ*, it was

⁹⁷ 'Parliamentary Bills Committee: Memorandum on the Massage Question', (c.May 1895), pp.1-2, TNA, MEPO 2/460, pp.1-2.

⁹⁸ For a study highlighting effort of medical orthodoxy to regulate hypnotism see, Mary Elizabeth Leighton, "Hypnosis Redivivus": Ernest Hart, "British Medical Journal," and the Hypnotism Controversy', *Victorian Periodicals Review*, 34:2 (Summer 2001), 104-127.

⁹⁹ Petrow, *Policing Morals*, p.157.

¹⁰⁰ St James' Vestry, 'Report of Parliamentary Bills and General Purposes Committee on the Subject of Massage Establishments', (26 April 1898), pp.1-4, TNA, MEPO 2/460, p.1.

¹⁰¹ St James' Vestry, 'Report on Massage Establishments', TNA, MEPO 2/460, p.1.

felt that the only way to 'suppress immorality' and deal with the 'root of the evil' was to police the boundaries of intimacy altogether.

These efforts show that the discourses and aims of social purity, morality and medicine were intricately intertwined over the massage question. While the Home Office was sympathetic, no legislation was passed and by 1913 the use of manicure, massage, and bathing premises for prostitution had increased.¹⁰² It was not until 1915 that any significant change to legislation was made, when the London County Council was empowered to register and inspect massage establishments.¹⁰³ Massage scandals, however, were an on-going issue that echoed throughout the period discussed in this thesis. Debates were not resolved or eliminated by the professionalisation of massage and regulating its practice continued to be a concern. For example, writing to the Home Office in 1920 President of the National Institute for the Blind, Arthur Pearson, called for more stringent regulation of massage establishments used for 'improper purposes' as 'the matter' was 'so important to the whole professional life of properly qualified masseurs, whether blind or sighted' and 'great stigma is cast upon the profession as a whole'.¹⁰⁴

This section has explored some of the ways that massage was contested ethically and professionally, and intersected a number of social and medical concerns in 1894. The massage scandals show us more than grievances against the 'massage-parlour brothel'. They also offer insights into the broader socio-cultural anxieties about sexuality, intimacy, and the movement of women into new public spaces that bore on the professionalisation of massage by the

¹⁰² Petrow, *Policing Morals*, p.155.

¹⁰³ Petrow, *Policing Morals*, p.155.

¹⁰⁴ 'Arthur Pearson, (The National Institute for the Blind) letter to Mr. Shortt', (11 May 1920), Byelaws: London County Council. Registration of Massage Establishments (1897-1920), TNA, HO 45/10912/A56145. This archive highlights that the debate was ongoing.

STM. The desire to regulate massage was part of a wider social effort to make sense of, rationalise and police the shifting boundaries of gender and medicine.

The Society of Trained Masseuses

In February 1895, the journal *Nursing Notes* announced the formation of an organisation called the Society of Trained Masseuses. 'For some time', the journal suggested, 'those members of the Trained Nurses' Club who taught massage, have sought to devise some plan for placing their pupils on a firmer and surer professional footing that the majority of Masseuses have hitherto attained', in order to 'be protected from any such suspicions as have recently been rife in regard to a few individuals'.¹⁰⁵ The STM organised an independent examination, granted certificates, and offered registration, 'securing a uniform standard of proficiency'.¹⁰⁶ Practical proficiency, however, was not the only qualification necessary for membership of the STM; masseuses also had to pledge to work along recognised rules that governed their practice and ethical behaviour. The final section of this chapter investigates why and how the STM sought to 'make massage a safe, clean and honourable profession for British women'.¹⁰⁷

Biographical information of the founding members offers insights into the motivation and strategies adopted for their project. The STM was a group of nurses and midwives, trained in massage and affiliated with the Midwives' Institute and Trained Nurses Club. Founding members included Rosalind Paget

¹⁰⁵ Augusta Arthur, 'Massage Notes', *NN* (February 1895), 21.

¹⁰⁶ Arthur, 'Massage Notes', *NN* (February 1895), 21.

¹⁰⁷ Wicksteed, *The Growth of a Profession*, p.26.

and Paulina Ffynes-Clinton,¹⁰⁸ nurse-midwives at the London Hospital. Paget and Ffynes-Clinton first learned massage in 1886 after the Hospital's Matron Eva Lückes sent them for lessons from Elizabeth Buckworth, described as a 'Playfair protégée' and 'superb rubber', in order that they could give the rest cure. At this time, Paget wrote, patients with neurasthenia:

were being treated by bed, stuffing and massage for Dr Weir Mitchell. I and my friend [...] did this at the London, sent by the matron to learn how to massage by Miss Buckworth (a delightful teacher and superb rubber – more practice than theory perhaps). After this we did a good deal of massage at the London Hospital and taught the private staff – some of our nurses made very good general masseuses but it knocked up some who could not combine it at the same time as her ward work.¹⁰⁹

While Rosalind Paget's role in midwifery reform is more widely known, her work as a masseuse and influential role in the early development of physiotherapy has received less attention.¹¹⁰ Margaret Palmer was another nurse-midwife who worked at the London Hospital, and was engaged there in 1891 to manage the massage department and to teach the nursing staff (Figure 2).¹¹¹ Considered an authority in 'English massage' she ran a private massage school and published a book in 1901, *Lessons in Massage*, which was re-published in numerous editions.¹¹² Likewise, sisters Elizabeth and Guilelma Manley were two nurse-masseuses who established a private training school that gave training in massage, gymnastics and electricity, while also instructing nurses at Guy's

¹⁰⁸ For a short biography of Rosalind Paget, see John Rivers, *Dame Rosalind Paget, D.B.E., A.R.R.C. 1855-1948, A Short Account of her Life and Work* (London: Midwives Chronicle, 1981).

¹⁰⁹ 'Historical Notes by Dame Rosalind Paget', WL, SA/CSP/P.2/3/1.

¹¹⁰ For a study of Rosalind Paget and the midwifery reform movement see, June Hannam, 'Rosalind Paget: The Midwife, the Women's Reform Movement and Reform before 1914', in *Midwives, Society and Childbirth: Debates and Controversies in the Modern Period*, ed. by Hilary Marland and Anne Marie Rafferty (London: Routledge, 1997), pp.81-101.

¹¹¹ Barclay, *In Good Hands* p.26.

¹¹² Margaret Palmer, *Lessons on Massage* (London: Ballière, Tindall and Cox., 1901).

Hospital.¹¹³ Elizabeth Manley studied massage and electricity at Fletcher Little's London School of Massage, and trained in medical gymnastics at Bergman Österberg's physical training college.¹¹⁴ These women were themselves products of the highly varied training opportunities available for massage in the late-nineteenth century. Schooled in a variety of massage traditions, leading members brought together an openness and flexibility towards expertise that characterised the early profession.

¹¹³ Barclay, *In Good Hands*, pp.25-26. Also for information of where the founder members trained see, 'Committee Meeting', (3 January 1896), Chartered Society of Physiotherapy: Council Minutes (4 October 1895-31 May 1899), WL, SA/CSP/B.1/1/2.

¹¹⁴ Barclay, *In Good Hands*, pp.25-26.

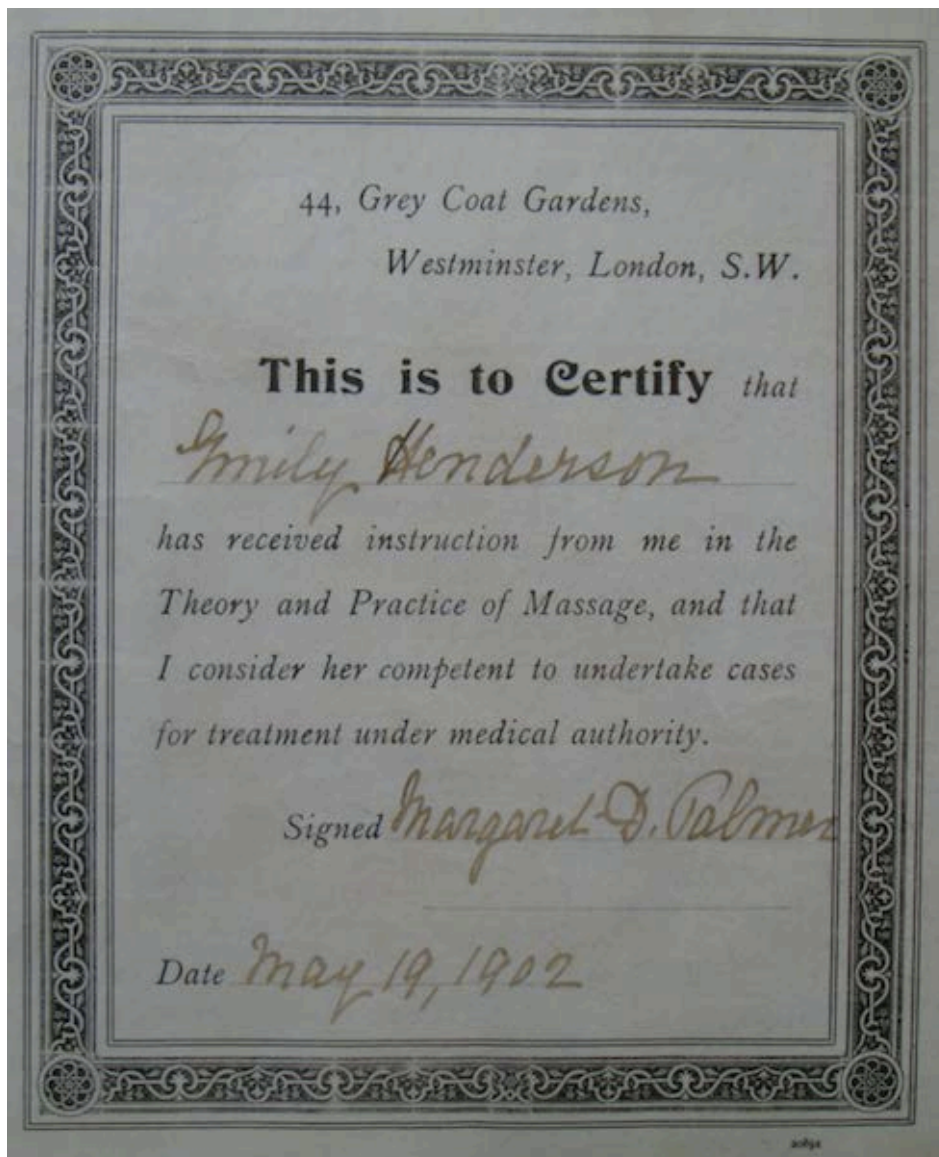


Figure 2 -'Certificate of Massage theory and practice signed by Margaret D. Palmer', (19 May 1902), Courtesy of The Royal London Hospital Archives (henceforth RLHA), RLHLH/X/201/3.

Many other women with similar backgrounds were involved in and influential for the formation and early development of the STM.¹¹⁵ These were typically well-educated, middle-class women who, as successful nurses, midwives and masseuses, had a number of personal and professional interests invested in the practice. Reflecting in February 1897 the STM commented that:

¹¹⁵ More detailed information on the STM's founder members can be found in the work of Wicksteed and Barclay.

People were afraid to employ the treatment on account of the character of the persons who might be introduced into their houses, Doctors hesitated to recommend it for the same reason, and the opinion was gaining ground that massage was not a respectable employment by which women could earn their living.¹¹⁶

As nurses they aimed to protect what they saw as 'a branch of the nursing profession which has hitherto been conducted practically without status, or certificates of value to the public'.¹¹⁷ By establishing an association of masseuses affiliated through qualification and governed by a code of conduct, the STM aimed to offer a guarantee of the training and morality of their members. They also hoped to circumvent the identity of the 'nurse-masseuse' as a disguise for prostitution. As studies show, the complaint that prostitutes wore the nurse's 'outdoor uniform' as a disguise was a wider issue throughout the second half of the nineteenth century, and the actions of the STM can be viewed as part of the wider campaign against this practice.¹¹⁸ Writing in November 1898, the STM protested that:

It is exceedingly hard for the respectable and competent masseuse that the innocent term massage should be taken to cloak a vile trade; it is also hard on the trained nurse to have to discard her out-door uniform because disreputable women chose [sic] to masquerade as nurses. Let us hope there will be some time an end to both these abuses.¹¹⁹

As massage teachers in a context where the value of certificates was dependent upon the reputation of the instructor, and where 'there are no difficulties in the way of obtaining a certificate, or of setting up in this

¹¹⁶ 'Massage Notes', *NN* (February 1897), 23.

¹¹⁷ 'Massage Notes' *NN* (January 1894), 8.

¹¹⁸ For a discussion of the use of the nurses 'outdoor uniform' and cultural analysis of how it came to be used as a disguise for prostitution, see Bashford, *Purity and Pollution*, pp.58-59.

¹¹⁹ 'Massage Notes', *NN* (November 1898), 155.

profession', they also had an economic interest in distinguishing their own practice from the ambiguity of the wider massage market.¹²⁰

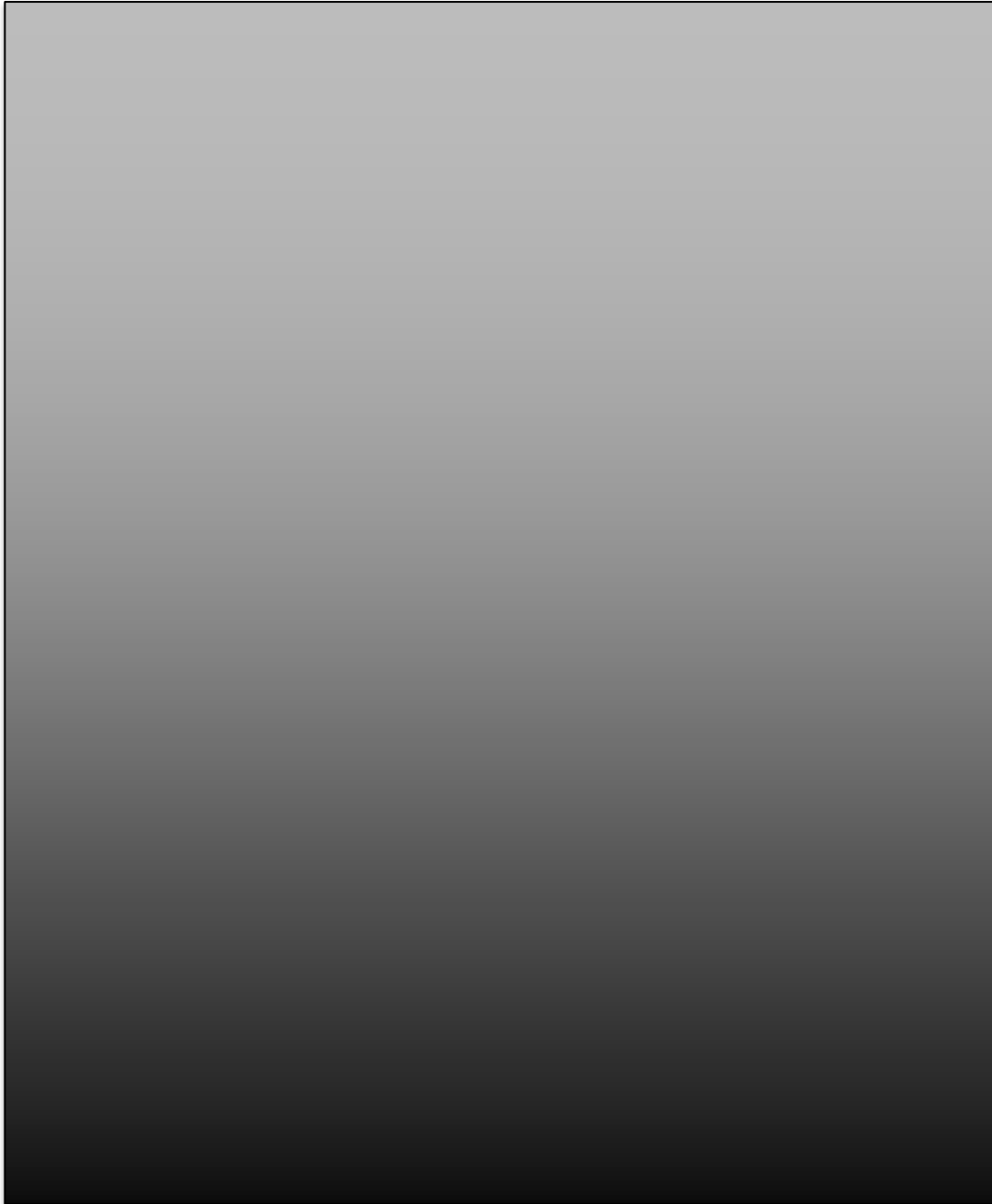


Figure 3 - Photograph of a group of nursing sisters from the London Hospital. Back row are nurse-masseuses Miss Fynes-Clinton (left), Rosalind Paget (centre), Elizabeth Anne Manley (right). From Rivers, *Dame Rosalind Paget*, p.58.

¹²⁰ 'Massage Notes', *NN* (December 1894), 161.

The significance of the Midwives' Institute has been examined by historians interested in the nursing and midwifery reform movement. It was also central to the early professionalisation of massage, as the STM grew out of and was supported by the Institute from its foundation to the First World War. The Midwives' Institute was established in 1881 'with the aim of raising the efficiency and status of the midwife, to petition Parliament for recognition, and to establish a professional *esprit de corps*'.¹²¹ Many of the first leaders of the STM were not only members of the Midwives' Institute but also actively engaged in its leadership and campaign to achieve the Midwives Act and other legislation that would uplift the midwifery profession (Figure 3). For example, Rosalind Paget provided a driving force behind the Midwives' Institute's activities from the mid-1880s to the First World War, Paulina Ffynes-Clinton was the Institute's secretary from 1897 for twelve years,¹²² and midwife and masseuse Lucy Robinson was actively involved in bringing in the Midwives Bill.¹²³ June Hannam has argued that Rosalind Paget and the Institute represent 'a group of female "professional" workers', who were dedicated to carving out professional roles and raising the status of women's work at a time when 'even the women's movement was reluctant to challenge notions of women's special qualities and their role as wives and mothers'.¹²⁴ The Institute was not only interested in the professional status of its members, but was dedicated to women's suffrage and social change.¹²⁵ The STM was born out of this political culture and the wider effort of these professional women to advance the status of women's work in the late-nineteenth century.

¹²¹ Hannam, 'Rosalind Paget', pp.82-83.

¹²² Hannam, 'Rosalind Paget', pp.83-84.

¹²³ Barclay, *In Good Hands*, p.25.

¹²⁴ Hannam, 'Rosalind Paget', p.82.

¹²⁵ Hannam, 'Rosalind Paget', p.92.

Class was also an important factor influencing the aspirations and success of the STM's professional project. As the work of Alison Nuttall has shown, leaders of the Institute were mainly single women from upper middle-class families.¹²⁶ Many were able to embrace nursing and midwifery as a voluntary pursuit rather than a necessary source of income.¹²⁷ The STM relied upon the unpaid work of its leadership and the resources of the Midwives' Institute to support its activities. In October 1894, until it branched off in 1915, the STM had a dedicated section in the Institute's journal *Nursing Notes* entitled 'massage notes', owned by Rosalind Paget.¹²⁸ 'Massage notes' offered a means of communicating, publicising and reinforcing their views among the nursing community and their membership. The Society also shared an office with the Institute at 12 Buckingham Street until it needed more space and moved to 99 Mortimer Street in November 1912.¹²⁹

As well as material support, the success of the STM relied upon a strong network of medical and social patronage to legitimate its project. The accreditation of the STM came from its constitution as a branch of the Midwives' Institute, whereby members were placed on a 'Roll of Masseuses' and became eligible for employment through the Institute's register.¹³⁰ Many of the leaders of the STM had family and other connections among the medical and charitable elite, and were able to harness them to their cause. Early medical patrons included William Playfair, Sir Frederick Treves, Sir Francis Lakin, Sir William

¹²⁶ Alison Nuttall, 'Midwifery, 1800-1920: The Journey to Registration', *Nursing and Midwifery in Britain since 1700* ed. by Anne Borsay and Billie Hunter, (Basingstoke: Palgrave Macmillan, 2012), pp.128-143, (p.137).

¹²⁷ Nuttall, 'Midwifery, 1880-1920', p.138.

¹²⁸ Barclay, *In Good Hands*, p.19.

¹²⁹ Barclay, *In Good Hands*, p.33.

¹³⁰ Barclay, *In Good Hands*, p.27. Its constitutional link with the Midwives Institute was one of the primary reasons why membership to the STM was confined to women.

Bennett and Sir Cooper Perry.¹³¹ From 1895 the Society also garnered a number of 'associates' representing the 'elite of the massage profession'.¹³² During their campaign for Incorporated status in 1900 their social position enabled them to petition a number of high profile names for support, including Florence Nightingale and the Queen, who became a patron in 1916.¹³³ These elite associations elevated the reputation of the STM and brought recognition and legitimacy to its model of professionalisation. It helped to make massage into an occupation that 'respectable' middle-class women would choose to do.

Demonstrating the significance of patronage to the success of the STM's professional project, was the emergence and decline of a number of other massage associations throughout the period. These included the Harley Institute, the British Massage Association (1894) and the National Association of Trained Masseurs and Masseuses (1912).¹³⁴ The Minutes of the STM show an often strained relationship with competing massage organisations such as these, and their campaign for medical and public recognition was part of an effort to establish and maintain an 'elite' position. In the wake of the massage scandals in January 1895, masseur and hypnotist Thomas Maltby formed the British Massage Association. Echoing the *BMJ*, Maltby considered that '[i]t is the system which is at fault, a system which permits of ignorant young women in the possession of what is really a worthless certificate, posing as qualified operators'.¹³⁵ His Association, like the STM, aimed to provide examination and registration of massage operators. However, in contrast to the STM, Maltby's venture lacked high-profile support and was short-lived. As orthopaedic surgeon

¹³¹ Wicksteed, *The Growth of a Profession*, p.42.

¹³² 'Massage Notes', *NN*, (May 1895), 67.

¹³³ Wicksteed, *The Growth of a Profession*, p.55.

¹³⁴ Barclay, *In Good Hands*, p.36.

¹³⁵ 'Massage Secrets: Extraordinary Revelations, Interview with an Expert', *The Morning* (17 July 1894), WL, SA/CSP/P.1/1.

Luke Freer noted, while such an organisation was needed, the British Massage Association lacked influential medical and lay patrons.¹³⁶

While social background and patronage were crucial factors in the success of the STM, ultimately, survival depended upon the alignment of their professional aspirations with dominant social values and medical interests. Emerging from a generation of reformed nurses and midwives and inspired by the movement for women's suffrage the STM drew upon a number of familiar strategies to carve out an independent career for educated women. For the STM, the professional masseuse required a mixture of essential character and intellectual qualifications. 'Before undertaking massage professionally', Lucy Robinson wrote in March 1894, 'the suitability of the employment should be carefully considered'. Physical assets, she continued, including '[a] good amount of health and strength, the power of standing for a long time, a cool and comfortably soft hand for rubbing' were deemed 'essential qualifications'.¹³⁷ It was also essential that the masseuse possess certain personal characteristics including 'gentleness, patience, punctuality, and sympathy',¹³⁸ and 'the moral qualities of thoroughness, patience and perfect control over the tongue', which were thought to be 'indispensable'.¹³⁹ These character traits were central to the STM's understanding of the professional masseuse and mirrored those qualities thought to be the ideal of respectable 'middle-class' womanhood.

In its bid for professional status, however, the STM asserted intellectual expertise as well as certain personal assets and character traits. The STM held regular examinations in the theory and practice of massage certifying scientific

¹³⁶ Barclay, *In Good Hands*, p.23.

¹³⁷ Lucy Robinson, 'Massage', *NN* (March 1894), 30-31, (p.30).

¹³⁸ Robinson, 'Massage', (March 1894), 30.

¹³⁹ 'Massage Notes', *NN* (October 1894), 135.

and technical expertise (Figure 4).¹⁴⁰ Examinations were rigorous, in February 1895 for example, assessments included practical massage on a living model, a viva voce on anatomy and massage theory, as well as a written exam.¹⁴¹ While the STM did not define the curriculum ('we do not ask that pupils should be trained under any special system'), candidates had to satisfy examiners that they were 'good practical masseuses, competent to undertake a case under doctor's orders, and they must supply evidence that they have undergone a systematic course of practical instruction'.¹⁴² Massage was believed to be a technical skill that, while a certain amount of natural aptitude was necessary, had to be refined and practised. Writing in October 1894, the STM asserted that '[t]o be a skilful masseuse is as much a gift as to be a good musician, but equally requires to be carefully developed and cultivated and to be kept in constant practice'.¹⁴³ Throughout its formative years the STM continually fought 'against the idea that good massage is an easy and quickly acquired art', and one of the ways in which they did so was to argue that 'to be really proficient it is necessary to have a good knowledge of anatomy and physiology'.¹⁴⁴

In order to claim professional status and distance themselves from the 'untrained', the STM argued that their expertise was intellectually grounded in medical science. Knowledge of anatomy and physiology was deemed essential 'for the proper performance and comprehension of the work'.¹⁴⁵ Pupils, the STM wrote, 'should possess a knowledge of the origin, insertion and action of the chief muscles of the superficial layer, and, if possible, they should be familiar

¹⁴⁰ 'Massage Notes', *NN* (February 1895), 21.

¹⁴¹ 'Massage Notes', *NN* (April 1895), 49.

¹⁴² 'Massage Notes', *NN* (May 1895), 67.

¹⁴³ 'Massage Notes', *NN* (October 1894), 135.

¹⁴⁴ 'Massage Notes', *NN* (October 1894), 135.

¹⁴⁵ Robinson, 'Massage', (March 1894), 30.

with the actual bones of the human skeleton'.¹⁴⁶ Analysis of the examination papers demonstrates the level of theoretical knowledge required by the STM, as well as the types of treatment that masseuses were expected to be able to undertake. In the examination of April 1895, questions included '[n]ame the bones of the spinal column, their number and divisions'; '[g]ive the position, origin, insertion and use of *four* leading muscles'; '[w]hat are lymphatics? How does massage affect them?' and '[d]escribe the circulation of the blood.'¹⁴⁷ Alongside nervous complaints, candidates were asked to explain how they would treat constipation, dislocated joints, sprains, strains and recent fractures.¹⁴⁸

This call to knowledge was not confined to those masseuses without a nurse training. From the outset, the STM defined their occupational territory as a branch of, but separate to nursing, arguing that massage required a depth of knowledge more advanced than that received in nurse training. 'Nurses are, I think', Elizabeth Manley wrote in December 1897, 'a little in danger of trusting too much to the meagre amount of anatomy usually conveyed in their hospital lectures on surgical nursing, when they take up a branch of work requiring more detailed and definite knowledge'.¹⁴⁹ 'It should be clearly understood by all adopting the profession of massage', she continued, 'that it is not enough to be able to name the bones and to point them out in a skeleton or a diagram' but rather an 'intimate acquaintance' with the muscular-skeletal system and physiological action of massage on the body was necessary.¹⁵⁰

¹⁴⁶ 'Massage Notes', *NN* (May 1895), 67.

¹⁴⁷ 'Massage Notes', *NN* (May 1895), 67.

¹⁴⁸ 'Massage Notes', *NN* (May 1895), 67.

¹⁴⁹ Annie Manley, 'Massage', *NN* (December 1897), 163.

¹⁵⁰ Manley, 'Massage', *NN* (December 1897), 163.

20.

TRAINED NURSES' CLUB,

12, BUCKINGHAM STREET,
STRAND, W.C.

THE SOCIETY OF TRAINED MASSEUSES.

This is to Certify that *Julia Newlyn*
has been instructed in the Theory and Practice of Massage, and that
we consider her to be fully qualified to carry out treatment by Massage
under the direction of a Medical Practitioner.

Signed *Mary Molony*
Maggie D. Palmer
Gulielma Manley Examiners.
Lucy M. Robinson
Augusta Arthur Secretary.

Date *8th May, 1895*

I agree to keep the following Rules, and will return this Certificate if, at any time, the
Council of The Society of Trained Masseuses consider I have been guilty of unprofessional conduct.

Signed *Julia Hayden Newlyn*

RULES.

- I. No Massage to be undertaken except under Medical direction.
No General Massage for Men to be undertaken. Occasional exceptions may be made at a Doctor's special request for urgent or nursing cases.
- II. No Advertising permitted in any but strictly Professional Papers.
- III. No sale of Drugs to Patients allowed.

N.B. *Julia Newlyn*'s name has been entered on the Register of the Society of Trained Masseuses at the Trained Nurses' Club, and any enquiry concerning her should be made to the Secretary at the above address.

Figure 4 - Certificate of Julia Newlyn, signed by Mary Molony, Margaret Palmer, Gulielma Manley, Lucy Robinson and Augusta Arthur, (8 May 1895), Personal Papers, WL, SA/CSP/P.4/4/10.

As studies of the nursing reform movement show, the intellectual status of nursing was a topic of debate in the late-nineteenth century.¹⁵¹ Traditionally, women legitimised their entry into careers such as nursing and teaching by asserting widely held gender assumptions about their potential for moral and domestic influence.¹⁵² Rafferty argues that gendered claims such as these, 'justified her confinement' to a certain number of 'wifely, child-rearing and caring duties' in which 'character' rather than 'theory or intellectual talents' were cornerstones.¹⁵³ With asserting women's special 'character' traits, however, also came an anti-intellectualism that justified the exclusion of women from professional work.¹⁵⁴

By the end of the century, however, as domestic ideology came to be challenged by feminists and the debate surrounding female education intensified, a new generation of nurse reformers strove to redefine their profession on technical and scientific expertise.¹⁵⁵ The STM's professional project was a product of this movement; while they asserted commonly held values of middle-class womanhood, they also made intellectual claims. These claims did not go unchallenged; for example it took the STM more than two years of negotiations with the London School of Medicine for Women to arrange a course of anatomy lectures for members and students in training.¹⁵⁶ Furthermore, in 1898 Guilema Manley reported that she asked Dr. Cooper Perry permission for members to study anatomy with the aid of the wax models at Guy's Hospital, to which he replied that while an application would be

¹⁵¹ For a detailed account of this debate and its relationship to the campaign for registration, see Anne Marie Rafferty, *The Politics of Nursing Knowledge* (London: Routledge, 1996), particularly Chapters 2 and 3.

¹⁵² Rafferty, *Politics of Nursing Knowledge*, p.40.

¹⁵³ Rafferty, *Politics of Nursing Knowledge*, p.40.

¹⁵⁴ Rafferty, *Politics of Nursing Knowledge*, p.41.

¹⁵⁵ Rafferty, *Politics of Nursing Knowledge*, p.40.

¹⁵⁶ Wicksteed, *The Growth of a Profession*, p.49.

favourably received, it 'must be kept in secret as female students were much objected to at that Hospital'.¹⁵⁷

The STM's claims to knowledge were significant because they challenged commonly held beliefs about the intellectual status of both women and massage. They justified their claims in a threefold way, as essential for the masseuse as a professional, for the patient and for the doctor. As Chapter 1 highlighted, massage was widely considered amongst the public and the medical profession to be a manual occupation. Describing this in October 1898, the STM wrote:

In this nineteenth century it seems almost unnecessary that one should write an apology for the study of elementary anatomy by masseuses. There is still, however, a lingering doubt in the minds of some whether much knowledge is necessary for what is often regarded as a merely mechanical occupation.¹⁵⁸

'If, however', the article continued, 'one views the work in the light of a profession, as a therapeutic agency, which may be of great benefit or equally great detriment, according to the skill, knowledge and experience of the operator, then perhaps it will be allowed that *some* knowledge, at least, is necessary of the delicate machinery which we have to manipulate'.¹⁵⁹ It was through knowledge, they argued, that a rational understanding of how massage affected the human body could be obtained, and it was the rational application of massage that differentiated the professional from the 'empiric' or 'untrained'. From the outset, then, the STM challenged the notion of massage as a 'purely mechanical occupation' and knowledge became a cornerstone of their professional claims. '[T]he experience of all *masseuses*, as distinct from

¹⁵⁷ 'Committee Meeting', (4 November 1898), WL, SA/ CSP/ B.1/1/2.

¹⁵⁸ 'M.A.E.', 'Necessity of a Study of Elementary Anatomy for Masseuses', *NN* (October 1898), 134-135, (p.134).

¹⁵⁹ 'M.A.E.', 'Necessity of a Study', 134.

rubbers', the article concluded, was that 'we are always wanting to know more and more of this wonderful human machinery'.¹⁶⁰

Challenging conventional understandings of gender and massage in this way, however, meant identifying closely with medical norms, values and practice, in order to avoid encroaching on the physicians' territory. The STM argued that intellectual training was in the interest of both the patient and the physician. For the patient, detailed knowledge enabled the masseuse to 'understand' 'the cause of the various symptoms of pain or discomfort', and 'intelligently set to work for their relief'.¹⁶¹ Without such insight, they argued, the masseuse could not perform manipulations that were 'the result of intellectual exercise and discriminating judgement' and had the potential to do harm.¹⁶²

Far from encroaching on the physicians' interests, the STM argued, scientific expertise was a necessary prerequisite to understanding medical direction and authority. 'I take it for granted', the STM wrote in 1898, 'that properly trained masseuses will not usurp the doctor's prerogative of diagnosis and recommend treatment on their own account'.¹⁶³ 'The more the masseuse knows', they continued, 'the less is she inclined to flaunt her limited knowledge in a vulgar, ostentatious way before either doctor or patient; the better trained, the more obedient and open to instruction will she be'.¹⁶⁴ It was argued that the more intellectually equipped the masseuse, the more likely she was to understand her position and the dividing line between her duties and that of the doctor. In 1892, Elizabeth Manley wrote for *Nursing Notes* that, '[a]nything like criticism of the doctor's treatment [...] is usually a result of ignorance', and 'the

¹⁶⁰ 'M.A.E.', 'Necessity of a Study', 135.

¹⁶¹ 'M.A.E.', 'Necessity of a Study', 134.

¹⁶² 'M.A.E.', 'Necessity of a Study', 135.

¹⁶³ 'M.A.E.', 'Necessity of a Study', 134-135.

¹⁶⁴ 'M.A.E.', 'Necessity of a Study', 135.

more we learn, and the more experience we gain, the less shall we be inclined to dogmatize upon matters which do not come within our province'.¹⁶⁵ Rafferty has argued that far from being a value neutral activity, professional knowledge has been a cultural resource to create and sustain power relations.¹⁶⁶ While the STM's knowledge claims challenged gender inequality and forwarded the professional aspirations of women, they also had to invoke conventional patriarchal social relations within medicine for legitimation and survival.

Passing the examination was not the only prerequisite for membership to the STM; masseuses were also required to subscribe to a set of rules. As Beth Linker has argued, professional codes can be viewed as 'statements of distinct fears, concerns, and desires of a professional group of people in a specific time and place'.¹⁶⁷ The professional rules of the STM were developed in tandem with the interests and values of social purity, the medical profession and were inherently shaped by gender. They were a product of a negotiation of interests; by limiting their role the STM achieved professional status as well as the medical and moral high ground.

The Society's byelaws were put in place to control the actions of members. By making the boundaries of professional conduct explicit they were also a system by which membership could be policed. The STM had the prerogative to punish members who deviated from the stated rules, which meant revoking their certificate, membership from the Society and the removal of their name from the Institute's Roll of Masseuses. As the reasoning went, if a masseuse did not have her name on the STM's Roll, she would not have

¹⁶⁵ E. A. Manley, 'Hints to Masseuses', *NN* (May 1892), 50.

¹⁶⁶ Rafferty, *Politics of Nursing Knowledge*, p.8.

¹⁶⁷ Beth Linker, 'The Business of Ethics: Gender, Medicine, and the Professional Codification of the American Physiotherapy Association, 1918-1935', *Journal of the History of Medicine and Allied Sciences*, 60:3 (2005), 320-354, (p.323).

access to a supply of patients that normally came from physician referrals, as well as losing a valuable credential.

The Society's rules were not directly aimed towards the patient's wellbeing but rather intended to regulate the relationships between patient–masseuse, and masseuse–physician. The STM sanctioned that '[n]o General Massage for *Men* to be undertaken', although '[o]ccasional exceptions may be made at a Doctor's special request for urgent or nursing cases'.¹⁶⁸ It is important to note that this ruling applied to general as opposed to local massage. As Lucy Robinson wrote in October 1898 the topic of 'massing men' was an 'oft debated and misunderstood question' and 'local work, such as knee, shoulder, may frequently be taken'.¹⁶⁹ Sex-segregated practice clearly defined the patient-therapist relationship and was a way of neutralising the gender-intimacy dynamic of the therapeutic encounter, which, as we have seen, caused so much controversy.

The circumscription of the masseuse's practice was an outward expression of her purity and respectability. It was a professional boundary formulated in dialogue with Victorian understandings of gender and sexuality that problematised intimacy. The STM's professional project was formulated to contrast with the moral and professional ambiguity surrounding massage that allowed it to be used as a disguise for prostitution. The STM aimed to pull the disguise away by making the practice transparent. As highlighted in the previous section, the *BMJ*, social purity commentators, and masseuses alike welcomed such a clearly defined rule. As masseuse M. Eva Ellison expressed in *The Nursing Record* in February 1894, 'as long as one sex *massers* [sic] the other sex there will always be scandals, therefore, we Masseuses must bind

¹⁶⁸ 'Massage Notes', *NN* (March 1895), 37.

¹⁶⁹ Lucy Robinson, 'The Masseuse', *NN* (October 1898), 133.

ourselves strictly to invariably refuse to masser an adult male patient', 'both for our own protection and that of the public'.¹⁷⁰ The decision to keep practice sex-segregated, then, was in line with the STM's professional aspirations to decouple massage from sexual inferences in order to offer women security in a fiercely contested arena. As such, the professionalisation of massage can be viewed as part of the wider social purity movement, and it is, perhaps, not surprising that Wicksteed notes 'in the early years, the work of the STM was carried on hand in hand with the Vigilance Committee'.¹⁷¹ While its professional aspirations sought to improve the status of a female profession and give masseuses license to work with impunity, the realisation of these aspirations, in the form of professional boundaries, was expressed through the discourses of social purity that sought to police gender and define womanhood.

The other byelaws of the Society were concerned with defining the relationship between the masseuse and the physician. These rules were in place to assure physicians and the public that STM masseuses were part of the medical establishment and willing to adhere to its mandates of professionalism. The primary principle was that masseuses should only undertake a case under a physician's prescription.¹⁷² Reliance on medical referrals clearly demarcated a dividing line between the duties of the physician and the masseuse, maintaining the premier position of the medical profession. Diagnosing and prescribing treatment was deemed strictly the physician's responsibility and it was the masseuse's duty to diligently carry out his directions.

The STM continually called for 'scrupulous loyalty' to the medical profession: 'let us beware that we are really loyal and honourable to the

¹⁷⁰ 'The Massage Question', *The Nursing Record* (9 February 1895), WL, SA/CSP/P.1/1.

¹⁷¹ Wicksteed, *The Growth of a Profession*, p.53.

¹⁷² 'Massage Notes', *NN* (March 1895), 37.

doctors, whose *helpers*, not equals, we aspire to be'.¹⁷³ It was deemed unprofessional for a masseuse to criticise or suggest medical procedure in any way. As Lucy Robinson commented in March 1894, '[a] masseuse should be as loyal to the doctor who trusts her with a case as any nurse, and no suggestions for slight alterations of the treatment made without first referring to him':¹⁷⁴

Any peculiarity of development should be described to the doctor or surgeon; if such information is given simply as the result of observation, and *not* as an opinion, it will always be accepted willingly by the medical man, and may be of great use.¹⁷⁵

In September 1895, Chairwoman Rosalind Paget spoke to new members, suggesting that 'the more professionally they behaved with regard to the medical man, the more successful they would be'.¹⁷⁶ She told them that a masseuse should abandon cases where she found that, 'unknown to the doctor, the patient was consulting other physicians (or quacks of various kinds), if his orders were being distinctly disobeyed' or if any 'matters were concealed from him that it would be important that he should know in the interests of the patient'.¹⁷⁷ The division of labour complemented rather than challenged existing authority relations within the medical establishment and aimed to embed the massage profession within medicine. Professional survival depended upon mutual loyalty, for which it was necessary to gain favour from the medical profession.

Through explicit loyalty and dependence upon the medical practitioner the STM aimed to be viewed as ethical practitioners. Medical legitimacy enabled them to dissociate from 'unethical' and 'untrained' practitioners. For the STM,

¹⁷³ 'M.A.E.', 'Necessity of a Study', 135.

¹⁷⁴ Robinson, 'Massage', (March 1894), 31.

¹⁷⁵ Robinson, 'Massage', (March 1894), 31.

¹⁷⁶ 'Massage Notes', *NN* (September 1895), 120.

¹⁷⁷ 'Massage Notes', *NN* (September 1895), 120.

the code of conduct strengthened rather than limited the profession. 'We wish in no way to curtail legitimate work', they wrote in October 1898; rather rules were there to 'protect' 'members from unpleasantness' and had given doctors 'a feeling of security that our rubbers are not prescribing quacks, and the general public a feeling of trust that our members are masseuses of irreproachable character'.¹⁷⁸ Confining work to medical referrals meant that the nature of the work could not be disputed as either immoral or un-medical. It was also believed that prescription should be in the hands of the medically trained to ensure safe practice: 'no case should be undertaken without a doctor', Robinson noted in 1894, 'as massage may be injurious and even dangerous to some people to whom this remedy is unfitted'.¹⁷⁹

The STM defined unethical or unprofessional practice as any work taken outside of the remit of medical direction. It was important for them to dissociate themselves from any anti-establishment or irregular as well as 'immoral' massage practice. Speaking in September 1895 Rosalind Paget warned at the:

inadvisability of masseuses tampering with hypnotism, etc., seeing that meddling ignorantly with these sorts of questions constantly gets the profession of massage into disrepute, and one of the objects of our Society is to try to neutralise the impression made on the public by the unprofessional conduct of people calling themselves masseuses.¹⁸⁰

Even cosmetic work, frequently referred to as 'toilette massage', was prohibited. 'Cases that come under the category of face and toilette massage, usually combined with manicure and chiropody and hairdressing, are not undertaken by

¹⁷⁸ 'One of the Founders of the STM', 'Nurses in Council', *NN* (October 1898), 138.

¹⁷⁹ Robinson, 'Massage', (March 1894), 31.

¹⁸⁰ 'Massage Notes', *NN* (September 1895), 120.

our Society',¹⁸¹ as it only involved 'beautifying the complexion', which 'does not need doctor's orders'.¹⁸²

The final two rules prohibited advertising in any place but 'strictly Professional Papers' and the sale of any drugs to patients.¹⁸³ Like the pledge to confine work to medical direction, these measures ensured alignment with the professional interests of medicine. Advertising outside of medical journals, the STM argued, 'seldom results in satisfactory cases', and when patients ordered massage for themselves, 'disastrous results' often ensued with the masseuse receiving 'a great deal of well-deserved blame'.¹⁸⁴ This rule was especially important in light of the controversy over massage advertising in the 1894 massage scandal, whereby the *BMJ* claimed that there was no clear way of distinguishing genuine practitioners. With regard to advertising, the STM stated plainly, if the masseuse would 'take a walk down Piccadilly she will see numerous examples of what to avoid'.¹⁸⁵ It was the medical credibility of the journal that lent the advertisement authenticity and removed uncertainty.

As P.S Brown shows, the relationship between patent medicine proprietors and the medical profession was a difficult one throughout the nineteenth century.¹⁸⁶ The sale of proprietary medicines was objectionable to the medical profession for a number of professional and economic reasons. Patent vendors often styled themselves with medical titles; they also usurped medical authority and presented market competition to medical prescription. The STM wished to avoid any involvement in this territorial debate and

¹⁸¹ Anon., founder, 'Nurses in Council', *NN* (October 1898), 138.

¹⁸² Wicksteed, *The Growth of a Profession*, p.51.

¹⁸³ 'Massage Notes', *NN* (March 1895), 37.

¹⁸⁴ Anon., founder, 'Nurses in Council', 138.

¹⁸⁵ Anon., founder, 'Nurses in Council', 138.

¹⁸⁶ Brown, 'Social Context and Medical Theory', pp.216-219.

prohibiting the sale of medications neutralised this potential threat to the medical profession. The ruling they argued:

is to prevent the chance of unrecognised practices, such as puffing and recommending proprietary articles, supplying patients with drugs, and taking a commission or prescribing applications or drugs that have not been ordered by the medical attendant.¹⁸⁷

By clearly defining ethical massage practice within the mandates of the medical profession the STM aimed to gain favour that would ultimately support their own professional aspirations. The STM's byelaws were a product of a negotiation of professional interests, worked out in a highly specific context. While their definition of professional practice restricted and subordinated the masseuse's role it also gave them moral and medical legitimacy and authority over an arena of expertise.

While so far this section has looked at how the STM established its professional territory, another important dimension to their project was establishing a professional image and identity. As nurse historians demonstrate, educating the probationer nurse in middle-class, domestic ideology was a central element of hospital training.¹⁸⁸ This 'character training' was a crucial part of the nursing reform movement whereby nursing was transformed from a 'base occupation suitable only for the lowest orders' into a 'profession' in which women from the upper echelons of society took an interest.¹⁸⁹ The STM undertook a similar project with massage, aiming to transform the identity of massage from a morally, medically and ethically questionable occupation, to a

¹⁸⁷ Anon., founder, 'Nurses in Council', 138.

¹⁸⁸ For studies of 'character training' see, Bashford, *Purity and Pollution*, Chapter 2; Rafferty, *Politics of Nursing Knowledge*, Chapter 2.

¹⁸⁹ Christine Hallett, 'Nursing, 1830-1920: Forging a Profession', in *Nursing and Midwifery in Britain since 1700*, ed. by Anne Borsay and Billie Hunter (London: Palgrave Macmillan, 2012), pp.46-73, (p.50).

'safe, clean and honourable profession'. One of the ways in which they aimed to do this was by inculcating certain character values and *esprit de corps* amongst its membership.

While the leaders of the STM came from a background of the nursing and midwifery elite, schooled in the London Hospitals and the language and social etiquette of the 'new nurse', they were aware that not all masseuses had the same social or professional background. As President of the Midwives' Institute Jane Wilson emphasised to new STM members in November 1895:

Personal dignity is wanted. You are *making* the profession by your character. Do not give trouble and make difficulties. Remember you come to it giving less time and money than is required for a nurse's calling. The sentiment that has surrounded the latter does not surround your profession.¹⁹⁰

The STM aimed to establish an identity akin to nursing, based on the middle-class values of honesty, morality, sobriety, cleanliness and self-sacrifice. As many new members did not have hospital training, however, the Society was anxious that they were aware of the appropriate professional etiquette for their new line of work. Masseuses were warned that their name would be removed from the Roll in the event of 'unprofessional conduct' or 'any breach of the ordinary moral code, of sobriety, honesty and respectability'.¹⁹¹

Although the STM did not have control over massage training at this point, they worked hard to influence the behaviour of members through their examinations, journal, rules and disciplinary code. The massage examination frequently included ethical questions such as: 'What are your duties as a

¹⁹⁰ 'Massage Notes', *NN* (December 1895), 161.

¹⁹¹ 'Massage Notes', *NN* (June 1895), 78.

masseuse, to the Doctor, the patient, and yourself?’¹⁹², ‘Of what advantage is the Incorporated Society of Masseuses to- (a) The medical practitioner, (b) The patient, (c) The masseuse’,¹⁹³ and ‘How may the personal habits of the masseuse be responsible for success or failure in her profession?’¹⁹⁴ Successful new members of the Society were also given a list of ‘suggestions’, ‘for the help of those just entering the profession’ – the ‘wilful disregard’ of such ‘deemed to amount to unprofessional conduct’.¹⁹⁵ They included:

1. The dress of a masseuse should be plain and suited to her work
2. She should avoid gossip respecting her patients, and should refrain from even mentioning their names to other parties.
3. She should refuse any offers of stimulants at the house of her patients.
4. She should not recommend any drugs to her patients, or make any profit by procuring them; but in every way she should observe the strictest loyalty towards the medical advisers.
5. She should take every precaution against conveying infectious disease
6. The fees she charges should be in accordance with professional rules.¹⁹⁶

These suggestions demonstrate the STM’s expectations of the masseuse’s character and conduct.

The behaviour of the masseuse was thought to directly impact the reputation of the profession. The suggestions were an attempt to regulate the relationship between the masseuse and patient in a therapeutic encounter that often took place in private at the patient’s home. Rafferty’s work shows how the nurse’s character was deemed especially important when they were sent out to attend patients in their homes, and ‘were no longer under the surveillance of the hospital’.¹⁹⁷ Fears that the ‘unsupervised’ nurse might exploit patients for

¹⁹² ‘Massage Supplement to NN’, *Nursing Notes and Midwives’ Chronicle* (February 1914), i. (henceforth *NNMC*) *Nursing Notes* changed titles to *Nursing Notes and Midwives’ Chronicle* in January 1908.

¹⁹³ ‘The Incorporated Society of Trained Masseuses’, *NNMC* (November 1912), 304.

¹⁹⁴ ‘The ISTM’, *NNMC* (July 1911), 186.

¹⁹⁵ ‘Massage Notes’, *NN* (June 1895), 78.

¹⁹⁶ ‘Massage Notes’, *NN* (June 1895), 78.

¹⁹⁷ Rafferty, *Politics of Nursing Knowledge*, p.54.

personal gain or conduct herself unprofessionally were echoed amongst the STM. Regulating the appearance of the professional masseuse was another method of identity formation. In February 1909 the examiners complained that candidates 'short petticoats, high heeled shoes, and transparent stockings, and an exceedingly obnoxious styles of hairdressing' went 'extremely ill with a print dress, bonnet and veil'.¹⁹⁸ As Figure 3 showing the founders wearing their nurse's uniform illustrates, a uniform appearance was encouraged to bestow a sense of professional coherence and authority. Like education and byelaws, establishing a professional appearance was a professional strategy that countered the massage scandals.

In giving advice to new masseuses, Jane Wilson warned, 'I think I will begin by saying 'Don't'. The general behaviour and manner of a masseuse is of more consequence to her patient than she generally has the least idea of'.¹⁹⁹ She called for masseuses to be confident and certain when dealing with patients, but most of all to avoid gossip. It is wise, she said, 'never to discuss the patient's health except with the person who is responsible for her welfare'.²⁰⁰ The importance of confidentiality was reiterated in many of the STM's articles: '[i]t is impossible to be too careful about names and addresses of patients. Walls reveal secrets and getting behind screens as we do perforce, we ought to be most scrupulous in practising a golden silence'.²⁰¹ Through the behaviour of its members, the STM sought to influence the social standing and status of the new massage profession. As Jane Wilson continued, 'with regard to another very difficult subject - your attitude to servants', '[t]he servant of the present day has not yet been able to "place the masseuse"', The doctor they

¹⁹⁸ 'Examination Committee', (23 February 1909), in Barclay, *In Good Hands*, p.42.

¹⁹⁹ 'Massage Notes', *NN* (December 1895), 161.

²⁰⁰ 'Massage Notes', *NN* (December 1895), 161.

²⁰¹ 'Massage Notes', *NN* (September 1895), 120.

understand. The trained nurse they are beginning to understand, but the masseuse has at present no fixed position in their minds'.²⁰² It was because the first generation of masseuses were setting a precedent for the profession and faced strongly held prejudices against massage and women's work, that there was such a strong concern to define and regulate the masseuse. 'We are doing all we can to fit you for your work', wrote the Society, 'but all our exertions will be useless without the co-operation of the members of the Society; *you* must be a credit to the Society by your conduct, and by giving honest, loyal, *good care* and attention to your patient.'²⁰³

The STM aimed to establish a professionalism and *esprit de corps* based on a notion of masseuses as self-sacrificing healers of the suffering. By presenting their work as vocational, the STM aimed to configure themselves as professionals and move away from the view of massage as a trade or occupation. The rhetoric of self-sacrifice, familiar to the nursing reform movement, was often presented to the masseuse: 'no one who is a true masseuse, loving her work and her patients as she ought to do, can fail to find in it room for plenty of sacrifice for constant patience and tact'.²⁰⁴ In December 1895 the STM wrote:

A masseuse ought to have an ideal. She comes to those who are in an exhausted condition, often suffering much pain, as 'the healer,' one who comes to take away the pain that is the 'counsel of perfection'.²⁰⁵

The Society encouraged members to see the charitable aspect of massage work and not only as a way of making money. '[I]t seems to me very often that

²⁰² 'Massage Notes', *NN* (December 1895), 161.

²⁰³ 'Massage Notes', *NN* (September 1895), 120.

²⁰⁴ 'Massage Notes', *NN* (December 1895), 161.

²⁰⁵ 'Massage Notes', *NN* (December 1895), 161.

the patient gets regarded as a means, not an end', lamented Lucy Robinson in December 1895.²⁰⁶

if getting patients and getting fees for them is our primary object (no matter how desirable both these points are) it is not the right standard, the well-being of the patient, the hope of helping to cure them, or at all events alleviating their suffering, ought to hold the first place in our minds, and to do this more than mere rubbing is necessary, we need to cultivate patience, sympathy and gentleness, in addition we have to try to bring interest and brightness to those to whom it may be very difficult to find it for themselves.²⁰⁷

'Manners maketh man,' she concluded, and 'we are naturally judged by our conduct, which is apt to be very sharply criticised'.²⁰⁸ As an organisation whose professional aspirations were challenged on multiple fronts, the STM tapped into the ideological authority of middle-class womanhood to negotiate their interests. Although small 'details always seem dull and dry', the STM wrote, 'unless we love our work and so glorify them, we shall not be able 'to hitch our waggon to a star''.²⁰⁹

Conclusion

This chapter has explored why and how massage was professionalised by the STM in 1895. Analysis of the massage scandals offers insights into the ways in which massage was contested ethically and professionally in the late-nineteenth century, and the powerful social purity and medical discourses through which the STM negotiated its professional aspirations. This chapter argues that the STM's professional project can be seen as simultaneously part and product of the women's movement and social purity campaign. In order to

²⁰⁶ 'Massage Notes', *NN* (September 1895), 120.

²⁰⁷ 'Massage Notes', *NN* (September 1895), 120.

²⁰⁸ 'Massage Notes', *NN* (September 1895), 120.

²⁰⁹ 'Massage Notes', *NN* (September 1895), 120.

carve out massage as a 'respectable' profession for women in a context in which the status of both massage and women's professional roles were fiercely debated, the STM formulated its territory and professional identity in tandem with the dominant patriarchal social relations governing society and medicine. By subordinating and limiting their practice the massage profession gained moral and medical legitimacy and authority over an increasingly valuable therapeutic territory.

Together the first two chapters have outlined the forces upon which professionalisation of massage was contingent. They have argued that it was a process dependent upon the reformulation of massage into medical orthodoxy, a division of medical labour, socio-cultural debates about intimacy and a movement of aspirant female professionals. The next two chapters examine the broader development of massage as a practice and profession in the period before 1914. While scholarship has looked the professionalisation of massage in terms of the massage scandals, these chapters widen the frame of reference to examine the development of massage in relation to disability, rehabilitation and the medical profession.

Chapter 3

Massage, Disability and Injuries, pre-1914

Massage nowadays includes so many things that the actual fact of rubbing or manipulation is merely the alphabet of the work [...] Those of us who remember massage in its youth know that it was chiefly used for rheumatism, stiffness and kindred ills. Then came its use for maladies, such as constipation, sluggish liver, sciatica, neuralgia, etc. A great step was taken in the prescription of rest cure cases including vigorous massage. And following this the employment of massage for surgical work, beginning with lateral curvature, flat foot and other deformities, and old fractures, and ending in the deeply interesting treatment by massage of twenty-four hours old fractures with the great saving of pain and time which has been gained thereby.¹

This chapter investigates the use of massage before the First World War. By tracing the practice of massage this chapter offers insights into why and how massage was incorporated into medicine. It shows that the treatment of disability and the rehabilitation of musculo-skeletal injuries were key drivers for the development of massage as a practice and profession in this period, a development that highlights the increasing socio-economic importance of disability to medicine and limitations within regular therapeutics in treating these patients. It demonstrates how the assimilation of physico-therapeutic techniques into medicine – such as massage – aided the expansion of orthodox therapeutics into these areas. It also shows that the assimilation of massage into medicine was a platform for professionalisation. The lack of medical involvement in this arena opened up a vista for the massage profession to develop expertise in the territory of physical treatment and practice with a level of autonomy. It demonstrates how massage was used alongside a number of other physical methods, showing that the treatment of disability and injuries

¹ Lucy Robinson, 'Massage in Connection with Monthly Nursing', *Nursing Notes* (henceforth *NN*), (October 1904), 163.

were locations that cultivated the development of a multi-skilled specialism embryonic of physiotherapy before 1914.

To investigate these questions, this chapter focuses on two areas. The first half explores how massage was used in the context of deformity, paralysis and pain. To do so it looks at four conditions massage was frequently used to treat: club foot, spinal curvature, infantile paralysis and rheumatism. The second half examines how massage featured in debates about the rehabilitation of injuries, firstly by looking at how it was used as an after-treatment for old fractures and secondly by examining its use for the treatment of recent fractures. Using medical journals, texts and lectures; the STM's institutional records and commentary in *Nursing Notes*; hospital reports and records, this chapter traces the use of massage to multiple locations that have not been researched before. By analysing why and how massage was used in the period before 1914 this chapter shows that the practice and profession of massage played a key part in the early development of rehabilitation within medicine, a role that would become magnified during the First World War.

Deformity, Paralysis and Pain

As historians have shown, disability and deformity were common amongst Victorian and Edwardian populations. Poverty related diseases such as rickets, poliomyelitis and surgical tuberculosis, poor maternal health and malnutrition were amongst the causes of a variety of idiopathic, congenital and acquired chronic impairments. As Humphries and Gordon identify, between 1900 and 1950 the majority of the physically disabled were under the age of fourteen, with more than half a million children suffering from rickets, polio, tuberculosis,

cerebral palsy, impaired vision, deafness and other disabilities.² Adults were also at risk of disablement through sickness, old-age and military service, as well as urban and work related accidents.³

While disability was not new, the late-nineteenth century was a moment in which impairment became spotlighted and problematised. Social investigations into urban slum life by individuals such as Charles Booth and Seebohm Rowntree from the 1880s contributed to shifting understandings of the causes and management of poverty. Rather than being the result of indolence and immorality, and best treated through the ethic of 'self-help', Booth and Rowntree argued that the morality of the poor was not to blame for their condition and that they were not able to alleviate their situation without external assistance. The Education Acts of the 1870s and 1880s, which brought universal education to children between five and thirteen highlighted the extent of ill-health and impairment amongst the young. Anxieties surrounding the physical health of the population were further intensified in the wake of the Second Boer War (1899-1902), when around 40 per-cent of all men who signed up to the British Army were found to be underweight, under-height, and suffering from disease or malnourishment.⁴ It was in a climate of fears about the declining health of the British population and national degeneration that health reforms and initiatives to manage disability emerged.

Fears of the population's physical decline were linked to growing national-cum-nationalist anxieties about the rise of Bismarck's Germany and

² Steve Humphries and Pamela Gordon, *Out of Sight: The Experience of Disability 1900-1950* (Plymouth: Northcote House, 1992), p.12.

³ Meaghan Kowalski, 'Enabling the Great War: Ex-Servicemen, the Mixed Economy of Welfare and the Social Construction of Disability, 1899-1930', (Unpublished doctoral thesis, University of Leeds, 2007), p.23.

⁴ Kowalski, 'Enabling the Great War', p.28.

Britain's position as a leading imperial power.⁵ In this context industrial and military efficiency was considered of paramount importance, making the health of the population, especially of children as the nation's future soldiers, workers and mothers, a political issue. As scholarship demonstrates, there were a number of different responses to the political drive for national efficiency, including genetic approaches expressed through eugenics, and environmental approaches such as health reforms.⁶ Medical interest in the treatment of disability and injuries in this period was part of this wider turn toward disability and growing socio-economic awareness of the importance of individual productivity.

It is important, however, not to overemphasise medical provision for disability and injuries in this period, nor medical interest in these developing arenas. Scholarship shows that disability continued to be viewed within society as a problem to be tackled more through educational means than medicine and surgery, until the interwar years. This view was reified by a common belief amongst the medical profession that many chronically disabled were 'stationary cripples' 'beyond the surgical pale'.⁷ In Britain, these beliefs were reinforced by many limitations within organised medicine that blocked the development of treatment in this arena, some of which are illuminated by an examination of the adoption physico-therapeutic techniques, such as massage, into regular practice.

⁵ Roger Cooter, *Surgery and Society in Peace and War: Orthopaedics and the Organization of Modern Medicine, 1880-1948* (London: Macmillan Press, 1993), p.57.

⁶ For discussion see, Greta Jones, *Social Darwinism and English Thought: an Interaction between Biological and Social Theory* (Brighton: Harvester Press, 1980); Geoffrey Searle, *The Quest for National Efficiency: A Study in British Politics and Political Thought, 1899-1914* (Oxford: Blackwell, 1971); Bernard Harris, *The Health of the Schoolchild: A History of the School Medical Service in England and Wales, 1908-74* (Buckingham; Philadelphia: Open University Press, 1995).

⁷ Cooter, *Surgery and Society*, p.60.

Club Foot

Two disabilities considered amenable to medical treatment in the late-nineteenth century were club foot and curvature of the spine. Club foot, also known as 'talipes', was a condition emphasised within medicine throughout the nineteenth century due to the availability of an operation that promised to correct the impairment. Surgical treatment for the condition originated in France and Germany in the last decades of the eighteenth century.⁸ The procedure was introduced into Britain in the 1830s by London surgeon, William John Little (1810-1894) after undergoing the operation himself in Hanover, conducted by Louis Stromeyer.⁹ It was upon the success of this operation that William Little founded the first orthopaedic institution in 1838, the Infirmary for the Correction of Club Foot and Other Contractions that became known as the Royal Orthopaedic Hospital in 1845.¹⁰ Two further orthopaedic institutions were opened largely for this purpose, the City Orthopaedic Hospital (1851) and the National Orthopaedic Hospital (1864), and the three hospitals were amalgamated in 1907 to become the Royal National Orthopaedic Hospital (RNOH).¹¹ Before this time the condition was considered 'hopeless' and patients largely in the hands of instrument makers.¹² David LeVay has shown that the condition was traditionally dealt with by an array of treatments including hot baths, poultices, manipulation, shoes, braces and splints, and that there was little change in this approach from ancient times to the development of

⁸ Pat Starkey, 'Club Feet and Charity: Children at The House of Charity, Soho, 1848-1914', in *Disabled Children: Contested Caring, 1850-1979*, ed. by Anne Borsay and Pamela Dale (London: Pickering & Chatto, 2012), pp.15-28, (p.20).

⁹ Anne Borsay, *Disability and Social Policy in Britain Since 1750* (Basingstoke: Palgrave Macmillan, 2005), p. 50. For a primary account of William Little's experience, see William John Little, *A Treatise on the Nature of Club-Foot and Analogous Distortions: Including their Treatment Both With and Without Surgical Operation: Illustrated by a Series of Cases and Numerous Practical Instructions* (London: W. Jeffs, 1839), preface.

¹⁰ Starkey, 'Club Feet and Charity', p.18.

¹¹ Cooter, *Surgery and Society*, p.17.

¹² Little, *A Treatise on the Nature of Club-Foot*, p.xxi.

orthopaedics in the nineteenth century.¹³ As this chapter demonstrates, however, these methods continued to be practised in and of themselves as well as within orthopaedic surgery in the treatment of disability into the late-nineteenth and early-twentieth centuries.

Before the First World War orthopaedics was principally concerned with treating the chronic diseases and deformities of children. While adults would have been treated, the average age of patients was quite low for a number of reasons.¹⁴ Children were often less chronic and as their bones were softer thought to be more amenable to corrective treatment than adults. Children were also considered easier to manage as patients.¹⁵ Unless wealthy, adults were often breadwinners and mothers who could rarely afford to undergo a prolonged period of treatment,¹⁶ and as Little described, the poor population were the 'profession's most numerous clients'.¹⁷ Although the treatment of club foot and other deformities remained the preoccupation of orthopaedic institutions throughout the century,¹⁸ other conditions including spinal curvature, joint contractures, paralysis, knock knees and bow legs were also treated.¹⁹

As Pat Starkey's study of the House of Charity for Distressed Persons, founded in Soho in 1846 suggests, the majority of children would have attended hospitals for orthopaedic treatment as out-patients.²⁰ Although some would have been admitted as in-patients, at least for the initial stage of their treatment,

¹³ David LeVay, *The History of Orthopaedics* (Carnforth, Lancs: Perthenon Pub. Group, 1990), pp.491-97.

¹⁴ Cooter, *Surgery and Society*, p.15.

¹⁵ Cooter, *Surgery and Society*, p.15.

¹⁶ Beth Linker, *War's Waste: Rehabilitation in World War I America* (Chicago; London: University of Chicago Press, 2011), pp.46-47.

¹⁷ William John Little, *Remarks on the Treatment of Infantile Congenital Club-Foot* (London: For Private Medical Circulation Only, 1876), p.21.

¹⁸ Cooter, *Surgery and Society*, p.15.

¹⁹ J.A. Cholmeley, *History of the Royal National Orthopaedic Hospital* (London: Chapman and Hall, 1985), p.15.

²⁰ Starkey, 'Club Feet and Charity', p.18.

the majority were seen at out-patient clinics. The lack of long-stay in-patient facilities was a feature characteristic of voluntary hospitals in this period. Reliant upon subscriptions and charitable income, these hospitals had to maintain evidence of a high 'success' rate and 'scientific' teaching status, which led them to direct their efforts towards acute over chronic cases. Outlying charitable houses, like that at Soho, offered temporary accommodation for children living outside of London in order that they could attend appointments at regular intervals.²¹ As Starkey notes, however, the shortage of beds and suitably trained practitioners meant that only a minority of those in need would have been able to access treatment.²²

Orthopaedic institutions were not the only places that the disabled received treatment, however. Rosemary Stevens and George Weisz show that from the middle of the century 'special' departments started to emerge in the London general hospitals.²³ By the end of the century, the majority of the large voluntary institutions including Guy's, St Thomas's, the London and St George's had established various physico-therapeutic and orthopaedic departments that treated chronic disabilities.²⁴ With specialisation on the fringe of British medical practice, however, the majority of these departments were not well appointed and often supervised by junior staff members.²⁵

Manipulative and mechanical methods were important surgical tools in the nineteenth century and often a primary means of treating disability. Orthopaedics in particular had a reputation closely associated with conservative

²¹ Starkey, 'Club Feet and Charity', p.19.

²² Starkey, 'Club Feet and Charity', p.22.

²³ Rosemary Stevens, *Medical Practice in Modern England; the Impact of Specialization and State Medicine* (New Haven, Yale Univ. Press, 1966), p.26; George Weisz, 'The Emergence of Medical Specialization in the Nineteenth Century', *Bulletin of the History of Medicine* 77:3 (Fall, 2003), 536-574, (p.572).

²⁴ Leonard Goldstone, 'Massage as an Orthodox Medical Treatment Past and Future', *Complementary Therapies in Nursing & Midwifery* 6 (2000), 169-175, (p.171).

²⁵ Stevens, *Medical Practice in Modern England*, p.30.

surgery before the First World War.²⁶ Defining the orthopaedic surgeon's instruments in 1905, William Little's son, Ernest Muirhead Little (1854-1935) surgeon at the National Orthopaedic Hospital, wrote:

The surgical treatment of deformities consists of operations with knife, saw or chisel on tendons, ligaments, the soft parts generally and on bones, and in addition to these means, or alone in suitable cases, massage, manipulations and exercises are largely employed and splints and other instruments.²⁷

Describing the tenotomy in 1891, Muirhead Little noted that the procedure involved a combination of surgical and conservative techniques. The aim of the tenotomy operation was to overcome any eversion of the foot and contraction of the Achilles tendon. Ideally the procedure was to be undertaken in a number of stages over the course of three to six months and sometimes much longer.²⁸ In the first instance the tibial muscles – the Tibialis Anticus and Tibialis Posticus – were subcutaneously divided.²⁹ After the operation, the wound was bandaged and splinted in order to secure the foot in its new position. The foot was then massaged and mobilised twice daily and the splint readjusted into 'the best attainable position', for six weeks.³⁰ In severe cases, this would be followed by a further operation to divide the Achilles tendon, as well as further massage, mobilisation and splinting. When discharged, patients were sent home with

²⁶ Cooter, *Surgery and Society*, p.80.

²⁷ Ernest Muirhead Little, 'Deformities', *NN* (September 1905), 140-141, (p.140); part of a series, see (October 1905), 155-156.

²⁸ Mary Pinsent, 'The Nursing of Orthopaedic Cases', in *Cassell's Science and Art of Nursing: A Guide to the Various Branches of Nursing, Theoretical and Practical* Vol.3, by Medical and Nursing Authorities (London: The Waverly Book Company, c.1909), pp.249-260, (p.251); The technique of tenotomy varied, see Starkey, 'Cub Feet and Charity', p.20, note 26.

²⁹ Ernest Muirhead Little, 'Notes on Orthopaedic Surgery', *NN* (April 1891), 43-45, (p.44), part of a series, see (May 1891), 57-57; (July 1891), 93; (August 1891), 105-106.

³⁰ Muirhead Little, 'Notes on Orthopaedic Surgery', (April 1891), 44.

special surgical boots to be worn day and night until an age at which the child had stopped growing, in order to retain the corrected position.³¹

As a description of the tenotomy operation suggests, the success of the operation depended upon the fulfilment of a wider procedure that included prolonged after-care as well as a range of auxiliary means besides surgery. Nurses were often responsible for undertaking surgical after-treatment; writing in 1909, matron at the RNOH Mary Pinsent (1868-1960), described the important role that nurses played in the success of orthopaedic surgery:

The success of orthopaedic treatment rests to a very considerable extent, perhaps more than in any other branch of surgery, on skilful observation and minute attention to detail on the part of the nurse. The treatment is mainly operative, but largely depends, too, on mechanical appliances and physiological processes consequent on massage, electrical applications, douchings, exercises, and careful manipulation.³²

As undertaking orthopaedic work required the nurse to have specialist skills, which included splinting, bandaging, plastering, and a number of physical methods, surgical after-care became a site for specialisation. Although the history of orthopaedic nursing is often traced back to 'the specialty's matriarch' Agnes Hunt, the work of nurses at the RNOH suggests that there were other arenas, including 'pre-modern' orthopaedics, that were involved.³³ The tenotomy procedure demonstrates that while massage and other means were considered as 'supplementary' or 'auxiliary' modes of treatment to surgery 'proper', the relationship was one of interdependence. Pre-modern orthopaedics

³¹ Pinsent, 'The Nursing of Orthopaedic Cases', p.252.

³² Pinsent, 'The Nursing of Orthopaedic Cases', p.249.

³³ Quoted from the National Association of Orthopaedic Nurses, see <http://www.orthonurse.org/page/what-is-orthopaedic-nursing> last accessed 12.6.17. Also see, Barbara A. Kahn, 'The Evolution of Orthopaedic Nursing at the Hospital for Special Surgery: The First Orthopaedic Institution in the United States', *Orthopaedic Nursing*, 24:5 (September/October 2005), 343-348, (p.343).

opened an arena in which physico-therapeutic methods were incorporated into medical orthodoxy. While harnessing a therapeutic territory crucial to its own success and progress, it offered an opportunity for the professionalisation and specialisation of auxiliary services.

The rate of relapse after tenotomy was high due to insufficient after-treatment. For William Little, the blame lay with surgeons who were quick to operate but ignorant of the after-treatment necessary for the completion of the cure.³⁴ Complaining in 1876, he wrote that surgeons did not attend to manipulative and mechanical treatment themselves 'nor placed the management, after operation, in the hands of competent assistants'.³⁵ He called on them to take more involvement in applying and directing these methods if their operations were to be successful.³⁶ Day-to-day responsibility for the patient often rested with parents and William Little emphasised that surgeons should not 'hand over the cured case to the sole management of the parents until he has thoroughly *instructed* them in the duties they will have to perform in order to maintain the cure'.³⁷ There were many complaints at parental non-compliance – for example by adjusting or removing appliances to make them more comfortable to wear – frustrating the efforts of the surgeon.³⁸ Borsay's work highlights how 'many treatments relied on the long-term application of splints and plaster casts and parents were urged to play an active part in

³⁴ Little, *Remarks on Club-Foot*, pp.13-14.

³⁵ Little, *Remarks on Club-Foot*, p.14.

³⁶ Little, *Remarks on Club-Foot*, pp.19-22.

³⁷ Little, *Remarks on Club-Foot*, p.21, (original emphasis).

³⁸ Linker, *War's Waste*, p.46.

implementation'.³⁹ With club foot, for example, massage and manipulation was considered 'very useful' whenever splints were taken off.⁴⁰

By the end of the century the limitations of the tenotomy operation had generated a number of creative therapeutic responses to circumvent the reliance on after-care. In 1903 Ernest Little wrote that he sometimes resorted to a more radical procedure called the 'Phelp's operation' which cut all contracted tendons simultaneously rather than in stages over time, which he considered to be more practical in cases that 'owing to the poverty or indifference of the friends, are neglected as regards after-treatment and relapse again and again'.⁴¹ Plaster-of-Paris was another method increasingly used.⁴² The plaster method corrected deformity by massaging and manipulating the foot into an over-corrected position and fixing it there in plaster for several weeks at a time, replacing the need for on-going attention, expensive retentive apparatus and parental responsibility.⁴³ Treating deformity by manipulation and plaster rose to fame in the work of Austrian orthopaedic surgeon Adolf Lorenz (1854-1946), in the treatment of congenital hip dislocation at the turn of the century. In this procedure, frequently referred to as 'bloodless surgery' or the 'Lorenz method', the hip was wrenched into a corrected position and held in place with plaster, offering an alternative to open operation.⁴⁴

³⁹ Anne Borsay, 'From Representation to Experience: Disability in the British Advice Literature for Parents, 1890-1980', in *Disabled Children: Contested Caring, 1850-1979*, ed. by Anne Borsay and Pamela Dale (London: Pickering & Chatto, 2012), pp.87-101, (p.91).

⁴⁰ Borsay, 'From Representation to Experience', p.91.

⁴¹ Ernest Muirhead Little, 'Phelp's Operation for Club-Foot', *BMJ* (17 October 1903), 977-981, (p.977).

⁴² Edmund Owen, *The Surgical Diseases of Children*, 3rd ed. (London: Cassel & Co., 1897), p.469.

⁴³ Little, *Remarks on Club-Foot*, p.21. Describing the limitation of expensive apparatus for the treatment of the poor.

⁴⁴ H.A.T. Fairbank, 'A Clinical Lecture on Congenital Dislocation of the Hip and its Treatment', *The Lancet* (20 June 1908), 1752-1760, (p.1757).

Spinal Curvature

Deformity was not always treated with surgery, and physico-therapeutic techniques were considered as corrective measures in and of themselves and not only as surgical auxiliaries. The treatment of spinal deformities illustrates a trend within medical orthodoxy in the late-nineteenth century towards correcting deformity by massage and exercise. Curvature of the spine was a common condition in this period, more frequently found in girls than boys;⁴⁵ its incidence thought to be on the increase and it was a condition treated both at orthopaedic institutions and general hospitals.

The cause of spinal curvature was a topic of debate amongst the medical profession. Commenting in 1905, Ernest Little wrote that while '[m]uch has been written about the cause of scoliosis' its aetiology remained 'obscure'.⁴⁶ Certain key factors, however, were recognised as having a strong influence in causing the deformity, including diseases such as rickets, tuberculosis, a 'deterioration of general health',⁴⁷ or 'defect of growth',⁴⁸ that weakened the strength of the bones. Weakening of the bones, it was believed, combined with poor posture or 'the assumption of an incorrect attitude',⁴⁹ allowed 'undue yielding of the spine under strain and pressure',⁵⁰ causing it to curve. While some patients entering hospitals for the correction of spinal deformities had actively diseased bones - tuberculosis of the spine (Pott's disease) for example was a frequent occurrence - the treatment given to patients with active disease was different to that given to those at a post-acute stage and left with chronic residual

⁴⁵ Starkey, 'Club Feet and Charity', p.22. For this opinion also see Muirhead Little, 'Deformities', (October 1905), 155-156, (p.155).

⁴⁶ Muirhead Little, 'Deformities', (October 1905), 155.

⁴⁷ A.H. Tubby, 'The Treatment of Scoliosis in Childhood', *Nursing Notes and Midwives' Chronicle* (henceforth *NNMC*), (January 1912), 27, part of a series, see (February 1912), 59; (March 1912), 82-84; (April 1912), 110.

⁴⁸ Muirhead Little, 'Deformities', (October 1905), 155.

⁴⁹ Tubby, 'The Treatment of Scoliosis', (January 1912), 27.

⁵⁰ Muirhead Little, 'Deformities', (October 1905), 155.

impairments.⁵¹ In cases of active disease, doctrine indicated little to no exercise,⁵² recumbency and healthy surroundings as bones were at risk of further deterioration. In contrast post-acute or chronic patients could be treated more safely with more active approaches such as forceful manipulation and exercise.

The treatment of spinal deformity was as varied as debates surrounding its aetiology. Like many other deformities, spinal curvature had traditionally been the domain of the instrument maker. Fulminating against conventional modes of treatment in 1856, Mathias Roth complained that patients were frequently made 'to remain for hours in a horizontal or reclined position', and treated by 'stretching beds', 'iron stays or other supports' and other various 'mechanical contrivances'.⁵³ While the use of instruments remained dominant throughout the nineteenth century other measures were also used. In his study of five hundred cases of lateral curvature in 1900, surgeon at the City Orthopaedic Hospital Chisolme Williams wrote that, 'I can safely say that no five of these consecutive cases were treated alike from "start to finish"'.⁵⁴ Listing the widely varying forms of treatments he noted auxiliary crutched back supports, spring supports, cogwheel plate apparatus, corsets, poroplastic felt jackets, plaster-of-paris, Swedish movement cure, braces and straps. The greater number of patients he received, however, he commented, received no previous

⁵¹ See Robert Jones, 'Manipulation as a Therapeutic Measure', *Proceedings of the Royal Society of Medicine* (15 April 1932), 1405-1412, (p.1407), for a discussion of the debate surrounding the extent of rest and recumbence in the treatment of Pott's disease, see Linker, *War's Waste*, p.44.

⁵² Pinsent, 'The Nursing of Orthopaedic Cases', p.255.

⁵³ Mathias Roth, *Hand-book of the Movement cure: a Description of the Positions, Movements, and Manipulations, Used for Preventive and Curative Purposes, According to the System of Ling & the Works of Rothstein, Naumann, & Others* (London: Groombridge, 1856), p.229.

⁵⁴ J.Jackson Clarke, Chisolme Williams, Eldred Noble Smith, Ernest Muirhead Little, James Green and Frederick Taylor, 'A Discussion on Lateral Curvature of the Spine, Flat-Foot, and Knock-Knee', *BMJ* (1 September 1900), 575-579, (p.578). This article illustrates the medical debate around causes and treatment of spinal deformity at the turn of the century.

treatment at all.⁵⁵ It was amid a catalogue of approaches that treatment by massage and exercise, or as Roth called it 'the movement cure', appeared.

By the turn of the century treatment by massage and exercise had become accepted as a means, in and of itself, in the correction of spinal deformity.⁵⁶ Writing in 1898 STM masseuse Florence Dove commented that '[t]he belief in the use of massage for the treatment of curative curvature of the spine is, I think, general and indisputable'.⁵⁷ The emergence of this mode of treatment raised a debate about the place of mechanical instruments; as Dove noted, '[s]ince, happily, the method of treatment by artificial means- *i.e.*, supports, etc.- is no longer in vogue, there can be no question as to the lasting success in the results of what has taken their place, *i.e.*, massage, combined with physical exercises'.⁵⁸ According to Dove, the view was that artificial supports only worked temporarily, and that ultimately by supplanting the use of the spinal muscles resulted in further physical deterioration.⁵⁹ In contrast, massage and exercise, by strengthening the spinal muscles, promised both to correct deformity and maintain the new position over the long-term. According to Dove, scoliosis, perhaps more than any other condition, showed what massage could do, 'one's work is at once evident, and the hopeful conviction of a good result always before one'.⁶⁰

The use of instruments, however, was not eliminated; rather their role was reconceptualised. For surgeon of the National Orthopaedic Hospital Alfred

⁵⁵ Jackson Clarke, Williams, Noble Smith, Muirhead Little, Green and Taylor, 'Curvature of the Spine', 577-578.

⁵⁶ Jackson Clarke, Williams, Noble Smith, Muirhead Little, Green and Taylor, 'Curvature of the Spine', 575-579.

⁵⁷ Florence Dove, 'Massage in the Treatment of Spinal Curvature, Combined with the Use of Physical Exercises', *NN* (October 1898), 136-137, (p.136).

⁵⁸ Dove, 'Spinal Curvature', 136.

⁵⁹ Dove, 'Spinal Curvature', 136.

⁶⁰ Dove, 'Spinal Curvature', 136.

Tubby (1863-1930) in 1912, the use of supports remained a 'vexed question'.⁶¹ 'Supports have a bad name', he wrote, 'because some people have tried to treat curvature by them only. They are merely passive agents, of course, and the whole object of this treatment should be to maintain the spine in the improved position'.⁶² While medical doctrine turned away from the use of instruments to correct deformity, they remained in use as retentive apparatus that worked alongside gradual correction by massage and exercise, and a common resort for patients to whom such treatment was unavailable.⁶³

Spinal deformities formed a large proportion of orthopaedic patients seen at orthopaedic and general hospitals.⁶⁴ Describing the prognosis of such a case, Mary Pinsent wrote that 'the success of the treatment is often decided by the stage at which the deformity has arrived when treatment is commenced'. 'If a patient applies for treatment at the very onset of the deformity', she continued, 'there is every prospect of great improvement, if not always of complete cure'.⁶⁵ Treatment was not only directed toward the correction of deformity, but also to the prevention of its increase or of its recurrence in the future.⁶⁶ The approach at the RNOH involved a combination of methods, including rest, recumbency, massage, mobilisation, as well as free and mechanical exercises:

The patient is ordered complete rest, lying flat on his back on a hard mattress with no pillow for several hours daily. Special exercises, in the gymnasium and on the Zander apparatus, massage and manual manipulation must be given as ordered by the surgeon.⁶⁷

⁶¹ Tubby, 'The Treatment of Scoliosis', (March 1912), 82.

⁶² Tubby, 'The Treatment of Scoliosis', (March 1912), 82.

⁶³ Tubby, 'The Treatment of Scoliosis', (March 1912), 82. Also see Ernest Muirhead Little in, Jackson Clarke, Williams, Noble Smith, Muirhead Little, Green and Taylor, 'Curvature of the Spine', 578.

⁶⁴ Pinsent, 'The Nursing of Orthopaedic Cases', p.196.

⁶⁵ Pinsent, 'The Nursing of Orthopaedic Cases', p.257.

⁶⁶ Pinsent, 'The Nursing of Orthopaedic Cases', p.257.

⁶⁷ Pinsent, 'The Nursing of Orthopaedic Cases', p.257.

Similarly special out-patient departments at general hospitals such as the physical exercise department at St Thomas's, engaged staff to direct massage, mobilisation and mechanical exercises for the treatment of such conditions.⁶⁸ Spinal curvature was not the only orthopaedic condition to be treated in this way; this approach offered a means of correcting a number of chronic disabilities that otherwise had little hope for improvement in this period.

While prescribed by the surgeon, practically the treatment was often devised and undertaken by a nurse or masseuse. Writing in 1903, a STM prize essay winner wrote that '[i]f a surgeon is consulted he usually orders a course of daily massage of some months' duration, accompanied by well-arranged physical exercises, carefully graduated and directed'.⁶⁹ Prize winner 'R.U.B.' described that while 'sometimes the surgeon orders the rubbing and exercises in detail, oftner he simply orders "massage for spinal curvature," with exercises according to the discretion of the masseuse he employs'.⁷⁰ Similarly Dove noted that '[i]f the surgeon gives the masseuse any instructions as to which side he wishes her to mass most [...] then she has her direct orders and knows what line to go upon accordingly'. More often, however, 'he orders simply massage of the back for spinal curvature, with no further particulars (which is more usual)'.⁷¹ Not only was the masseuse left in charge of the prolonged day-to-day treatment of cases, but also vague prescriptions meant that the masseuse also had to devise the course of treatment. While the level of medical involvement varied, for the majority, responsibility for the treatment of such disabilities was the territory of the masseuse.

⁶⁸ E. O. Thurstan, 'The New Department for Physical Exercises', in *St Thomas's Hospital Report* Vol.28, ed. by Hector Mackenzie and G.H. Makins (London: J. & A. Churchill, 1898), pp.195-198, (p.195).

⁶⁹ 'R.U.B.' 'Prize Essay: Lateral Curvature', *NN* (November 1903), 162.

⁷⁰ 'R.U.B.' 'Lateral Curvature', 162.

⁷¹ Dove, 'Spinal Curvature', 136.

Being left to devise the course of treatment devolved a high level of responsibility upon the masseuse. Lacking medical direction meant that a significant amount of knowledge and skill was required in order to treat such conditions. As Dove wrote, the masseuse needed an 'understanding [of] the nature of scoliosis, what is involved in the rotation of the vertebrae, the approximate relations of the curves, in short, the anatomy of the spine in this deformed condition'.⁷² Besides medical knowledge the masseuse had to be able to adapt treatment to each individual case. Describing the complexity of the treatment of scoliosis by massage Dove wrote:

The manipulations by massage for the different sides must necessarily be somewhat different. One avoids all movements that tend to stretch the already stretched muscles on the convex side, working more crosswise to the spine than any dragging movements from above downwards; and one applies all deep movements, that would naturally be most effectual, in getting out the shortened muscles on the concave side.⁷³

In the absence of medical direction masseuses were left to their own discretion, a situation that required them to have a thorough practical and theoretical knowledge. It demonstrates that lack of medical interests in this arena before the war offered an opportunity for the massage profession to exercise a level of practical autonomy and develop specialist expertise in this territory.

Massage and exercise were closely related and used alongside each other in the treatment of spinal deformity. Describing the aim of remedial exercise Dove wrote that '[c]ombined with massage, further deformity may be prevented in the more severe cases' and 'in spines that are more easily put right, their result is admirable'.⁷⁴ Passive, active, manual and mechanical

⁷² Dove, 'Spinal Curvature', 136.

⁷³ Dove, 'Spinal Curvature', 136.

⁷⁴ Dove, 'Spinal Curvature', 136.

exercises were given to patients. At the RNOH nurses gave special exercises to cases of 'spinal curvature, flat foot, and any other deformity' in an 'orthopaedic gymnasium and massage room', equipped with Zander appliances.⁷⁵ Mechanotherapy was found useful when a large amount of force was needed for the manipulation, but also as a labour-saving device to deal with a high volume of patients, as Pinsent wrote: 'it would be difficult, without a very large staff of nurses, to give the necessary massage or long-continued passive movements'.⁷⁶ General hospitals established similar departments, labelled under various titles such as 'physical exercise', 'orthopaedic' or 'massage' department, which also offered treatment by exercise. For example, the physical exercise department established at St Thomas's in 1898 received many patients with severe scoliosis and other deformities 'generally seen in the outpatients' department', and treated them by exercise and 'various machines' that had been installed.⁷⁷

Treatment by massage and exercise required consistent and on-going attention. Discussing this work in 1894 masseuse Lucy Robinson wrote that: '[i]n massage for spinal lateral curvature and flat foot, or any case in which an abnormal growth is being treated', 'the advance will be slow and tedious, and the time and money expended are apt to discourage parents'.⁷⁸ Perseverance, however, 'often brings its reward, though it may take years to achieve a cure', 'I have seen [...] little feet that had been born completely turned in and useless until three years old, as active as any others after two years' treatment'.⁷⁹ While conservative in its approach and slow in its results, however, the work of

⁷⁵ Pinsent, 'The Nursing of Orthopaedic Cases', p.255.

⁷⁶ Pinsent, 'The Nursing of Orthopaedic Cases', p.255.

⁷⁷ Thurstan, 'The New Department for Physical Exercises', p.196.

⁷⁸ Lucy Robinson, 'Massage', *NN* (March 1894), 31.

⁷⁹ Robinson, 'Massage', (March 1894), 31.

massage and exercise could also, according to the argument of Gert Breiger, be considered as 'radical' and 'progressive' in that it offered a means of completely correcting deformity.⁸⁰

The correction of deformity by exercise required both knowledge of anatomy and the theory of exercise, and like massage, nurses and masseuses were often responsible for directing the treatment. As highlighted in Chapter 1, throughout the nineteenth century remedial gymnastics had become the professional expertise of the Swedish gymnast. Many hospitals, including the London Hospital, St Thomas's and the National Orthopaedic Hospital employed Swedish trained professionals before the war, to direct treatment and instruct nurses.⁸¹ If the exercises were not carefully selected, it was argued, the treatment would not have a corrective value. According to Dove, 'physical exercises' needed to be 'intelligently carried out', and knowledge of the 'direct application of each one' was essential.⁸² Exercises were specifically chosen for the individual patient, 'and none without its direct use, merely tiring the patient'.⁸³ To tire the patient was to risk them falling back into 'the bad position – the position that has gone on unfortunately too long already'; it was only with this 'individual attention one can be sure of certain results'.⁸⁴

Opinion among orthopaedic surgeons reiterated this view. In 1912 Alfred Tubby wrote that 'it is of no use to tell the patient what to do and leave her to it.

⁸⁰ Gert H. Brieger, 'From Conservative to Radical Surgery in Late Nineteenth-century America', in *Medical Theory, Surgical Practice*, ed. by Christopher Lawrence (London: Routledge, 1992), pp.216-231, (p.222).

⁸¹ The London Hospital, employed Mr and Mrs Koch in 1904, ('Meeting of the Medical Council', (16 April, 1904), Medical Council: Minutes (7 May 1903-1 April 1905), Royal London Hospital Archives (henceforth RLHA), RLHLM/1/5); St Thomas's employed Swedish trained Miss Nicodemi in 1898, (Thurstan, 'The New Department for Physical Exercises', p.195); the RNOH employed Professor of Gymnastics, B. Bertrand in 1874, (Cholmeley, *History of the RNOH*, p.74).

⁸² Dove, 'Spinal Curvature', 136.

⁸³ Dove, 'Spinal Curvature', 136.

⁸⁴ Dove, 'Spinal Curvature', 136.

She must be placed under careful, intelligent and conscientious supervision. If she is left to go on as she pleases, the result will be worse than negative, it will be extremely harmful'.⁸⁵ Chisolme Williams complained that he received cases that had become 'muscle-bound' by the indiscriminate use of exercise. That is, he wrote, when 'the whole of the muscular system had been brought up to an equal stage of power' rather than specifically strengthening the weakened area, therefore making the deformity 'either stationary or worse'.⁸⁶ Similarly, surgeon to the City Orthopaedic Hospital E. Noble Smith wrote that while he had 'advocated exercises for more than twenty years', that 'it was not sufficient [...] to recommend exercises', unless carried out, 'carefully and accurately' under the observation of the surgeon.⁸⁷ The call of surgeons such as Noble Smith and Chisolme Williams for their peers to take more involvement in the supervision of cases was linked to their own interests in orthopaedics and the reputation of this treatment.

As these concerns also suggest, however, aside from a small number of surgeons interested in orthopaedics, the medical profession showed little interest in prescribing and supervising exercises. For example, lay specialists were often engaged in institutions such as the London voluntary hospitals to take charge of physical therapeutic departments. Those, with professional interests in exercises, such as Jackson Clarke, considered this detrimental: 'very much harm and much unnecessary trouble and expense are incurred by persons untrained in medicine prescribing and directing exercises'.⁸⁸ For these

⁸⁵ Tubby, 'The Treatment of Scoliosis', (April 1912), 110.

⁸⁶ Jackson Clarke, Williams, Noble Smith, Muirhead Little, Green and Taylor, 'Curvature of the Spine', 578.

⁸⁷ Jackson Clarke, Williams, Noble Smith, Muirhead Little, Green and Taylor, 'Curvature of the Spine', 578.

⁸⁸ Jackson Clarke, Williams, Noble Smith, Muirhead Little, Green and Taylor, 'Curvature of the Spine', 575.

men, the failure of their peers to direct treatment frustrated successful cures and damaged the reputation of orthopaedic methods. For the masseuse, it was an arena where she was called to gain knowledge and expand her skillset. As Dove wrote, 'I think there can be no doubt that the masseuse who can carry out physical exercises in cases of spinal curvature, in addition to her other profession, is more satisfactory to the patient and the surgeon, whilst her results are far more encouraging to herself'.⁸⁹

The case studies of club foot and spinal deformity demonstrate that massage and exercise became valuable surgical tools in the treatment of deformity in the late-nineteenth century. Assimilating this therapeutic offered medical orthodoxy an opportunity to extend its influence to an increasingly visible and socio-politically significant demographic, while also lessen the monopoly of instrument makers and other unlicensed practitioners over this territory. Furthermore, devolving the routine work to nurses and masseuses meant that medical practitioners could pass on time-consuming and low-status manual work while maintaining authority over central diagnostic and prescribing tasks. These case studies also show, however, that medical involvement in the treatment of disabilities and the use of physical methods was, in general, limited. The lack of 'medical direction' in practice suggests that this was not a sphere of interest for the majority of medical men. Day-to-day responsibility for treatment was often the remit of the nurse or masseuse, which became a platform for the professionalisation of massage.

⁸⁹ Dove, 'Spinal Curvature', 136.

Infantile Paralysis

Doctors in the nineteenth century often experienced a degree of powerlessness in their inability to cure certain illness, or control patients through long and uncertain courses of treatment.⁹⁰ Two such conditions that were commonly faced and frustrated medical cure were infantile paralysis and rheumatism. Infantile paralysis was a symptom of an acute disease such as polio-myelitis,⁹¹ and most commonly affected children from one to four years old.⁹² Describing the onset of disease, Ernest Muirhead Little wrote that: '[a] child hitherto in good health is seized with a feverish attack lasting a day or two; he is convulsed but speedily recovers, apparently completely, when it is found that he has lost the use of one or more of his limbs entirely'.⁹³ As the child recovered over a number of months or years, it was often found that certain groups of muscles remained permanently paralysed. 'The part', Muirhead Little continued, 'is smaller and colder than its fellow. A whole limb may be thus paralysed and hang a useless appendage'.⁹⁴

Throughout the nineteenth and early-twentieth centuries, the prognosis for paralysis was poor. Writing in 1890, William Murrell admitted that 'the outlook is indeed bad, and the ultimate chances of recovery are small':

Even when the paralysis to some extent passes away, one or two muscles, or groups of muscles, fail to perform their accustomed

⁹⁰ David Cantor, 'The Aches of Industry: Philanthropy and Rheumatism in Inter-War Britain', in *Medicine and Charity Before the Welfare State*, ed. by Jonathan Barry and Colin Jones (London: Routledge, 1991) pp.225-246, (p227).

⁹¹ Mathias Roth, *Contributions to the Hygienic Treatment of Paralysis, and of Paralytic Deformities: Illustrated by Numerous Cases with a Short Sketch of Rational Medical Gymnastics, or, the Movement Cure* (London: Groombridge, 1860), p.20; 'W.A.', 'Prize Essay: Infantile Paralysis', *NN* (July 1899), 99-100, (p.99).

⁹² Muirhead Little, 'Notes on Orthopaedic Surgery', (May 1891), 58.

⁹³ Muirhead Little, 'Notes on Orthopaedic Surgery', (May 1891), 58.

⁹⁴ Muirhead Little, 'Notes on Orthopaedic Surgery', (May 1891), 58.

functions; and the child, even if able to get about, walks with a limp and is a cripple.⁹⁵

Infantile paralysis was the cause of many deformities including club foot, spinal curvature, torticollis, abnormal growth and muscular contractions.⁹⁶ Paralysis was a class of disease in which, as Roth lamented in 1860, 'the usual remedies have, in general, no prominent effect', 'and in the majority of inveterate cases nothing is even attempted for restoring the patient's power of movement'.⁹⁷ In his promotion of the movement cure, Roth critiqued the regular treatment of paralysis. Roth described how paralytic deformities were dealt with by an assortment of procedures including tenotomy or instruments to lengthen the healthy, retracted muscles; powerful medications, leeches, electricity and douchings, yet 'without any improvement in the paralysed part' and moreover 'many other patients are left entirely to their fate' receiving no treatment at all.⁹⁸

The powerlessness of conventional therapeutics opened an opportunity for lay-practitioners, 'quacks and rubbers', who regularly treated paralysis. Roth, for example, fulminated that:

Many patients fall into the hands of rubbers, belonging to the craft of St. Crispin while boasting of their ignorance and the sharpness of their eyes, apply in every case embrocations of ammonia and other strong stimulants, cover the backs and limbs of their victims with pitch plasters, which are torn down two or three times a week [...] Other rubbers ashamed of ignorance, explain to their credulous patients the origin of their complaint by a thickening of the synovial fluid, which must be rubbed away, even where no synovia exists.⁹⁹

⁹⁵ William Murrell, *Masso-therapeutics, or, Massage as a Mode of Treatment*, 5th edn. (London: H.K.Lewis, 1890), p.93.

⁹⁶ Murrell, *Masso-therapeutics*, p.94; Pinsent, 'The Nursing of Orthopaedic Cases', p.253; Roth, *Treatment of Paralysis*, p.18.

⁹⁷ Mathias Roth, *Notes on the Movement-Cure, or Rational Medical Gymnastics, the Diseases in Which it is Used, and on Scientific Educational Gymnastics* (London: Groombridge & Sons, 1860), p.10.

⁹⁸ Roth, *Treatment of Paralysis*, pp.1-2.

⁹⁹ Roth, *Treatment of Paralysis*, p.3.

Other patients, he wrote, were 'daily' 'shampooed and smeared over with infallible Indian oil and other ointment' after hot-air vapour baths.¹⁰⁰ Roth complained that 'many patients are induced to place themselves under the treatment of such quacks by the advice of regular practitioners'.¹⁰¹ This suggests that while the medical profession acknowledged 'the importance of embrocations, plasters, and frictions', it was not, in 1860, commonly considered to be part of the work of regular practitioners.¹⁰² It highlights that in the nineteenth century the relationship between rubbing and medical orthodoxy was not necessarily one of outright hostility and competition, but rather they worked alongside one another. Rubbers operated in a sphere outside of the scope of regular practice and offered a service that the majority of medical practitioners had neither experience nor desire to undertake. The incorporation of massage and other physical therapies into medicine over the course of the century supported the development of regular therapeutics into these medically challenging arenas.

Still, by the turn of the century there was emerging within British medicine a new optimism surrounding the outlook for paralysis. This was rooted in the work of Robert Jones and his colleagues, who before the First World War had begun 'cultivating a site which was significant in being separate both from the work of general surgeons in general hospitals and from the narrow 'orthopaedics' conducted in the old orthopaedic hospitals'.¹⁰³ In 1903 Robert Jones and Alfred Tubby published *Modern Methods in the Surgery of Paralysis*, reporting the development of procedures such as muscle-grafting, tendon-transplantation, and arthrodesis, which they claimed 'widened the scope

¹⁰⁰ Roth, *Treatment of Paralysis*, p.3.

¹⁰¹ Roth, *Treatment of Paralysis*, p.2.

¹⁰² Roth, *Treatment of Paralysis*, p.3.

¹⁰³ Cooter, *Surgery and Society*, p.78.

of surgical treatment, both of paralysis itself and of its resulting deformities, and promise to effect an entire revolution in this branch of surgery'.¹⁰⁴ Both Jones and Tubby identified themselves as general surgeons with a specialist interest in the field of orthopaedics.¹⁰⁵ Cooter has described the work of Jones, Tubby and their likeminded colleagues as a branch of 'new surgery' that was later extended into military orthopaedics in the First World War. Marginalised by the surgical elite from the major voluntary hospitals, yet encompassing a greater scope than the traditional orthopaedic institutions, the 'new surgery' interests were forced to develop provincial projects.¹⁰⁶ While the new orthopaedic surgery of Jones and his colleagues distinguished itself from traditional orthopaedics, the majority – including Jones – still advocated the use of a range of conservative and invasive techniques in the treatment of deformity, according to the type of case.¹⁰⁷

Massage and physical therapy played an important role as an auxiliary to the new surgery of paralysis. Lecturing to the STM in 1910, physician and masseuse Florence Barrie Lambert described the place of massage in the new surgical procedures.¹⁰⁸ For example, massage was given 'as soon as possible after the operation' in cases of tendon transplantation or tenotomy to restore stimulus, lengthen or shorten tendons. Similarly, 'muscle massage' was to be given after a case of arthrodesis where the object was 'to give a fixed joint instead of a flail joint'.¹⁰⁹ Before the war these techniques were used at the RNOH and Mary Pinsent noted that 'general surgical nursing' was required after

¹⁰⁴ Alfred Tubby and Robert Jones, *Modern Methods in the Surgery of Paralysis: with Special Reference to Muscle-Grafting, Tendon-Transplantation & Arthrodesis* (London: Macmillan, 1903), p.v.

¹⁰⁵ Cooter, *Surgery and Society*, p.35.

¹⁰⁶ Cooter, *Surgery and Society*, p.51.

¹⁰⁷ Cooter, *Surgery and Society*, pp.37-38.

¹⁰⁸ Florence Barrie Lambert, 'The Use of Massage in Nervous Diseases', *NNMC* (January 1911), 6-7, (p.6). Notes of a lecture delivered to members of the STM, (9 November 1910).

¹⁰⁹ Barrie Lambert, 'Nervous Diseases', 7.

operation 'followed by massage and gentle passive movements or exercises'.¹¹⁰ This demonstrates that massage, which was a primary surgical tool of traditional orthopaedics, was not eliminated but reconceptualised within the new surgery of orthopaedics, as an auxiliary.

Physical therapy was not only used as an adjunct or surgical auxiliary in the treatment of paralysis, however. As Chapter 1 highlighted, massage was widely understood to be one of the most valuable therapeutic tools available in the primary treatment of paralysis and immobilisation. In an STM prize essay written on 'Infantile Paralysis' in 1899, for example, 'W.A.' wrote that '[m]edical authorities seem to view the outlook as somewhat dark, but most agree in saying that massage, begun early and continued long and patiently, is worth all the other measures advised'.¹¹¹ Despite advances in surgery and new optimism surrounding the rehabilitation of paralysed and disabled limbs, there was very little that medicine could do to stop polio-myelitis once it had commenced. Massage, however, offered a means of radically transforming the progress of the disease. In their 1903 text, Jones and Tubby wrote that '[t]he surgeon is often asked "[a]t what time should treatment be commenced?" the answer is, as soon as possible after the attack'.¹¹² They advocated general massage from the outset to 'minimise the practical effects of the damaged or destroyed cells',¹¹³ and as soon as it was possible to identify the paralysed muscles, to adopt a 'more special line of treatment', whereby '[m]assage should be mainly directed to strengthening the affected muscles, and the limb [...] kept in a position opposed to the deforming tendency'.¹¹⁴ 'If this were generally recognised', they

¹¹⁰ Pinsent, 'The Nursing of Orthopaedic Cases', p.257.

¹¹¹ 'W.A.', 'Infantile Paralysis', 100.

¹¹² Tubby and Jones, *Surgery of Paralysis*, p.38.

¹¹³ Tubby and Jones, *Surgery of Paralysis*, p.39.

¹¹⁴ Tubby and Jones, *Surgery of Paralysis*, p.40.

continued, 'there would be no fixed deformities requiring tenotomy; for only those surgical procedures which aim at the restoration of muscular power, or at the stability of limbs, or fixation of joints, would be required'.¹¹⁵

Massage, then, was used both to prevent deformity and restore function. Barrie Lambert wrote that '[t]he paralysed muscles have to be prevented from atrophying by means of effleurage, petrissage, hacking and clapping'; 'the non-paralysed muscles have to be prevented from shortening by means of passive stretching'; 'the joints are kept from becoming stiff by means of passive movements', 'the nerves are saved from degeneration by means of vibrations, both static and rubbing' and 'active movements' were encouraged in the 'paralysed arc muscles'.¹¹⁶ Masseuses sought to promote and maintain muscle nutrition 'so that when the slow repair takes place in some portions, at least, of the spinal cord, the renewed motor impulses may find themselves cooperating with health and normal, and not atrophied muscle fibres' and function could be restored.¹¹⁷ To undertake this treatment masseuses required specialist knowledge in order to effectively develop wasted muscles without overdeveloping unparalysed muscles or stretching paralysed ones.¹¹⁸ Challenging the treatment of paralysis by massage was the fact that progress often took place gradually over months or even years.¹¹⁹ Very few sufferers could have afforded to be in the care of a trained masseuse for such a prolonged period and it was for this reason that medical practitioners advised a patient's parents and friends to give massage on a day-to-day basis.¹²⁰

¹¹⁵ Tubby and Jones, *Surgery of Paralysis*, p.38.

¹¹⁶ Barrie Lambert, 'Nervous Diseases', 7.

¹¹⁷ 'W.A.', 'Infantile Paralysis', 100.

¹¹⁸ 'W.A.', 'Infantile Paralysis', 100.

¹¹⁹ 'W.A.', 'Infantile Paralysis', 100.

¹²⁰ Barrie Lambert, 'Nervous Diseases', 7; also see Weir Mitchell in Chapter 1.

Other physical therapies also featured alongside massage in this treatment. Outlining the combined approach in a lecture given to the STM in December 1909, physician J. Curtiss Webb said that:

It must be remembered that these cases require months of care, and that it is not on electricity alone that we must depend, for this is but an adjunct to massage, passive movements and many other remedial means tending to strengthen the weakened muscles, to prevent deformities of the limb and contractions and to assist in restoring the function to the damaged cells of the spinal cord.¹²¹

Physical treatments were used in tandem towards the same end to restore health and function. Heat in the form of 'hot-water bottles', 'douches' and 'woollen stockings' were all used to promote circulation and improve the temperature of paralysed muscles.¹²² Similarly, electricity was used to increase blood flow, temperature and stimulate muscle function.¹²³

The nurse or masseuse who treated these cases was often responsible for the administration of this range of therapies. As in the treatment of spinal curvature and other deformities, however, masseuses rarely received thorough medical instructions, which meant they were often responsible for devising and carrying out the treatment. Masseuses frequently used electricity to treat paralysis and as Curtiss Webb noted, 'owing to the protracted nature of the treatment, you will frequently find yourselves compelled to rely on your own judgement as to what special electrical application to use, and when to vary the treatment'.¹²⁴ For Curtiss Webb this meant that it was essential for the masseuse to gain a knowledge of electricity:

¹²¹ J. Curtiss Webb, 'A Few Points on Electricity for Masseuses and Nurses', *NNMC* (May 1910), 113-114, (p.114). Notes of a lecture given at the Trained Nurses' Club (10 December 1909).

¹²² Barrie Lambert, 'Nervous Diseases', 7.

¹²³ Webb, 'A Few Points on Electricity', 114.

¹²⁴ Webb, 'A Few Points on Electricity', 112.

Remember that just as when a medical man orders massage for a case he often leaves it to your presumably expert knowledge to apply the correct kind of manipulations, so it not unusually is in the kindred applications of electricity, and so it behoves you to thoroughly understand the *modus operandi* of the means you are using.¹²⁵

By the turn of the century, the STM felt that an elementary knowledge of electricity was ‘necessary to all practising massage’.¹²⁶ This knowledge would ensure that masseuses were equipped to direct the treatment themselves as well as undertake complex medical instructions if given.¹²⁷ Writing in 1901 Council member and masseuse Elizabeth Manley argued that without training:

she will be equally at a loss, whether she receive the vague instruction, “a little electricity” [...] or whether she receive definite instruction from one who knows, but couched in language which is to her as an unknown tongue.¹²⁸

The STM warned, however, that a training in electricity ‘did not justify the assumption of the title “Electricians” or Electriciennes’’, as this was ‘suggestive of quackery’.¹²⁹ Examining the use of massage in the treatment of paralysis demonstrates how the massage profession was expanding the scope of its expertise and skillset in a context we can discern as early rehabilitation within medicine.

Rheumatism

Another condition that did not readily respond to conventional forms of medical or surgical treatment in the late-nineteenth century was rheumatism. The work of David Cantor has shown that the poor prognosis and provision for cases of

¹²⁵ Webb, ‘A Few Points on Electricity’, 114.

¹²⁶ ‘The ISTM’, *NN* (March 1904), 45.

¹²⁷ A. Manley, ‘The Curriculum Necessary for a Masseuse’, *NN* (August 1901), 107.

¹²⁸ Manley, ‘The Curriculum’, 107.

¹²⁹ ‘Massage Notes’, *NN* (March 1904), 45; Manley, ‘The Curriculum’, 107.

chronic rheumatism and arthritis was the cause of demoralisation amongst both patients and the profession.¹³⁰ Like the treatment of fractures, rheumatism did not receive sustained attention from the medical profession until the interwar years, when it became aligned with political and professional interests.¹³¹ There was little to no public provision available for these types of chronic cases. Cantor shows that even by the interwar years voluntary hospitals rarely saw chronic arthritics. In 1928 the Ministry of Health estimated that these cases formed around 6.4 per cent of in-patient work and less than 0.3 per cent of the out-patient work of the English voluntary hospitals, and at the Royal Orthopaedic Hospital 2.8 per cent and 4.5 per cent respectively.¹³² In contrast, Bath physician Dr Kerr Pringle estimated that the seven mineral water hospitals in Britain saw around 8,600 patients a year, of which around 93% would have been rheumatic, and such figures fell far short of the numbers requiring treatment.¹³³

Physical therapies, however, had historically been used to treat rheumatic complaints on the margins of regular medical practice. In particular rheumatic conditions were strongly associated with hydrotherapy and bathing establishments. Spas flourished across continental Europe in the eighteenth and nineteenth century including Britain where a number of mineral water hospitals opened, such as Bath in 1738, Harrogate in 1824 and Buxton in 1858.¹³⁴ Massage had also been used historically for rheumatic complaints,¹³⁵ and was often part of the treatment offered at bathing establishments. For

¹³⁰ David Cantor, 'The Contradictions of Specialization: Rheumatism and the Decline of the Spa in Inter-War Britain', *Medical History*, 34 (January, 1990), 127-144, (p.127).

¹³¹ Cantor, 'The Contradictions of Specialization', 129.

¹³² Cantor, 'The Contradictions of Specialization', 127.

¹³³ Cantor, 'The Contradictions of Specialization', 126-127.

¹³⁴ Jean Barclay, *In Good Hands: The History of the Chartered Society of Physiotherapy 1894-1994* (Oxford: Butterworth-Heinemann Ltd, 1994), p.2.

¹³⁵ Robinson, 'Monthly Nursing', 163.

example, the 'douche-massage' first developed at Aix-les-Bains in France became famous at the turn of the century, whereby patients were massaged and given passive movements while being hosed with hot and cold water.¹³⁶ By 1900 the 'douche-massage' had been introduced at 'several places in England, notably at Bath and at Buxton' and cases of rheumatoid arthritis were 'often ordered to one of these places for a few weeks' course of treatment, with very good results'.¹³⁷

For economic reasons physical therapy was not available to the majority of sufferers and for many chronically disabled by rheumatism the only recourse was Poor Law infirmaries. Although Poor Law infirmaries admitted patients of the same social class as the voluntary hospitals, the percentage of chronic and senile cases was at least treble in the former institutions.¹³⁸ As working medical schools, voluntary hospitals could not afford to have their beds filled with long-term chronic cases regarded 'not useful for clinical instruction', and these patients were drafted to the nearest Poor Law hospital.¹³⁹ Describing this problem, nurse inspector of Poor Law infirmaries Helen Todd wrote that, 'all helpless or paralysed patients, and those suffering from such chronic ailments as rheumatism and arthritis, are sent to the infirmary. It is by no means uncommon to see patients who have lain in the same ward for 15 or 20 years in a helpless condition'.¹⁴⁰ Lacking status and scope for private practice, these

¹³⁶ 'C.M.M.' 'A Visit to Aix-les-Bains', *NN* (October 1906), 155.

¹³⁷ Elizabeth Manley, 'Massage in Rheumatoid Arthritis', *NN* (October 1900), 145.

¹³⁸ Helen Todd, 'Nursing in Poor Law Institutions in England and Wales', in *Cassell's Science and Art of Nursing: A Guide to the Various Branches of Nursing, Theoretical and Practical* Vol.1, ed. by Medical and Nursing Authorities (London: The Waverly Book Company, c.1909), pp.128-148, (p.141).

¹³⁹ Todd, 'Nursing in Poor Law Institutions', p.141.

¹⁴⁰ Todd, 'Nursing in Poor Law Institutions', pp.141-142.

institutions had no visiting honorary physicians or surgeons¹⁴¹ and 'owing to the meagreness of staff', time and resources were heavily stretched.¹⁴²

With the development of physical therapy departments in general hospitals, however, emerged a capacity to treat rheumatic cases. For example, in 1908 the German Princess Hatzfeldt donated 'a complete set of Dr. Tyrnauer's hot-air baths for the treatment of rheumatism' to the London Hospital,¹⁴³ which were to be closely linked to the massage department.¹⁴⁴ By 1910 the Tyrnauer Baths 'for the treatment of rheumatism by hot air' had relieved hundreds of patients.¹⁴⁵ At St Thomas's Hospital in 1912, electric heat baths were transferred from the X-ray and Electro-therapeutic Department to the Physical Exercise and Massage Department, which swelled its case list with arthritic patients. The transference of the heat baths to the Massage Department was decided because 'the majority of cases for such baths received treatment by massage and exercises as well'.¹⁴⁶ Before 1914, departments like these emerged haphazardly and were frequently managed by nurses, Swedish gymnasts, masseurs, masseuses, and often lacked medical supervision.¹⁴⁷ Physical treatment departments became, as one commentator described, 'dumping grounds' for chronically disabled cases not amenable to other medical

¹⁴¹ Todd, 'Nursing in Poor Law Institutions', p.131.

¹⁴² Todd, 'Nursing in Poor Law Institutions', p.135.

¹⁴³ 'Reflections: From a Board Room Mirror', *The British Journal of Nursing* (12 December 1908), Royal College of Nursing online archive (henceforth RCN), 480. Tyrnauer baths were a form of radiant heat, used for the treatment of rheumatism by hot air, see W.S. Tegner, Michael Mason, and C.G. Barnes, 'The London Hospital Department of Physical Medicine and Rheumatology', *Annals of Physical Medicine* Vol. X. No 5 (1970), 218-222, (p.219).

¹⁴⁴ 'Minutes of a Meeting of the House Committee', (29 March 1909), House Committee: Minutes (3 February 1908-2 May 1910), RLHA, RLHLH/A/5/51.

¹⁴⁵ E.W. Morris, 'A History of the London Hospital', (London: Edward Arnold, 1910), pp.15-16.

¹⁴⁶ Richard Timberg, 'Report of the Physical Exercise and Massage Department for 1912', in *St Thomas's Hospital Report* Vol.41, ed. by J.J. Perkins and C.A. Ballance (London: J. & A. Churchill, MDCCCCXIV), pp.211-214, (p.211).

¹⁴⁷ Harold Balme, 'Principles of Organization', in *Recent Advances in Physical Medicine*, ed. by Francis Bach (London: J.A. Churchill, 1950), pp.333-343, (p.333).

or surgical treatment.¹⁴⁸ While patients were often sent for physical therapy as a last resort, lost sight of by the medical practitioner who referred them, and their treatment left unsupervised, these therapies often offered the only relief for many symptoms that frustrated medicine.

Massage and mobilisation were widely advocated for the treatment of rheumatic conditions. In *The Causes and Treatment of Rheumatoid Arthritis* in 1896, Buxton spa physician Samuel Hyde wrote that, '[i]t is surprising that so little attention has been paid to the use of massage and exercises in the treatment of rheumatoid arthritis whilst so much has been written upon the curative effects of baths and mineral waters'.¹⁴⁹ Hyde suggested that this was linked to the self-promotion of spa-practitioners who were 'naturally exposed to the temptation to exaggerate the advantages of baths and waters in this'.¹⁵⁰ '[B]ut truth compels me to say', he continued:

that whilst certain balneological methods possess an undoubted value in rheumatoid arthritis, it is not improbable that massage and suitable movements are even more valuable. I will even go so far as to say [...] I should elect to use massage and manipulations of the joints in preference to the use of baths in this disease.¹⁵¹

Writing in 1900, STM council member Elizabeth Manley wrote that '[m]assage is frequently ordered in cases of rheumatoid arthritis' and therefore it was a 'matter of importance' that masseuses understood the best method of undertaking the case.¹⁵² The aim of massage and mobilisation was to reduce swelling, relieve pain, and improve mobility. 'What the masseuse has to aim at', Manley continued, was 'relief of pain, to promote absorption of exudations and

¹⁴⁸ Balme, 'Principles of Organization', p.333.

¹⁴⁹ Samuel Hyde, *The Causes and Treatment of Rheumatoid Arthritis* (London: Henry Kimpton, 1896), p.51.

¹⁵⁰ Hyde, *Rheumatoid Arthritis*, p.51.

¹⁵¹ Hyde, *Rheumatoid Arthritis*, p.51.

¹⁵² Manley, 'Massage in Rheumatoid Arthritis', 145.

deposits in and round the joint, the restoration of muscular vigour and elasticity, and also, in cases where passive movements are permitted by the doctor, gradual restoration of mobility to the joints'.¹⁵³

While massage and heat had long been combined in bathing establishments, STM masseuses also recorded using heat alongside manipulations in their treatment of rheumatic patients. By reducing pain and stiffness – two common inhibitors to movement – masseuses were able to give more advanced treatment. Writing in 1901 one masseuse commented that, '[s]ometimes massage for ten minutes under water as hot as can be borne, makes the movements less painful'.¹⁵⁴ '[A]s an adjunct to massage', heat was found to 'materially shorten the period usually taken to make an appreciable difference in the condition of a stiff limb'.¹⁵⁵ Masseuses used 'hot packs', hot-water douches and 'dry heat' generated by electricity.¹⁵⁶ 'Dry heat' could be applied generally to the body or locally to a specific body part, and a variety of dry heat 'baths' were patented on the market. Masseuse 'A.M.B.' had the 'Greville System' installed at her nursing home and she described that 'I have been enabled to give considerable relief to one patient who had been unable to walk for over twelve months':

She came to me for a course of hot-air baths, and after the use of these, combined with local massage and joint movement daily, in a very short time she was able to move about without assistance, and before she left my Home, in just under two months, she could walk by herself with the aid of a stick.¹⁵⁷

¹⁵³ Manley, 'Massage in Rheumatoid Arthritis', 145.

¹⁵⁴ 'W.A.', 'Massage for Stiff and Painful Joints', *NN* (March 1901), 40.

¹⁵⁵ 'A.M.B.', 'Hot-Air Baths', *NN* (July 1902), 90.

¹⁵⁶ 'A.M.B.', 'Hot-Air Baths', 90.

¹⁵⁷ 'A.M.B.', 'Hot-Air Baths', 90.

Describing a similar system in 1899, M.A. Ellison wrote of the 'Dowsing radiant heat treatment', whereby electric heat lamps were directed towards affected areas of the body.¹⁵⁸ She noted that '[t]he apparatus has been used with marked success at many hydropathic establishments in England' and '[m]any doctors recommend its use in combination with massage and Swedish movements'.¹⁵⁹ It was found that radiant heat 'so softens and relaxes the muscles that the massage is not nearly so painful with as without it'.¹⁶⁰

While the luxury of a minority, treatment by massage and physical therapy often drastically altered the prognosis of patients and afforded considerable relief. Lasting results, however, often depended upon prolonged treatment. In 1896 Samuel Hyde wrote that 'there is no disease in which patience and perseverance in a given course of treatment are more necessary for success; many weeks and several months must elapse before the disease shows decisive signs of yielding to the treatment'.¹⁶¹ The STM frequently encouraged its members to take up such long-term cases 'thought to be very tedious' being 'often very chronic, and in which lasting improvement is nearly always slow' because the 'visit of the masseuse is a little event often in a weary day' full of 'pain, sleeplessness, and helplessness'.¹⁶² *Nursing Notes* often published reports of successful treatments. For example, in 1901 masseuse 'H.E.K.' described that:

He had been, I think, eleven weeks in hospital when the senior house surgeon asked me to rub him [...] he looked like an old man; he could not hold himself upright [...] It looked almost a hopeless task, but I began by rubbing the extremities, then after a few times manipulated the joints and the spine [...] After a week I began to try

¹⁵⁸ M.A. Ellison, 'Dowsing Radiant Heat Treatment', *NN* (November 1899), 150.

¹⁵⁹ Ellison, 'Dowsing Radiant Heat Treatment', 150.

¹⁶⁰ 'An Interesting Case', *NNMC* (October 1913), 292.

¹⁶¹ Hyde, *Rheumatoid Arthritis*, p.38.

¹⁶² Manley, 'Massage in Rheumatoid Arthritis', 145.

passive movements, but it was quite three weeks before there was any appreciable movement of the joint [...] At the conclusion of the treatment, which lasted five months, the patient could walk three miles without the use of a stick, or feeling undue fatigue.¹⁶³

'The case was long and tedious', she concluded, 'but I was amply repaid by the good result and the patient's gratitude'.¹⁶⁴ *Nursing Notes* also recorded that massage was being used alongside vaccination therapy for rheumatism, pioneered at the turn of the century by immunologist Almroth Wright.¹⁶⁵ In one case of muscular rheumatism, 'the patient was treated by forty inoculations of Fibro-lysin' with massage 'ordered after the twentieth inoculation'.¹⁶⁶ 'When the massage begun [...] [t]he patient could hardly bear gentle stroking, but as the treatment went on it was possible to gradually increase the massage from gentle effleurage to vigorous petrissage and rollings' and by the end of the course 'most of the pain had disappeared'.¹⁶⁷

Relieving poor and chronically disabled patients offered a site through which the STM could harness its professional identity to public service. As Council member Elizabeth Manley described, rheumatic patients were 'not the cases from which we reap the most glory, but at the same time they are cases which call out the moral and social qualities of the masseuse'.¹⁶⁸ The STM continually encouraged its members to undertake 'infirmity massage' and 'charitable cases' in the spirit of altruism and personal development. Masseuses volunteered their services for charitable organisations such as the Invalid

¹⁶³ 'H.E.K.' 'A Note on Chronic Rheumatism', *NN* (June 1901), 83.

¹⁶⁴ 'H.E.K.' 'A Note on Chronic Rheumatism', 83.

¹⁶⁵ W. Maxwell Penny, 'Correspondence: Vaccine Treatment of Rheumatoid Arthritis', *BMJ* (14 May 1949), 867-868, (p.867).

¹⁶⁶ 'Interesting Cases', *NNMC* (October 1911), 262. See also 'An Interesting Case', *NNMC* (October 1913), 292.

¹⁶⁷ 'Interesting Cases', *NNMC* (October 1911), 262.

¹⁶⁸ Manley, 'Massage in Rheumatoid Arthritis', 145.

Children's Aid Association,¹⁶⁹ and during the Boer War to The 'Absent Minded Beggar' Fund, and the Soldiers' Families Association.¹⁷⁰ In 1896 the STM collaborated with Lambeth infirmary and later with Paddington infirmary to offer practical experience for volunteering trainees, presenting the work as an 'opportunity of self improvement and of gaining valuable experience'.¹⁷¹ Writing in 1903, 'M.E.G.' lamented that '[i]t seems a pity that more masseuses do not give a little help at the various infirmaries. The work there is most interesting and – except financially – most remunerative'.¹⁷² 'M.E.G.' appealed to the masseuse describing how '[t]he work is interesting and helpful to oneself, as well as giving the opportunity to help those who could get relief in no other way'.¹⁷³ 'Cases of paralysis and chronic rheumatism, weeded out from the general hospitals, accumulate there', she wrote, 'and for them massage and electricity offer the greatest, if not the only, hope of relief'.¹⁷⁴ Massage was a luxury at these institutions and accounts relay 'gratitude' extended to masseuses by both patients and medical staff for their work.¹⁷⁵ 'If one wants gratitude and an almost spoiling appreciation of one's work', 'M.E.G.' continued, 'it is in the infirmary that one meets with it'.¹⁷⁶ Masseuse Ada Marsh described that the 'chronics' were always 'very grateful for the temporary relief given them by the rubbing, and look forward to the afternoon on which they may expect their "rubber," as the workers are called by the patients'.¹⁷⁷ Furthermore, 'our work is thoroughly appreciated by the medical authorities at the Infirmary, who

¹⁶⁹ 'The ISTM', *NN* (September 1902), 120.

¹⁷⁰ 'Massage for the Wounded', *NN* (October 1900), 140.

¹⁷¹ 'Massage Notes', *NN* (April 1896), 50. Practical experience became a requirement of the STM qualification in 1913.

¹⁷² 'M.E.G.' 'Infirmary Massage', *NN* (January 1903), 11.

¹⁷³ 'M.E.G.' 'Infirmary Massage', 11.

¹⁷⁴ 'M.E.G.' 'Infirmary Massage', 11.

¹⁷⁵ 'M.E.G.' 'Infirmary Massage', 11.

¹⁷⁶ 'M.E.G.' 'Infirmary Massage', 11.

¹⁷⁷ Ada M. Marsh, 'Lambeth Infirmary', *NN* (July 1906), 109.

are grateful to us for supplying an “aid to recovery” which would otherwise have to be considered a luxury in such a poor parish as Lambeth’.¹⁷⁸

Despite these calls, however, masseuses were often disinclined to take on chronic cases and preferred more therapeutically ‘exciting’ and remunerative work. ‘H.E.K.’ pointed out that ‘[w]e often hear of masseuses, especially the younger ones, being disappointed by the tediousness and want of improvement shewn in chronic rheumatic cases’.¹⁷⁹ Appeals for masseuses to take on ‘infirmity massage’ emphasised the variety of ‘interesting’ cases found there.¹⁸⁰ For example, ‘M.E.G.’ wrote that ‘[t]he practice is excellent, for the work is by no means confined to paralysis and rheumatism. Nervous cases, recent fractures and injuries of various kinds are included’.¹⁸¹ These reports suggest that masseuses viewed their work as increasingly involved in acute as opposed to palliative medical care.

Invested in the STM’s interest in charitable work was the public image of the massage profession. The Society was concerned that masseuses should view their occupation as a vocation as well as an economic enterprise. ‘[T]he free cases she can make time to undertake’, one member wrote:

will save her from the deplorable consequences of admitting the commercial spirit into her work, and will preserve for her the wider more sympathetic outlook and sane appreciation of the true values of well-paid, under-paid and unpaid work in her profession, and a realisation of the responsibility her skill involves.¹⁸²

¹⁷⁸ Marsh, ‘Lambeth Infirmary’, 109.

¹⁷⁹ ‘H.E.K.’ ‘A Note on Chronic Rheumatism’, 83.

¹⁸⁰ Marsh, ‘Lambeth Infirmary’, 109.

¹⁸¹ ‘M.E.G.’ ‘Infirmity Massage’, 11.

¹⁸² ‘W.A.’, ‘True Values of “Free Cases”’, *NNMC* (October 1913), 289-290, (p.290).

Putting self-interest aside for the good of the community was one way of presenting massage as a profession, masseuses as professional workers, and the STM as a professional organisation, as opposed to a trade and trade union.

Rehabilitating Injuries

Old Fractures and Injuries

In a clinical lecture published by the *BMJ* in 1867 'On Cases that Bone-Setters Cure', surgeon at St Bartholomew's Hospital James Paget (1814-1899) said to his peers that 'few of you are likely to practise without having a bone-setter for an enemy'.¹⁸³ Paget called surgeons to:

Learn then to imitate what is good and avoid what is bad in the practice of bone-setters; and, if you would still further observe the rule, *Fas est ab hoste deceri*, [it is right to learn even from an enemy] which is in no calling wiser than in ours, learn next what you can from the practice of rubbers and plaisterers: for these also know many clever tricks; and if they had but educated brains to guide their strong and pliant hands, they might be most skilful curers of bad joints and many other hindrances of locomotion.¹⁸⁴

This article marked the beginning of a wave of interest in the subject and what Cooter notes 'can be seen as the beginning of the end of traditional bone-setting'.¹⁸⁵ Bone-setters were irregular practitioners who gave relief to a range of musculo-skeletal complaints including stiff and ankylosed joints, sprains, dislocations and fractures, by manipulative techniques.¹⁸⁶ Up to this point, bone-setters had existed fairly harmoniously alongside organised medicine

¹⁸³ James Paget, 'On Cases that Bone-Setters Cure', *BMJ* (5 January 1867), 1-4, (p.1).

¹⁸⁴ Paget, 'On Cases that Bone-Setters Cure', 4.

¹⁸⁵ Roger Cooter, 'Bones of Contention? Orthodox Medicine and the Mystery of the Bone-Setters Craft', in *Medical Fringe and Medical Orthodoxy 1750-1850*, ed. by W. F. Bynum and Roy Porter (London: Croom Helm, 1987), pp.158-173, (p.159). For other articles in this debate see, Wharton Hood, 'So-Called "Bone-Setting," Its Nature and Results', *The Lancet* (11 March 1871), 336-338; (18 March 1871), 372-374; (1 April 1871), 441-443; (15 April 1871), 499-501; W.J. Penny, 'On Bone-Setting', *BMJ* (26 May 1888), 1102-1108; Howard Marsh, 'Bonesetting', *BMJ* (27 May 1911), 1231-1239.

¹⁸⁶ Cooter, 'Bones of Contention?', p.159.

because their activities did not directly threaten the interests of regular practitioners.¹⁸⁷ By the second-half of the nineteenth century, however, both the manipulative techniques of the bone-setter and the disabilities that they served had become of interest to regular medicine. As Paget's reference to 'rubbers' and 'plaisterers' above suggests, Cooter's argument extends to a more general phenomenon whereby traditional lay specialists in physical therapies were gradually replaced by the assimilation of their techniques into medicine.

The bone-setter debate was not only important for orthopaedics but also a movement within medicine that sought the reform of fracture and injury treatment. Although it was not until the interwar years that the management of fractures became a significant politico-medical issue,¹⁸⁸ conventional fracture therapy was increasingly subject to clinical debate from the 1890s leading to a BMA report in 1912.¹⁸⁹ The second half of this chapter investigates why and how massage featured in this debate and considers its significance to the massage profession.

Prior to the First World War, the treatment of traumatic injuries and fractures were part of the routine work of general practitioners and hospital general surgeons.¹⁹⁰ Trauma work, however, had a low-status within medicine and simple fractures were regularly dealt with in out-patient departments staffed by unsupervised junior medical officers.¹⁹¹ Although more complex cases, such as compound or leg fractures, were dealt with in better-managed in-patient wards, they were considered of little interest to the majority of senior surgeons

¹⁸⁷ Cooter, 'Bones of Contention?', p.162.

¹⁸⁸ For full discussion see Roger Cooter, 'The Meaning of Fractures: Orthopaedics and the Reform of British Hospitals in the Inter-war Period', *Medical History*, 31 (1987), 306-332.

¹⁸⁹ Roger Cooter, 'The Meaning of Fractures', 307.

¹⁹⁰ Cooter, *Surgery and Society*, p.80.

¹⁹¹ Robert Jones, 'Lady Jones Lecture on Crippling due to Fractures: its Prevention and Remedy', *BMJ* (16 May 1925), 909-913, (p.910).

who resented them for blocking beds.¹⁹² The customary method of treating injuries such as sprains, dislocations and fractures was by immobilisation and rest.¹⁹³ Describing the treatment of fractures in 1913, surgeon Bernard Ward wrote:

Custom has decreed that two essentials are necessary to the proper treatment of a fracture. They are:- (1) accurate setting of a bone, and (2) absolute fixation until the ends of the bone are firmly united. That is the traditional treatment of fractures, handed down from generation to generation, and it is generally accepted without hesitation.¹⁹⁴

This was achieved in a variety of ways and a range of operative and non-operative methods to reduce and fix fractures, were developed and debated before the First World War. Generally speaking, Robert Jones recalled in 1925, fractures were put carelessly in plaster and sent out at the first opportunity, '[a] more unscientific and certainly less satisfactory method is not easy to conceive'.¹⁹⁵

By the turn of the century, however, the protocol of fixation and immobilisation became subject to critique. While immobilisation and prolonged rest were necessary for the fixation and healing of the bone it also had a number of negative side effects. Writing in 1909 surgeon at the London Hospital R. Warren explained the reason for this:

Few fractures are perfectly simple, *i.e.*, such that the bone is the only part injured; in most cases there is a varying degree of injury to

¹⁹² Jones, 'Crippling due to Fractures', 910.

¹⁹³ This section will focus on the treatment of fractures in particular, however, the principles also applied to the treatment of injuries such as sprains and dislocations. For description of this see Murrell, *Massotherapy*, pp.215-221.

¹⁹⁴ Bernard Ward, 'Massage in the Treatment of Fractures and Sprains', *NNMC* (June 1913), 178, part of a series, see also (August 1913), 221-223. These conservative principles are most famously associated with the work of Hugh Owen Thomas who advocated 'rest, absolute, uninterrupted and prolonged', Leonard F. Peltier, *Fractures: A History and Iconography of their Treatment* (San Francisco: Norman Pub., 1990), p.48.

¹⁹⁵ Jones, 'Crippling due to Fractures', 910.

surrounding structures, viz., blood-vessels, lymphatics, nerves, muscles, ligaments, tendons, joints or skin.¹⁹⁶

In this situation, the usual method of ‘treating a fracture by prolonged retention of the affected limb in splints which allow of practically no movement of the soft parts about the fracture’ led to a ‘matting process’ in and around the injury, resulting in what was commonly referred to as ‘adhesions’.¹⁹⁷ Describing this in 1898, surgeon at St. George’s Hospital London, Percy Lockhart-Mummery (1875-1957) wrote that:

The stiffness of the joint is caused by adhesions in and around the capsule, for as you know the capsule of a joint is more or less loose membrane, and when the joint is at rest tends to lie in folds or pleats, the sides of which, when they remain long in contact, become stuck together, so preventing the normal movements of the joint, and causing a great deal of pain when any attempt at movement is made.¹⁹⁸

Lockhart-Mummery described how lacerated tendons, muscles and veins at the site of a fracture quickly stuck together resulting in a range of disabling impairments, such as stiffness, pain and swelling – especially common when in and around joints. Lockhart-Mummery’s discussion of fractures also extended to incidences of sprains and dislocations whereby traditional methods of bandaging and rest neglected ‘to regard the limb as a whole’.¹⁹⁹

For the general practitioner, the main concern in the treatment of a fracture was the restoration of the bone rather than the function of the limb as a whole. Simple fractures often resulted in long-term incapacity as a result of

¹⁹⁶ R. Warren, ‘The After-Results of Fractures’, *The British Journal of Nursing* (23 October, 1909), 334-335, RCN, 334.

¹⁹⁷ William Bennett, ‘On the Use of Massage in the Treatment of Recent Fractures’, *The Lancet* (5 February 1898), 359-361, (p.360).

¹⁹⁸ Percy Lockhart-Mummery, ‘The Use of Massage in the Treatment of Fractures, Sprains and Dislocations’, *NN* (January 1903), 8-9, (p.8); part of a series, see also (February 1903), 26-27; (March 1903), 36-38.

¹⁹⁹ Warren, ‘The After-Results of Fractures’, RCN, 334.

conventional treatment. After fixation, cases were often lost sight of and a degree of residual dysfunction considered inevitable.²⁰⁰ Increasingly, however, these ill-effects became a cause of criticism. The majority of accident cases came from the working classes,²⁰¹ to whom impairment could be the cause of severe and prolonged socio-economic deprivation. For example, a simple fracture of the arm – one of the most common injuries taken to general practitioners and hospital casualty departments – even under the best medical attention, could keep a person from work for up to four weeks, and a fracture of the leg could take up to six months to heal.²⁰² More commonly, however, as fractures were not well managed, residual dysfunction and impairment often became chronic, which, in the context of a skilled labour market, frequently meant loss of employment, whereby ‘if one were not a member of a friendly society, the only recourse was to friends and relatives, or to the dreaded Poor Law’.²⁰³ The emergent medical conscience surrounding fracture treatment and rehabilitation can be viewed as part of what Cooter has identified as a wider social consciousness emerging in the 1870s and 1880s around accidental injuries.²⁰⁴

A large proportion of the bone-setter’s work was fixing the chronic residual effects of traumatic injuries, often produced by conventional treatment. Describing a ‘no more typical case’ of ‘impaired mobility or usefulness of limbs after injury’ restored by the bone-setter, general practitioner Wharton Hood wrote that:

²⁰⁰ Annie Hower, ‘Fractures’, *NN* (March 1893), 34-36, (p.36).

²⁰¹ Fractures were slightly different in that they were ‘not uncommon among horse-riding ladies and gentlemen’ and may partly explain the medical interest, see Cooter, *Surgery and Society*, p.84.

²⁰² Cooter, *Surgery and Society*, p.85.

²⁰³ Cooter, *Surgery and Society*, p.85.

²⁰⁴ Roger Cooter, ‘The Moment of the Accident: Culture, Militarism and Modernity in Late-Victorian Britain’, in *Accidents in History: Injuries, Fatalities and Social Relations*, ed. by Roger Cooter and Bill Luckin (Amsterdam: Rodopi, 1997), pp.107-146, (p.108).

A healthy man sustained a fracture of one or both bones of the forearm, and went to a hospital, where splints were applied in the usual way. He was made an out-patient, and the splints were occasionally taken off and replaced. After the lapse of a certain number of weeks the bones had become firmly united, the splints were laid aside, and the man was discharged cured. He said that he could not use either his arm or his forearm, but was assured that his difficulty only arose from the stiffness incidental to long rest of them, and that it would soon disappear.²⁰⁵

'Instead of disappearing', Wharton Hood continued, 'it rather increased', and it was at this point that a patient took recourse to the bone-setter who would then 'cure' the case by forcible manipulation breaking down adhesions.²⁰⁶ Continuing the discussion in 1911, orthopaedic surgeon at St Bartholomew's, Frederick Howard Marsh (1839-1915), considered that '[m]any thousands of such injuries occur every year', and it was up to 'those who treat these cases in practice to determine how many or how few of them are to be manufactured for bonesetters to cure'.²⁰⁷

From the 1880s, however, surgical nurses, masseuses and physical treatment departments were increasingly involved in dealing with the residual impairments of conventional injury treatment. At the London Hospital in 1905, for example, three nurses from the massage department, trained by Margaret Palmer, treated stiffened joints with various apparatus.²⁰⁸ Similarly, in 1898 the physical exercise department at St. Thomas's reported the use of mechanotherapy, which had 'given very gratifying results in the cases of stiff joints'.²⁰⁹ While the general trend in large voluntary hospitals was the establishment of a massage department and the incorporation of gymnastics and equipment from

²⁰⁵ Hood, 'So-Called "Bone-Setting"', (18 March 1871), 372.

²⁰⁶ Hood, 'So-Called "Bone-Setting"', (18 March 1871), 372.

²⁰⁷ Marsh, 'Bonesetting', 1235.

²⁰⁸ 'A Meeting of the Medical Council', (14 June 1905), Medical Council: Minutes (12 May 1905-1 April 1907), RLHA, RLHLM/1/6.

²⁰⁹ Thurstan, 'The New Department for Physical Exercises', p.196.

the 1880s, there are examples of some institutions using these methods to rehabilitate injuries much earlier. Liverpool's Royal Southern Hospital, for example, had installed gymnastic equipment in 1858, to 'accelerate the perfect use of the patient's limbs, and shorten the period of their recovery', and in 1906 a Massage and Exercise Department was opened.²¹⁰

As the presence of bone-setters indicates, the use of physical therapy for injuries was not new. It is probable that part of the work of the traditional 'rubber' or 'shampooer' was – perhaps overlapping with the bone-setter – dealing with swelling, stiffness and pain resulting from accidents. In an article for *The Practitioner*, senior surgeon at St George's, Sir William Bennett noted that:

The advantages derivable from shampooing and manipulation in sprains, wrenches and similar injuries have been recognised for centuries, especially as shown in the rapid removal of extravasated blood, the cure of oedema, the prevention of stiffness and the checking of muscle waste, the *identical* complications which are prone to occur in fractures; indeed a fracture is nothing more than an exaggerated form of sprain.²¹¹

Massage and exercise became a routine prescription for surgeons to deal with the after-effects of fractures. Writing in 1898 nurse Annie Hewer noted that treating fractures formed a large part of surgical nursing, and that '[a]fter every fracture there is some muscular atrophy due to the forced inactivity, but rubbing, massage, usage and electricity will soon put matters right'.²¹² In 1905, the David Lewis Northern Hospital introduced 'several joint exercise machines of a modified Zander pattern' to the department of massage and orthopaedics.²¹³

²¹⁰ Macalister, *Liverpool Royal Southern*, pp.69-72, in Cooter, *Surgery and Society*, p.258, (note 43).

²¹¹ William Bennett, 'The Use of Massage, Early Movements and Position in the Treatment of Recent Fractures', *The Practitioner*, in Lucy Robinson, 'The Massage of Fractures', *NN* (October 1901), 139-140, (p.139).

²¹² Hewer, 'Fractures', 36.

²¹³ 'Mechano-Therapeutics', *BMJ* (12 March 1910), 656-657, (p.656).

Surgeon in charge, W.H. Broad, wrote that 'as a matter of routine, all cases of joint stiffness resulting from fracture, dislocation, or other injury are sent as early as possible for systematic treatment'.²¹⁴ He considered that '[t]he period of incapacity from work following accidents of the nature mentioned is materially diminished' and that, 'if all such cases were undertaken early and aggressively there would be a marked diminution in the number of neglected fibrous adhesions upon which bonesetters' successes are mainly founded'.²¹⁵

As suggested, massage and exercise was often used to remedy residual dysfunction once it had become established. As the chief surgeon of the Metropolitan Police Charles Ballance noted in 1913, massage departments often received cases 'at a very late stage of treatment, and usually only when all other forms of treatment have been tried and found wanting', and surgeons themselves were rarely involved in the treatment.²¹⁶ Masseuses used a variety of physical means to restore function to limbs 'kept too long in splints' or 'too tightly bandaged'.²¹⁷ Describing the treatment of a case of stiffness in an 'old Colles' fracture' by massage and 'Local Dowsing Radiant Heat' in 1911, the STM wrote:

The patient was 65 and the bone had been set three months. There was great stiffness in the thumb, wrist and radio-ulnar joints, in the latter the movement was very restricted. Local Radiant Heat was applied, and immediately afterwards massage of the whole arm and shoulder followed by passive movements. After a month's treatment the arm was practically well.²¹⁸

²¹⁴ 'Mechano-Therapeutics', 656.

²¹⁵ 'Mechano-Therapeutics', 657.

²¹⁶ Charles Ballance, 'Memorandum: The Treatment of Recent Injuries', (28 May 1913), pp.1-12, Medical: Treatment of Injuries by Massage, The National Archives (henceforth TNA), MEPO 2/1549, p.2.

²¹⁷ Florence Dove, 'Massage for Fractures', *NN* (May 1900), 65-66, (p.65).

²¹⁸ 'Interesting Cases', *NNMC* (October 1911), 262.

The rough handling and pain associated with breaking down stiff joints and adhesions became part of the masseuse's reputation. In 1899 female physician Mrs Stanley Boyd wrote that where 'the masseuse is called in to manipulate a joint stiff from adhesions', 'energetic and persistent methods will have to be adopted, and passive movements will need to be pushed further, in spite of the patient's resistance'.²¹⁹ Writing in 1901, masseuse 'W.A.' described the clinical uncertainty and unease she felt as a female professional inflicting pain. 'I think stiff-joint massage is the most painful and trying branch of the work to the workers as well as to the patients', she wrote; 'first we are harassed by fears of doing too much or not enough in the way of passive movements' and '[e]ven if patients show a quiet and brave endurance it is very hard to have to inflict such keen suffering'.²²⁰ For 'W.A.' it was 'hard "not to mind"' as a surgeon once said to me, "being the chief torturer"; but it has to be done'.²²¹

As the wider on-going debate about bone-setters suggests, very few general surgeons were involved in manipulative treatment or willing to undertake this type of work.²²² Cooter has indicated that '[f]ragmentary evidence suggests that bone-setting may have obtained some moorings in hospital surgery towards the end of the sixteenth century, but that thereafter it was let slip – the manipulative part of the craft being wholly abandoned, while fracture treatment absorbed into general surgery'.²²³ The criticism that general surgeons neglected manipulation was one that resonated from the general area of orthopaedics, from Paget in the mid-nineteenth century through to the

²¹⁹ Mrs Stanley Boyd, 'The Structure of the Knee-Joint', *NN* (December 1899), 164-165, (p.165).

²²⁰ 'W.A.' 'Stiff and Painful Joints', 40.

²²¹ 'W.A.' 'Stiff and Painful Joints', 40.

²²² For a commentary on the neglected status of manipulation within medicine outside of the bone-setting debate, see Edgar F. Cyriax and Richard J. Cyriax, 'Mechano-Therapeutics and Disease', *BMJ* (1910), in *Collected Papers on Mechano-Therapeutics*, ed. by Edgar F. Cyriax, (London: John Bale, Sons & Danielsson, 1924), pp.406-407.

²²³ Cooter, 'Bones of Contention?', p.159.

interwar years. Writing in 1888 Bristol surgeon, W.J. Penny, complained, '[b]one-setters gain their harvest because we, the legitimate practitioners, too frequently consider the necessary details and delicate manipulations beneath our notice', and 'condemn a large number of individuals to a life-long suffering; for these patients get pain as well as impairment of function'.²²⁴ The massage profession and physical treatment, then, offered a therapeutic that was marginal to medical practice and customarily received from lay practitioners. Physical methods compensated for the after-effects of conventional treatment and enabled the rehabilitation of the injured worker, which was of growing socio-economic and medical importance. At the same time as addressing these shortcomings, as the massage profession and other auxiliary workers undertook these practices, the medical profession was able to remain distant from low-status work and patients while also marginalising competing lay practitioners. The development of the massage profession and physical therapy departments in this period, then, can be viewed as part of the wider process of medical professionalisation and demonstrates one way that traditionally lay physical treatments were incorporated into regular medical practice.

Masseuses demonstrated the evolution of their responsibility in the arena of after-care and rehabilitation during the Boer War when the STM organised after-treatment for injured soldiers. During the Boer War provision for disabled or discharged servicemen was considered the province of voluntary and charitable organisations rather than the state or military medical services. In October 1900 the STM announced that:

our Council think that soldiers invalided home from South Africa who are still suffering from the effects of injuries (either from fractures,

²²⁴ Penny, 'On Bone-Setting', 1108.

wounds, or rheumatism), must need massage to complete their cure. These men, if not in hospital, can hardly command such treatment owing to its expense [...] we are glad to feel that massage, which we hear has been of much advantage to many wounded officers, can thus be available for a large number of cases unable to afford such treatment, and who are probably not attending the out-patient department of any hospital or institution.²²⁵

Masseuses offered their services voluntarily to medical men and charity organisations dealing with injured servicemen, and gave treatment at the Trained Nurses Club, Buckingham Street.²²⁶ *Nursing Notes* published a number of accounts describing how the STM used a combination of physical therapies to rehabilitate soldiers. In one example, Florence Dove wrote of her treatment of an 'officer in the Highland Brigade, who was shot through the foot in action at Magersfontein' in December 1899; the 'conditions which ensued [...] caused anxiety and a question of amputation':

On arrival in England the foot was very stiff, the calf muscles much wasted, and any hope of being able to march seemed remote. After a few weeks' massage of the foot and leg and tip-toe exercises the limb became normal again, and the officer passed his Medical Board and returned to the front and his foot has given him no more trouble.²²⁷

In another example saved from amputation, a 'Quarter-Master Sergeant' of the 'South African Mounted Volunteer Corps' was returned home after being shot in action, just below the left knee. 'When I first saw it', 'W.A.' wrote, 'the wound at the back of the leg was healed, the wound over the fracture nearly so, but it opened afresh at intervals for many weeks as splinters of dead bone worked their way to the surface':²²⁸

²²⁵ 'Massage for the Wounded', 140.

²²⁶ 'Massage for the Wounded', 140.

²²⁷ 'The ISTM', *NN* (May 1901), 66-67, (p.66).

²²⁸ 'The ISTM', (May 1901), 67.

There was considerable anaesthesia of the sole of the foot [...] severe wasting of all the muscles and shortening of the leg, with a very bad sore on the heel [...] great stiffness of the toe, ankle and knee-joints, and a foot swollen, shapeless and tense [...] Three months' daily massage and the Faradic current greatly altered the condition of things [...] The knee flexed and extended perfectly, also the toes, and the whole leg gained largely in tone and power of muscle, both wounds being quite healed.²²⁹

While on a small scale, these accounts demonstrate an early co-ordinated effort towards organised rehabilitative provision for injured servicemen, and how masseuses were equipped to use a range of physical methods in their treatment.

The Boer War was significant for the massage profession for a number of reasons. As pointed out in the Introduction, the Boer War stimulated concerns about the physical condition of the population, and the treatment of disabilities and injuries gained political importance. In the wake of the war Royal Army Medical Corps (RAMC) orderlies started to be trained in massage; in January 1905 the STM was asked to examine candidates on behalf of the War Office.²³⁰ By May 1905 the Director General of the Medical Services had become a medical patron of the Society, and the Society's articles of association that provided only for the examination of women, was altered to include men by the Board of Trade.²³¹ The incorporation of massage into the Army, and later Naval, medical services, demonstrates the broad appreciation of its value for rehabilitation, and such official endorsement also raised the credibility of the massage profession.²³² In this context, the STM was able to further cultivate an

²²⁹ 'The ISTM', (May 1901), 67.

²³⁰ 'Council Meeting' (13 January 1905), Chartered Society of Physiotherapy: Council Minutes (13 January 1905-14 December 1906), Wellcome Library (henceforth WL), SA/CSP/B.1/1/6.

²³¹ Jane H. Wicksteed, *The Growth of a Profession: Being the History of the Chartered Society of Physiotherapy, 1894-1945* (London: Edward Arnold & Co., 1948), pp.61-62.

²³² 'Council Meeting', (10 November 1911), Chartered Society of Physiotherapy: Council Minutes, (15 January 1909-14 February 1913), WL, SA/CSP/B.1/1/8.

identity of civic self-sacrifice and hinge the profession to public interest. It also helps us to understand the rationale behind the formation of the massage corps in the First World War.

Recent Fractures and Injuries

At the same time that massage was becoming a routine after-treatment for fractures and injuries there were also increasing calls for conventional treatment to be reformed altogether. Like the orthopaedists' appeal for surgeons to adopt manipulation to break down adhesions, central to the argument for the reform of fracture therapy was a critique of the disabling effects of customary methods.

Writing in August 1913, surgeon Bernard Ward described:

When the splint is taken off at the end of three, four weeks, or longer, the bone may be firmly united, but the limb generally is crippled to such an extent as to be useless, and it is many weeks before the patient can use it. Massage and passive movements are now commenced in order to *undo the damage already done*, it is like shutting the stable door after the horse has bolted.²³³

In contrast, exponents like Bernard Ward argued that 'a fracture which has been treated with massage from the first' could prevent ill-effects altogether.²³⁴

The principle for the treatment of fractures by movement was most famously introduced by French surgeon, Just Lucas-Championnière (1843-1913) in the 1880s.²³⁵ Based on Aristotle's axiom 'movement is life', what was called the 'Lucas-Championnière method' advocated mobilisation of the injured

²³³ Ward, 'Fractures and Sprains', (August 1913), 221-223, (split by advertisement page).

²³⁴ Ward, 'Fractures and Sprains', (August 1913), 223.

²³⁵ For Championnière's description of his technique see Lucas Championnière, 'Appendix F: Treatment of Fractures by Massage and Mobilisation', in 'British Medical Association, Report of the Committee on Treatment of Simple Fractures' *BMJ* (30 November 1912), 1505-1541, (appendix F, pp.1533-1534). The BMA's report highlights the debate and range of operative and non-operative techniques developed before the war in response to customary fracture treatment described by surgeon Arbuthnot Lane as 'a disgrace to surgical practice'.

limb as soon as possible after the receipt of trauma.²³⁶ 'Secondary massage and mobilisation', advocates argued, where treatment was commenced 'from the second or third week after the traumatism',²³⁷ was to risk 'permanent crippling'.²³⁸ Whereas fixation and immobilisation diminished the 'vitality' of the limb and the natural repair process causing 'bony atrophy, stiffening of the joints and tendinous sheaths, stiffness of the muscles and muscular atrophy', massage and mobilisation from the outset, they argued, provided the best conditions for healing the limb.²³⁹ In contrast to rigid splinting methods that reduced blood supply, slowed healing and forced the lacerated soft-tissue to heal matted together, massage encouraged blood circulation promoting rapid repair;²⁴⁰ mobilisation kept joints supple and encouraged muscles, tendons and nerves to heal independently. As one surgeon H.L. Barnard described:

A fracture is like a railway smash. It blocks the up and down line and disorganises the whole traffic. Massage is the emergency gang which clears the line, and as soon as a thorough service is established the wreckage is rapidly removed by the normal channels.²⁴¹

Amongst the many benefits of the massage method described by advocates were: the relief of pain and muscular spasm, removal of swelling and the promotion of blood circulation, and the prevention of muscular atrophy, the

²³⁶ James Mennell, 'The Treatment of Fractures by Massage', *NNMC* (April 1914), iv, part of a series, see also (June 1914), i-ii; (July 1914), i-ii; (August 1914), ii.

²³⁷ Lucas Championnière, 'BMA Report on Simple Fractures', 1534.

²³⁸ Bennett, 'On the Use of Massage in the Treatment of Recent Fractures', 360.

²³⁹ Lucas Championnière, 'BMA Report on Simple Fractures', 1533.

²⁴⁰ James Mennell, *The Treatment of Fractures by Mobilisation and Massage* (London: Macmillan and Co., 1911), p.36.

²⁴¹ H.L. Barnard, 'The Treatment of Fractures by Massage and Passive Movements', *NN* (December 1901), 165-166, (p.165).

formation of adhesions and stiffness.²⁴² Overall, massage promised to shorten recovery time and restore optimum function to the limb.²⁴³

The massage method emphasised the importance of function over form. In contrast to customary fixation methods which focussed on anatomical alignment, the primary aim of massage treatment was to restore function. For Lucas-Championnière writing in 1912, '[e]xperience has shown me the but slight importance, from the point of view of function, of a moderate shortening', and urged that 'the surgeon should cease to have in the first rank of his preoccupations the question of shortening and of the complete re-establishment of the length and form of the bone'.²⁴⁴ While '[s]hortening was not commendable', these surgeons argued it was 'the less of two evils'.²⁴⁵ Writing in 1913, surgeon Bernard Ward wrote that 'if you have to choose between a useful limb combined with slight deformity, and one in which you may, by prolonged fixation, obtain a good anatomical result at the expense of subsequent usefulness, you must in your patient's interest, choose the former.' 'You must bear in mind', he continued:

that in treating fractures your aim should be to restore your patient the full use of his limb as rapidly as possible. It matters little to him if one leg is half-an-inch shorter than the other, or if the bone is not quite straight, or if the X-rays show that the ends of the bone overlap, so long as the limb is strong, pliant, painless, and as useful as it was before the accident. If his limb remains painful, liable to swell up on the slightest exertion, and the movement of his joints limited, he will not thank you when you assure him that the bone is quite straight.²⁴⁶

This movement encouraged surgeons to broaden their perspective on the meaning of 'recovery'. It placed responsibility on surgeons for a patient's

²⁴² Lockhart-Mummery, 'Treatment of Fractures', (January 1903), 9.

²⁴³ Lockhart-Mummery, 'Treatment of Fractures', (January 1903), 9.

²⁴⁴ Lucas Championnière, 'BMA Report on Simple Fractures', 1534.

²⁴⁵ Warren, 'The After-Results of Fractures', RCN, 334.

²⁴⁶ Ward, 'Fractures and Sprains', (June 1913), 178.

ultimate rehabilitation and not only the immediate success of a procedure. As Howard Marsh wrote in 1911, '[d]o not let the practitioner use the term "recovery" in too narrow a sense, and say, in a case of fracture, that the patient is all right, merely because the bone is united'. Although, '[i]n the narrow sense', he continued, 'the bone is firm' and 'the patient has recovered', 'as he has pain and cannot get his heel down, to tell him that he is all right sounds to him like mockery'.²⁴⁷

Underpinning the movement to reform fracture treatment was the growing socio-economic importance of individual productivity and efficiency.²⁴⁸ Anson Rabinbach shows that this was a phenomenon that took place across Europe between the 1880s and 1920s. He argues that it was a backlash against the widespread fear that 'the energy of mind and body was dissipating under the strain of modernity', 'the health of the nation was being squandered' and an 'irreversible decline in force'.²⁴⁹ These concerns led to the widespread application of 'rationalisation' principles to promote economic efficiency and eliminate inefficiency. Arguments for therapeutic reform drew upon the principles of rationalisation and may be seen as part of this broader socio-economic phenomenon. The case for the massage method was articulated around making medical treatment more efficient and restoring productivity to workers. Describing the aim of the method in 1903, Lockhart-Mummery wrote:

In these days of bustle and hurry it is often a very serious matter, if a busy man is prevented from walking, owing to his having sprained his ankle or broken his leg, and this form of treatment is then of great value in enabling such a patient to resume his ordinary occupation at an early date. Probably of no period in the world's history, has the old saying "Time is money" been more truly applicable than of the

²⁴⁷ Marsh, 'Bonesetting', 1239.

²⁴⁸ Anson Rabinbach, *The Human Motor: Energy, Fatigue and the Origins of Modernity* (Berkeley: University of California Press, 1990), p.238.

²⁴⁹ Rabinbach, *Human Motor*, p.6.

present: and it should be our object to shorten the period of inactivity enforced by accidents as much as possible, by the adoption of suitable treatment.²⁵⁰

Part of the medical interest in massage, then, was in its capacity to rehabilitate and restore function to both old and recent injuries.

By the turn of the century, Lucas-Championnière's ideas had been adopted by a number of practitioners in Britain. Senior surgeon at St. George's Hospital, Sir William Bennett (1852-1931) was amongst the first to use the treatment.²⁵¹ Introducing the subject in *The Lancet* in February 1898, Bennett wrote '[t]he use of massage in the treatment of recent fractures, although it may have been adopted by a small number of individual surgeons, does not appear to have received the general attention in this country which in my opinion it deserves'.²⁵² Calling the treatment a rational 'application of common sense':

it cannot but excite surprise in the mind of any intelligent person that the stiffness, pain and other disadvantages which so constantly follow the treatment of fractures on classical lines should have been countenanced for so many years when they can in the majority of cases be entirely obviated by a treatment so simple as that not under consideration.²⁵³

Bennett, like many other British surgeons, adapted Lucas-Championnière's doctrine to include splinting to reduce the risk of displacement. While Lucas-Championnière 'did away entirely with the use of splints and simply supported

²⁵⁰ Lockhart-Mummery, 'Treatment of Fractures', (March 1903), 38.

²⁵¹ Lockhart-Mummery, 'Treatment of Fractures', (January 1903), 9. Bennett established the massage department at St George's in 1899, was a leading patron of the STM and the published three clinical lectures on massage, see William Bennett, *On the Use of Massage and Early Passive Movements in Recent Fractures and Other Common Surgical Injuries and the Treatment of Internal Derangements of the Knee-Joint* (London: Longmans, Green, and Co., 1900).

²⁵² Bennett, 'On the Use of Massage in the Treatment of Recent Fractures', 359.

²⁵³ William Bennett, 'In the Use of Massage in the Treatment of Recent Fractures', in Florence Dove, 'The Massage of Fractures', *NN* (October 1901), 139-140, (p.139).

the injured limb on a pillow',²⁵⁴ Bennett found the combined use of splints and massage safer. While an advocate of the massage method, Bennett relied on different therapies according to the case; in 1901 he wrote that '[t]he method is not to be regarded as a substitute for treatment by splints on one hand, or operative measures on the other, but should be used as a rational adjunct to each'.²⁵⁵

Treatment by the massage method was a carefully graduated procedure. The technique, according to Bennett, was 'a simple one' and comprised of three stages.²⁵⁶ Firstly, as soon as the fracture had been set and fixed in removable splints,²⁵⁷ the surgeon could commence 'gentle rubbing' to sooth pain, relieve muscular spasm, and promote circulation. Massage was gradually increased over a number of days, when 'passive movements of the joints above and below the fracture' were then given 'by which all matting of the soft parts at the seat of the fracture and about the joints is prevented'.²⁵⁸ Finally, after union was complete, stronger massage movements and voluntary movements were directed to prevent muscle atrophy and towards the gradual restoration of strength.²⁵⁹ While Bennett and Lockhart-Mummery considered the method 'simple' and could be learned 'without much trouble after a few practical lessons', they also highlighted that a certain amount of medical knowledge was necessary. Writing in 1903 Lockhart-Mummery described that 'anyone carrying out the treatment should have a preliminary knowledge of fractures in general', because, 'without such knowledge the manipulator will be unable to realise in

²⁵⁴ Lockhart-Mummery, 'Treatment of Fractures', (January 1903), 9.

²⁵⁵ Bennett, 'In the Use of Massage in the Treatment of Recent Fractures', in Dove, 'The Massage of Fractures', 140.

²⁵⁶ Bennett, 'On the Use of Massage in the Treatment of Recent Fractures', 360.

²⁵⁷ Lockhart-Mummery, 'Treatment of Fractures', (January 1903), 9.

²⁵⁸ Bennett, 'On the Use of Massage in the Treatment of Recent Fractures', 360-361.

²⁵⁹ Bennett, 'On the Use of Massage in the Treatment of Recent Fractures', 361.

what directions it will be safe to press, and in which it will be dangerous, also he will not know how intelligently to steady the fracture while moving the joints'.²⁶⁰ Furthermore, 'knowledge of splints and their mode of application' was necessary 'in order for the manipulator to be able to re-fix the splints after he has finished massaging the limb', and not disturb the alignment of the bones.²⁶¹ In an effort to promote its adoption by general surgeons, Bennett and Lockhart-Mummery of St. George's reassured peers that after the initial stage, treatment could be devolved to suitably 'skilled' operators, preferably the masseuse, masseur, nurse or dresser.²⁶² It remained, however, the responsibility of the surgeon to supervise and direct this largely unfamiliar treatment.

Another well-known advocate of the Lucas-Championnière method in Britain was physician James Mennell. Mennell learnt the technique from Lucas-Championnière himself over the course of three visits to Paris,²⁶³ and first introduced the method to St Thomas's hospital during his junior appointment there in October 1908.²⁶⁴ Mennell described that the method initially 'met with opposition' and 'ridicule' from his peers but gradually this was replaced by 'interest' and acceptance.²⁶⁵ As a self-styled 'English disciple' of Lucas-Championnière he complained that the method had been 'misinterpreted and misunderstood' 'by those who took his name in vain, and practised various treatments of their own imagination and then laid the blame of their failure at his door'.²⁶⁶

²⁶⁰ Lockhart-Mummery, 'Treatment of Fractures', (March 1903), 37-38.

²⁶¹ Lockhart-Mummery, 'Treatment of Fractures', (March 1903), 38.

²⁶² Lockhart-Mummery, 'Treatment of Fractures', (March 1903), 37.

²⁶³ Mennell, *Mobilisation and Massage*, p.v.

²⁶⁴ Mennell, 'The Treatment of Fractures by Massage', (April 1914), iv.

²⁶⁵ Mennell, 'The Treatment of Fractures by Massage', (April 1914), iv.

²⁶⁶ Mennell, 'The Treatment of Fractures by Massage', (April 1914), iv.

According to Mennell one of the primary misunderstandings was the interpretation of massage. Central to this was the therapeutic understanding of pain. When Lucas-Championnière gave a paper on the method of treatment at Moscow Congress in 1897, German professor Zabludowski (mentioned in Chapter 1) commented that ‘massage become painless ceases to be massage, and is merely treatment by suggestion’.²⁶⁷ For Zabludowski, Swedish gymnasts, and many other medical and public contemporaries, massage was associated with technical manoeuvres and ‘vigorous’ application, appearing to Mennell based upon the ethos: ‘give the patient as much as he can stand’.²⁶⁸ In contrast, he argued, when treating recent fractures ‘massage’ was not ‘the use of any specialised movements’ but rather ‘the slow and rhythmical repetition of a single movement, which, whatever may be the nature of the movement, is “little more than a caress,” performed with uniform speed and monotonous regularity’.²⁶⁹

Contrasting to the vigorous and often painful manipulations required to break down stiff, adhesive tissue in cases of old fractures, recent fractures required light, painless massage. Mennell regarded massage as a means to an end, the aim of which was to relax the limb so as to administer mobilisation. Mennell described mobilisation as a rationally applied ‘therapeutic measure, the “dose” of which is regulated by the nature of the complaint it is calculated to cure’.²⁷⁰ A ‘dose’ of mobilisation meant the passive movement of the joints surrounding the fracture to prevent the formation of adhesions.²⁷¹ By using the term ‘dose’, Mennell drew an analogy between the use of manual therapy and

²⁶⁷ Mennell, *Mobilisation and Massage*, p.18.

²⁶⁸ Mennell, *Mobilisation and Massage*, p.19.

²⁶⁹ Mennell, *Mobilisation and Massage*, p.22.

²⁷⁰ Mennell, *Mobilisation and Massage*, p.22.

²⁷¹ Mennell, ‘The Treatment of Fractures by Massage’, (June 1914), ii.

the use of drugs and vaccines. As he argued, the reason why massage required prescription by the medically trained was because, also like drugs, it had a specific physiological action. As observed in Chapter 1, bringing massage into the language of orthodoxy gave it therapeutic validity and was a professional strategy for those with specialist interests in the territory. Passive movements were to be progressed gradually; Mennell warned that 'the golden rule' was 'that nothing you administer or prescribed shall cause the slightest pain. If there is pain at any period of treatment you may rest content that you have exceeded the bounds of safety'.²⁷² This demonstrates how treatment by remedial massage was directly linked to patient's experience of pain and remained largely based on anecdotal evidence.

The inherent ambiguity surrounding the use of massage in recent injury caused anxiety that the reputation of the method was being brought into 'disrepute'.²⁷³ For Lucas-Championnière and Mennell cases of recent fracture should not be 'left in the hands of the ordinary masseur' without special knowledge and experience of handling trauma.²⁷⁴ 'Indeed', Mennell wrote, 'the majority of trained masseurs are found to scoff openly at the methods advocated, and, not unnaturally, fail lamentably to attain success; inflicting prolonged agony, and ultimately, perhaps, irreparable injury on their patients'.²⁷⁵ Echoing these concerns in 1913, Chief Surgeon to the Metropolitan Police, Charles Ballance (1856-1936), argued that regular hospital massage departments were not suitable to treat cases of recent fractures. 'Swedish exercises, drill and massage, while admirable',²⁷⁶ in cases such as 'curvatures

²⁷² Mennell, 'The Treatment of Fractures by Massage', (August 1914), ii.

²⁷³ Mennell, *Mobilisation and Massage*, p.13.

²⁷⁴ Mennell, *Mobilisation and Massage*, p.14.

²⁷⁵ Mennell, *Mobilisation and Massage*, pp.13-14.

²⁷⁶ Ballance, 'Memorandum', TNA, MEPO 2/1549, p.2.

of the back, flat-feet and other more or less chronic ailments',²⁷⁷ he wrote, were 'totally unsuitable for the treatment of recent injury of any description'.²⁷⁸ The blame for poor results, he continued, was 'attached [...] to the treatment rather than to the total inefficiency of the operators to apply the treatment which alone is applicable to injury'.²⁷⁹ These discussions illustrate the ambiguity inherent in the use of massage for the treatment of injuries in the period leading up to the First World War. It shows how a seemingly simple prescription for 'massage' could be interpreted in a variety of different ways and lead to misunderstanding and controversy.

Cases of recent fractures did, however, become the work of massage and physical exercise departments. At St. Thomas's in 1908, for example, physician, Swedish trained 'Gymnastic Director' and head of the physical exercise department, Richard Timberg noted that it was 'especially the Casualty Department that has supplied the additional number of new patients – cases of trauma and fractures – and it is a gratifying feature that these have been sent for treatment at a much earlier date than used to be the rule'.²⁸⁰ By 1911 the department treated 248 cases of fracture, out of a total 873 cases,²⁸¹ and in 1912 the department extended its opening hours to every morning of the week to treat accident and emergency cases.²⁸² While it undertook this work alongside the treatment of chronic patients, by 1913 the increase in the number of fracture cases was 'considerably more than proportionate to the whole amount', highlighting that the 'value of the Department's work in the treatment

²⁷⁷ Ballance, 'Memorandum', TNA, MEPO 2/1549, p.2.

²⁷⁸ Ballance, 'Memorandum', TNA, MEPO 2/1549, pp.2-3.

²⁷⁹ Ballance, 'Memorandum', TNA, MEPO 2/1549, p.3.

²⁸⁰ Richard Timberg, 'Report of the Physical Exercise Department for 1908', in *Saint Thomas's Hospital Reports* Vol.37, ed. by H. G. Turney and W.H. Battle (London: J & A. Churchill, MDCCCX), pp.245-247, (p.245).

²⁸¹ Timberg, 'Report for 1912', pp.212-213.

²⁸² Timberg, 'Report for 1912', p.212.

of recent injuries' was 'becoming more recognised and taken advantage of' by surgeons'.²⁸³

Evidence shows that masseuses undertook this work as part of their general practice particularly in the hospital setting.²⁸⁴ Often, as noted, cases were prescribed 'massage' with little further instruction. Speaking to the STM in April 1914, James Mennell said:

Most of you will be summoned by a medical man and told that your patient has a fracture in a given situation and that you are to treat it by massage; and [...] the chances are that you will receive no other instruction from your medical man.²⁸⁵

Work with trauma and the frequently unsupervised nature of this treatment, strengthened the link between massage and nursing expertise. Writing in 1900 Florence Dove noted that nurse-masseuses had the 'enormous advantage of dealing with dressings and bandages (and the *familiarity* of such work)'.²⁸⁶ The Society regularly published reports of cases of recent fracture in *Nursing Notes*. In November 1909, for example, Sister Astley-Cooper at Guy's Hospital treated Frank Hunt, aged 45 with a fractured left leg.²⁸⁷ The Pott's fracture of the leg was 'raised on a wedge pillow and kept in a good position with sandbags'.²⁸⁸ She began massage and passive movements from the first day and within a month, Astley-Cooper reported, the patient was walking without crutches, the foot restored to an 'excellent position' with its 'movements perfect'.²⁸⁹

²⁸³ Richard Timberg, 'Report of the Physical Exercise Department for 1913', in *Saint Thomas's Hospital Reports* Vol.42, ed. by J.J. Perkins and C.A. Ballance (London: J. & A. Churchill, MDCCCCVV), pp.191-194, (p.191).

²⁸⁴ Dove, 'Massage for Fractures', 66.

²⁸⁵ Mennell, 'The Treatment of Fractures by Massage', (April 1914), iv.

²⁸⁶ Dove, 'Massage for Fractures', 66.

²⁸⁷ 'Massage Notes', *NNMC* (November 1909), 228. For more case studies of massage in recent fracture, also see 'Massage Notes', *NNMC*, (February 1910), 50-51; Dove, 'Massage for Fractures', 65.

²⁸⁸ 'Massage Notes', *NNMC* (November 1909), 228.

²⁸⁹ 'Massage Notes', *NNMC* (November 1909), 228.

The increasing use of massage in the rehabilitation of injuries elevated the status of the practice within medicine. As a consequence of working in an arena considered of higher therapeutic importance than the treatment of chronic disabilities the massage profession achieved professional uplift. It was the development of massage in the treatment of injuries which led the profession to believe that it was an emergency service and should stand alongside nursing in the military medical services. Writing in 1900, Florence Dove described how the recent developments of massage had shown that it could restore power and movement to mutilated limbs that might otherwise have been amputated.²⁹⁰ For this reason, she wrote:

I have so strongly felt skilful massage might do in South Africa at the present time, among our wounded, if one was on the spot to begin immediately, at the discretion of the surgeon; in many cases of shattered bones, nerve lesions [...] so much long and weary wasting of the injured muscles might surely in many cases have been saved, and in many cases even permanent disablement. Unhappily many will come into our hands weeks or months afterwards, and one feels most bitterly all the good that skilful massage might have done during those weeks and months that those men are in hospitals and convalescent homes out there, before they are finally sent home, and massage is suggested as a last resource instead of in the first place.²⁹¹

Four members of the STM did serve in the South African conflict although their primary role was likely to have been as nurses.²⁹² Examining the massage profession in this arena helps explain its role in the First World War.

While the principle of mobilising fractures and injuries early became generally accepted within medical practice, customary methods of treatment remained dominant. There proved a number of obstacles to the adoption of the massage method in Britain. One complaint was that it required too much time

²⁹⁰ Dove, 'Massage for Fractures', 66.

²⁹¹ Dove, 'Massage for Fractures', 65.

²⁹² 'Massage Notes', *NN* (March 1902), 38.

and attention to become a routine treatment;²⁹³ as Lockhart-Mummery wrote, the 'busy general practitioner would not be able to afford the time necessary in all the cases of fracture which he was called upon to treat'.²⁹⁴ The method compromised the clinical efficiency and economic potential of conventional methods; Lockhart-Mummery noted that many patients would be 'unwilling to pay him for the time spent in carrying out the treatment'.²⁹⁵ Furthermore, as this method required medical men to give and supervise manual treatment, it represented a radical departure from ordinary practice. Amid a prejudice towards manual methods and specialisation more broadly, it is unlikely that many practitioners would have been interested in making themselves familiar with and adopting the massage method.

Regardless of the proven therapeutic benefits of the massage method, then, medical disinterest in the reform of fracture treatment meant that massage was relegated as a routine after-treatment rather than a primary surgical approach. While at St George's Hospital it had been trialled 'with excellent results', Bennett found that it was difficult to institute within a large general hospital, '[n]ot because there is anything wrong in the principle of the method or with its results' but because it was difficult to obtain staff 'sufficiently instructed in the details to enable it to be safely carried out'.²⁹⁶ Similarly, at St Thomas's Mennell was given a year to trial his methods in which he proved 'beyond doubt the efficacy of the treatment, and that its application to Hospital patients was a practicable possibility', yet when he was promoted, 'the special department founded by him lapsed into abeyance as a separate entity and became merged

²⁹³ Lockhart-Mummery, 'Treatment of Fractures', (March 1903), 37.

²⁹⁴ Lockhart-Mummery, 'Treatment of Fractures', (March 1903), 37.

²⁹⁵ Lockhart-Mummery, 'Treatment of Fractures', (March 1903), 37.

²⁹⁶ William Bennett, 'Two Clinical Lectures on the Use of Massage in Recent Fractures and Other Common Injuries-Lecture I', *The Lancet* (2 June 1900), 1569-1574, (p.1569), for lecture II, see (9 June 1900), 1640-1643.

once more into the Physical Exercise Department under the care of a Swedish Superintendent'.²⁹⁷

Interestingly in 1913 Charles Ballance was granted permission to pilot a segregated fracture service for the Metropolitan Police Force where he intended to institute the Lucas-Championnière method.²⁹⁸ Rather than sending injured police officers 'to hospitals to be fixed up in splints' all cases would be sent to this new department supervised by Mennell and specially trained staff.²⁹⁹ While the fruition of this scheme was side-lined by the First World War, it highlights that it was felt that a fracture service controlled separately from the general hospitals was necessary to effectively implement this method. The obstacles to and principles of the massage method in Britain, anticipated many of those faced by Robert Jones who reignited the movement for reform in the interwar period. While their technical views differed, they argued that effective fracture treatment was dependent upon segregation, expert supervision, team-work, continuity of treatment and appropriate after-care.³⁰⁰

Cooter's work has shown that fractures received little attention from general practitioners and surgeons before the war, the exceptions being the private practices of Robert Jones and his uncle Hugh Owen Thomas in Liverpool.³⁰¹ The emergence of the 'massage method', the increasing adoption of massage and physical therapy as a prescription for after-treatment, and the work of the massage profession, however, indicates that there was an impulse towards therapeutic reform. While small provincial projects such as Jones's work at Baschurch have been identified as precursors to wartime rehabilitation,

²⁹⁷ Ballance, 'Memorandum', TNA, MEPO 2/1549, p.7.

²⁹⁸ Ballance, 'Memorandum', TNA, MEPO 2/1549, p.1.

²⁹⁹ Ballance, 'Memorandum', TNA, MEPO 2/1549, p.9.

³⁰⁰ Cooter, 'The Meaning of Fractures', 312.

³⁰¹ Cooter, 'The Meaning of Fractures', 307-308.

this work suggests that there were a variety of other hubs feeding into the early development of rehabilitation within medicine.

Conclusion

This chapter has traced why and how massage was used in the treatment of deformity, paralysis, pain and injuries in the period before the First World War. Examining the incorporation of massage into medicine during this period indicates the increasing socio-economic importance of disability and rehabilitation, as well as shortcomings within regular practice in the treatment of musculo-skeletal conditions. It suggests that massage was one of many physical methods that offered a means of expanding the scope of regular therapeutics into new practical and patient territory. This chapter also argues that these sites were key locations for the development of massage as a practice and a profession before the war. Used alongside many other physical methods, these were arenas that cultivated a multi-skilled specialism embryonic of physiotherapy. It argues that the lack of medical involvement in the field of physical medicine and the treatment of disabilities and injuries enjoined the massage profession to exercise a level of practical autonomy and was an opportunity to develop expertise in and authority over this arena. While the massage scandals are often the only point of reference to the early professionalisation of physiotherapy, examining the use of massage in the treatment of orthopaedic conditions before the war suggests that it was intricately linked to the development of early rehabilitation within medicine. These developments also underpinned the entry and evolution of the massage profession and physical therapy in First World War.

Chapter 4 builds on the context laid out in the previous three chapters and discusses in more detail the professionalisation of massage in this period. It examines how the massage profession drew from nursing and Swedish gymnastics to formulate a specialism and how its relationship with medicine changed over time.

Chapter 4

The Massage Department and Professionalisation, pre-1914

[A]s a profession rises in importance and usefulness so necessarily the standard of efficiency becomes higher, the rubber of twenty years ago was a very different person from the masseuse required by the surgeon of the present day to carry out his instructions.¹

By 1910 the London Hospital out-patient department saw over a quarter of a million new patients each year and contained many specialist sub-departments.² By this time, massage, which had been practised at the London from the 1880s, had become formally established as a 'department'.³ The 'massage department' consisted of a contingent of qualified and trainee nurse-masseuses as well as two Swedish gymnasts, Herr Koch and his wife, who together treated a range of medical and surgical afflictions by massage, mobilisation and exercise. The London Hospital was not the only institution to incorporate massage in this period; as the treatment became increasingly valuable to medicine many institutions including St George's, St Bartholomew's, St Thomas's, the RNOH, Lambeth and Paddington Poor Law Infirmaries, as well as smaller nursing homes such as Baschurch, started to employ massage expertise. This chapter considers the evolution of the London Hospital massage department using it as a lens through which to explore key factors reflected in the professionalisation of massage in Britain before the First World War.

¹ 'L.M.G.', 'Notices', *Nursing Notes* (henceforth *NN*) (September 1902), 120.

² E.W. Morris, *A History of the London Hospital*, 2nd edn. (London: Edward Arnold, 1910), p.12, p.17. Note that in this second edition there is no mention of massage or the massage department despite archival evidence showing its existence.

³ The term 'massage department' is used as shorthand throughout this thesis to capture a range of professional activities, practices and personnel that came under the remit of 'massage' and the profession of massage in this period. While often called the 'massage department', other titles were sometimes used, for example 'physical exercise and massage department' at St Thomas's. Furthermore the term 'department' in this period may not refer to a physical department or place, rather a body of massage staff.

To investigate these questions, this chapter focuses on three main themes. The first section explores the changing relationship between nursing and the massage profession. The second part investigates the significance of the Swedish gymnastics model of expertise for professionalisation. The final section examines the changing status of the massage profession within medicine. Although this chapter separates these themes with the purpose of analysing the significance of each, they were, however, intricately intertwined within the broader process of professionalisation during this period. Each section makes use of archival and published sources. This includes material from the London, St. Thomas's and Baschurch Hospitals, the STM's institutional records, articles from *Nursing Notes* and the wider nursing community, in order to illuminate key features in the evolution of the massage department and profession. This chapter shows that nursing and Swedish gymnastics were two professional models that were particularly important for the early professionalisation of massage in Britain. By emulating aspects of each the STM was able to carve out a distinct expertise, professional identity and establish a working relationship with medicine. It argues that this formative period of professionalisation was key to its entry into organised medicine, the First World War and evolution to physiotherapy.

Massage and Nursing

While a 'certain amount of medical rubbing' had long been considered as an ordinary part of nursing work,⁴ this became a more prominent feature in Britain from the 1880s.⁵ The London Hospital, founded in 1740, like other charitable

⁴ 'Old Hand', Nurses in Council', *NN* (August 1898), 108.

⁵ 'As regards Guy's Hospital, massage was first systematically practised and taught in 1888', 'Prospectus - Guy's Hospital Massage Department', (1918), pp.1-18, Appointments Department:

institutions established in the eighteenth century, aimed to care for patients drawn from the poorer sections of the working classes who had nowhere else to go. As the history of the STM suggests, however, nurses at the London first trained in massage not to cater for the poor but to give the rest cure to the private patients of hospital medical men. We know that founder members and nurse-midwives, Rosalind Paget and Paulina Ffynes-Clinton, first learnt massage in 1886 for this reason, when hospital Matron Eva Lückes sent them to nurse Elizabeth Buckworth for instruction.⁶

Elizabeth Buckworth was trained by British rest-cure exponent William Playfair and was described by Paget as ‘a delightful teacher and a superb rubber’.⁷ Recounting this in 1886, Playfair wrote that when he ‘first attempted’ to introduce the rest cure treatment in Britain, ‘there was, so far as I knew, no such thing as a “masseur” in this country’. ‘I then’ he continued:

had to instruct a nurse, with much trouble, from the few and imperfect descriptions of the process I could lay my hands on, but with results that were thoroughly satisfactory. She taught another, in a few lessons only, and from this origin I have obtained a staff of competent masseuses sufficient for my own purposes.⁸

It was not uncommon for nurses to learn massage ‘in a week’ or ‘six lessons’ in the late-nineteenth century.⁹ After their initial instruction at the London, Rosalind Paget and Paulina Ffynes-Clinton said that they ‘did a good deal of massage

Details Institutes and Hospitals for Training in Massage and Medical Gymnastics, The National Archives (henceforth TNA), LAB 2/1505/AD/1426/2/1919, p.1; Massage was used by 1887 at Maida Vale Hospital, see, Marguerite Herbert, ‘Notes on the History of Maida Vale Hospital for Nervous Diseases’, (c.1912), pp.1-9, Old Membership Files: Maguerite Maude Catherine Herbert, Wellcome Library (henceforth WL), SA/CSP/D.4/1/4, p.3; At St Thomas’s ‘Dr Sharkey’ gave instruction in massage before 1893, ‘St. Thomas’ Hospital School of Physiotherapy Prospectus’, [n.d], p.1, Records of St Thomas’ Hospital, Records of the School of Physiotherapy, London Metropolitan Archives (henceforth LMA), H.1/ST/PS, p.1.

⁶ Jane H. Wicksteed, *The Growth of a Profession: Being the History of the Chartered Society of Physiotherapy, 1894-1945* (London: Edward Arnold & Co., 1948), p.21.

⁷ Wicksteed, *The Growth of a Profession*, p.21.

⁸ William Playfair, ‘Treatment by Massage’, *The Lancet* (23 October 1886), 794-795, (p.794).

⁹ Octavius Sturges, ‘Treatment by Massage’, *The Lancet* (9 October 1886), 702-703, (p.703).

and taught the private staff'.¹⁰ Similarly, at St. Thomas's, physician 'Dr Sharkey' gave instruction to nurses before 1893 when this duty was taken over by 'Nurse Marks' who in turn trained the sisters to teach nurses and probationers.¹¹ Massage developed quite rapidly amongst nurse-masseuses in this way, and by the end of the 1880s, physician at the Westminster Hospital Octavius Sturges observed that Playfair's difficulty at the beginning of the decade in finding a masseuse was no longer a problem, writing that: 'there is probably no hospital in London, and no nursing home of repute, which cannot furnish trained rubbers'.¹²

The training of nurses, however, became increasingly formalised and specialised in the two decades before the First World War. As the use of massage as a medical and surgical treatment increased hospitals progressively sought to train their own contingent of staff nurses. For example, at the London Hospital in the 1890s, nurse-masseuse Margaret Palmer was engaged to supervise and instruct nurses; giving a 'course of systematic lectures and practical teaching, three days a week for six weeks, followed by an examination and the granting of a certificate' (Figure 2).¹³ In 1911, St Thomas's developed its massage training from the informal nurse tutoring outlined above to opening one of the first hospital massage training schools. The decision to do so was made because 'members of the Staff experienced difficulty in getting their ward patients treated, such treatment as was obtainable being given by the nursing

¹⁰ Rosalind Paget quoted in Wicksteed, *The Growth of a Profession*, p.21.

¹¹ 'St. Thomas' Hospital School of Physiotherapy Prospectus', LMA, H.1/ST/PS, p.1.

¹² Sturges, 'Treatment by Massage', 703.

¹³ 'A Meeting of the Medical Council', (14 June 1905), Medical Council: Minutes (12 May 1905–1 April 1907), Royal London Hospital Archives (henceforth RLHA), RLHLM/1/6; Jean Barclay, *In Good Hands: The History of the Chartered Society of Physiotherapy 1894-1994* (Oxford: Butterworth-Heinemann Ltd, 1994), p.26.

staff who received 12 lessons in massage for this purpose'.¹⁴ Pupils at the school treated patients under the direction of the Sister, nurse-masseuse Minnie Randell, and the medical officer in charge Richard Timberg, whilst receiving lectures, demonstrations and practical lessons to prepare for the STM examination.¹⁵ The development of nurse training courses in general hospitals shows that massage was increasingly considered as 'special nursing', a specialisation and post-graduate qualification, and not only a part of general nursing work.

Another interesting illustration of the development of hospital training schools for massage is the Baschurch convalescent home, in Shropshire. Opened in 1900, the home's famous regime of prolonged rest, fresh-air and good diet was initially intended for convalescent and phthisical patients. The involvement of surgeon Robert Jones in 1903, however, quickly changed the patient profile and by 1908 the home was filled with patients suffering from an array of orthopaedic conditions, and particularly surgical tuberculosis.¹⁶ With the increasing pressure of surgical work, the Baschurch home, like many other charitable institutions in this period, found its resources stretched and in particular required more nursing staff. To resolve this dilemma, founder and nurse Agnes Hunt, decided to start a training school for probationer nurses 'for this branch of their profession',¹⁷ who would work at the home without a salary. The challenge, however, was that the narrow surgical focus of the treatment meant that the home was unable to offer a general nurse training or a certificate

¹⁴ 'History of the Physiotherapy Training School', [n.d.], pp.1-2, Miscellaneous Papers: History of the School, LMA, HI/ST/PS/Y/04/001, p.1.

¹⁵ 'History of the Physiotherapy Training School', LMA, HI/ST/PS/Y/04/001, p.1.

¹⁶ 'Executive Committee Meeting', (17 July 1905), Baschurch Home: Minutes of Meetings (22 April 1901-22 October 1910), Robert Jones and Agnes Hunt Orthopaedic Hospital Archives (henceforth RJAHOH) See also Agnes Hunt, *This is my Life*, (London: Blackie & Son, Ltd, 1940), p.158; Marian Tidswell, *Adversity the Spur: The History of Physiotherapy Education at Oswestry* (London: Athena Press, 2009), pp.35-37.

¹⁷ Hunt, *This is my Life*, p.158.

of any real value. Hunt later wrote that: 'I have always had a great prejudice against taking people's time and giving them nothing in return, and certainly our certificates at that time would have been merely waste paper'.¹⁸ As a result of this in 1910 Agnes Hunt instituted a course of massage training in order for probationers to receive a marketable STM certificate; 30 years later she wrote that: 'it occurred to me that many of the cripples would be much better for massage'.¹⁹

Massage then, occupied an interesting, perhaps even an anomalous position at the Baschurch home in contrast to many other institutions before the First World War. At Baschurch, massage, and later remedial gymnastics, was established primarily as a supplementary measure within the broader regime of surgery and after-care that Robert Jones was developing for his surgical cases. This auxiliary role contrasted with the more varied and often primary way that massage and exercise was used in other institutions, for example, as a method of correcting disabilities such as scoliosis or breaking down adhesions post-injury. Part of the explanation for this can be found in the type of surgical cases treated at Baschurch, which were predominantly cases of surgical tuberculosis. Robert Jones sent many of his tubercular joint cases to the home, 'preferring' that they should 'remain in the country, in the open air'.²⁰

While bone disease was the cause of many chronic disabilities found in this period, doctrine dictated that patients with active or latent 'destructive infections' or 'inflammatory lesions' (such as tuberculosis and arthritis), were to rest 'until active disease and pain are modified, or complete recovery has taken

¹⁸ Hunt, *This is my Life*, p.158.

¹⁹ Hunt, *This is my Life*, p.160.

²⁰ 'General Half-yearly Meeting', (15 September 1905), RJAHOH.

place'.²¹ Although records do not detail how the early probationer nurses used massage at Baschurch before the First World War, the memoirs of probationer Frances Taylor recount her use of massage to prevent pressure sores. In 1914 when she was given responsibility for the care of 'eight little girls' immobilised 'in various complicated splints', she was taught that '[p]ossible pressure points were kept from becoming sore by gentle massage of the underlying parts'.²² 'There was no more terrible disgrace than to let one's patient develop a pressure sore', she wrote, 'this was a skilled business as the limb had to be kept exactly in place with one hand, while the restraining straps were loosed, and the flesh gently kneaded with the other'.²³ Inquiry into the use of massage at Baschurch is interesting because of the symbolic role that the home occupies in the history of modern orthopaedics and orthopaedic nursing. We can trace the auxiliary role of massage at Baschurch into that of physical therapy within Robert Jones's regime of military orthopaedics during the First World War. However, to examine the history of physiotherapy only through Baschurch and military orthopaedics offers a limited picture of the practical and professional significance of massage before the war.

In contrast to Baschurch, staff nurses trained at general hospitals treated a broad variety of cases. At the London Hospital, nurse-masseuses made up what was designated by medical staff as the 'English division' of the massage department. Although by 1905 Margaret Palmer no longer headed the massage department or taught nurses at the hospital, the 'English' department was

²¹ See Robert Jones, 'Manipulation as a Therapeutic Measure', *Proceedings of the Royal Society of Medicine* (15 April 1932), 1405-1412, (p.1406); for a discussion about the medical debate surrounding the extent of rest and recumbence in the treatment of Pott's disease see, Beth Linker, *War's Waste: Rehabilitation in World War I America* (Chicago; London: University of Chicago Press, 2011), p.44.

²² Margaret (Peggy) Kenyon [or Frances Taylor], (c.1971), pp.1-24, Staff and Student Memoirs, RJAHOH, pp.4-5.

²³ Frances Taylor, RJAHOH, pp.4-5.

worked by her old pupils, 'two sisters and a private staff nurse', who treated 'all the in-patients for whom massage is ordered, and about 63 out-patients daily', annually treating approximately 18,000 out-patients.²⁴ They used massage, passive movements and 'various machines'²⁵ to mobilise joints and treat a range of conditions, including injuries such as fractures, dislocations and 'crushed fingers'; chronic afflictions such as flat-foot and club-foot; as well as arthritic and paralytic conditions.²⁶ The types of cases treated at St Thomas's in 1908 were of a similar nature, with cases of spinal curvature and fractures predominating with 76 cases respectively, and including a range of surgical and medical conditions such as paralysis, nerve injury, arthritis, rheumatism, chorea and heart disease.²⁷ While massage departments and their equivalents often undertook much of the same type of work in the early twentieth century – predominantly chronic disabilities, traumatic injuries and paralysis – the type of treatments given also varied according to the expertise of staff and resources available at the hospital.

²⁴ 'A Meeting of the Medical Council', (14 June 1905), RLHA, RLHLM/1/6.

²⁵ T.H. Openshaw and Cecil Wall, 'Notes and Recommendations by the Medical Council on the Massage Department', (8 March 1907), pp.1-2, RLHA, RLHLH/A/17/24, p.1.

²⁶ 'A Meeting of the Medical Council', (14 June 1905), RLHA, RLHLM/1/6.

²⁷ Richard Timberg, 'Report of the Physical Exercise Department for 1908', in *Saint Thomas's Hospital Reports* Vol.37, ed. by H. G. Turney and W.H. Battle (London: J & A. Churchill, MDCCCX), pp.245-247, (pp.246-247).

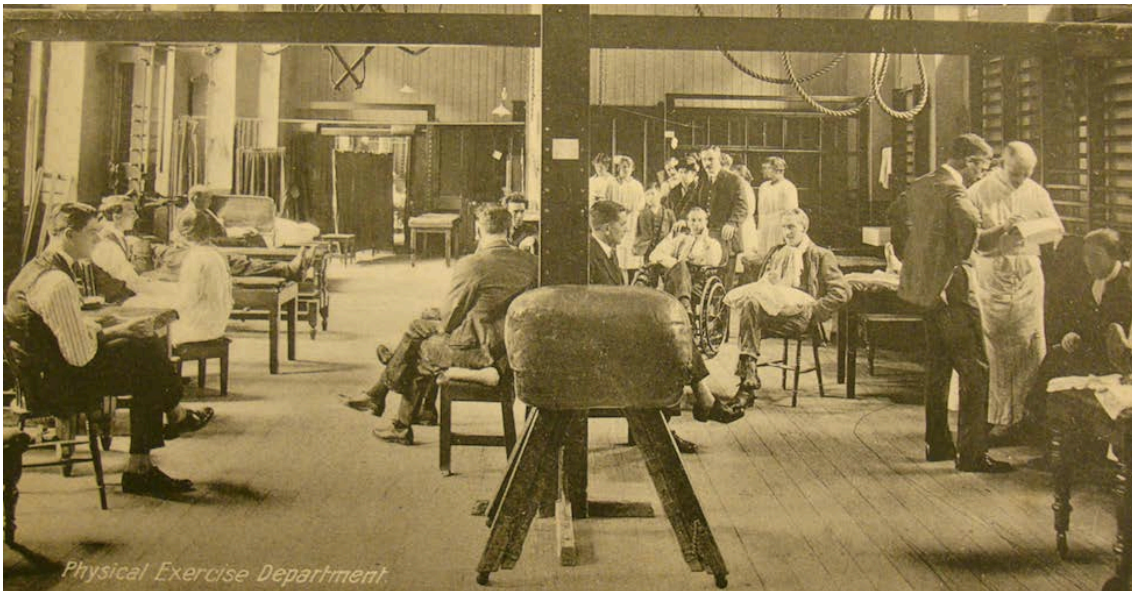


Figure 5 - Male physical exercise department, [location unknown], (c.1910), WL, SA/CSP/Q.1/4.

Treatment in general hospitals was most often sex-segregated, with women treating women and children, and men treating men (Figures 5 and 6). While nurses were trained in hospitals to undertake massage work for women, without a similar male auxiliary service it was more difficult to find masseurs. It was not unusual for massage to be carried out by hospital porters,²⁸ electrical assistants and Swedish gymnasts.²⁹ For example, in 1888, the Maida Vale Hospital for Epilepsy and Paralysis in London hired a 'Masseur' to instruct the porter to give massage, who 'was to have 5s a week extra while engaged in massage work'.³⁰ Likewise, orthopaedic surgeon Reginald Elmslie (1878-1940) reflected in 1929 that when he 'was a student at St. Bartholomew's, shortly before 1900, the entire massage and exercise treatment was carried out by one

²⁸ 'This was apparently for male patients only', Herbert, 'Maida Vale Hospital for Nervous Diseases', WL, SA/CSP/D.4/1/4, p.3. Maida Vale hospital founded in 1867 by Julius Althaus (1833-1900).

²⁹ Richard Timberg, 'Report of the Physical Exercise and Massage Department for 1911', in *St Thomas's Hospital Report* Vol.41, ed. by J.J. Perkins and C.A. Ballance (London: J. & A. Churchill, MDCCCXIII), pp.189-193, (p.190).

³⁰ Herbert, 'Maida Vale Hospital for Nervous Diseases', WL, SA/CSP/D.4/1/4, p.3.

masseuse and one porter'.³¹ At St Thomas's in 1911 a Swedish masseur was engaged every morning and three afternoons a week to treat the in- and out-patients, and give massage in the wards. 'To help him out with this somewhat formidable amount of work', however, head of department Richard Timberg noted, 'part of it is entrusted to the male attendant in the Electrical Department', who carried out a 'large proportion of the massage in the wards' as well as in cases sent to the Electrical Department for heat treatment preceding massage.³²



Figure 6 – Female Treatment Room, St Mary's Hospital, Paddington, (c.1910), WL, SA/CSP/Q.1/3.

³¹ 'Chartered Society of Massage and Medical Gymnastics', *BMJ* (26 October 1929) 767, (p.767).

³² Timberg, 'Report for 1911', p.190.

The predominance of women practitioners and difficulty in finding male operators before and during the First World War demonstrates the significance of nursing as a carrier for massage and physical therapeutic expertise into British medical practice. Gerald Larkin has argued that the growth of the division of labour between doctors and others provided an important channel for devalued and discarded aspects of health work.³³ Tasks considered 'unpleasant' or that lacked 'esteem' such as massage were delegated to support the professional interests and status of medical men. Structuring this delegation were a range of distinctions between intellectual and manual, male and female work. While in one way nurses can be viewed as passive recipients of massage work 'passed down' by medicine, the professionalisation of massage demonstrates that it was an arena in which they asserted considerable agency.

The development of massage within nursing was part of the wider process of nurse specialisation. Christine Hallett has written that the nineteenth century was the era that nursing first began to specialise, wherein the profession became more fragmentary, divided, and specialisms such as 'physiotherapy' split away.³⁴ Apart from the desire of hospitals to train their own contingent of masseuses for hospital work, the emergence of 'private nursing' was another force that stimulated the specialisation of nurses in massage in this period. On completion of training, large numbers of nurses began to turn to private nursing as a remunerative career option. Private nurses practised independently and either managed their work through personal connections

³³ G. Larkin, *Occupational Monopoly and Modern Medicine* (London; New York: Tavistock Publications, 1983), pp.4-5.

³⁴ Christine Hallett, 'Nursing, 1830-1920: Forging a Profession', in *Nursing and Midwifery in Britain since 1700*, ed. by Anne Borsay and Billie Hunter (London: Palgrave Macmillan, 2012), pp.46-73, (p.65).

with medical men or remained affiliated to a hospital.³⁵ When affiliated with an institution, private staff nurses could develop working relationships with its medical staff sometimes opening a space for specialisation in new forms of treatment³⁶ – an example being William Playfair's engagement of nurses at the London to undertake massage on his private cases.

The private nurse was an active force in the development of a number of specialties as they sought training besides their general qualification in order to expand their experience, expertise and employment opportunities. Probationers were given training at specialist institutions including hospitals for women and children, and hospitals for paralysis, infections and skin diseases.³⁷ By 1910 several of the large general hospitals also offered opportunities for their probationers to gain special training, for example in fever nursing, ophthalmic nursing and massage.³⁸ Massage became a familiar part of nurse training; writing in 1909 superintendent of the Queen Victoria's Jubilee Institute for Nurses, Amy Hughes wrote that 'a certificate in massage is held to be an almost essential qualification'.³⁹ Matron of the London Hospital Eva Lückes who established the private nursing institution there in 1886,⁴⁰ wrote in 1894 that 'a thorough knowledge of Massage and Swedish Exercises' was a 'useful asset' to

³⁵ Amy Hughes, 'Nursing as a Vocation', in *Cassell's Science and Art of Nursing: A Guide to the Various Branches of Nursing, Theoretical and Practical* Vol.1, by Medical and Nursing Authorities (London: The Waverly Book Company, c.1909), pp.94-108, (p.103).

³⁶ Hughes, 'Nursing as a Vocation', p.103.

³⁷ Lilian Maule, 'Training Schools and Other Institutions', in *Cassell's Science and Art of Nursing: A Guide to the Various Branches of Nursing, Theoretical and Practical* Vol.1, by Medical and Nursing Authorities (London: The Waverly Book Company, c.1909), pp.46-93, (p.63).

³⁸ Maule, 'Training Schools and Other Institutions', p.63.

³⁹ Hughes, 'Nursing as a Vocation', p.107.

⁴⁰ 'Typescript text of an article by Eva Luckes', pp.2-9, RLHA, RLHPP/LUC/4/6, p.7.

the nurse, and that '[e]lectrical and X ray treatment' offered scope for specialisation, especially 'useful if combined with a massage qualification'.⁴¹

Whether massage should be considered as an independent specialty or a branch of nursing was being negotiated in the period before the First World War. A considerable proportion of the massage profession was foremost practising nurses and midwives who did not rely upon massage as their primary employment.⁴² Increasingly, however, numbers of nurses chose to devote their time to massage entirely as the work was more remunerative.⁴³ Reading a paper on behalf of the STM at the Annual Nursing and Midwifery Conference and Exhibition in April 1910, leading member Elizabeth Manley described:

Within the last twenty-five to thirty years, what may be called a new department in nursing has arisen and has been organised in this country, and this department has become so important to the British public, to the nursing profession, and lastly, but not in a less degree, to the medical profession, that the ladies and gentlemen to whom we owe the organisation of this very interesting conference have felt that it would be incomplete unless a place in it were assigned to the subject of *Massage*.⁴⁴

Although it was generally accepted within the medical and nursing community that massage had emerged as an important 'department' of nursing and could be pursued as a distinct employment,⁴⁵ the extent to which it could be regarded as distinct or separate from nursing was contested ground.

⁴¹ 'Article by Eva Luckes', RLHA, RLHPP/LUC/4/6, p.7. A number of major innovations occurred within medicine in the late-nineteenth century including asepsis, Xray and new drug applications, which promoted new specialties (Larkin, *Occupational Monopoly*, p.3).

⁴² Elizabeth Manley, 'Massage', *Nursing Notes and Midwives Chronicle* (henceforth *NNMC*), (July 1910), 179-182, (p.182). This is in two parts, see also (June 1910), 154-156. It is the publication of a paper read by Elizabeth Manley, on 30 April 1910 at the Annual Nursing and Midwifery Conference and Exhibition, Royal Horticultural Hall, Westminster. The work Elizabeth Manley is used extensively in this chapter, she was a key figure within the STM and articulated the vision of the STM through her writing for *Nursing Notes*.

⁴³ 'Old Hand', *Nurses in Council*, 108.

⁴⁴ Manley, 'Massage', *NNMC* (June 1910), 154.

⁴⁵ Sarah Tooley, 'Nursing, Past and Present', in *Cassell's Science and Art of Nursing: A Guide to the Various Branches of Nursing, Theoretical and Practical* Vol.1, by Medical and Nursing Authorities (London: The Waverly Book Company, c.1909), pp.1-31, (p.26).

There was strong opinion amongst the STM, the nursing community and doctors that nurse training was essential for massage work. The STM frequently noted that ‘the demand is for the *nurse masseuse*’,⁴⁶ and nurse training was considered indispensable for the masseuse for a number of reasons. Speaking in 1910, Elizabeth Manley said that ‘a thorough training in massage, built upon the foundation of a thorough training in nursing or midwifery, is the “counsel of perfection,” for nothing that a nurse has ever learned comes amiss in massage work’.⁴⁷ Many commentators felt that ‘hospital training before acquiring a knowledge of massage’ gave the masseuse a ‘background of experience and substratum of knowledge’ essential for ‘her new profession’.⁴⁸ In 1897 the STM described:

The masseuse who is not a trained nurse is confronted with the names of diseases and deformities with which she is called upon to deal, but of whose nature, causes, symptoms and results, she is in many cases profoundly ignorant.⁴⁹

While masseuses might acquire some medical knowledge as part of their training, it was argued, this was ‘chiefly theoretical’ in contrast to nurses who had ‘been gradually absorbing knowledge on these subjects, practical as well as theoretical, from the commencement of her nursing life’.⁵⁰

For the STM, it was medical knowledge that moved the masseuse beyond the ‘suspicion of quackery’,⁵¹ and differentiated the professional worker who could understand the ‘effect of the massage on the patient’, from the

⁴⁶ ‘Massage Notes’, *NN* (November 1896), 153; also see Elizabeth Manley, ‘Massage’, *NN* (December 1897), 163; ‘Massage Notes’, *NN* (February 1896), 25.

⁴⁷ Manley, ‘Massage’, *NNMC* (June 1910), 154.

⁴⁸ Manley, ‘Massage’, *NN* (December 1897), 163.

⁴⁹ Manley, ‘Massage’, *NN* (December 1897), 163.

⁵⁰ Manley, ‘Massage’, *NN* (December 1897), 163.

⁵¹ Manley, ‘Massage’, *NNMC* (June 1910), 156

empirical rubber simply 'doing' massage.⁵² This knowledge gave the practice and profession of massage a medical legitimacy that was vital when we consider its morally and medically contested status. It was also considered necessary in order to carry out medical directions, and the STM reported that doctors sought nurse-trained masseuses because 'they can count upon their orders being more intelligently executed'.⁵³ 'Naturally', they wrote, doctors 'can place greater confidence in one who knows when a case is not going on satisfactorily and when the need arises to call in medical aid'.⁵⁴

Nursing skills and experience were also considered important for massage work. This included familiarity and experience handling recent injuries; handling the sick; lifting and turning helpless patients; and details such as 'taking a temperature, counting pulse and respiration, applying a bandage or formentation'.⁵⁵ Writing in 1897 Elizabeth Manley indicated that this type of practical experience had become essential for massage practitioners:

A doctor may naturally suppose that one who is accustomed to the handling of sprains, fractures and dislocations in their earliest stage, may be more competent to mass the injured member, than one whose experience in bones and joints is limited to the handling of a skeleton or to practising massage upon a perfectly normal limb.⁵⁶

In a correspondence to *Nursing Notes* in 1896, 'an Enquirer' wrote that: 'I have frequently asked myself whether it would not be better for the profession, if certificates in massage were denied to all persons who had not been either fully trained as nurses, or else passed some specified time in a hospital'.⁵⁷ 'By doing

⁵² 'Massage Notes', *NN* (November 1896), 153.

⁵³ Manley, 'Massage', *NN* (December 1897), 163.

⁵⁴ 'Massage Notes', *NN* (February 1896), 25

⁵⁵ Manley, 'Massage', *NN* (December 1897), 163.

⁵⁶ Manley, 'Massage', *NN* (December 1897), 163.

⁵⁷ 'An Enquirer', 'Massage Notes', *NN* (October 1896), 137.

so', they continued, 'they would learn a variety of things useful to them to know' including:

how to make the bed of a person unable to be moved, to turn a patient skilfully and with the smallest possible amount of inconvenience, to be clean and methodical in the sick room, and if not themselves called upon to do any actual nursing, they would be able to appreciate intelligently the nursing part of the business, and thus not deter the work of the nurse or doctor by any stupid blunders.⁵⁸

It was one thing, then, commentators believed, 'to learn what the various movements are', but to gain the confidence of doctors masseuses needed to learn how to support them as 'helpers', by having the medical and nursing knowledge to work 'intelligently' and handle patients 'in a finished and easy manner'.⁵⁹

Medical knowledge and nursing experience were not the only attributes that nurse training offered the massage profession. The 'discipline' and 'etiquette' learned during hospital training were facets that the STM sought to emulate in the massage profession. As 'Experience' felt in 1896, 'a nurses training provides knowledge not only of nursing, but of a hundred points of conduct and professional etiquette unknown to the lay worker'.⁶⁰ As Elizabeth Manley continued in 1897, everything the nurse 'gained from the discipline of training, helps her as a masseuse'.⁶¹ For the STM working out the boundaries of the new massage profession nursing offered a model that structured how the profession sought to present itself to medicine and the public. As discussed in Chapter 2, professional image was a key component within professionalisation, and standards around details such as dress, hygiene, punctuality and gossip

⁵⁸ 'An Enquirer', 'Massage Notes', 137.

⁵⁹ 'An Enquirer', 'Massage Notes', 137.

⁶⁰ 'Experience', *NN* (November 1896), 153.

⁶¹ Manley, 'Massage', *NN* (December 1897), 163.

were based upon existing expectations of the nursing profession. The STM sought to guarantee the professionalism of its members and details such as etiquette and discipline were considered especially important due to the intimate nature of the work and because many worked privately, outside of the hospital where their work and behaviour could be monitored. This mirrored broader anxieties amongst the nursing profession of how to manage the potential risks of unsupervised private nurses.⁶²

Nursing discipline and etiquette also covered another important aspect which was clearly demarcating the division of labour between masseuses and medical practitioners. As Anne Marie Rafferty argues, hospital training provided one means of institutionalising a stable and hierarchically arranged social order.⁶³ Like nursing, the massage profession sought to gain the patronage and acceptance of medicine by showing that they clearly understood the dividing line between the doctors' duties and their own. As Elizabeth Manley noted in 1897, 'there may be a latent fear that the masseuse who is not a nurse may sometimes rush in with heroic measures where nurses and even doctors fear to tread'.⁶⁴ The STM were anxious that without being trained in the 'habit of obedience',⁶⁵ masseuses might not fully appreciate the limits of their responsibility and usurp the prerogative of the medical practitioner. By emulating established social relations between doctors and nurses, the massage profession sought to negotiate for itself a position as a medical auxiliary akin to nursing.

While it was generally agreed amongst the nursing, massage and medical community that nursing was essential for massage work, how this

⁶² Anne Marie Rafferty, *The Politics of Nursing Knowledge* (London: Routledge, 1996), p.54.

⁶³ Rafferty, *Politics of Nursing Knowledge*, p.26.

⁶⁴ Manley, 'Massage', *NN* (December 1897), 163.

⁶⁵ Manley, 'Massage', *NN* (December 1897), 163.

should be gained was a topic of debate. As an article in *The Hospital* complained in 1903, '[i]t has never even been decided whether massage should be taken as an adjunct to general nursing, or whether it should be regarded as a quite distinct profession'.⁶⁶ For *The Hospital* '[w]e believe massage to be a branch of the nursing profession; we maintain that it should never be taught except to nurses who have had a general training'.⁶⁷ They argued that this should be the case because 'the medical man leaves so much to the masseuse that the general training is necessary to guide her'.⁶⁸ They contrasted this with the Continent, 'where rubbing is given in clinics with doctors looking on, but it is different here'.⁶⁹ In Britain, then, they considered that the lack of medical involvement compelled those engaged in massage to have a nurse training in order to be safely responsible for the patient's treatment.⁷⁰ The view that massage should be a post-graduate qualification of nursing, however, threatened the aspirations of the STM that massage should be a distinct profession. This also highlights that without the actions of the STM the professionalisation of massage may have been realised in a different way.

Though it emphasised that nursing expertise was essential for massage work, the STM maintained that massage was a discipline distinct from nursing. Rather than requiring the masseuse to be a trained nurse, the STM incorporated certain elements of nursing into its professional framework. As discussed in Chapter 2, professional discipline was enforced through the Society's byelaws, code of conduct and professional register. The STM

⁶⁶ 'The Trained Masseuse', *The Hospital: (Nursing Section)* (30 May 1903), in, 'Special Meeting of Founders of the Society', (8 June 1903), Chartered Society of Physiotherapy: Council Minutes (8 January 1903-6 January 1905), WL, SA/CSP/B.1/1/5, p.115.

⁶⁷ 'The Trained Masseuse', WL, SA/CSP/B.1/1/5, p.115.

⁶⁸ 'The Trained Masseuse', WL, SA/CSP/B.1/1/5, p.115.

⁶⁹ 'The Trained Masseuse', WL, SA/CSP/B.1/1/5, p.115.

⁷⁰ 'The Trained Masseuse', WL, SA/CSP/B.1/1/5, p.115.

encouraged masseuses to gain practical experience in a hospital, and coordinated with the Lambeth and Paddington Infirmaries to offer trainee masseuses work experience.⁷¹ '[T]o any who can spare the time' they wrote in 1896:

I would strongly advise a course of training at a hospital, not only for the experience gained, but also for the discipline, knowledge of professional etiquette and manners, and of the numerous details of sick-room management, which add so much to the comfort of the patient and undoubtedly contribute to the success of the masseuse.⁷²

Writing in 1897 Elizabeth Manley complained that some masseuses were 'lamentably, though needlessly, ignorant of nursing'. 'I say needlessly,' she continued, 'because instruction in such details can, and ought to be, obtained by every masseuse who is not also a nurse [...] without such knowledge no masseuse can be said to be properly equipped for her work'.⁷³ By 1900 during the Boer War, nursing knowledge was no longer an 'option' and candidates who were not trained nurses were required to 'attend a course of lectures on 'first aid'',⁷⁴ and have knowledge of 'bandaging and the elements of nursing', as a prerequisite of the STM certificate.⁷⁵

While assimilating established nursing norms, regulations and knowledge into the massage profession, the STM maintained that it was a distinct discipline. As Elizabeth Manley argued in 1910 nurse training did not circumvent the need for a thorough training in massage:

⁷¹ Reference to Lambeth Infirmary see 'Massage Notes', *NN* (April 1896), 50, and Paddington Infirmary, 'The ISTM', *NNMC* (July 1913), 204.

⁷² 'Massage Notes', *NN* (February 1896), 25.

⁷³ Manley, 'Massage', *NN* (December 1897), 163.

⁷⁴ 'Committee Meeting' (9 April 1897), Chartered Society of Physiotherapy: Council Minutes, (4 October 1895-31 May 1899), WL, SA/CSP/B.1/1/2; by 1900 a first aid certificate or a 'few months training in hospital' were demanded, see 'Council Meeting' (21 September 1900), Chartered Society of Physiotherapy: Council Minutes (27 July 1900-12 December 1902), WL, SA/CSP/B.1/1/4.

⁷⁵ 'The ISTM', *NN* (August 1901), 107.

When the massage undertaken by the trained nurse or midwife is the result of skilled training, practice and careful study, this is a great advantage to the public; it is a danger in cases where a “smattering” only has been acquired, when the nurse has perhaps “seen massage done” or been “shown how,” and, holding the status of the nurse, she is under the impression that the training necessary for the professional masseuse is needless for her [...] in cases where skilled manipulations are essential to success this naturally tends to failure in attaining the desired result, and brings massage into discredit.⁷⁶

As the development of massage training suggests, by 1910 the demand for and diversification in the uses of massage had increased so that, as nurse superintendent Amy Hughes wrote, ‘proficiency in the art of massage’ was now far more than ‘mere knowledge of “how to rub” which contented many nurses not so long ago’.⁷⁷

At the same time that the fully trained nurse-masseuse was described as the ‘counsel of perfection’ there were also increasing numbers of women entering the profession without a preliminary training in nursing - the masseuse who ‘devotes her efforts entirely to manipulations, to the giving of remedial exercises and frequently also to the administration of electrical treatment’.⁷⁸ While emphasising their alignment with nursing the massage profession asserted its difference by claiming its authority and expertise in the territory of physical therapy. By the First World War the STM claimed that massage had become ‘important to the British public, to the nursing profession, and lastly, but not in less degree, to the medical profession’.⁷⁹ ‘Recognised by the medical profession as an indispensable form of treatment in many cases, both surgical and medical’, they argued, the masseuse was ‘in constant request’ and had become a ‘calling’, ‘added to the repertory of handicrafts and occupations

⁷⁶ Manley, ‘Massage’, *NNMC* (June 1910), 154.

⁷⁷ Hughes, ‘Nursing as a Vocation’, p.107.

⁷⁸ Manley, ‘Massage’, *NNMC* (June 1910), 154.

⁷⁹ Manley, ‘Massage’, *NNMC* (June 1910), 154.

whereby women may serve their generation and earn their living'.⁸⁰ Incorporating nursing was one way in which the massage profession was able to establish itself within the space created by the demand for physical therapy within medicine. It was, however, only part of the process; another equally important facet was the way in which the STM claimed to have expertise that simultaneously distinguished the profession from nursing and made it 'indispensable' to medicine.

Massage, Swedish Expertise and Training

On the request of Sydney Holland, chairman of the London Hospital House Committee, in April 1904, the Swedish 'Doctor Koch' and his Danish wife were appointed at the hospital to give Swedish massage and exercises.⁸¹ The appointment was initially a diplomatic manoeuvre as the request to trial the practitioners had come from the Queen who knew and recommended them personally. Mr and Mrs Koch came with teaching experience from Copenhagen as well as the 'machinery needful for the Swedish movements'.⁸² They were to work alongside the nurses in a six-month trial, treating patients 'sent to them by the Staff over in the Massage Department',⁸³ on four afternoons a week, with Mr Koch treating men and Mrs Koch treating women.⁸⁴

Soon, however, the London Hospital found that the 'growth of this department', had been 'enormous'.⁸⁵ By February 1905 Herr Koch had been

⁸⁰ Manley, 'Massage', *NNMC* (June 1910), 154.

⁸¹ 'A Meeting of the Medical Council', (16 April 1904), Medical Council: Minutes (7 May 1903-1 April 1905), RLHA, RLHLM/1/5.

⁸² 'A Meeting of the Medical Council', (16 April 1904), RLHA, RLHLM/1/5.

⁸³ 'A Meeting of the Medical Council', (16 April 1904), RLHA, RLHLM/1/5.

⁸⁴ 'Regulations, re. Swedish Massage', Medical Council: Files and Miscellaneous: Reports and Papers re. Massage Department, 1906-1907, RLHA, RLHLM/5/28.

⁸⁵ 'A Meeting of the Medical Council', (7 April 1905), RLHA, RLHLM/1/5.

asked to draw up a curriculum, to supervise the training of nurses,⁸⁶ and there emerged, quite organically, a 'Swedish division' to the London Hospital's massage department.⁸⁷ Commenting on the growth of the department, hospital secretary E.W. Morris informed the medical council that Koch had 'trained nine of our nurses in Swedish massage', six of whom had to be 'permanently' engaged to 'carry on the routine work of his department'.⁸⁸ 'Such a necessity', he wrote, 'was never contemplated when the Swedish massage was commenced'.⁸⁹ The Swedish division of the massage department used massage, exercise and mechano-therapy to treat a wide variety of medical and surgical conditions,⁹⁰ although by March 1906 over sixty per-cent of attendances were cases of scoliosis.⁹¹

The London Hospital was not the only hospital to employ Swedish expertise before the War. For example, in 1898 St Thomas's Hospital established a small gymnasium equipped with apparatus and engaged 'a skilled instructor to carry out a system of Swedish exercises'.⁹² Initially open for two afternoons a week, the gymnasium included 'two Sargent's combination pulley machines' to exercise joints; treadle machines to mobilise the ankles; as well as a 'horizontal bar, a trapeze, and couches for the exercises on the Swedish system especially devoted to the extension and rotary movements of the spine, and for ordinary massage'.⁹³ Describing the motivation behind establishing a gymnasium at the hospital surgical registrar E.O. Thurstan, wrote that:

⁸⁶ 'A Meeting of the Medical Council', (10 February 1905), RLHA, RLHLM/1/5.

⁸⁷ Openshaw and Wall, 'Recommendations', RLHA, RLHLH/A/17/24, p.1.

⁸⁸ 'A Meeting of the Medical Council', (7 April 1905), RLHA, RLHLM/1/5.

⁸⁹ 'A Meeting of the Medical Council', (7 April 1905), RLHA, RLHLM/1/5.

⁹⁰ 'A Meeting of the Medical Council', (14 June 1905), RLHA, RLHLM/1/6.

⁹¹ 'A Meeting of the Medical Council', (23 March 1906), RLHA, RLHLM/1/6.

⁹² E. O. Thurstan, 'The New Department for Physical Exercises', in *St Thomas's Hospital Report* Vol.28, ed. by Hector Mackenzie and G.H. Makins (London: J. & A. Churchill, MDCCCXCVIII (1898)), pp.195-198, (p.195).

⁹³ Thurstan, 'Physical Exercises', p.198.

The difficulties attendant on the treatment of hospital out-patients suffering from lateral curvature of the spine, stiff joints, and other deformities, by proper mechanical exercise, have been long felt, and the unsatisfactory results of directing the use of certain exercises by the patients themselves either at their own homes, or in the case of young persons at the Board School gymnasiums, abundantly proved.⁹⁴

The hospital engaged Swedish trained Miss Nicodemi to provide 'a course of exercises on the Swedish system' to female cases of 'lateral curvature' and other deformities.⁹⁵ Other institutions in this period engaged Swedish expertise, installed various apparatus, and developed massage, exercise and mechanotherapeutic departments for similar reasons. For example, in 1858 Liverpool's Royal Southern Hospital had gymnastic equipment installed to 'accelerate the perfect use of a patient's limbs, and shorten the period of their recovery', which developed into a Massage and Exercise Department in 1906,⁹⁶ and in 1874 the RNOH had employed B. Bertrand, a 'Professor of Gymnastics'.⁹⁷

The incorporation of Swedish expertise into British hospitals signals two things that were important for the professionalisation of massage. Firstly it suggests there was a gap within British medicine for specialist expertise in the field of physical therapy, and secondly it highlights the status of Swedish gymnasts as professionals in this field. In an article for the *BMJ* in 1910 Swedish physician and physical therapist Edgar Cyriax (1874-1955) wrote that

⁹⁴ Thurstan, 'Physical Exercises', p.195.

⁹⁵ Thurstan, 'Physical Exercises', p.196.

⁹⁶ Macalister, *Liverpool Royal Southern*, pp.62-72, in Roger Cooter, *Surgery and Society in Peace and War: Orthopaedics and the Organization of Modern Medicine, 1880-1948* (London: Macmillan Press, 1993), p.258, (note 43).

⁹⁷ J.A. Cholmeley, *History of the Royal National Orthopaedic Hospital* (London: Chapman and Hall, 1985), p.74.

'[i]t is greatly to be regretted that the medical profession in this country has largely neglected mechano-therapeutics':⁹⁸

Members of the lay public who have heard of Swedish treatment, mechano-therapeutics, massage, or allied forms of treatment, have in consequence come to regard such methods of healing as outside the domain of the regular medical profession, and have gone to unqualified practitioners to obtain them.⁹⁹

For Cyriax, the only solution was for the medical profession to 'take mechano-therapeutics into its own hands', and to teach it 'at the universities and medical schools as part of the regular curriculum instead of being practically neglected as it is now'.¹⁰⁰ Indeed, British practitioners often had to attend one of the Institutes in Sweden in order to gain specialist training in this field, including Richard Timberg, who became the head the St. Thomas's physical exercise and massage department,¹⁰¹ Mary Coghill Hawkes and Florence Barrie Lambert.¹⁰² For hospitals such as those discussed above, however, the Swedish gymnast provided access to this therapeutic with which the majority of practitioners were unfamiliar. It was because Swedish gymnasts operated in a sphere that lacked interest to British medicine that a working relationship rather than one of hostility was able to emerge in the late-nineteenth century. As will be discussed later in this chapter and also shown in Chapter 6, however, these amicable relations broke down as medical interest in physical therapy increased.

⁹⁸ Edgar F. Cyriax and Richard J. Cyriax, 'Mechano-Therapeutics and Disease', *BMJ* (1910), in Edgar F. Cyriax, *Collected Papers on Mechano-Therapeutics* (London: John Bale, Sons & Danielsson, Ltd., 1925), pp.406-407, (p.406).

⁹⁹ Cyriax and Cyriax, 'Mechano-Therapeutics and Disease', p.406.

¹⁰⁰ Cyriax and Cyriax, 'Mechano-Therapeutics and Disease', p.406.

¹⁰¹ Richard Timberg, Report of the Physical Exercise and Massage Department for 1912', in *St Thomas's Hospital Report Vol.41*, ed. by J.J. Perkins and C.A. Ballance (London: J. & A. Churchill, MDCCCXIV), pp.211-214, (p.211), 'G.D. (Stockholm)' indicates gymnastic director trained in Stockholm.

¹⁰² Isobel Smith, 'The Growth of the Swedish Institute', in *St. Mary's Hospital School of Physiotherapy (Swedish Institute), Magazine*, (1953), pp.2-5, Olive Guthrie-Smith and St Mary's Hospital School of Physiotherapy (1895-1969), WL, SA/CSP/P.4/1/1/1, pp.3-4.

The appointment of Swedish experts to leading hospitals also reflects the status that they held socially and professionally. As discussed in Chapter 1, gymnastics had emerged as a scientific discipline and profession through the work of Ling and the Central Institute in Stockholm. The Central Institute, and later Dr Arvedson's Gymnastic Institute for women in Stockholm and Major and Mrs Thulin's Institute in Lund, were prestigious government supported institutions that conferred the title 'gymnastic director' upon graduates.¹⁰³ Their status as professional workers in the field of massage and gymnastics was largely undisputed and rested upon their internationally renowned theoretical and practical training. All 'Swedish' training, whether conducted at one of the government institutions or not, was perceived in Britain to be as rigorous and received prestige purely by association. As the work of Anders Ottoson has pointed out, it was not unusual for Swedish gymnasts to call themselves 'doctors' or 'professors', and the government on occasion officially conveyed these titles.¹⁰⁴ Swedish gymnasts, especially graduates of the government sponsored institutions, were frequently connected with the upper classes and practised manual work 'without in any way losing caste'. 'On the contrary', Swedish gymnast Theodora Johnson wrote in 1897, by doing so 'they raise the standard of their profession, which holds a higher social position in Sweden than, as yet, in any other country'.¹⁰⁵ The prestigious status of Swedish gymnasts as professionals and specialists was significant because it contrasted with the low status of those who traditionally worked in the field of manual

¹⁰³ Barclay, *In Good Hands*, p.46. Although officially it was only these institutions that were allowed to confer this title it was adopted by many Swedish practitioners working in Britain.

¹⁰⁴ Anders Ottoson, 'The Manipulated History of Manipulations of Spines and Joints? Rethinking Orthopaedic Medicine Through the 19th Century Discourse of European Mechanical Medicine', *Medicine Studies*, 3 (2011), 83-116, (p.94).

¹⁰⁵ Theodora Johnson and Per Henrik Ling, *The Swedish System of Physical Education: Its Medical and General Aspects* (Kent: Simpkin, Marshall, Hamilton, 1897), p.18.

therapy in Britain, such as rubbers and bonesetters. For this reason, the Swedish gymnast offered a professional model that those interested in raising the status of the massage profession in Britain sought to emulate. One of the primary ways they did so was by drawing from Swedish training and expertise.

As Jane Wicksteed wrote, in the period before the First World War ‘the supremacy of Sweden’ in the field of massage and physical exercise ‘was not challenged’.¹⁰⁶ Being trained in Sweden was regarded as a hallmark, it was increasingly sought after and often used as a point of contrast to British training.¹⁰⁷ While, by 1900, there were many well-respected English training schools, such as Fletcher Little’s London School of Massage and the Manley sisters’ school at Buckingham Street, ‘English massage’ found that it could not ‘compete’ with the reputation of massage on the Continent.¹⁰⁸ As the personal recommendation of Herr Koch from the Queen suggests, there was a lucrative market for continental practitioners, and as one correspondent ‘J.S’, wrote to *The Nursing Record & Hospital World* in 1897, ‘Swedish manual treatment is considered expensive in comparison with ordinary medical rubbing’, but ‘if you want a superior thing you have to pay a higher price’.¹⁰⁹

The perceived differences between ‘English’ and ‘Swedish’ massage also resonated in medical practice. One example of this was at the London Hospital where the ‘English division’ of the massage department, consisting of graduates of Margaret Palmer, was considered a separate entity to the ‘Swedish division’ headed by Herr Koch.¹¹⁰ It was found that medical staff at the London specifically ordered ‘Swedish’ or ‘English’ massage according to their

¹⁰⁶ Wicksteed, *The Growth of a Profession*, p.65.

¹⁰⁷ Wicksteed, *The Growth of a Profession*, p.65.

¹⁰⁸ Smith, ‘Swedish Institute’, WL, SA/CSP/P.4/1/1/1, p.2.

¹⁰⁹ ‘J.S’, ‘Letters to the Editor: Physical Education’, *The Nursing Record & Hospital World* (17 April 1897), 325-326, Royal College of Nursing online archive (henceforth RCN), 326.

¹¹⁰ ‘A Meeting of the Medical Council’, (14 June 1905), RLHA, RLHLM/1/6.

understanding, prescribing 'English' massage to mobilise stiff joints and 'Swedish' massage to correct deformities.¹¹¹ While distinctions were ambiguous at best and became increasingly artificial in practice, the perceived superiority and distinction of 'Swedish' methods was enduring. It is interesting to note that this distinction was still made in 1919 at St Thomas's hospital, with Timberg and Mennell in charge of Swedish and English massage treatment respectively.¹¹²

The British massage profession not only emulated and aspired to the status of Swedish expertise but also competed with Swedish practitioners. Speaking to the STM in 1902 William Bennett stated that: 'the English masseuse is less advanced than those educated in Sweden and Denmark', warning that '[t]he foreign masseuse is amongst us and if the English one [...] is to hold her own and not let cases slip into other hands, it behoves her to look to herself that she is perfect throughout'.¹¹³ Likewise in March 1903, the STM noted that in the 1890s 'there seemed a danger' that 'the English masseuse might be superseded by her foreign sisters even in her own land'.¹¹⁴ The reason for this was the common belief amongst the public and medical profession that Swedish training signalled 'more theoretical knowledge and practical skill'.¹¹⁵ Swedish training was used as a standard to contrast and critique massage training in Britain. According to Swedish gymnast 'J.S' in 1897:

massage used in this country is very insufficient, and practised by people who know nothing whatever of anatomy, physiology, pathology, or medical or educational gymnastics, and for that reason we who practise Ling's system [...] do not care to call our treatment

¹¹¹ 'A Meeting of the Medical Council', (14 June 1905), RLHA, RLHLM/1/6.

¹¹² [Untitled Document], (1919), pp.1-3, Miscellaneous Papers: History of the School, LMA, HI/ST/PS/Y/04/001, p.1.

¹¹³ William Bennett, quoted in, 'The ISTM', *NN* (September 1902), 120.

¹¹⁴ 'The ISTM', *NN* (March 1903), 43.

¹¹⁵ For a commentary on this see, Adga Adelgren, 'Swedish Massage', *NNMC* (August 1913), 236.

'massage' or 'medical rubbing,' or to be put on a level with people who learn massage in a few days or weeks.¹¹⁶

Writing in 1905, female physician Mary Coghill Hawkes described that it was the thoroughness of the Swedish training that meant 'that the Swede has been chosen by English practitioners to carry out treatment in preference to the native article'.¹¹⁷

Knowledge, instituted and controlled through education and training, has been identified as a central part of a professionalising process.¹¹⁸ As discussed in Chapter 2, one of the primary ways in which masseuses sought to improve the status of British massage was by improving education and training. Writing in 1902 the STM warned its members that 'it is time that teachers and pupils alike realised that a month's training is perfectly inadequate in which to acquire the knowledge necessary for the variety of cases for which massage is now employed'.¹¹⁹ Through their examination, the STM was able to enforce a standard level of knowledge and training and emphasise the intellectual basis of the work. While 'scientific massage' was articulated through the language of medical science it was the Swedish gymnast rather than the medical profession that provided the British massage profession with a model to emulate. Like Swedish gymnasts, theoretical and practical knowledge gained through education and training was one way that the STM sought to elevate the massage profession and distinguish massage as a specialist discipline distinct from 'rubbing'.

¹¹⁶ 'J.S', 'Physical Education', RCN, 326.

¹¹⁷ Mary Coghill Hawkes, 'Uses and Advantages of Physical Exercises in Health and for Remedial Purposes', *NN* (April 1905), 59-60, (p.59), part of a series, see also (June 1905), 91-93.

¹¹⁸ Richard Hugman, *Power in the Caring Professions* (Basingstoke: Macmillan, 1991), p.93.

¹¹⁹ 'The ISTM', *NN* (September 1902), 120.

Writing for the STM in 1902, Lucy Robinson noted that ‘the difference between continental and English methods’ was a foremost consideration for the British masseuse.¹²⁰ ‘[I]n Sweden’, she continued, ‘there is a prolonged and elaborate training’ while ‘in Germany and France a considerable amount of training and a great difference in the manner of work’, ‘working far more under the direct supervision of the doctor’ where a ‘definite description is given for the amount, kind, duration and locality of the massage, so that a masseuse has exact instructions’.¹²¹ In contrast:

quite apart from the wrong of taking a case without medical permission, we in England are far more left to our own discretion, that is, as a rule, the doctor orders massage daily or on alternate days, to obtain some particular result, and concludes that we know how to do it, and can be trusted to do it.¹²²

This suggests that the same lack of medical involvement in the territory of mechanical medicine that invited the Swedish gymnast into British medicine was also a force driving the professionalisation of massage. As Robinson concluded, ‘[i]t therefore behoves us to really understand what we are to do and to justify the confidence doctor and patient place in us [...] a properly trained masseuse knows her movements, has acquired manual dexterity, speed and has a clear though elementary knowledge of anatomy’.¹²³ The professionalisation of massage was a process responding to the demand for treatment, the absence of medical expertise and threat of foreign competition.

Another important development of the early massage profession was the diversification of its skill-set and therapeutic territory. The STM quickly realised the importance of physical exercise alongside massage for the survival of the

¹²⁰ Lucy Robinson, ‘Massage in 1902’, *NN* (November 1902), 146-147, (p.147).

¹²¹ Robinson, ‘Massage in 1902’, 147.

¹²² Robinson, ‘Massage in 1902’, 147.

¹²³ Robinson, ‘Massage in 1902’, 147.

profession. Voicing her anxiety at a meeting of 'Masseuses in Council' in 1901, masseuse Florence Dove argued 'the very great importance of the study of Physical Exercises', 'whether they are called Swedish, Danish or what not'.¹²⁴

For Dove:

many of the present women training did not devote nearly enough time and attention to this branch, and that, therefore, cases were slipping away from English masseuses, as there were such large numbers of Swedish and Danish practitioners who undertook this work.¹²⁵

Increasingly training in massage was considered the starting point rather than the finish of a masseuse's education and it was expected that 'anyone who said she was trained in massage would also have been trained in Physical Exercises'.¹²⁶ As highlighted in Chapter 1, massage had always been closely linked to remedial gymnastics, especially so within Swedish doctrine; as authority Margaret Palmer wrote for *Cassell's* in 1910, '[m]edical gymnastics and massage are not separable; neither is complete without the other'.¹²⁷

While some massage schools offered instruction in remedial exercises, it was most frequently taken up as further study after a masseuse's initial training.¹²⁸ The STM did not challenge the 'supremacy of Sweden' in the arena of physical exercise, and looked to the Swedish to guide their expansion into this territory. As early as 1903 the STM organised a course of 36 lessons over three months for its members, to be instructed by Swedish Director of Gymnastics Miss Adolphson, at the Chelsea Physical Training College.¹²⁹ From

¹²⁴ 'Masseuses in Council', *NN* (July 1901), 96-97, (p.97).

¹²⁵ 'Masseuses in Council', 97.

¹²⁶ 'Masseuses in Council', 97.

¹²⁷ Margaret Palmer, 'Massage', in *Cassell's Science and Art of Nursing: A Guide to the Various Branches of Nursing, Theoretical and Practical* Vol.4, by Medical and Nursing Authorities (London: The Waverly Book Company, c.1909), pp.103-121, (p.103).

¹²⁸ 'Masseuses in Council', 97.

¹²⁹ 'The ISTM', *NN* (August 1903), 113-114; Wicksteed, *The Growth of a Profession*, p.65.

around the turn of the century, training in physical exercises became increasingly available to British masseuses and a number of private schools were established by British medical women - many of whom trained in Sweden. For example, Dr Mary Coghill Hawkes along with Dr Mary Magill opened the Swedish Institute of Massage and Remedial Exercise in 1904, which was later taken over by two other well-known masseuses Dr Justina Wilson and her niece Olive Guthrie-Smith.¹³⁰ Mary Coghill Hawkes aimed to extend the training that she had received at Dr Arvedson's Institute in Sweden to British women. In 1905 she wrote:

Now there is no reason why, if this kind of training can be obtained in Sweden, it should not be also obtained in England, and I would plead that an English or British, shall I say, gentlewoman, educated on strict Swedish lines, is quite able, if properly and fully trained, to undertake this work and earn a suitable livelihood.¹³¹

Another well-known institution was the Training College for Massage and Remedial Gymnastics at Park Lane, established by Dr Florence Barrie Lambert and Dr Elizabeth Patterson.¹³²

For many involved in the massage profession the official incorporation of remedial exercise into the masseuse's professional territory was essential for survival. Throughout the first decade of the twentieth century the STM sought to provide training and examination for its members in Swedish remedial exercises. Aside from arrangements made with the Chelsea Physical Training College in 1903, the STM had on-going negotiations with Mary Coghill Hawkes

¹³⁰ Smith, 'Swedish Institute', WL, SA/CSP/P.4/1/1/1, pp.2-5.

¹³¹ Coghill Hawkes, 'Physical Exercises', (April 1905), 60.

¹³² Barclay, *In Good Hands*, p.48.

in an effort to conduct an examination for members.¹³³ It was, however, not until June 1909 that the STM held its first independent examination - the examiners appointed were teachers from the Physical Training Colleges and described as 'highly qualified ladies trained in Sweden'.¹³⁴ The Swedish Remedial Exercises (SRE) examination was considered to be a 'senior' qualification; it required candidates to undertake a six-month course of training. Examination included advanced anatomy, to a level Mennell wrote 'would tax the ordinary medical student severely',¹³⁵ physiology, the theory of gymnastic movement and the principles of teaching, alongside an anatomy viva and practical teaching exam held in Guy's Hospital massage department.¹³⁶

The move into the field of remedial gymnastics reflects the types of conditions that the massage profession were treating. Writing in 1898, the STM described how physical exercises were important for two aspects of massage work in particular: 'general muscular development' and also 'the correction of deformities'.¹³⁷

The masseuse cannot be said to be completely equipped for her work who has no knowledge of at least of those physical exercises which are recommended for the correction of deformities, and which a doctor naturally assumes that his masseuse knows how to administer or superintend.¹³⁸

The profession considered that '[t]he field of work for medical gymnastics is widening' and it sought to meet this demand.¹³⁹ As Mary Coghill Hawkes

¹³³ The negotiations with the Swedish Institute had broken down by December 1906, see 'Council Meeting', (12 October 1906), Chartered Society of Physiotherapy: Council Minutes (13 January 1905-14 December 1906), WL, SA/CSP/B.1/1/6.

¹³⁴ 'The Annual Meeting of the ISTM', *NNMC* (April 1909), 83.

¹³⁵ James Mennell, 'Massage in Orthopaedic Surgery', in *Orthopaedic Surgery of Injuries Vol.2*, ed. by Robert Jones (London: Holder & Stoughton, 1921), pp.505-559, (p.507).

¹³⁶ Barclay, *In Good Hands*, pp.48-49.

¹³⁷ 'Annual Meeting', *NN* (March 1899), 43.

¹³⁸ 'Annual Meeting', *NN* (March 1899), 43.

¹³⁹ Coghill Hawkes, 'Physical Exercises', (June 1905), 91.

described in 1905, 'the question of physical deterioration may mean eventually the employment of properly trained women, in the treatment of the diseases and deformities of children, induced by the condition of life of the lower classes'.¹⁴⁰

While physical exercises were emphasised in particular, the STM encouraged its members to develop their expertise in a range of treatments. Although the STM had singled out massage alone for professionalisation in 1895, influenced by their background as 'nurses who did massage' and the massage scandals, there had been from the outset a wider perspective on the scope of the massage profession. For example, in the first certificate drafted by the STM, they stated that:

This is to certify that [...] has been trained in Practical Massage with Swedish Movements, and we consider her fully qualified to carry out Massage treatment under the orders of a Medical Practitioner. She has been instructed in Elementary Anatomy and in the use of the Battery.¹⁴¹

The decision to ultimately limit themselves to massage, however, was taken on the advice of Dr Cooper Perry.¹⁴² By the turn of the century, the STM warned its members that the 'certified masseuse will find herself sorely handicapped in actual practice' if she did not supplement her massage qualification with further training.¹⁴³ 'Progressive study is of very great importance to the masseuse', the STM wrote in 1898, 'it appears manifest, therefore, that the range of our reading should embrace [...] kindred subjects'.¹⁴⁴ The 'kindred subjects' entering the scope of the massage profession changed over time absorbing new

¹⁴⁰ Coghill Hawkes, 'Physical Exercises, (June 1905), 93.

¹⁴¹ 'Midwives' Institute, Re. Massage', (December 1894), Chartered Society of Physiotherapy: Council Minutes (December 1894-9 August 1895), WL, SA/CSP/B.1/1/1.

¹⁴² 'Meeting of a Committee', (4 January 1895), WL, SA/CSP/B.1/1/1.

¹⁴³ 'The Curriculum Necessary for a Masseuse', *NN* (August 1901), 107.

¹⁴⁴ 'The Need of Study', *NN* (October 1898), 138-139, (p.138).

technologies, therapeutic developments and clinical demands. At the turn of the century, aside from physical exercises, masseuses extended their expertise into 'medical electricity' and a range of heat and water treatments, such as the 'Nauheim Treatment', which was a system of bathing, massage and exercise for heart conditions.¹⁴⁵

By 1914 the masseuse was a multi-skilled practitioner and the massage profession represented expertise in a range of physical treatments and technologies. Through training the STM was able to distinguish itself as an authority in physical treatments and rehabilitation distinct from both 'rubbers' and 'nurses who did massage'. By emulating the Swedish model of training the British massage profession closed the gap between continental and British expertise and was able to occupy a therapeutic territory increasingly important within British medicine. By 1914 Swedish gymnasts and the British massage profession had very similar expertise and while Swedish doctrine remained popular, increasingly the British masseuse was able to compete with Swedish practitioners for the territory.¹⁴⁶ Writing in June 1910, Elizabeth Manley stated that the massage profession was 'becoming indispensable' to the public and the medical profession, noting:

we no longer "dread foreign competition," and we welcome the co-operation of the friendly masseuse from other lands, realising that we can mutually learn from and help one another.¹⁴⁷

The profession was becoming 'indispensable' to medicine and able to compete with 'foreign competition' because while offering the same expertise as the

¹⁴⁵ 'The Curriculum Necessary for a Masseuse', 107; for essays on how masseuses used physical exercises, nauheim treatment and electricity, see 'Massage Notes', *NN* (October 1898), 132-139.

¹⁴⁶ An example of this, see Adga Adelgren, 'Swedish Massage', *NNMC* (August 1913), 236.

¹⁴⁷ Manley, 'Massage', *NNMC* (June 1910), 156.

Swedish gymnast, in contrast to foreign practitioners they held steadfast, like their nursing sisters, to their loyalty to the medical profession. As Lucy Robinson commented, the STM pledged to 'work *only* under the orders of a doctor, an excellent rule which we much sincerely wish our foreign fellow-workers adhered to in England'.¹⁴⁸ It was through this allegiance that the massage profession established a working relationship with medicine wherein it situated itself in a position to absorb some of the technical and labour intensive aspects of physical treatment entering into medicine.

Massage and Medicine

The last section of this chapter explores the evolution of the massage department at the London Hospital to illuminate certain features of the changing relationship between massage and medicine more widely. Massage underwent unprecedented growth at the London Hospital in the period before 1914. Like many other general hospitals, the London did not anticipate the demand for massage and allied treatments that would emerge from its poor patients. The development of massage departments to cater for their needs created an unprecedented demand for hospital space, putting strain on often already stretched resources, equipment, accommodation and staff.

Accommodating the growth of massage was an on-going problem for the London as in many other hospitals. At the London, the massage department was initially constituted as a sub-department of general out-patients,¹⁴⁹ but as the volume of its work expanded to 'enormous' levels it became critical that

¹⁴⁸ Lucy Robinson, 'Massage at the International Conference of Nurses', *NNMC* (August 1909), 168.

¹⁴⁹ Morris, *A History of the London Hospital*, p.12.

'some change of arrangement must be made if it is to go on'.¹⁵⁰ In order to consider the hospital's massage dilemma, the London established a 'massage committee' appointed from the medical and lay-managerial staff. In June 1905 they noted that: '[t]he 'Swedish' department is at present housed in a room which is so small that it is impossible for decency as understood in an English hospital to be observed'; 'it must', they continued, 'be provided with a large room or rooms'.¹⁵¹ Subsequently, the department was relocated to a 'vacant space in the basement of the Alexandra Wing',¹⁵² but massage continued to outgrow the hospital's accommodation provision.¹⁵³ The demand for space arose not only because of the increasing volume of patients but also because the 'massage department' undertook far more than 'simple Massage'.¹⁵⁴ A range of treatments was under the umbrella of the massage department before 1914 including Swedish exercise and gymnastic classes such as 'the Crawling class for curvature of the spine, and the stuttering class', mechano-therapeutics, electrical and heat treatment, all which required a considerable amount of equipment, space and 'restricted the accommodation available'.¹⁵⁵ The hospital's massage committee felt that 'before long they may have to face the expenditure of erecting a Department somewhat on the lines of a Zander Institute in the Out-patient Department'.¹⁵⁶ Figure 7 shows the type of remedial work undertaken in a hospital massage department or gymnasium at the turn of the century and illustrates the 'crawling' exercise for curvature of the spine.

¹⁵⁰ 'A Meeting of the Medical Council', (7 April 1905), RLHA, RLHLM/1/5; Similarly at St Thomas's: 'The work has been made independent of the out-patient Department, of which it used to previously merely to form a part', Timberg, 'Report for 1911', p.190.

¹⁵¹ 'A Meeting of the Medical Council', (14 June 1905), RLHA, RLHLM/1/6.

¹⁵² 'A Meeting of the Medical Council', (21 July 1905), RLHA, RLHLM/1/6.

¹⁵³ 'Meeting of the Medical Council', (20 November 1908), Medical Council: Minutes (1 May 1908-9 March 1909), RLHA, RLHLM/1/8.

¹⁵⁴ 'Meeting of the Medical Council', (20 November 1908), RLHA, RLHLM/1/8.

¹⁵⁵ 'Meeting of the Medical Council', (20 November 1908), RLHA, RLHLM/1/8.

¹⁵⁶ 'Meeting of the Medical Council', (20 November 1908), RLHA, RLHLM/1/8.



Figure 7 - Gymnasium at King's College Hospital with female patients and staff, (c.1900), WL, SA/CSP/Q.1/2.

The development of massage departments reflects its increasing use for the treatment of disabilities and injuries amongst the poor more broadly, as discussed in Chapter 3. Reporting in December 1908, the London Hospital massage committee wrote that '[we] recognise the great value of treatment by massage and exercises, mechanical and otherwise and realise the even greater part these methods will play in efficient medical and surgical treatment'.¹⁵⁷ In this context hospital massage departments operated closely alongside general out-patient, orthopaedic and other physical treatment departments, all of which at this time, were considered to be low status and often supervised haphazardly by junior members of staff.¹⁵⁸

The number of attendances at out-patient departments during the second half of the nineteenth century increased dramatically and between 1850 and 1911 reached 'crisis' proportions with one and a half million attendances by

¹⁵⁷ 'Meeting of the Medical Council', (14 December 1908), RLHA, RLHLM/1/8.

¹⁵⁸ Cooter, *Surgery and Society*, p.84.

1887 in London alone.¹⁵⁹ The out-patient crisis faced by the London voluntary hospitals was fed by a high number of casualty, accident and chronic cases.¹⁶⁰ As a treatment frequently used in these types of cases, the growth of the massage department was directly linked to the expansion of out-patients. As Richard Timberg noted at St Thomas's, the number of cases treated in his department rose rapidly each year and while many were 'referred from the Casualty Department', it also included chronic patients in increasing numbers.¹⁶¹ While on one hand this growth highlights that massage was becoming more 'recognised by the medical profession as an indispensable form of treatment in many cases',¹⁶² it also indicates that massage became a convenient referral for patients who did not readily respond to the usual forms of medical and surgical therapy. Reflecting in 1950 Harold Balme wrote that 'the massage department became a dumping ground, not only for the type of cases likely to recover after a short course of physical treatment, but also for many varieties of chronic disability in which physical treatment [...] acted as little better than placebo'.¹⁶³ The massage department absorbed a portion of chronically impaired patients, whether through illness or injury, who entered hospitals in increasing numbers.

Specialist departments emerged in many of the London general hospitals towards the end of the nineteenth century.¹⁶⁴ At this time, however, specialisation was still on the margins of medical practice and received widespread opposition, particularly from the older generation of practitioners

¹⁵⁹ Cooter, *Surgery and Society*, pp.89-90.

¹⁶⁰ Cooter, *Surgery and Society*, p.90.

¹⁶¹ Timberg, 'Report for 1912', p.212.

¹⁶² Manley, 'Massage', (June 1910), *NNMC*, 154.

¹⁶³ Harold Balme, 'Principles of Organization', in *Recent Advances in Physical Medicine*, ed. by Francis Bach (London: J.A. Churchill, 1950), pp.333-343, (p.333).

¹⁶⁴ Rosemary Stevens, *Medical Practice in Modern England; the Impact of Specialization and State Medicine* (New Haven, Yale Univ. Press, 1966), p.26.

who associated specialisation with quackery.¹⁶⁵ By 1910 a range of specialist sub-departments had been established at the London Hospital.¹⁶⁶ As suggested in the case of the massage department, the growth of specialist departments cannot be viewed simply as a response to developments in medical knowledge and techniques but also by socio-economic and political pressures. At the London for example, networks of patronage were heavily influential in the development of physical treatment. While one example includes the Queen's recommendation of Herr and Mrs Koch, another was the case of the Finsen Light Department, which was established after Queen Alexandra donated the first lamp in 1899.¹⁶⁷ Two doctors and two nurses were sent to Copenhagen to learn how to use the lamps and the department attracted patients from around the world for its treatment of lupus.¹⁶⁸ Another example includes the Tyrnauer Bath Department, established in 1909 after they were donated to the Hospital by 'Princess Hatzfeldt'.¹⁶⁹ Inventor of the baths, Dr. Tyrnauer of Carlsbad came to the London Hospital personally to instruct staff 'both lay and medical', in their use,¹⁷⁰ and the department 'relieved hundreds of patients [...] from the pain of rheumatism and rheumatoid arthritis'.¹⁷¹ While the development of these physical treatment departments remains to be fully explored, they offer insight into an interesting process whereby physical treatments were imported and absorbed into British medical practice to treat chronically disabled patients.

¹⁶⁵ Stevens, *Medical Practice in Modern England*, p.27, also see George Weisz 'The Emergence of Medical Specialization in the Nineteenth Century', *Bulletin of the History of Medicine* 77:3 (Fall, 2003), 536-574, (p.572).

¹⁶⁶ Morris, *A History of the London Hospital*, p.12, interesting that in the 1910 edition the Finsen Lamp, Tyrnauer Bath, X ray and Electrical departments are mentioned but not the massage department; A.E. Clark-Kennedy, *London Pride: The Story of a Voluntary Hospital* (London: Hutchinson, 1979), p.115.

¹⁶⁷ Morris, *A History of the London Hospital*, p.12.

¹⁶⁸ Sheila M. Collins, *The Royal London Hospital: A Brief History* (London: The Royal London Hospital Archives, 1995), p.22.

¹⁶⁹ Morris, *A History of the London Hospital*, pp.15-16.

¹⁷⁰ 'Meeting of the House Committee', (2 December 1908), House Committee: Minutes (3 February 1908-2 May 1910), RLHA, RLHLH/A/5/51.

¹⁷¹ Morris, *A History of the London Hospital*, pp.15-16.

Orthopaedics was another specialty within general hospitals closely linked to the massage department. Writing to the House Committee in December 1908, head of the London Hospital's newly established orthopaedic department, Thomas Openshaw, pointed out 'the very great growth which had taken place in the Orthopaedic Department' and urged 'the necessity of building further accommodation [...] under the same roof as the Massage Department'.¹⁷² As Cooter's work has observed, orthopaedic departments established before the war in some of London hospitals dealt largely with chronic cases.¹⁷³ Complaining in 1920, Robert Jones noted that even after the war 'on entering a so-called orthopaedic department [...] we find merely a massage room, a few Zander machines, some electric apparatus, but nobody with the requisite knowledge of affairs!'¹⁷⁴ As noted previously, massage departments were heavily associated with the treatment of deformities such as spinal curvature. Thomas Openshaw used manual and mechanical methods extensively in his orthopaedic practice,¹⁷⁵ and his connections with such treatment were reflected in his appointment as head of the 'surgical' side of the massage department in 1906.¹⁷⁶ Again this demonstrates the close relationship between massage and orthopaedics before 1914.

For the London hospital massage department, 'not only was the accommodation inadequate, but the working of the Department was not so satisfactory as it might be'.¹⁷⁷ While members of medical staff referred their patients to the massage department, there was 'no member of Staff definitely

¹⁷² 'Meeting of the House Committee', (2 December 1908), RHLA, RLHLH/A/5/51.

¹⁷³ Roger Cooter, 'The Meaning of Fractures: Orthopaedics and the Reform of British Hospitals in the Inter-war Period', *Medical History*, 31 (1987), 306-332, (p.312).

¹⁷⁴ Robert Jones, 'Remarks on Orthopaedic Surgery in Relation to Hospital Training', (20 November 1920), 773-775, (p.773).

¹⁷⁵ 'Meeting of the Medical Council', (21 July 1905), RLHA, RLHLM/1/6.

¹⁷⁶ 'The Annual Meeting of the Medical Council', (4 May 1906), RLHA, RLHLM/1/6.

¹⁷⁷ 'Meeting of the House Committee', (16 November 1908), RLHA, RLHLH/A/5/51.

appointed as head of this department with power to continue or discontinue treatment' until 1907.¹⁷⁸ Due to their low status, specialty and out-patient departments tended not to be well appointed within hospitals.¹⁷⁹ The actual administration of the massage department at the London Hospital was left in the hands of the nursing sisters, masseuses and Herr and Mrs Koch.¹⁸⁰ For the massage committee this was problematic because 'there was no head of the Department who had power to discharge cases when he considered further treatment unnecessary'; consequently:

patients who were transferred to the Massage Department from general out-patient departments, continued to attend for months and months long after those who were expert in massage and exercises were of opinion that no further good could be done the patient.¹⁸¹

The discharge of patients from the massage department rested with the medical practitioner who originally referred them for treatment and not with the staff of the department itself, 'an anomaly which did not exist anywhere else in the hospital',¹⁸² and frequently resulted in overly prolonged treatment.

Another problem was the lack of medical direction over the course of treatment more generally. Reporting in March 1907, the massage committee wrote that, '[t]he details of massage prescription are largely in the hands of the Sister' and 'explicit directions seldom being given by the Member of Staff who refers the patient to the Department'.¹⁸³

The order for "Massage" is interpreted by the Sister in charge to mean simple rubbing, stroking, kneading and clapping, with passive movements carried out manually. Without special orders she does

¹⁷⁸ 'Meeting of the Medical Council', (15 February 1907), RLHA, RLHLM/1/6.

¹⁷⁹ Weisz, 'The Emergence of Medical Specialization in the Nineteenth Century', p.572.

¹⁸⁰ 'Meeting of the Medical Council', (23 March 1906), RLHA, RLHLM/1/6.

¹⁸¹ 'Meeting of the House Committee', (16 November 1908), RLHA, RLHLH/A/5/51.

¹⁸² 'Meeting of the House Committee', (16 November 1908), RLHA, RLHLH/A/5/51.

¹⁸³ Openshaw and Wall, 'Recommendations', RLHA, RLHLH/A/17/24, p.1.

not consider herself at liberty to treat patients by the machines or by exercises.¹⁸⁴

The massage committee found that the majority of patients sent to the department were not under medical supervision, 'many of them [...] not seen by a member of the staff for two months at a time, or longer'.¹⁸⁵ The complaint that patients were often referred to the massage department with vague prescriptions for 'massage' and thereafter lost sight of, was one that was often heard. While the frequent change of medical officers in out-patient departments, meant that there was little accountability for patients undertaking prolonged periods of treatment generally,¹⁸⁶ the ambiguous prescription for 'massage' further demonstrates the lack of medical interest in the work of the massage department. Other specialty departments such as electricity and Tyranauer baths were also 'carried on without medical supervision', and there were increasing calls by 1914 to bring them under medical control.¹⁸⁷

At the London, the absence of a medical officer in charge of the massage department meant that, in practice, Herr Koch and nursing sisters assumed this authority. This situation and in particular the privileged position of independent practitioner Herr Koch, became a cause of angst for the hospital's medical staff. While he was introduced to the hospital as a 'doctor' it was soon realised that he was not medically trained and 'although an extremely skilled manipulator', did not have 'training in the theory of his work, and has no knowledge of anatomy, physiology, medicine, surgery or pathology'.¹⁸⁸ The

¹⁸⁴ Openshaw and Wall, 'Recommendations', RLHA, RLHLH/A/17/24, p.2.

¹⁸⁵ 'Meeting of the Medical Council', (23 March 1906), RLHA, RLHLM/1/6.

¹⁸⁶ Richard Timberg, 'Report of the Physical Exercise Department for 1913', in *Saint Thomas's Hospital Reports* Vol.42, ed. by J.J. Perkins and C.A. Ballance (London: J. & A. Churchill, MDCCCCV), pp.191-194, (p.191).

¹⁸⁷ 'Meeting of the House Committee', (25 April 1910), RLHA, RLHLH/A/5/51.

¹⁸⁸ Openshaw and Wall, 'Recommendations', RLHA, RLHLH/A/17/24, p.1.

committee found that: 'the patients treated by Herr Koch are not under medical supervision' and that 'Herr Koch signs the books himself'.¹⁸⁹ The primary concern was that by default Herr Koch had achieved a position of authority over the department for which he was not qualified - one which threatened that of medical staff. Reporting in 1906, the massage committee wrote that while they considered Swedish massage to be valuable, when practised by foreign specialists who did not work under medical direction, it had 'certain disadvantages':

The work of Mr and Mrs Koch is excellent in many respects, but they could never become suitable persons to guide and control the Department. They are unmethodical, devoid of any organising power and do not and cannot understand the relations which should subsist between members of the medical profession and masseurs.¹⁹⁰

This example demonstrates that as the significance of massage increased the presence of the Swedish gymnast began to unsettle the economic interests and authority of the medical practitioner. As Mary Coghill Hawkes pointed out, 'English medical men employ Swedes because they are well trained and do their work thoroughly, but complain that the patient is given to understand that no one knows anything outside Sweden of this work, and the patient returns to the medical man no more'.¹⁹¹

The London Hospital's concerns with the efficiency of the massage department can also be seen as part of wider rationalisations taking place within society and medicine. Historians show that from 1870 a number of managerial and organisational changes took place within Britain in response to the changing political, social and economic circumstances of health-care

¹⁸⁹ 'Meeting of the Medical Council', (23 March 1906), RLHA, RLHLM/1/6.

¹⁹⁰ 'The Annual Meeting of the Medical Council', (4 May 1906), RLHA, RLHLM/1/6.

¹⁹¹ Coghill Hawkes, 'Physical Exercises, (April 1905), 60.

delivery.¹⁹² Calls for the reorganisation of medical work within hospitals reflected broader rationalisations occurring within the state and industry that aimed to reduce waste and inefficiency. The London Hospital was influenced by these ideas, particularly after the appointment of Sydney Holland (1855-1931), a progressive hospital reformer who became chairman of the House Committee in 1896.¹⁹³ The London Hospital's massage committee aimed to reorganise the department to make it more efficient and productive. In 1910 they proposed that a combined physical therapy department be formed called the 'department of electrical and physical therapeutics'.¹⁹⁴ This department was to be separate but closely connected to the general out-patient department and include medical electricity, X ray, medical and surgical massage, physical exercises and the Tyrnauer baths.¹⁹⁵

Amalgamation of these sub-departments made sense because treatments were often used alongside each other. Housing the physical methods under one roof allowed the activities to be more easily combined and needed fewer medical staff to supervise the treatment, raising them, as the massage committee commented, to the 'proper level of efficiency'.¹⁹⁶ Patients were to have 'books, in which notes of the cases and the prescribed treatment could be recorded',¹⁹⁷ to better integrate and coordinate the tasks of diagnosis, prescription and treatment. The rationalisation of physical treatment

¹⁹² Steve Sturdy and Roger Cooter, 'Science, Scientific Management, and the Transformation of Medicine in Britain c.1870-1950', *History of Science*, 36:4 (1998), 421-466, (p.436).

¹⁹³ Morris, *A History of the London Hospital*, p.312.

¹⁹⁴ 'Meeting of the House Committee', (25 April 1910), RLHA, RLHLH/A/5/51.

¹⁹⁵ 'Meeting of the House Committee', (25 April 1910), RLHA, RLHLH/A/5/51. In 1935 the department consisted of massage, Tyrnauer baths and electrodiagnosis, see W.S.Tegner, Michael Mason and C.G. Barnes, 'The London Hospital Department of Physical Medicine and Rheumatology', *Annals of Physical Medicine* Vol. X. No 5 (1970), 218- 222, (p.218).

¹⁹⁶ 'Meeting of the House Committee', (25 April 1910), RLHA, RLHLH/A/5/51; For discussion of the link between the heat baths and the massage department, see 'Meeting of the House Committee', (2 December 1908), RLHA, RLHLH/A/5/51.

¹⁹⁷ Openshaw and Wall, 'Recommendations', RLHA, RLHLH/A/17/24, p.2.

departments before the war was not unique to the London Hospital. By 1912 at St Thomas's Hospital, for example, the combined 'Physical Exercise and Massage Department' had been provided with an entire ground floor ward, established a massage school, and had integrated the electric heat baths from the 'X-ray and Electro-therapeutic Department'.¹⁹⁸ This shows that the principles of rationalisation were an organisational force structuring the development of 'physiotherapy' as a specialism more widely.

In the name of improved efficiency, the London Hospital massage committee also sought to increase the level of medical supervision over the department. In March 1907 the committee decided that the department 'should be under the control of two members of Staff who shall decide the length and variety of the special treatment', one member of staff being a surgeon in charge of surgical massage cases and the other a physician in charge of medical massage cases.¹⁹⁹ Responsibility for treatment was to be shifted from the medical officer who referred the case to the head of the department who could more easily direct and monitor the progress of treatment.²⁰⁰ The actual work of massage, however, was to be undertaken by auxiliary staff that undertook a range of technical and labour intensive tasks. 'The treatment', the massage committee wrote, 'should be carried out by the Nurses in the Department, under the control of the sister, in accordance with the prescription of the officer in charge'.²⁰¹ Within the development of the hospital massage department, then, emerged a clear division of labour which protected the position and interests of medical men.

¹⁹⁸ Timberg, Report for 1912', p.211.

¹⁹⁹ 'Meeting of the Medical Council', (8 March 1907), RLHA, RLHLM/1/6.

²⁰⁰ Unless the case was marked 'special' in which they would remain in the care of the staff who sent them to the department, see 'The Annual Meeting of the Medical Council', (4 May 1906), RLHA, RLHLM/1/6.

²⁰¹ 'Meeting of the Medical Council', (8 March 1907), RLHA, RLHLM/1/6.

Foreign practitioners were also increasingly ostracised. By May 1906, the London's massage committee planned to quietly replace Herr and Mrs Koch with 'a suitable woman teacher who has been trained in Sweden, or trained in England by Swedish methods'.²⁰² In June 1906, the hospital secretary E.W. Morris reported that 'Mr Koch of the Massage Department, has come to me in a great state of anxiety':

He wept copiously at the interview because "no member of the staff sent him cases of private", and he reports that he must with reluctance give up his appointment at the London Hospital as he cannot afford to live in London any longer, unless the staff can do something to help him earn his living.²⁰³

This demonstrates that the decision to replace Koch was not because Swedish massage had become obsolete but because as a practitioner he presented a threat to the hospital's medical staff. The replacement of Koch with a woman trained in Swedish methods indicates how the London Hospital assimilated valuable Swedish expertise while ostracising competing Swedish experts, by devolving this work to women who could more easily understand 'the relations which should subsist between members of the medical profession and masseurs'.²⁰⁴ It shows how the massage profession was a vehicle through which this field of expertise was incorporated into British medicine and the Swedish practitioner marginalised. At the same time as the expertise of the massage profession increasingly developed to mirror that of the Swedish gymnast they also held steadfast to their nursing ethics that bound them to work strictly under medical authority. This was the process of professionalisation that

²⁰²'The Annual Meeting of the Medical Council', (4 May 1906), RLHA, RLHLM/1/6. Koch was replaced by Beatrice Copestake who published the book, *The Theory and Practice of Massage* (London: H.K.Lewis, 1917), published in multiple editions.

²⁰³'Meeting of the Medical Council', (8 June 1906), RLHA, RLHLM/1/6.

²⁰⁴'The Annual Meeting of the Medical Council', (4 May 1906), RLHA, RLHLM/1/6.

placed them in a prime position to become 'indispensable' to the medical profession and take the place of foreign competition.

Conclusion

This chapter argues that the development and reorganisation of the London Hospital massage department reflects many key features of the incorporation of massage into medicine, a process closely linked to the professionalisation of massage. The period before the First World War saw the transition of massage from a marginal medical practice to an 'indispensable' therapeutic expertise embedded within medicine. The growth of massage and massage departments reflects the increasing importance of massage and physical methods in the treatment of disabilities, injuries and chronic impairments, which can be seen as part of a broader socio-economic drive for productivity and efficiency.

This chapter has also shown, however, that the massage department continued to represent a demographic of patients and treatment modalities on the margins of medical practice. Massage departments became places that medical men sent and lost sight of difficult or uninteresting patients. It was in the context of medical disinterest, however, that nurses and masseuses took the initiative to develop a therapeutic territory that would make them an 'indispensable' medical auxiliary. Drawing from the professional models of nursing and Swedish gymnastics, the massage profession became an authority in a field of expertise largely unfamiliar to the majority of medical practitioners. This chapter shows that both models were key to the professionalisation of massage: alignment with nursing guaranteed their alliance to medicine and emulating Swedish gymnastics offered specialist knowledge and status. This process of professionalisation occurred because both medicine and massage

benefitted. While the massage profession carved out and secured a role within medicine, the medical profession gained an auxiliary expertise that enabled it to extend its therapeutic scope while maintaining its economic and professional aspirations.

The preceding two chapters have aimed to show that the period before the First World War was critical in shaping the practical and professional parameters of the early massage profession. They have argued that the evolution of the massage profession was instrumental in the development of early rehabilitation and physical treatment within medicine. The final two chapters look to how the First World War both magnified this pre-war role and transformed it.

Chapter 5

Massage in the First World War

When the medical history of the war comes to be written the Director-General's scheme for the establishment of Convalescent Camps, where the work of the general military hospitals can be completed and large numbers of men restored to the fighting service, will be ranked at its full value. That it has not received its full recognition up to the present is due to the quiet and gradual way in which the whole scheme of after-treatment has been set on foot.¹

In 1916 medical officer in charge of physical treatment in wartime Convalescent Camps and Command Depots, Florence Barrie Lambert, wrote that she hoped that when the war was over the contribution of the massage profession would be more fully recognised. Her article in *The Lancet* was a response to contemporary criticism and eclipse of the profession's work by advancing specialties within medicine. The First World War was a watershed in the development of military medicine and a moment that massage and physical therapies were mobilised to treat injured soldiers on a scale unprecedented. As Julie Anderson's work has argued, much of the provision developed during this conflict formed the basis of the comprehensive system of rehabilitation that emerged in the Second World War.² Often, discussions of medical rehabilitation in the First World War focus upon the work of Robert Jones and orthopaedics who are cast as heroes against a backdrop of general ignorance, disorder and incompetence.³ The aim of this chapter is to examine why, where and how massage participated in the war effort. By tracing the use of massage this

¹ Florence Barrie Lambert, 'Massage and Medical Electricity in the After-Treatment of Convalescent Soldiers', *The Lancet* (4 November 1916), 788-790, (p.788).

² Julie Anderson, *'Soul of a Nation': War, Disability and Rehabilitation in Britain* (Manchester: Manchester University Press, 2011), p.43.

³ Roger Cooter, *Surgery and Society in Peace and War: Orthopaedics and the Organization of Modern Medicine, 1880-1948* (London: Macmillan Press, 1993), p.109; In contrast, for a typical hagiography-style depiction of Robert Jones and orthopaedics see Frederick Watson, *The Life of Sir Robert Jones* (London: Hodder & Stoughton, 1934).

chapter illuminates another facet of rehabilitation within medicine, highlighting a broader picture than a focus on orthopaedics allows. It argues that the massage profession was instrumental both to the development of rehabilitation as a service in itself, and to supporting medical specialisation in physical medicine and orthopaedics. It also shows that the broad political and military drive for rehabilitation radically shaped the trajectory of the massage profession.

To investigate these issues this chapter explores massage in two ways. The first half examines where the massage profession was mobilised to restore injured soldiers to fitness. It considers its relationship to the emergent specialties of physical medicine and orthopaedics with which it shared its territory. The second half of the chapter looks in more detail at how masseuses rehabilitated injured soldiers. It investigates the way in which masseuses adapted treatments, techniques, and principles learnt from their work in the late-nineteenth century to wartime circumstances. Using material including the institutional records and journal of the STM, medical journals and texts, war office records and trench journals, this chapter aims to reconstruct a picture of massage during the First World War. Adopting this lens offers another perspective on the treatment of disabled soldiers and medical rehabilitation effectively broadening the historiographical focus on advances in medicine and contributing to the medical history of the First World War.

The Mobilisation of Massage

The Almeric Paget Massage Corps and Portland Place Clinic

The massage profession was drawn into the First World War through the Almeric Paget Massage Corps (APMC).⁴ The APMC was a voluntary initiative established in August 1914 by the philanthropists Almeric Hugh Paget (1861-1949) and his wife Pauline Paget (1874-1916), which aimed 'to treat all soldiers and sailors requiring massage during and after the war'.⁵ While at the beginning of the war the organisation was maintained as a philanthropic venture, the APMC acted in a type of de facto state capacity. Approved by the surgeon Director General of the Army Medical Services (AMS), Arthur Sloggett, the Corps were to be 'sent wherever the War Office notifies that they are required',⁶ and commenced work in territorial force general hospitals in September 1914.⁷ Initially the corps consisted of 50 STM trained masseuses, with Barrie Lambert appointed as honorary medical officer, and masseuse-gymnast Eleonora Essex French (daughter of General French, leader of the British expeditionary force) as secretary, (Figure 8).⁸

⁴ The word 'military' was added to the title of the corps in December 1916, becoming the Almeric Paget Military Massage Corps (APMMC) and in January 1919 the APMMC became the Military Massage Service (MMS), but this chapter will use the acronym APMC throughout.

⁵ 'Massage for the Wounded', *Nursing Times* (22 August 1914), in 'Massage Supplement to Nursing Notes', *Nursing Notes and Midwives' Chronicle* (henceforth *NNMC*), (September 1914), i.

⁶ 'Massage for the Wounded', *Nursing Times*, (22 August 1914). Interesting note that 'the importance of massage as a remedial measure' noted in an Intelligence Summary of Sloggett 23 April 1915, in Cooter, *Surgery and Society*, p.304, (note 148).

⁷ W.G. Macpherson, *Medical Services General History* Vol.1, (London: HMSO, 1921), p.142.

⁸ Florence Barrie Lambert, 'Massage', *Summerdown Camp Journal: Representative Organ of Summerdown Military Convalescent Hospital* (2 October 1915), 31-32, Trench Journals and Unit Magazines of the First World War, Imperial War Museum (henceforth *IWM*), 31.

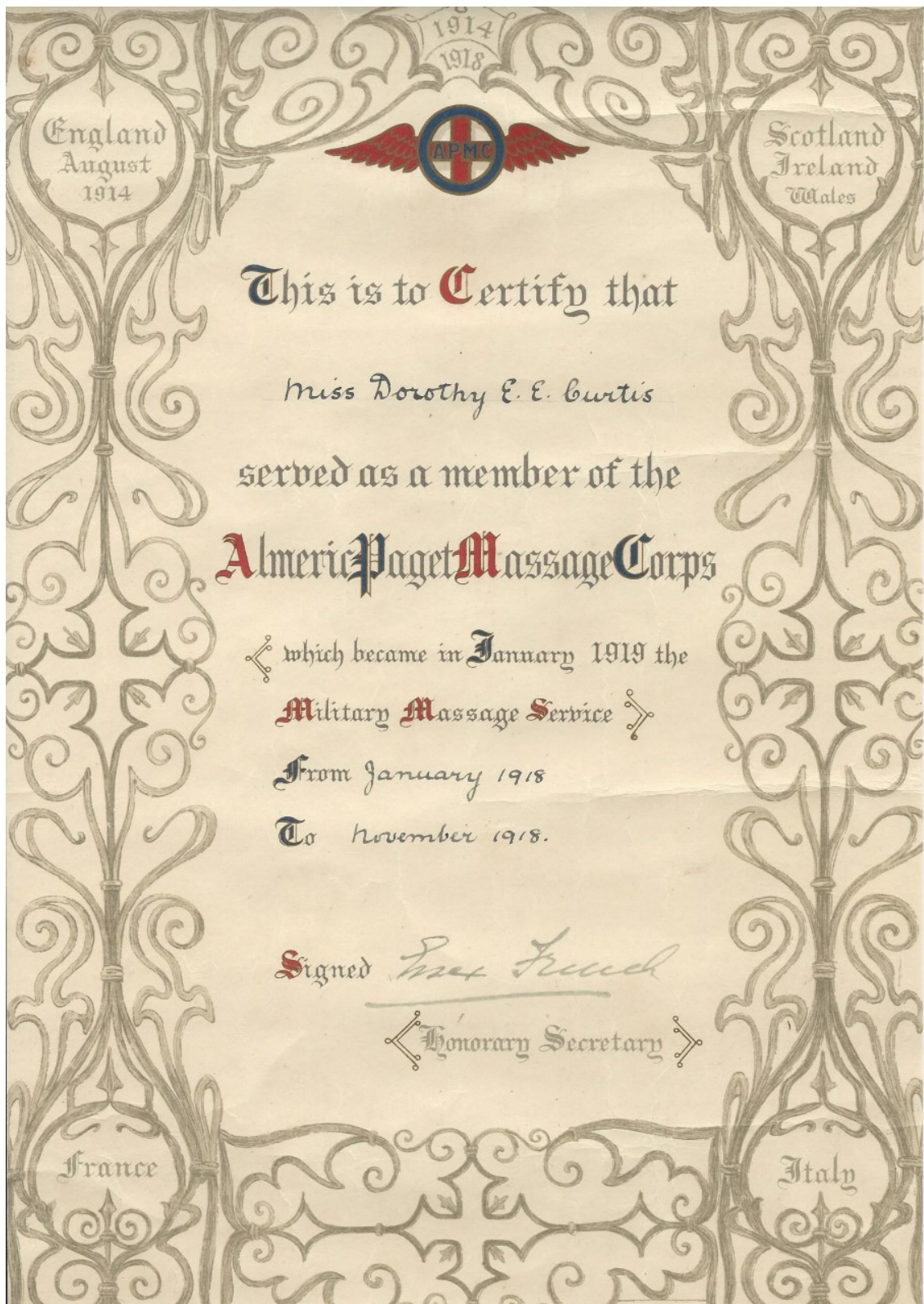


Figure 8 - APMC certificate of Dorothy Curtis, (Courtesy of Elizabeth Sherwood).

The motivation and logic behind the establishment of a massage corps was based in the tradition of charity and the nature of massage work as it had developed before 1914. Seth Koven shows that charitable and voluntary initiatives in the areas of social welfare were well-established before 1914 and that 'whenever possible, the British state built upon existing networks and institutions in implementing policy instead of creating entirely new ones'.⁹ As such the state was familiar with working alongside voluntary organisations and many often functioned with a de facto 'state capacity'.¹⁰ The First World War saw a great civilian response to support the military medical services and while, Alfred Keogh noted, 'they were rarely on a large scale and were not co-ordinated', they were, 'productive of much good', and provided a vital support network for discharged and disabled soldiers.¹¹ For example, numerous private homes – some of which were large country houses – were lent by private donors and set up as convalescent hospitals, many of which were funded and maintained by the Red Cross or the Order of St John of Jerusalem.¹² In order to manage and coordinate the many 'competitive enthusiasms of the various voluntary agencies', the War Office organised the Joint War Committee of the Red Cross and Order of St John in October 1914.¹³ The formation of the massage corps by the Pagets, who were 'most anxious to assist with the care of

⁹ Seth Koven, 'Borderlands: Women, Voluntary Action, and Child Welfare in Britain, 1840 to 1914', in *Mothers of a New World: Maternalist Politics and the Origins of the Welfare State*, ed. by Seth Koven and Sonya Michel (New York: Routledge, 1993), pp.94-135, (p.127).

¹⁰ Koven, 'Borderlands', p.127.

¹¹ Alfred Keogh, 'The Treatment of the Disabled', *Recalled to Life: A Journal Devoted to the Care, Re-Education and Return to Civil Life of Disabled Sailors and Soldiers*, 1 (1 June 1917), 5-16, IWM, 6.

¹² Christine Hallett, *Containing Trauma: Nursing Work in the First World War* (Manchester: Manchester University Press, 2009), p.114.

¹³ Cooter, *Surgery and Society*, p.116; for a comprehensive account of the Joint Committee's work during the First World War, see *Reports by the Joint War Committee and the Joint War Finance Committee of the British Red Cross Society and the Order of St. John of Jerusalem in England on Voluntary Aid Rendered to the Sick and Wounded at Home and Abroad and to British Prisoners of War, 1914-1919* (London: H.M.S.O., 1921).

the wounded in the most practical way',¹⁴ was part of a broader charitable culture within British society and civilian response to the war.

According to Barrie Lambert and Essex French, Pauline Paget 'had always been interested in Massage',¹⁵ and 'knowing the enormous amount of good that had been done by Massage in the recent Servian War', the Pagets 'felt this to be the most useful form of assistance to offer the authorities of the War Office'.¹⁶ As demonstrated in Chapter 3, massage work had already shown itself to be of value in the context of rehabilitation and had been used in the military context for this reason. Not only had the massage profession organised provision for the after-treatment of injured soldiers in the Boer War, but both the Army and Navy had begun to train medical orderlies in massage before 1914.¹⁷ The incorporation of massage into the military reflects the development of massage as a valued mode of rehabilitating injuries and treating chronic impairments. With approximately 65 per cent of casualties suffering from a degree of functional impairment, principally as the result of fractures caused by bullets and shrapnel,¹⁸ the First World War provided an opportunity for the massage profession to extend this pre-war work.

As Roger Cooter has pointed out, few within medicine had experience in treating patients with traumatic injuries before 1914.¹⁹ Furthermore, he argues that, apart from Jones's experience handling trauma at Liverpool and the Manchester Ship Canal project, orthopaedics had largely focussed on the

¹⁴ Eleonora Essex French, 'Further Account of the Corps', (25 August 1915), IWM, B.R.C.S.25.6/8.

¹⁵ Barrie Lambert, 'Massage', IWM, 31.

¹⁶ Essex French, 'Further Account of the Corps', IWM, B.R.C.S.25.6/8.

¹⁷ RAMC medical orderlies trained in massage by 1905; Naval sick bay attendants were trained in massage by 1911, see 'Council Meeting', (10 November 1911), Chartered Society of Physiotherapy: Council Minutes (15 January 1909-14 February 1913), Wellcome Library (henceforth WL), SA/CSP/ B.1/1/8.

¹⁸ Cooter, *Surgery and Society*, p.105.

¹⁹ Cooter, *Surgery and Society*, p.107.

congenital deformities of children, and was therefore 'hardly the most obvious group to be beckoned'.²⁰ The immediate mobilisation of the massage profession, however, suggests by contrast, that physical therapy was considered a logical response to the crisis of rehabilitating the nation's soldiers. As Barrie Lambert wrote, the massage profession, 'realized at once that a greater demand would be made on the profession than ever before'.²¹ In contrast to America where, as Beth Linker has shown, 'physiotherapy was a new and undefined field' and a massage service had to be established to support orthopaedics,²² in Britain massage had long been used as a service in and of itself in the sphere of rehabilitation. From the outset of war in 1914 Britain already had an organised body of personnel, expertise and experience to draw upon, before the development of Jones' orthopaedic empire.

The mobilisation of a military massage service, however, 'was a new departure and had never been tried before' and the authorities expressed 'a good deal of doubt [...] as to the advisability of women working as masseuses in Military Hospitals'.²³ While the nature of the work was familiar to the masseuse, handling severely wounded male bodies was not. Since its inception in 1895 massage work had been organised along strictly sex-segregated principles in order to protect the reputation of the masseuse and legitimise intimate physical contact. There were, however, very few trained masseurs who could serve as an alternative. As highlighted in Chapter 4, hospitals often drafted in foreign workers or trained porters to massage men in the decades before the war, and the number of medical orderlies who had been trained in

²⁰ Cooter, *Surgery and Society*, p.107.

²¹ Barrie Lambert, 'Massage', IWM, 31.

²² Beth Linker, *War's Waste: Rehabilitation in World War I America* (Chicago; London: University of Chicago Press, 2011), p.62.

²³ Barrie Lambert, 'Massage', IWM, 31.

massage was insufficient to cope with the volume of work. Furthermore, training a large-enough male force de novo was impractical as men were more urgently needed for the front line than the auxiliary services which could draw from women. While still pledged to work under medical orders,²⁴ the sex-segregated ruling that had underpinned the profession from the late-nineteenth century was overturned for the war, dramatically changing the therapeutic encounter.²⁵

Writing in October 1914, the *British Journal of Nursing* anticipated that with '[t]he treatment of fractures by massage [...] now widely practiced', they had 'no doubt the services of the Corps will be in much demand'.²⁶ Indeed, the demand for massage personnel exceeded all expectations and throughout the conflict the War Office struggled to supply requirements. As soon as the end of September 1914 the initial Corps of 50 had to be enlarged, and by October there were 110 masseuses working in military hospitals and Red Cross convalescent homes.²⁷ To give an idea of the scale of work done by the Corps, it was reported that by October 1914 they had 1,500 cases and given 13,000 treatments,²⁸ and by August 1915, 25,796 cases and 375,597 treatments.²⁹ By the end of the war with 3,388 personnel enrolled in the massage service, 'all military hospitals had representatives of the Corps in them',³⁰ and over 2,000 members were at work on armistice day, 56 deployed overseas in France and

²⁴ 'Massage for the Wounded', *Nursing Times* (22 August 1914), i.

²⁵ Richard Timberg of the Physical Exercise and Massage Department of St Thomas's Hospital noted in 1914 that, it would have been impossible to deal with the amount of military cases in the Department without allowing its masseuses to treat wounded soldiers. See Richard Timberg, 'Report of the Physical Exercise and Massage Department for 1914', in *St Thomas's Hospital Report* Vol.43, ed. by J.J. Perkins and C.A. Ballance (London: J. & A. Churchill, MDCCCXVI), pp.285-288, (p.286).

²⁶ *The British Journal of Nursing* (31 October 1914), Royal College of Nursing online archive (henceforth RCN), 342.

²⁷ 'Massage for the Wounded', *NNMC* (December 1914), ii.

²⁸ 'Massage for the Wounded', *NNMC* (December 1914), ii.

²⁹ Barrie Lambert, 'Massage', *IWM*, 32.

³⁰ 'Correspondence Re. Badges', (6 October 1919), The Women at Work Collection, *IWM*, B.R.C.S.25.6/23.

Italy.³¹ The APMC, however, does not represent a full picture of the scope of massage work during the First World War as it was undertaken by many others not part of the Corps, including nurses, medical orderlies, Swedish trained gymnasts, V.A.D.'s, Red Cross and other voluntary workers.³²

The significance of this auxiliary service was immediately recognised by the War Office. In early 1915 it officially sanctioned the APMC by making it the body to which all massage personnel engaged for service in military hospitals should belong.³³ By the end of the year, in order to increase its control over recruitment and deployment, the War Office established a 'Massage Board Advisory Committee' to 'advise in all matters relating to Massage in Military Institutions',³⁴ and widened entry requirements to the Corps from STM membership to include other certificates.³⁵ In December 1916, the Pagets ceased financial responsibility for the Corps,³⁶ and it became a state funded service, receiving the title Almeric Paget Military Massage Corps.³⁷ The War Office's investment in and increasing control over the massage service demonstrates the political significance of massage as a practice and profession during the war. It shows that it became an intrinsic part of the war machine and state discourse on rehabilitation.

At the beginning of the war the massage service and physical therapy represented one of few forms of medical rehabilitation and after-care available to injured soldiers. Writing in March 1915, one APMC member noted 'the large

³¹ 'Account of the Military Massage Service', [n.d.], pp.1-2, IWM, B.R.C.S.25/6/6, p.2.

³² Only military institutions had to appoint APMC masseuses, other institutions such as civilian hospitals, Red Cross auxiliary hospitals and other homes had more flexibility regarding staff.

³³ 'Account of the Military Massage Service', IWM, B.R.C.S.25/6/6, pp.1-2.

³⁴ 'Account of the Military Massage Service', IWM, B.R.C.S.25/6/6, p.2.

³⁵ Jean Barclay, *In Good Hands: The History of the Chartered Society of Physiotherapy 1894-1994* (Oxford: Butterworth-Heinemann Ltd, 1994), p.62.

³⁶ 'Correspondence, re. Army Leaflet', (19 February 1921), IWM, B.R.C.S.25/6/5.

³⁷ Macpherson, *Medical Services General History*, p.143. There is a discrepancy in the date at which the War Office took over financial control over the APMC, Paget's and Eleonora Essex French report December 1916, while Macpherson in text above reports May 1917.

quantity of massage which the medical men in charge of our wounded soldiers are ordering'.³⁸ 'A very large percentage of our wounded home from the Front, in the base hospitals, nursing homes, and convalescent homes, are receiving massage', she continued, and 'in some cases this is the only or chief part of the treatment which is helping them to recover the use of injured limbs'.³⁹ From being 'a new departure' in military hospitals the massage profession quickly became viewed as essential; as Barrie Lambert wrote in October 1915, 'the Masseuse is accepted without question almost as part of the hospital equipment'.⁴⁰

In December 1914 the War Office requested the APMC organise an out-patient clinic to treat the 'great numbers of men on furlough in London who required treatment'.⁴¹ Sick furlough was a system adopted by the War Office early during the war to cope with the demand for hospital accommodation. As historians show, casualties in the First World War were unprecedented in terms of number, rate and injuries sustained;⁴² although the Royal Army Medical Corps (RAMC) had reformed many inefficiencies after the Boer War,⁴³ it was still unprepared for the demands made upon it. Very quickly a system was devised to deal with casualties as efficiently as possible, whereby stretcher bearers, aid posts and clearing stations evacuated and provided emergency treatment to men injured in the field, at which point they were sent to base

³⁸ 'Where Women Can Help', *NNMC* (March 1915), iii.

³⁹ 'Where Women Can Help', iii.

⁴⁰ Barrie Lambert, 'Massage', *IWM*, 31.

⁴¹ Barrie Lambert, 'Massage', *IWM*, 32.

⁴² Seth Koven, 'Remembering and Dismemberment: Crippled Children, Wounded Soldiers, and the Great War in Great Britain', *The American Historical Review*, 99:4 (October 1994), 1167-1202, (1185-1186).

⁴³ Cooter, *Surgery and Society*, p.114. As Director-General of the Army Medical Service between 1905 and 1910, Alfred Keogh had been responsible for many of the major reforms in military medicine in the wake of the Boer War.

hospitals in Britain.⁴⁴ These hospitals soon became, however, 'full to overflowing', and military policy dictated patients be evacuated as soon as possible to make room for others.⁴⁵ Men who were not in need of acute care but also not fit enough to return to the front line could either be given a period of sick furlough in order to recover or if permanently disabled discharged from military service completely.

While the military medical services were coordinated in their movement of patients from field to base, it provided no further link in this chain of treatment for injured or disabled men. As Jeffrey Reznick has shown, after-care was mainly given only after discharge and was under the auspices of voluntary initiatives and associations such as the British Red Cross.⁴⁶ Private homes for convalescent soldiers were quickly established in large numbers throughout the country (in September 1915 coming under the authority of the military medical services classified as auxiliary hospitals), and many men took convalescent furlough in their own homes.⁴⁷

It was for men on sick furlough that the APMC opened '55 Portland Place' in December 1914, a physical treatment clinic that saw over 200 patients per day throughout the war.⁴⁸ The London premises was a house lent by Pauline Paget, fitted with a variety of apparatus including electrical equipment and whirlpool baths as well as facilities for massage.⁴⁹ Portland Place constitutes one of the few places during the early stages of the war that offered

⁴⁴ Cooter, *Surgery and Society*, p.111.

⁴⁵ Robert Jones, 'A Few Surgical Lessons of the War', *BMJ* (8 November 1919), 587-590, (p.587).

⁴⁶ Jeffrey Reznick, *Healing the Nation: Soldiers and the Culture of Caregiving in Britain during the Great War* (Manchester: Manchester University Press, 2004), p.120.

⁴⁷ Macpherson, *Medical Services General History*, pp.88-89.

⁴⁸ 'Account of the Military Massage Service', IWM, B.R.C.S.25/6/6, p.1. The Portland Place clinic closed in December 1920, see 'Correspondence, re. Army Leaflet', (19 February 1921), IWM, B.R.C.S.25/6/5.

⁴⁹ 'Their Majesties' Interest in the Work of the A.P.M.M.C.', *Journal of the Incorporated Society of Trained Masseuses* (henceforth *JISTM*), (April 1917), 297.

systematic after-treatment to convalescent soldiers. It stood alongside out-patient departments attached to civilian hospitals, the British spas and a few other small clinics which also offered similar provision.⁵⁰ Civilian out-patient departments absorbed an influx of injured soldiers requiring physical treatment. For example, by December 1914 St Thomas's had treated over 100 military cases by physical exercise and massage,⁵¹ and in August 1916 James Mennell and Walter Rowley Bristow were appointed to head the Massage and Electro-therapeutic Departments respectively and given charge of military patients.⁵² The British spas were also another hub of early rehabilitative treatment. Bath spa, for example, offered its facilities from the outset of the war in September 1914, and by February 1917 had given 15,000 physical treatments to 948 patients, while the Royal Mineral Waters Hospital had given 40,000 treatments to 1,720 patients in the same period.⁵³ Another small out-patient clinic called the Alexandra Therapeutic Institute (later taken over by the British Red Cross and called the Red Cross Clinic for Physical Treatment of Disabled Soldiers) was also organised early in the war to provide physical treatment.⁵⁴ While these institutions have been little studied, they represent an early coordinated effort to provide after-treatment to and restore injured soldiers. They did so through physical treatment, demonstrating the significance of this therapeutic.

It quickly became clear, however, that the policy of granting sick furlough and the limited availability of after-treatment was not meeting the demands of war. Officers commanding hospitals found it difficult to supervise and ensure the

⁵⁰ Barrie Lambert, 'Massage and Medical Electricity', 788-789. For the wartime contribution of the British spas, see Robert Fortescue Fox, *Physical Remedies for Disabled Soldiers* (London: Baillière, Tindall and Cox, 1917), p.240.

⁵¹ Timberg, 'Report for 1914', p.286.

⁵² 'St. Thomas' Hospital, School of Physiotherapy, World War 1914-1918', [n.d], pp.1-8, Records of St Thomas' Hospital, School During World War One, London Metropolitan Archives (henceforth LMA), HI/ST/PS/Y/04/002, p.2.

⁵³ Fortescue Fox, *Physical Remedies*, p.240.

⁵⁴ *Reports by the Joint War Committee*, p.256.

quick return of their patients, and it was 'impossible in auxiliary hospitals and private convalescent homes to carry out the measures necessary to make convalescents rapidly fit for duty overseas'.⁵⁵ According to Barrie Lambert, the military medical services quickly became aware that a policy of giving injured soldiers un-planned convalescent leave ultimately 'militated against their recovery'.⁵⁶ Writing in October 1915, Essex French wrote that the majority of men on furlough 'could not obtain massage and electrical treatment' and 'consequently, they made no progress towards complete recovery'.⁵⁷ In contrast, she argued, '[m]any cases of stiff joints and nerve injuries tended to become worse and either the furlough had to be extended or the men sent to their depots on light duty'.⁵⁸ Not only were 'masses of men' left blocking up depots 'entirely unfit for the fighting line', but it was 'proving very injurious to getting the wounded fit in the shortest possible time', 'which of course', Essex French concluded, was 'essential to keep up the ever increasing supply of men needed at the Front'.⁵⁹

This situation soon became of military and political importance as it became clear that the conflict would be prolonged and the maintenance of Britain's fighting force depended upon the restoration of the wounded soldier. An acute manpower crisis made it essential for the military services that the interval between injury and return to duty was as short as possible. The treatment of these men was also a political concern: as American orthopaedic surgeon Joel Goldthwait described, thousands of disabled ex-servicemen

⁵⁵ Macpherson, *Medical Services General History*, p.89.

⁵⁶ Barrie Lambert, 'Massage and Medical Electricity', 788-789.

⁵⁷ Eleonora Essex French, 'An Account of the Military Convalescent Camps', *JISTM* (October 1915), 13-14, (p.13).

⁵⁸ Essex French, 'Military Convalescent Camps', 13.

⁵⁹ Essex French, 'Military Convalescent Camps', 13.

threatened to become either 'centres of revolution',⁶⁰ or 'hopeless derelicts',⁶¹ dependent upon state support. It was in this context that some form of rehabilitation became of paramount importance and the AMS decided in early 1915 to 'establish organized military convalescent hospitals on a large scale'.⁶²

Convalescent Camps

The convalescent hospital camps of the First World War were large-scale medical units established to relieve hospital accommodation and prevent the haemorrhage of manpower, by taking control of the period of convalescence. Five of these camps were opened in 1915, the first at Eastbourne in April with accommodation for 3,840; at Dartford in May for 1,200; at Epsom in June for 4,000, at Alwick in August for 2,080, and in Blackpool in October for 4,600.⁶³ Five other large camps were opened during the war, which altogether were able to accommodate up to 23,929 men.⁶⁴ The intention of these camps was to segregate the 'great number of men' who 'no longer required hospital treatment', but 'were unable to return to duty' because of impairment or dysfunction residual to their injury.⁶⁵ They were places 'where the work of the general military hospitals can be completed and large numbers of men restored to fighting service'.⁶⁶

While called a 'convalescent' camp, military convalescence was entirely different to that commonly understood in the civilian context. The First World War radically altered the meaning of 'convalescence' from a passive process of

⁶⁰ Cooter, *Surgery and Society*, p.119.

⁶¹ Linker, *War's Waste*, p.53.

⁶² Macpherson, *Medical Services General History*, p.89.

⁶³ Macpherson, *Medical Services General History*, p.89.

⁶⁴ Macpherson, *Medical Services General History*, p.89. These camps were intended for ordinary ranked soldiers, officers remained treated at auxiliary hospitals.

⁶⁵ Barrie Lambert, 'Massage and Medical Electricity', 788.

⁶⁶ Barrie Lambert, 'Massage and Medical Electricity', 788.

rest and recuperation to a period of active rehabilitation. The Convalescent Camps constituted large-scale physical treatment centres where men discharged from hospital would receive 'a final six weeks' treatment before being returned to their unit.⁶⁷ These camps were directly modelled upon the APMC's physical treatment clinic at Portland Place and an extension of the work of the massage profession. Writing in November 1916, Barrie Lambert who was appointed to the position of 'senior medical officer in charge of physical treatment at the Convalescent Camps' by the War Office, described that:

Almeric Paget's massage and electrical centre at Portland-place, can, I think, claim to be the parent of the mechano-therapeutic departments subsequently attached to the Convalescent-Camps, for it was after inspecting this centre that the Director-General asked that similar departments should be organised in connexion with the camps.⁶⁸

'[V]ery pleased indeed with the work', Keogh and the War Office funded the APMC to organise and equip physical treatment departments in each of the Convalescent Camps, and recognised it as the official Massage Department for the War Office.⁶⁹

Patients intended for the Convalescent Camps were those who were expected to recover from their injuries within a course of six weeks' physical treatment. Writing of the work at the Eastbourne camp (also known as the Summerdown Convalescent Hospital), masseuse I.M. Smith described the types of patients received at Convalescent Camps as varied and included: nerve injuries, stiff joints, contracted scars, open, discharging wounds, rheumatism, neuritis, sciatica, synovitis, trench foot, trench fever shell shock,

⁶⁷ Barrie Lambert, 'Massage and Medical Electricity', 789.

⁶⁸ Barrie Lambert, 'Massage and Medical Electricity', 789.

⁶⁹ Barrie Lambert, 'Massage', IWM, 31.

and general debility.⁷⁰ The large massage departments in the camps were equipped with mechano-therapeutic, electrical and hydro-therapeutic apparatus.⁷¹ Describing the work of the department, masseuse Smith wrote that '[t]o call it simply a massage department might be misleading to the uninitiated, as nearly every patient undergoes more than mere manipulative treatment'.⁷²

Treatments given included:

1. Massage. Including active, passive, and Swedish Remedial movements.
2. Radiant Heat, or hot water.
3. Electrical Treatment. In many forms, including also the electrical treatment of open wounds.
4. Re-education of muscle groups by means of simple apparatus and interesting occupations.⁷³

This highlights that the term 'massage department' and title 'masseuse' fell short of conveying the multi-faceted work and expertise encompassed within their role.

A high volume of patients received physical treatment at Convalescent Camps and throughout the war the work of the APMC continued to grow. Established in May 1915 with ten masseuses, within one week staff at the Eastbourne camp had to be increased as patients rose to 400 per day.⁷⁴ By May 1918 staff included 32 masseuses, a male and female gymnast, eight 'section heads', and a head masseuse, all of whom treated an average of 900 patients per day.⁷⁵ Each masseuse treated approximately 20 to 25 patients daily and often supervised multiple treatments at once.⁷⁶ These camps were

⁷⁰ I.M. Smith, 'Summerdown Convalescent Hospital, Eastbourne', *JISTM* (May 1918), 262-266, (p.262).

⁷¹ Barrie Lambert, 'Massage and Medical Electricity', 789.

⁷² Smith, 'Summerdown', 262.

⁷³ Smith, 'Summerdown', 262.

⁷⁴ Essex French, 'Military Convalescent Camps', 14.

⁷⁵ Smith, 'Summerdown', 262.

⁷⁶ Smith, 'Summerdown', 262.

highly successful in light of their primary purpose; at the Eastbourne camp alone, between May 1915 and May 1918, over 16,120 injured servicemen underwent treatment. An average of 580 men were discharged per month and within that 80.5 per cent considered fit to be redeployed, 7.15 per cent returned to hospital for further treatment, 5.65 per cent transferred to Command Depots and the remaining 6.7 per cent 'being unsuitable for general service' went for retraining and reemployment.⁷⁷ The scale of this rehabilitation effort was great; while exact figures are unknown, already by November 1916 and when only five of the total ten camps had been opened, approximately 77,759 men had received treatment.⁷⁸

The Convalescent Camps of the First World War constitute one of the first large-scale coordinated schemes developed to rehabilitate injured soldiers. They represent a significant state investment in physical treatment and the work of the massage profession, showing that they were considered a primary way to achieve military and political aims. Traced through to the APMC and the Portland Place clinic, these camps reflected a magnification of the therapeutic field and skillset developed by the massage profession from the late-nineteenth century. For her work as representative of the massage profession and physical treatment in military institutions, Barrie Lambert was officially recognised by the War Office in 1915. She was the first woman in Britain to be given the rank and salary of major and wear the badge and uniform of the R.A.M.C.,⁷⁹ acknowledgement of her military and political importance as a leading expert in physical treatment and rehabilitation.

⁷⁷ Smith, 'Summerdown', 262.

⁷⁸ Barrie Lambert, 'Massage and Medical Electricity', 789.

⁷⁹ 'Massage for the Wounded', *JISTM* (October 1915), 24.

Command Depots

Convalescent Camps were not the only large-scale attempt to rehabilitate injured soldiers by physical therapy. Of the first batches of patients sent to the camps it was found that many 'were largely unsuitable'.⁸⁰ Barrie Lambert described how for these men 'a final six weeks treatment' would not have been adequate, because many of them were 'suffering from injuries so severe' that they required a more prolonged period of physical treatment or were considered 'incapacitated' from all further service.⁸¹ Very quickly after the camps opened the War Office found that this 'residue of men'⁸² had 'begun to accumulate in considerable numbers'.⁸³ These cases typically 'drifted into auxiliary hospitals',⁸⁴ or were retained for prolonged periods in reserve units and regimental depots 'always finding that they were at the wrong address'.⁸⁵ Not only did these men occupy much-needed hospital and garrison accommodation but many of them, according to Barrie Lambert, were 'quite capable of being cured' under special medical arrangements.⁸⁶ It was for this type of case that in October 1915 the War Office established a series of units known as Command Depots.⁸⁷

Command Depots were for patients who required treatment longer in duration than available in the medical Convalescent Camps but not obtainable in their regular military regimental depots. Describing the place of these units within the military medical services, medical officer in charge of Heaton Park Command Depot in Manchester, Robert Tait McKenzie (1876-1938) wrote that,

⁸⁰ Barrie Lambert, 'Massage and Medical Electricity', 789.

⁸¹ Barrie Lambert, 'Massage and Medical Electricity', 789.

⁸² Barrie Lambert, 'Massage and Medical Electricity', 789.

⁸³ R.Tait McKenzie, 'The Treatment of Convalescent Soldiers by Physical Means', *BMJ* (12 August 1916), 215-218, (p.215).

⁸⁴ Macpherson, *Medical Services General History*, p.91.

⁸⁵ McKenzie, 'The Treatment of Convalescent Soldiers', 215.

⁸⁶ Barrie Lambert, 'Massage and Medical Electricity', 789.

⁸⁷ Macpherson, *Medical Services General History*, p.91.

‘[a] great military hospital may be compared to a general post office in which the sick and wounded from the front are sorted out into first, second, and third class matter’:

The first class matter is distributed rapidly to regular military hospitals under the Red Cross, where an operation, or a short course of treatment, puts them right, and after ten days’ leave they go back to the fighting line, with few exceptions. The second class matter requires an additional stay at a convalescent hospital, commanded by an officer of the Royal Army Medical Corps, in which they receive treatment by physical means, including exercise in addition to the usual hospital treatment, and a large proportion of these men again find their way to the front. The third class matter, however – the cases too tedious for the hospital and the convalescent camp – are more difficult to provide for and dispose of.⁸⁸

Command Depots, then, received this ‘residue of men’ considered from a military standpoint as ‘third class matter’. While discharged from hospital and unlikely to be fit for service overseas within three months,⁸⁹ they showed ‘some hope of cure, or improvement, within a period of six months’.⁹⁰

Formed in each command, 24 Command Depots were established by the end of the war.⁹¹ Each Depot constituted from two to five thousand men,⁹² and received a wide variety of injuries. McKenzie described patients as ‘a strange assemblage of cases’, that included ‘an endless stream of wounded’, neurasthenia, shell shock, contractures, paralysis, disease, rheumatism, typhoid, dysentery, and heart and lung disease.⁹³ The purpose of these depots was to restore the injured to maximum productivity. While, McKenzie wrote, these men were considered ‘useless from the military standpoint’, the

⁸⁸ McKenzie, ‘The Treatment of Convalescent Soldiers’, 215.

⁸⁹ Macpherson, *Medical Services General History*, p.91.

⁹⁰ McKenzie, ‘The Treatment of Convalescent Soldiers’, 215.

⁹¹ Macpherson, *Medical Services General History*, p.175.

⁹² Olive Guthrie-Smith, ‘Simple and Easily Made Apparatus for Stiff Joints and other Injuries’, *JISTM* (June 1918), (Special Conference Number), 19-23, (p.19).

⁹³ McKenzie, ‘The Treatment of Convalescent Soldiers’, 216.

manpower needs of the First World War led the state to invest in their rehabilitation. The camps represent the state's wartime commitment to 'return every available man to active service by treatment; to return men fit for light service abroad who could replace fit men in light duties on lines of communication; to fill positions requiring light duty at home by men who were unable to do anything more than to release a better man for active service; and to discharge from the army those for whom no treatment could be expected to give further results'.⁹⁴

Although not strictly regarded by the War Office as medical units, the Command Depots performed functions very similar to those of the Convalescent Camps.⁹⁵ For almost all patients, treatment involved physical therapy including electricity, hydrotherapy, massage, mechanotherapy, corrective exercises, physical training, and marching.⁹⁶ Although they took on a wide spectrum of cases, treatment at the Depots was still highly specific, systematic and co-ordinated. Throughout their time at the Depots men were continually inspected, categorised, and graded according to their disability. Injured patients were then given treatments and tasks specifically assigned to the category in which they were placed and passed up or down the scale of categories according to physical ability.⁹⁷ While details of the categories varied from Depot to Depot according to the medical officer in charge, some form of fitness categorisation was a common feature of all. For example, at the Seaford Command Depot, London, men were divided into six groups:

Group I. – Men practically fit, but requiring a final hardening process. Subjected to drill, route-marching, fatigues, and gardening.

⁹⁴ McKenzie, 'The Treatment of Convalescent Soldiers', 215-216.

⁹⁵ Macpherson, *Medical Services General History*, p.91.

⁹⁶ McKenzie, 'The Treatment of Convalescent Soldiers', 216.

⁹⁷ Barrie Lambert, 'Massage and Medical Electricity', 789.

Group II. – Men receive physical drill under Aldershot drill-sergeants and staff, and have a short route-marching, light fatigues, and general sports.

Group III. – Men have walks, physical training, light fatigues, and lectures on personal hygiene and other topics of interest.

Group IV. – Mostly medical cases, such as nephritis and heart affection, and convalescence after abdominal operations, pleurisy, &c. Subjected to walks, light physical training, gardening, and lectures.

Group V. – This group comprises the larger proportion of the massage cases, such as stiff joints, trench feet, nerve injuries, and sciatica.

Group VI. – Cases of shell-shock or cases so shattered as to be unfit for any form of exercise other than gardening, and walks, and certain special movements to improve co-ordination.⁹⁸

As the groupings at Seaford suggest, Depots combined physical therapy and military discipline: men wore khaki rather than hospital blues and were given drills and fatigues alongside physical therapy. This shows that physical therapy became part of the military regime and that the aim was restoring the individual for military service.

Like the Convalescent Camps, Command Depots contained large massage departments that represented a range of physical methods. The War Office equipped its depots with massage facilities, gymnasiums, mechano-therapeutic, electrical, light and hydrological apparatus.⁹⁹ Depots were also equipped with a large massage staff; for example, upon its relocation from Seaford to Shoreham in November 1917, the massage department of the London Command Depot consisted of a Medical Officer in charge, a head masseuse, four section heads and 20 masseuses, who treated on average 650 cases per day.¹⁰⁰ While there are no official figures as to the total number of

⁹⁸ Barrie Lambert, 'Massage and Medical Electricity', 789.

⁹⁹ For an extensive overview of the apparatus issued by the War Office see, Macpherson, *Medical Services General History*, p.175; also see McKenzie, 'The Treatment of Convalescent Soldiers', 215-218.

¹⁰⁰ Hazel Blandy, 'The London Command Depot, Shoreham', *JISTM* (October 1918), 76-80, (p.76).

patients treated in these camps, the fact that by April 1918 the 20 Command Depots in operation had a total accommodation for 75,500 men offers some perspective of their work.¹⁰¹

Similar to the Convalescent Camps, Command Depots were considered a success by medical and military authorities. An analysis of Heaton Park in August 1916 shows that the average time each man spent in treatment was under three months, with 50 per cent fit for active service, 15 per cent sent to lines of communication abroad, 15 per cent sent to work at home, and 20 per cent discharged as permanently unfit.¹⁰² By the end of 1916 the Depots were working together with orthopaedics; patients in the depots that showed no improvement were 'paraded and examined' in front of orthopaedic surgeons who would judge if further surgery was an option.¹⁰³ Even though a man may not be 'sent back in category "A,"', McKenzie wrote, 'his opportunities for a useful career in civil life after the war have been enormously increased and the burden on the nation in future pensions correspondingly lightened'.¹⁰⁴ For McKenzie the socio-economic and military usefulness of the Command Depots, 'thoroughly justified' the considerable financial investment that they entailed.¹⁰⁵

The Convalescent Camps and Command Depots of the First World War were militarily and politically significant institutions. They represent an extensive and co-ordinated response to the military manpower crisis and the socio-political threat of widespread disability. Part of a wider state discourse on rehabilitation, these institutions show that physical treatment and the massage profession were viewed as a way of achieving this aim as a service in itself.

¹⁰¹ Macpherson, *Medical Services General History*, p.91.

¹⁰² McKenzie, 'The Treatment of Convalescent Soldiers', 218.

¹⁰³ Barrie Lambert, 'Massage and Medical Electricity', 789.

¹⁰⁴ McKenzie, 'The Treatment of Convalescent Soldiers', 218.

¹⁰⁵ McKenzie, 'The Treatment of Convalescent Soldiers', 218.

Through these institutions, physical therapy became an 'indispensable link', in the chain of treatment for disabled men, beginning where ordinary hospital treatment ended.¹⁰⁶ While their significance has been overshadowed, their existence challenges the widespread view that before military orthopaedics the British government showed little interest in rehabilitation and efforts to restore the disabled were 'absorbed in chaos' and 'blighted by mismanagement'.¹⁰⁷ In contrast, the system instituted was highly pragmatic; guided by the ideals of efficiency and rationalisation the state built upon the experience and organisation of the massage profession that had been developing from the late-nineteenth century. While the RAMC could not be prepared in August 1914 for the scale of injuries they faced, within one year they had effectively organised a comprehensive chain of medical services. Furthermore, when orthopaedics became more established by 1917 and thereafter,¹⁰⁸ it worked with and alongside these institutions within the medical services rather than rendering them obsolete.

Investigating the establishment of these Camps and Depots, however, shows that behind the state's investment in physical therapy was a positive military and political valuation of rehabilitating the disabled. It was this positive valuation which offered an opportunity for the massage profession to extend the scope of its activities, propelling it to an unprecedented position of public, medical and state importance. As such, Barrie Lambert's 'hope' described at the beginning of this chapter, that the work of the Convalescent Camps and Command Depots would one day 'be ranked to its full value', was not an

¹⁰⁶ Fortescue Fox, *Physical Remedies*, p.194.

¹⁰⁷ Quotes from Cooter, *Surgery and Society*, pp.111-112.

¹⁰⁸ Cooter, *Surgery and Society*, p.112. Cooter notes that, while the first of the special orthopaedic hospitals (Alder Hey) was established in early 1915, the others were not established until 1917 and thereafter, after Jones raised what he referred to as an 'orthopaedic conscience'.

unjustified appeal.¹⁰⁹ That they did not receive ‘full recognition’ was partly because the work of these institutions represented that of women and physical treatment, socio-culturally and politically under-valued and obscured more broadly. The next section considers the relationship between the massage profession and the development of physical medicine and orthopaedics.

Physical Medicine

The history of physical medicine has not received sustained scholarly attention. One reason for this may be that, much like physiotherapy, the specialism has roots in a number of separate traditions, practices and technologies that can be difficult to trace. Rosemary Stevens and others have shown that the First World War was an important moment for the development of physical medicine as an independent specialism. It cannot, however, be discerned as a cohesive specialism at this moment; as Stevens has written, it represented ‘more a collection of individual methods of treatment than a unified discipline’, including balneology (use of baths), actinotherapy (use of light), electrology, massage, and exercise.¹¹⁰ Stevens also identifies that ‘lay physiotherapists’ had been working in this territory for over twenty years by the time physical medicine appeared on the scene.

Before 1914, specialist medical interest in physical treatments revolved around the separate methods such as hydrotherapy, electrotherapy and massage rather than a combined specialism, and this was largely marginalised to the fringes of organised medicine. Attitudes within medicine, however, began to change as, through the APMC, physical methods were drawn into hospitals

¹⁰⁹ Barrie Lambert, ‘Massage and Medical Electricity’, 788.

¹¹⁰ Rosemary Stevens, *Medical Practice in Modern England; the Impact of Specialization and State Medicine* (New Haven, Yale Univ. Press, 1966), p.47.

throughout the country and became subject to state investment. Writing in 1918, McKenzie observed that '[t]he calamity of war has been necessary to startle the profession into a realization of the wide field that should be occupied by the physical methods'; hitherto, he argued, physical methods were the 'Cinderella of the therapeutic family', 'despised, or ignored' by the medical profession.¹¹¹ Similarly, for Robert Fortescue Fox (1858-1940), the need to care for 'vast numbers of wounded and invalid soldiers',¹¹² enjoined medical practitioners 'to explore and utilize' the 'unfamiliar ground' of physical remedies.¹¹³ In this context, many of those who had experience in physical treatment before the war became leading experts in rehabilitation, such as Barrie Lambert, James Mennell, Fortescue Fox, McKenzie, Walter Rowley Bristow and George Murray Levick.

One particularly vocal group arising from the territory of physical medicine was the Section of Balneology and Climatology of the Royal Society of Medicine (SBC).¹¹⁴ The SBC was established in January 1915 to 'circulate information and advise army medical authorities in the treatment of wounded and invalid soldiers' by combined physical treatment, namely heat, massage, electricity and movements.¹¹⁵ Leading figures included chairman Fortescue Fox who also became honorary medical officer to the Red Cross Clinic for Physical Treatment of Disabled Soldiers opened in July 1916.¹¹⁶ The SBC was

¹¹¹ R.T. McKenzie, *Reclaiming the Maimed: A Handbook of Physical Therapy* (New York: The Macmillan Company, 1918), p.1.

¹¹² Fortescue Fox, *Physical Remedies*, p.1.

¹¹³ Fortescue Fox, *Physical Remedies*, p.ix.

¹¹⁴ For example another movement came from the British Association for the Advancement of Radiology and Physiotherapy (BARP) established in 1917, which created a diploma of Radiology and Physiotherapy in 1920.

¹¹⁵ Robert Fortescue Fox and J. Campbell McClure, 'A New Combined Physical Treatment for Wounded and Disabled Soldiers, (Heat, Massage, Electricity, Movements)' *The Lancet* (5 February 1916), 311-312, (p.311).

¹¹⁶ William Gordon, Septimus Sunderland, R. Fortescue Fox, and J. Campbell McClure, 'Physical Treatment for Disabled Soldiers', *The Lancet* (3 March 1917), 348-349, (p.348).

particularly interested in developing the use of hydrotherapy and many of their ideas were informed by methods used at the Hôpital Complémentaire at the Grand Palais in Paris.¹¹⁷

The Grand Palais was converted into a large hospital for physical treatment in January 1915.¹¹⁸ The hospital contained departments for hydrotherapy, massage, radiology, electrotherapy and mechano-therapeutics and had accommodation for 2400 by February the following year.¹¹⁹ By physical means, the SBC proclaimed to *The Lancet* in February 1916, the French hospital had fully rehabilitated 51 per cent of its patients, and 'where this is impossible the figure of incapacity has been considerably reduced, indicating a partial cure of disablement and a substantial economy to the State'.¹²⁰ They recommended similar physical treatment in Britain 'alike by humanity and by considerations of prudent war economy'.¹²¹

While the SBC's advocacy of physical methods is not surprising, however, it side-lined existing provision and the work of the massage profession before and during the war. While the SBC acknowledged that 'heat, massage, movements, and electricity' were 'familiar things' in Britain, they argued that 'the scope of their application in military practice, and the methods by which they are combined' was a new approach.¹²² 'Up to the present time', they argued in November 1916, physical treatment had not been used with the 'same thoroughness and precision as in France':

This clinic was formerly a private enterprise known as the Alexandra Therapeutic Institute established before the war, see *Reports by the Joint War Committee*, p.256.

¹¹⁷ Fortescue Fox and Campbell McClure, 'A New Combined Physical Treatment', 311.

¹¹⁸ Fortescue Fox and Campbell McClure, 'A New Combined Physical Treatment', 311.

¹¹⁹ Fortescue Fox and Campbell McClure, 'A New Combined Physical Treatment', 311.

¹²⁰ Fortescue Fox and Campbell McClure, 'A New Combined Physical Treatment', 312.

¹²¹ R. Fortescue Fox and J. Campbell McClure, 'A Combined Physical Treatment for Disabled Soldiers', *The Lancet* (27 November 1915), 1216, (p.1216).

¹²² Fortescue Fox and Campbell McClure, 'A New Combined Physical Treatment', 311.

In England heat, moist and dry, massage, and electricity are, of course, used throughout the country, and in a few cases baths and mechanical movements are being added. What is wanted is a combination and association of these powerful agencies under skilled direction. We think that a clear case has been made for the introduction of physical treatment upon an adequate scale into this country for the benefit of disabled and discharged soldiers.¹²³

What was lacking, in the SBC's opinion, then, was not the presence of the individual methods in themselves but 'their skilled direction' and 'combination' under medical direction. In response, Barrie Lambert complained that '[s]uch a statement is misleading in that it passes over as practically non-existent the splendid work of the Command Depots and Convalescent Camps'. 'The physical and electrical treatment of convalescent soldiers', she continued, was 'by no means lacking in coordination and skilled direction as certain criticisms might lead one to infer' and 'even a casual visitor would find it a revelation were he to [...] watch the work carried on any morning or afternoon inside the massage and electrical department'.¹²⁴ The debate between physical medicine and the massage profession demonstrates that downplaying the existing provision and the work of the massage profession was one way that burgeoning medical specialists carved out a role for themselves in the territory of physical medicine and rehabilitation.

Orthopaedics

Orthopaedics was another specialty interested in physical medicine and rehabilitation. Scholars such as Roger Cooter, Rosemary Stevens, Julie Anderson and Heather Perry have shown that the trajectory of orthopaedics

¹²³ Quote from Barrie Lambert, 'Massage and Medical Electricity', 788. This article was a response to 'the articles which have lately appeared in the lay press', and quotes this statement from the SBC.

¹²⁴ Barrie Lambert, 'Massage and Medical Electricity', 788.

was rapidly altered during the war. By 1918 the discipline had been transformed from a minor branch of surgery specialising in chronic deformities, to a sophisticated surgical specialism representing over 25,000 beds.¹²⁵ Of interest is the role that physical treatment and the massage profession played in the wartime transformation of orthopaedics.

As argued by historians, it was not inevitable that orthopaedics be mobilised in the First World War in the manner that it was. Its ascendancy depended upon a number of factors including the influential position of Jones and his pre-war experience; the case he presented to the AMS; and a military and socio-economic environment receptive to his ideas. Alongside physical medicine and the establishment of Convalescent Camps and Command Depots, the development of orthopaedics was part of the response to the manpower crisis and a positive valuation of rehabilitating the disabled. While being appointed Director of Military Orthopaedics in March 1916 in the midst of a severe manpower shortage (conscripted began in January 1916) greatly strengthened Jones' strategic position, he had been making a case for orthopaedics from the beginning of the war.

According to his biographer Frederick Watson, it was at the end of 1914 that Jones, after inspecting 'various hospitals in the Western Command', sent his first report to Alfred Keogh, which argued against the policy of rapid hospital evacuation.¹²⁶ In a letter written to George Makins Major-General of the AMS in May 1918, Jones recalled that '[d]uring the first twelve months of the War no provision of any sort was made for cases crippled and deformed, and early evacuation was both the instruction and routine'.¹²⁷ 'The result' he continued:

¹²⁵ Jones, 'A Few Surgical Lessons', 587.

¹²⁶ Watson, *The Life of Sir Robert Jones*, p.147.

¹²⁷ Watson, *The Life of Sir Robert Jones*, pp.147-148.

was that many men were discharged from the Army in a very large number of cases totally unfitted either for military or civilian life. These men promised to become foci of seething discontent and at that time a menace to successful recruiting. Letters poured in and representations were made which rendered it imperative that some effort be made to stem the tide of premature discharges. It was then that Sir Alfred Keogh asked me if I could help him, and it was decided (in early 1915) that an experiment should be made in Liverpool.¹²⁸

While this account has been interpreted to show that orthopaedics was the first and only attempt at rehabilitation for the disabled soldier, again, it omits mention of the work of the APMC, Camps and Depots. Side-lining other provision was a way of emphasising the role of orthopaedics. The work of the Camps and Depots suggest that the AMS envisioned orthopaedics as a part of a broader scheme of rehabilitation, using surgical intervention where physical methods were not effective alone, rather than viewing it as the only solution to the problem.

The first special orthopaedic hospital was established, by permission of Alfred Keogh, at Alder Hey, Liverpool in January 1915.¹²⁹ Starting with 250 beds, Alder Hey was intended as an experiment for cases in military hospitals likely to benefit from the kind of treatment Jones proposed.¹³⁰ According to Jones in 1919, Alder Hey 'proved so successful', that he was given a 'free hand' to increase the number of beds at Liverpool and start similar establishments elsewhere.¹³¹ Cooter argues, however, that the vindication of military orthopaedics was not, in reality, as simple as this, and that it was not until 1917

¹²⁸ Watson, *The Life of Sir Robert Jones*, pp.147-148.

¹²⁹ Cooter, *Surgery and Society*, p.114.

¹³⁰ Cooter, *Surgery and Society*, p.114.

¹³¹ From his speech to the American College of Surgeons, (November 1919), quote from Cooter, *Surgery and Society*, p.114.

and thereafter that other institutions were established.¹³² While Alder Hey demonstrated the economic legitimacy of Jones's principles (claims were made that 75 per cent of patients were returned to active duty),¹³³ he also had to emphasise that existing provision for rehabilitation was lacking. Within Jones' campaign to secure investment in orthopaedics, the work of the Convalescent Camps and Command Depots was presented as lacking competence and coordination.

According to Jones, two central 'problems' with existing military medical provision were, first that general surgeons lacked orthopaedic training, and second that there was a need for continuity of treatment and coordination between surgery and after-care. Jones called for what he described as an 'orthopaedic conscience', arguing that if general surgeons applied orthopaedic principles to their work disability and dysfunction could be avoided altogether. In 1921 Jones wrote that:

Frequent visits round our Command Dépôts revealed the shortcomings of the routine teaching, for one found segregated every type of deformity; most of it need never have occurred had sufficient time been spent in educating the student in the principles which govern the development of deformity.¹³⁴

For Jones, while residual impairment was explicable in the early stages of the war when the AMS faced an unmanageable volume of patients, unfamiliar wounds and sepsis, later chemical advances meant that surgeons had greater opportunity to be conservative.¹³⁵ It was vital, he argued, that surgeons considered how to give patients the best functioning limb possible, for example

¹³² Cooter, *Surgery and Society*, p.112, p.114.

¹³³ Cooter, *Surgery and Society*, p.114.

¹³⁴ Robert Jones, 'The Necessity of Orthopaedic Training: Its Relation to the Prevention and Cure of Deformities', *BMJ* (5 February 1921), 181-186, (p.182).

¹³⁵ Robert Jones, 'The Problem of the Disabled', *Recalled to Life*, 3 (April 1918), 366-378, (pp.377-378).

by ensuring that ankylosed joints were fixed in functional positions and that fractures were accurately set in the first instance.¹³⁶ Jones's 'orthopaedic conscience' echoed many of the principles discussed in Chapter 3, advocated by those who sought to reform fracture treatment around the turn of the century.

The second critique important for this study was that the existing chain of medical services, which separated surgery and after-care by transferring patients from military hospitals to auxiliary hospitals, Convalescent Camps and Command Depots was uncoordinated and ineffective. In a letter to George Makins in May 1917, Jones wrote that under this system 'continuity of treatment, an essential desideratum, was impossible'. For example:

A case might enter any of our large hospitals with an ulnar paralysis and stiff fingers. Early evacuation often meant that the surgeon would have to operate without an adequate preparation in the way of mobilising the fingers, and shortly after the wound had healed the case might be found nursing his stiff fingers in an auxiliary hospital or undergoing routine treatment at Command Depots, or sent back to another hospital for a fresh operation because recovery had not taken place in four or five months.¹³⁷

For Jones, patients received after-treatment too late, when disabilities had already set in and become chronic.¹³⁸ Command Depots, he said, housed 'large groups of cases where Nature unassisted had been allowed to do its curative work without regard to restoration of function'.¹³⁹ Much like the use of the massage department before the war, Jones highlighted that physical treatment was being used as a 'last resort', to mitigate the residual and often avoidable effects of injury and injudicious surgical treatment.

¹³⁶ Robert Jones, 'Orthopaedic Surgery in its Relation to War', *Recalled to Life*, 1 (June 1917), (50-59), (p.51).

¹³⁷ Watson, *The Life of Sir Robert Jones*, p.150.

¹³⁸ Jones, 'The Necessity of Orthopaedic Training', 182.

¹³⁹ Jones, 'The Necessity of Orthopaedic Training', 182.

Jones argued that in order to be effective, coordination between surgery and after-care had to be under orthopaedic control. 'Our experience of uncontrolled special departments led us to conclude that they were lacking in a sense of proportion, and that cases were being bathed, massaged, or electrified which required fundamentally different treatment'.¹⁴⁰ Jones argued that without medical supervision physical therapy was incompetent and could have disastrous results:

In one institution we visited we found several men being massaged who should have had their torn nerves sutured. Others being electrified required preliminary tenotomise, while the subjects of arthritis were undergoing harmful movements in Zander machines. Again, attempts were being made to break down old septic joints which required the gentlest care.¹⁴¹

Highlighting the dangers of physical treatment outside of medical supervision and disregarding the positive results of existing services, was a way of presenting a case for orthopaedic control: '[u]nless these special departments are guided by men with an orthopaedic training they might as well not exist'.¹⁴² The solution presented to the AMS was continuity of treatment whereby surgery and after-care was coordinated and controlled by orthopaedic surgeons. In a letter to Alfred Keogh in February 1916, Jones wrote;

There is [...] a want of cohesion between departments of treatment, such as massage, physical exercises, electricity and manipulative and operative groups of cases, all of which properly controlled make for success in orthopaedic surgery. It appears to me that we want one large orthopaedic hospital combining all these departments, and staffed by expert men under a director, who should be the final arbiter as to the conduct of treatment.¹⁴³

¹⁴⁰ Robert Jones, 'Military Orthopaedic Surgery: Its Scope and Aims', *The Lancet* (27 July 1918), 115-119, (p.115).

¹⁴¹ Jones, 'Military Orthopaedic Surgery', 115.

¹⁴² Jones, 'Military Orthopaedic Surgery', 115.

¹⁴³ Watson, *The Life of Sir Robert Jones*, p.165.

Casting existing surgical and after-care provision as unable to effectively rehabilitate injured servicemen was an important way that Jones made a case for orthopaedic control. It was through this campaign, as well as the work of King Manoel of Portugal in developing the orthopaedic 'curative workshop', that the military 'came to believe, and ultimately to invest, in Jones's orthopaedics'.¹⁴⁴ As this demonstrates, the emergence of both physical medicine and orthopaedics was based upon depicting physical treatment in a certain way. By negating or criticising existing provision these aspirant specialisms were able to justify a role for themselves.

The final part of this first section considers the status of massage treatment in Jones's orthopaedics, highlighting the important role it played in successful outcomes and why orthopaedic surgeons sought to control physical treatment. Cooter argues that the wartime value of orthopaedics was largely the way it managed and organised medical practice rather than any distinct body of theoretical knowledge.¹⁴⁵ The establishment of 'orthopaedic centres' was an expression of Jones' aim to establish specialist hospitals where all the resources to rehabilitate the disabled were brought together under one roof. The orthopaedic centre exemplified principles of rationalisation and efficiency that hospital reformers had been appealing to since the late-nineteenth century but wartime circumstances favoured. For Jones, the administration of integrated services extended from the front line whereby casualties were segregated and transported from Casualty Clearing Stations, base hospitals, to orthopaedic centres.¹⁴⁶ Similarly, the principles of rationalisation and efficiency applied to treatment within orthopaedic centres where a clear hierarchy of control and

¹⁴⁴ Cooter, *Surgery and Society*, p.118.

¹⁴⁵ Cooter, *Surgery and Society*, p.120.

¹⁴⁶ Cooter, *Surgery and Society*, p.120.

division of labour was organised towards the ultimate goal of rehabilitating the patient. This systematic approach to treatment required teamwork and the collaboration of a number of experts including surgeons, neurologists, physical treatment specialists, masseuses and limb-fitters.

Within the orthopaedic centre massage work and the masseuse had a clearly defined role as a surgical auxiliary. To examine this in more detail we can look at the massage department as it was configured at Shepherd's Bush military hospital, Britain's flagship orthopaedic centre opened in March 1916. Under the supervision of Jones, Shepherd's Bush received more funding than any other orthopaedic centre during the war and was intended as a model institution in terms of resources and organisation.¹⁴⁷ Physical treatments, including massage, remedial exercise, hydro- and electro-therapy, were each represented separately by different departments at Shepherd's Bush. Physical treatment was mobilised on a large scale in these centres; between its establishment in March 1916 and September 1917, the massage department at Shepherd's Bush alone gave over 146,000 treatments, averaging 250 treatments per day.¹⁴⁸

The massage department at Shepherd's Bush was headed by James Mennell.¹⁴⁹ The purpose of the massage department in the orthopaedic setting, Mennell wrote, was 'to prepare for, and to render complete, the work of the

¹⁴⁷ King Manoel, 'Appendix X', in *Reports by the Joint War Committee*, pp.732-744, (p.735).

¹⁴⁸ D.H. Eade, *Organisation and Methods of the Military Orthopaedic Hospital, Shepherd's Bush, London* (London: St. Clements Press, Ltd., 1917), IWM, LBY K.4203, p.13.

¹⁴⁹ Records of St Thomas's Hospital suggest that their physical therapy departments provided model for Shepherd's Bush. Mennell (massage) and Walter Rowley Bristow (electro-therapeutic) both worked at both St Thomas's and Shepherd's Bush, 'our Department was very closely inspected from time to time on behalf of the War Office and proved of great value as a basis of a scheme on which the great Military Hospital at Hammersmith has been established', see, [Untitled report], (1919) pp.1-3, LMA, H1/ST/PS/Y/04/001, p.2.

surgeon'.¹⁵⁰ In this scheme it was essential that 'those whose business it is to work in the department should know exactly what is the end in view' when the surgeon orders 'massage'.¹⁵¹ On admission to the orthopaedic hospital patients came under the charge of a surgeon who decided upon a plan 'to attempt to restore the function of the disabled limb' and was responsible for his treatment until discharged.¹⁵² While the orthopaedic surgeon assumed ultimate authority over each case, Mennell described that '[a]t the same time it is impracticable for every surgeon in the hospital to be in such constant touch with the Massage Department as to be able to dictate and supervise the treatment of each of his own patients for whom he may have ordered massage'.¹⁵³ It was therefore necessary that on-going responsibility for the work of the massage department be delegated to another medical specialist.¹⁵⁴ The role of the medical officer in charge was finely coordinated with the surgeon in charge; his aim, Mennell wrote, was 'to carry out, to the best of his ability in each individual patient, the wishes of the surgeon who sent the case to him'.¹⁵⁵ To do this, the medical officer discussed a treatment plan with the orthopaedic surgeon and then directly communicated instructions to massage personnel. It was believed that the department had to be under the charge of the medically trained. 'No masseuse', Mennell wrote:

however efficient and fully trained, can properly be left in sole control of the treatment to be administered in the department. The masseuse is no diagnostician.¹⁵⁶

¹⁵⁰ James Mennell, 'Massage in Orthopaedic Surgery', in *Orthopaedic Surgery of Injuries Vol.2*, ed. by Robert Jones (London: Hodder & Stoughton, 1921), pp.505-559, (p.505).

¹⁵¹ Mennell, 'Massage in Orthopaedic Surgery', p.505.

¹⁵² Robert Jones, 'Orthopaedic Surgery in its Relation to War', 52.

¹⁵³ Mennell, 'Massage in Orthopaedic Surgery', p.505.

¹⁵⁴ Mennell, 'Massage in Orthopaedic Surgery', p.505.

¹⁵⁵ Mennell, 'Massage in Orthopaedic Surgery', p.505.

¹⁵⁶ Mennell, 'Massage in Orthopaedic Surgery', p.505.

As calls for medical control indicate, massage and physical treatment were recognised as important elements of the broad orthopaedic approach to rehabilitation. A structured hierarchy and division of labour were key to securing successful outcomes and orthopaedic interests.

The use and administration of the massage department in the context of military orthopaedics contrasted sharply with that displayed in general hospitals before the war. Orthopaedics critiqued massage departments that were not under medical control, the common practice of vaguely prescribing 'massage' as a last resort, and losing sight of patients. As Jones complained in 1917, '[t]o send a patient to the massage department with a request for treatment without specifying its character is wrong; it is unjust to the masseuse and unfair to the patient'.¹⁵⁷ For Mennell, the war increased the accountability of the medical profession to the massage department:

In pre-war days there existed a tendency on the part of the surgeons of this country to relegate all the later part of the treatment of injuries to a massage – worker, and to interest themselves no more in the patient's career once the immediate surgical treatment had ceased [...] With the advent of a host of wounded in the country, the medical profession was faced with a problem which was, therefore, a comparatively new one to many of its members. The patients could no longer be discharged from hospital semi-cured, or sent to the physical exercise department of the hospital, or put under the care of a masseuse with an almost instinctive hope that they would not be heard of further. Treatment had to continue till the patient was fit once more to return to military duty.¹⁵⁸

Few surgeons, he wrote, 'appreciated how tedious and slow was the recovery of patients, even after the receipt of comparatively trivial injuries' and '[i]t has

¹⁵⁷ Jones, 'Orthopaedic Surgery in its Relation to War', 55-56.

¹⁵⁸ James Mennell, 'Re-Education in Walking', *JISTM* (May 1917), 308-313, (p.308).

come as a very unwelcome surprise to many how long and difficult is the task of eradicating a limp once it has been acquired'.¹⁵⁹

This demonstrates that the wartime focus on rehabilitation brought massage treatment more closely into medical practitioners' field of vision. As they now had no option but to face the task of rehabilitating injured soldiers physical treatment became increasingly familiar and important to harness. For Reginald Elmslie (1878-1940), lead orthopaedic surgeon at Shepherd's Bush, it was the responsibility of the medically trained to guide the whole process of rehabilitation including physical therapy: 'the surgeon who is responsible for the treatment of the patient should himself study the methods and results of massage and of the other forms of physiotherapy'.¹⁶⁰

Coordination and teamwork not only applied 'vertically' to the massage department but also 'horizontally', as its activities were systematically linked to the other physical treatment departments. Writing in 1918 Jones reflected that:

In organising an orthopaedic centre we decided to have every department represented, and that these departments should be so related that while they interdigitated they should not overlap. Our experience of uncontrolled special departments led us to conclude that they were lacking in a sense of proportion, and that cases were being bathed, massaged, or electrified which required fundamentally different treatment.¹⁶¹

Jones believed that physical treatments threatened to lose 'perspective of their powers' when practised independently outside of medical supervision.¹⁶² This echoed longstanding concerns that physical therapies were used as a

¹⁵⁹ Mennell, 'Re-Education in Walking', 308.

¹⁶⁰ Reginald Elmslie, *The After Treatment of Wounds and Injuries* (Philadelphia: P. Blakiston's Son & Co., 1919), p.305.

¹⁶¹ Jones, 'Military Orthopaedic Surgery', 115.

¹⁶² Jones, 'The Problem of the Disabled', 368.

'panacea' without well-defined therapeutic limitations, as evidenced in Chapter One.

For Jones, therefore, it was important that all physical treatment departments were contained within the orthopaedic centre and coordinated by the orthopaedic surgeon.¹⁶³ 'In order to get the best results from all forms of treatment at all stages', he wrote, 'it is essential that there should be proper coordination of plans of treatment between the surgeon who deals with the case and the various auxiliary departments'.¹⁶⁴ This, he wrote:

broadens the out-look of the various medical officers concerned, and helps to prevent that baneful tendency to a narrow-minded belief in the universal efficiency of one particular mode of treatment which so often mars the usefulness of establishments specially organized for one form of treatment.¹⁶⁵

While physical treatments were represented separately in the centre, it was intended that they worked together in a combined approach. As medical officer in charge of the Electro-therapeutic department, Walter Rowley Bristow described: '[t]he whole subject of physical treatment must be looked at broadly. The various forms, baths, electricity, massage, remedial exercises and gymnastics, cannot be separated into water-tight compartments. They must overlap'.¹⁶⁶

Examining the place of massage and physical treatment departments within the orthopaedic centre reveals their role within orthopaedics more broadly. A clearly defined hierarchy, division of labour and teamwork were organising principles that ensured physical treatment supported the work of the

¹⁶³ Jones, 'Military Orthopaedic Surgery', 115.

¹⁶⁴ Jones, 'Orthopaedic Surgery in its Relation to War', 51-52.

¹⁶⁵ Jones, 'Orthopaedic Surgery in its Relation to War', 51-52.

¹⁶⁶ Walter Rowley Bristow, 'Electrical Department', in *Orthopaedic Surgery of Injuries* Vol. 2, ed. by Robert Jones (London: Hodder & Stoughton, 1921), pp.491-501, (p.491).

orthopaedic surgeon. It shows that the role of massage was reconfigured during the wartime professionalisation of orthopaedics. While 'pre-war' orthopaedics used massage and manipulation as a primary surgical tool, 'modern' orthopaedics, as epitomised by the work of Jones, shifted this focus. Although orthopaedic surgeons still used these methods occasionally, more emphasis was placed on surgical procedures and massage was used less as a corrective measure and more as an auxiliary after-treatment. As demonstrated by the central place of physical treatment departments in the orthopaedic centre and calls for medical control, however, this role was equally important to the evolving specialism.

Massage in Practice

While the first half of this chapter explored some of the key locations for the development of massage during the war, the second half looks more closely at how massage work operated in practice. Exploring how massage was used during the war shows that the massage profession drew from, and adapted, pre-war principles to inform its rehabilitation work. It demonstrates that the practical and professional parameters of the profession were inherently shaped by a drive to restore injured men to fitness as rapidly as possible.

As suggested in the first part of this chapter, massage and physical therapy were deployed widely during the First World War, not only in Convalescent Camps, Command Depots and orthopaedic centres, but in many therapeutic settings including military hospitals, civilian hospitals and out-patient departments, Red Cross and auxiliary hospitals, private homes and small clinics. The war opened up a large field of work for the masseuse; with approximately 65 per cent of casualties left with some kind of functional

impairment as a result of injuries such as compound fractures, infected wounds, nerve and joint damage, physical therapy became a routine part of hospital life and was regarded as one of the most important techniques to restore function and fitness to injured men. Rather than limited to a specific group of patients, physical therapy was considered applicable to almost every type of injury or illness. Aside from the multitude of medical rationales, physical treatments – and massage in particular – were thought, at worst, to pose little risk to patients. The way massage was used varied greatly, and depended upon a number of factors, including the type of injury, the stage of recovery, the institution, the medic in charge of the case, as well as the training and experience of the masseuse.

Massage was used for a range of medical and surgical disablements. Writing in 1917, Fortescue Fox categorised the ‘different types of disablement’ resulting from the war into five groups.¹⁶⁷ First, were ‘those so disabled as to be incapable of any further work’.¹⁶⁸ Second, men who had ‘lost one or more limbs, but can still be restored, wholly or partially, to an active life’.¹⁶⁹ Third, ‘men suffering from more or less functional disablement of one or more limbs’.¹⁷⁰ Fourth, ‘the blind’, who ‘make a class by themselves’; fifth, ‘those who are disabled by maladies rather than by wounds, such as nervous and mental affections, rheumatism, and disordered action of the heart’.¹⁷¹

All these men were likely to have experienced massage and physical therapy in some capacity. Those permanently disabled, ‘incapable of further work’, were often discharged, either returning home, or cared for in special

¹⁶⁷ Fortescue Fox, *Physical Remedies*, pp.197-198.

¹⁶⁸ Fortescue Fox, *Physical Remedies*, p.197.

¹⁶⁹ Fortescue Fox, *Physical Remedies*, p.197.

¹⁷⁰ Fortescue Fox, *Physical Remedies*, p.198.

¹⁷¹ Fortescue Fox, *Physical Remedies*, p.198.

institutions.¹⁷² The first of such institutions was the Star and Garter Home for disabled Soldiers and Sailors opened in 1916, which provided a permanent residence for approximately 200 disabled ex-servicemen.¹⁷³ At the Star and Garter, 'continued treatment by massage and electricity' was given to the patients who were paralysed and bedridden,¹⁷⁴ and massage staff comprised five STM masseuses and five students, eight giving their services for free.¹⁷⁵ For the second group, amputees, massage and physical therapy were used to heal and relieve the painful stumps and to develop muscles and muscular sense upon which artificial limbs depended.¹⁷⁶ More than 41,000 British servicemen had one or more limbs amputated during the war,¹⁷⁷ and the majority would have received physical therapy. Limb fitting and rehabilitation centres were established throughout the country; the largest centre in Britain was Queen Mary's at Roehampton, set up in 1915. After being fitted with prostheses at St Mary's many men were transferred to St Thomas's hospital massage department for training in their use.¹⁷⁸

The third group, 'those with functional impairment', constituted the 'largest class of disabled soldiers'.¹⁷⁹ For these men physical therapy was a primary treatment, for example to relieve contractions, scars and restore movement and muscular strength. For soldiers blinded during the war, approximately 1,833, massage became an avenue of occupational retraining.

¹⁷² Cohen, *War Come Home*, p.34.

¹⁷³ Anderson, 'Soul of a Nation', p.53.

¹⁷⁴ 'The Proper Place for the Totally Disabled', *JISTM* (August 1916), 42-43, (p.42).

¹⁷⁵ Barclay, *In Good Hands*, p.68.

¹⁷⁶ Fortescue Fox, *Physical Remedies*, p.198; also see R.T. McKenzie, 'Massage, Passive Movement, Mechanical Treatment and Exercise', in *Physical Remedies for Disabled Soldiers*, by Robert Fortescue Fox (London: Baillière, Tindall and Cox, 1917) pp.89-121, (p.93).

¹⁷⁷ Julie Anderson, "Jumpy Stump": Amputation and Trauma in the First World War', *First World War Studies*, 6 (2015), 9-19, (p.9).

¹⁷⁸ St Thomas' hospital records show that the physical therapy department was involved in the development of prosthesis during the war, see 'St. Thomas' Hospital, School of Physiotherapy, World War 1914-1918', LMA, HI/ST/PS/Y/04/002, p.7.

¹⁷⁹ Fortescue Fox, *Physical Remedies*, p.198.

Facilities for retraining were provided through St Dunstan's Hostel for Blinded Soldiers and Sailors, first established in 1914; and 95 per cent of the blinded passed through this institution at some stage.¹⁸⁰ Those at St Dunstan's were trained in a variety of new skills and massage was one of the occupations that were 'taught to the men who do not wish to follow a manual occupation'.¹⁸¹ The National Institute for the Blind established its own massage school during the war; candidates entered the STM examination and by 1918 60 blind masseurs were serving in the APMC working in civilian and military hospitals, depots and camps, in training schools and privately.¹⁸² Not only the blinded were retrained in massage; at the end of the war a Government Training Grants Scheme offered support to ex-servicemen, particularly 'ex-officers and men of similar educational attainments' to retrain in a 'higher profession'.¹⁸³ Lastly, physical therapy was also commonly used for men disabled by medical illnesses such as shell-shock, rheumatism, trench foot and frost bite, as opposed to 'functional impairment'.

As this overview demonstrates disability opened up a great amount of work for the massage profession. Two particularly significant uses of massage, the mitigation of residual impairment and as a surgical auxiliary, will now, however, be discussed in more detail. Perhaps the most recognised use of massage was to treat functional impairments; as highlighted in part one, injuries, injudicious treatment and wartime conditions, all contributed to a crisis of residual stiff joints, immobility and pain. Pre-war lessons about the dangers of

¹⁸⁰ Anderson, *'Soul of a Nation'*, p.49.

¹⁸¹ 'Third Annual Report of Dt. Dunstan's Hostel for Blinded Soldiers and Sailors: For Year Ended March 31st 1918', (1918), pp.1-16, IWM, B.R.C.S.18/16, p.5.

¹⁸² Barclay, *In Good Hands*, pp.58-59.

¹⁸³ 'Miscellaneous Letter', (23 December 1920), pp.1-3, Appointments Department: Correspondence from the Incorporated Society of Trained Masseuses Regarding Training in Massage and Gymnastics (1919), The National Archives (henceforth TNA), LAB 2/1505/AD1426/1919, p.1.

prolonged fixation and immobilisation were largely negated during the war. In a context where up to 300,000 casualties could result from a single encounter, resources scarce and infection rife,¹⁸⁴ the civilian approach to injuries had to be adapted. For example, in contrast to simple fractures commonly found in civilian practice, wartime fractures were often compound and septic making them a major cause of death and disability.¹⁸⁵ With large wounds that took a long time to heal there was also a danger of stirring sepsis if limbs were massaged or mobilised early, which meant that rest until the wound had healed was a general protocol.¹⁸⁶ Prolonged immobility and badly set fractures combined, meant that shortened limbs, ankylosis (stiffness and fusion of bones and joints), and adhesions were common results.¹⁸⁷

It was these types of cases that caused chronic dysfunction and were treated by physical therapy in Convalescent Camps and Command Depots. At Heaton Park, McKenzie wrote that '[m]any cases come in with limbs which have become wasted and joints stiffened by long immobility in splints'.¹⁸⁸ It was the masseuse's job to 'coax' limbs 'back to strength and usefulness by skilled massage and manipulation'.¹⁸⁹ Massage followed by passive manipulation was given manually or by machines designed to stretch shortened ligaments, break down adhesions and restore movement to joints.¹⁹⁰ Treating such chronic impairments was a daunting task. Masseuse Olive Guthrie-Smith of Seaford Command Depot wrote that masseuses often faced cases where 'one feels

¹⁸⁴ Cooter, *Surgery and Society*, pp.107-108.

¹⁸⁵ Jones, 'A Few Surgical Lessons', 589, Jones claimed that in 1916 mortality from fracture was 80 per cent but reduced by 20 per cent in 1918 with the introduction of the Thomas splint.

¹⁸⁶ Alan H. Todd, 'Some Points in connection with the Treatment of Fractures in Military Practice', *JISTM* (June 1918), 281-289, (p.281).

¹⁸⁷ Jones, 'A Few Surgical Lessons', 587.

¹⁸⁸ McKenzie, 'The Treatment of Convalescent Soldiers', 217.

¹⁸⁹ McKenzie, 'The Treatment of Convalescent Soldiers', 217.

¹⁹⁰ McKenzie, 'The Treatment of Convalescent Soldiers', 217.

something rather heroic is required'.¹⁹¹ Indeed, as Jones reported, the odds were often stacked against physical therapy, as many cases were so severe that they required a surgical preliminary.¹⁹² In this context, he complained, massage was being used as a last resort when all other attempts at helping had failed. In 1917 he wrote that '[i]n hospitals which I visit it is common to meet patients who say they have had months of massage and are no better', and condemned surgeons who sent cases to the massage department without any 'idea or plan of treatment' simply to get rid of them.¹⁹³ As Chapters 3 and 4 showed, massage had long been used to break down adhesions and restore function; it was familiar territory for both masseuses and bonesetters. It is, therefore, perhaps not surprising that the First World War saw a surge in the activity of both these practitioners.¹⁹⁴

Increasingly as the war progressed, however, there were calls from some to mobilise injuries earlier as a prophylactic against chronic dysfunction. Factors including improved infection control and the drainage of open wounds meant that some medical men experimented with principle of early movement. Massaging injuries with exposed open wounds was a new trial and error procedure, however. Mennell argued that surgeons should not wait until wounds had healed to start treatment, 'I have frequently administered massage to a limb while still suppurating freely, with drainage tubes still in position'.¹⁹⁵ Similarly surgeon J.W.Dowden wrote in the *BMJ* in 1918 that, as long as septic wounds were 'thoroughly drained' that passive and active movements should be started as soon as possible, even arguing that 'splints should never be used

¹⁹¹ Guthrie-Smith, 'Apparatus for Stiff Joints', 19.

¹⁹² Jones, 'The Necessity of Orthopaedic Training', 182.

¹⁹³ Robert Jones, 'Introduction to the First Edition', in James Mennell, *Massage: Its Principles and Practice*, 2nd edn. (London: J.A. Churchill, 1920), pp.xi-xiii (p.xi, p.xii), first published 1917.

¹⁹⁴ Cooter, *Surgery and Society*, pp.119-120.

¹⁹⁵ Mennell, 'Massage in Orthopaedic Surgery', p.530.

except when absolutely necessary'.¹⁹⁶ Dowden complained that: '[t]housands of our soldiers have been more or less disabled for life simply and solely on account of prolonged immobilization of injured limbs',¹⁹⁷ and that 'I am not at all surprised, therefore, that there has been an insistent demand for the services of bonesetters, who overcome the adhesions which have been brought about by well meaning surgeons'.¹⁹⁸ This highlights the diversity of opinion amongst medical men as to the place of massage and physical therapy in the treatment of injuries during the war. While some advocated massage from the outset, for others it remained a prescription for after-treatment with which they had little involvement.

As Chapter 3 indicated, massaging old and new injuries required a radically different approach. While some level of discomfort was anticipated to restore long-standing stiff joints, most authorities agreed that pain was to be absolutely avoided when dealing with recent injuries. As Dowden described in 1918:

When passive or active movements are begun early, pain is the danger signal that shows harm is being done [...] When after prolonged immobilization adhesions have formed, however, pain has to be endured while the adhesions are being stretched or broken.¹⁹⁹

An indistinct prescription for 'massage' in the treatment of injuries, therefore, was open to a range of interpretations and had potential to cause suffering. This already difficult situation was exacerbated further given inconsistencies within the medical profession as to the correct procedure, the lack of medical supervision over the majority of massage work, as well as the inexperience of

¹⁹⁶ J.W.Dowden, 'The Curse of Immobilization', *BMJ* (23 November 1918), 570-571, (pp.570-571).

¹⁹⁷ Dowden, 'The Curse of Immobilization', 570.

¹⁹⁸ Dowden, 'The Curse of Immobilization', 571.

¹⁹⁹ Dowden, 'The Curse of Immobilization', 571.

many massage personnel. While STM masseuses underwent a minimum of six months training, many still felt unprepared for what the work entailed. VADs and others that gave massage often did not receive a thorough training and were sometimes given responsibility for treatments beyond their skill and experience. For example, the wartime memoirs of APMC masseuse Olive Millard describe that in 1916 the British Red Cross Auxiliary Hospital for Officers at Brighton opened its massage department with four workers, three of which did not have a certificate.²⁰⁰ She recalled an incident where a masseuse was mobilising an early fracture of the humerus when it broke in her hand, both patient and the masseuse fainting as a result.²⁰¹

These difficulties were further compounded because massage was a treatment that lacked scientific measure and remained largely based upon anecdotal evidence and interpretation of patient's physical limits. During the war, some medical men such as Fortescue Fox and others of the Section of Balneology and Climatology sought to establish physical treatment on a more 'scientific' basis. For this purpose, in 1915 the SBC issued 20,000 case-record cards to various British spas to collect data.²⁰² For the SBC 'the first requisite of scientific practice was an accurate measurement and record of cases',²⁰³ and they looked to test, measure and record the mobility of joints and muscular strength at intervals, to correlate the relationship between physical treatment and rehabilitation.²⁰⁴ This, however, did not change the fact that massage and many other physical treatments, in practice, remained experimental, experiential and empirical in nature. Pain was built into remedial massage and often

²⁰⁰ Olive Millard, *Under My Thumb*, (London: Christopher Johnson, 1952), p.59.

²⁰¹ Millard, *Under My Thumb*, p.60.

²⁰² Fortescue Fox, *Physical Remedies*, p.238.

²⁰³ Fortescue Fox, *Physical Remedies*, p.238.

²⁰⁴ Fortescue Fox, *Physical Remedies*, pp.184-189. Describes the instruments used to measure mobility of limbs.

treatment and progress were measured by a patient's pain response, expectations and the masseuse's interpretation.

It was in this context that debates about pain and massage therapy emerged. Massage treatment was informed by diverse medical opinion on the appropriateness of pain that made the interpretation of a prescription for massage challenging. For example, in October 1915 Mennell complained that he had received reports that 'some operators are unnecessarily violent in their massage treatment, a fact borne out by the attempts of patients to evade their masseur on his arrival at hospital in order to escape treatment'.²⁰⁵ According to Mennell, there was a widespread belief 'that pain and discomfort are inseparable from successful treatment', that "massage become painless ceases to be massage and is merely treatment by suggestion," and the duty of the operator is to give the patient "all he can stand".²⁰⁶ In contrast, McKenzie at Heaton Park warned that 'some patients wince on the slightest touch, and this false pain must be distinguished from real'.²⁰⁷ Ana Carden-Coyne and Fiona Reid have shown that the view on pain was infused by socio-cultural and political expectations of masculinity, fears of malingering and the pressure on medicine to return men to the front line as quickly as possible.²⁰⁸

It was against this backdrop that the masseuse received a reputation as 'chief torturer'. Trench journals and magazines frequently satirised the masseuse and her treatment; these expressions often reflected an experience

²⁰⁵ James Mennell, 'Massage in the After-Treatment of the Wounded', *The Lancet* (2 October 1915), 755-757, (p.755).

²⁰⁶ Mennell, 'Massage in the After-Treatment of the Wounded', 757.

²⁰⁷ McKenzie, 'Massage, Passive Movement', p.94.

²⁰⁸ The work of Ana Carden-Coyne and Fiona Reid analyse in detail the soldiers experience of physical therapy during the First World War, see Ana Carden-Coyne, *The Politics of Wounds: Military Patients and Medical Power in the First World War* (Oxford: Oxford University Press, 2014); Ana Carden-Coyne, 'Painful Bodies and Brutal Women: Remedial Massage, Gender Relations and Cultural Agency in Military Hospitals, 1914-18', *Journal of War and Culture Studies*, 1:2 (2008), 139-158; Fiona Reid, *Medicine in First World War Europe: Soldiers, Medics, Pacifists* (New York: Bloomsbury Academic, 2017).

of confusion, pain and embarrassment. Massage therapists were frequently characterised as ‘torturers’ and soldier-patients their ‘victims’ whose painful limbs were being coerced into submission by brute force and an unfamiliar array of technology.²⁰⁹ One example includes a poem written by a patient at Summerdown Convalescent Camp in October 1915, called ‘Massage (The Other Side)’:

I’m one of those, “wot comes and goes;”
I’m just a bird of passage,
I may get right; I may not-quite,
But doomed I am to “Massage.”
Each day I groan to feel my own
Stiff fingers bent to breaking,
Is it a myth? Well, ask Miss S—
Chief Torturer (in the making).

And when the switch is turned on, which
Is surely raising blisters,
I watch, with eyes that sympathise,
Victims of other “sisters.”
Heroes, who’ll face, nor yield a pace
To bombs asphyxiating,
Who’ll bay’net Huns and capture guns,
Can’t stand Ionisating!

O Sergeants, who recruiting do,
Avoid this gruesome topic,
Or you will find the “slacker” kind
Show courage microscopic.
Talk then of war, not Massage Corps
-- and leave me to complain,
That Summerdown’s no Eiderdown
Nor does it counterpane!²¹⁰

The massage department was often depicted, as one patient wrote, as full of ‘apparent instruments of torture and weird contrivances’.²¹¹ Describing a visit to the APMC Portland Place Clinic, masseuse Lucy Robinson noted:

²⁰⁹ The Imperial War Museum’s digitalised ‘Trench Journals and Unit Magazines of the First World War’ collection contains a large amount of material offering insight into the soldier’s perception of massage and physical therapy.

²¹⁰ G.S.W. L.- Hand, ‘Massage (The Other Side).’ *Summerdown Camp Journal: Representative Organ of Summerdown Military Convalescent Hospital*, (October 16, 1915), IWM, 50.

A hundred men often attended daily and the scene is both sad and amusing; men, two or three at a time with limbs in the radiant heat 'ovens', others having active exercises stretching limbs, with the buzz of vibrators and batteries, an occasional shout from a patient who remonstrated at a strong current, and the masseuses all hard at work, made a scene which justified the remark of a big sergeant – 'If the Kaiser saw this he might say:- 'The English Army is being tortured to make it go to the front.'²¹²

These depictions suggest that massage and physical therapy was considered part of the war machine more broadly, where the ultimate goal of healing was to replenish the manpower supply. These themes were drawn upon in a series of cartoon postcards produced by A.G. Bliss in 1916.²¹³ One entitled 'The Big Push!', shows a soldier-patient unhappily receiving passive mobilisation by two APMC masseuses, linking the force often used in physical therapy to restore the body, to the restoration of Britain's fighting force (Figure 9).

²¹¹ 'An Officer Patient', 'Hospital Impressions: The Massage Department', *The Gazette of the 3rd London General Hospital, Wandsworth* (1 November 1916), 48, 50, IWM, 48.

²¹² *JISTM*, (July 1915), 10-11, in Barclay, *In Good Hands*, pp.61-62.

²¹³ For the series of six postcards, see, 'Postcard Cartoons of APMC Treatments, A.G. Bliss', (1916), WL, SA/CSP/Q.1/15-20.

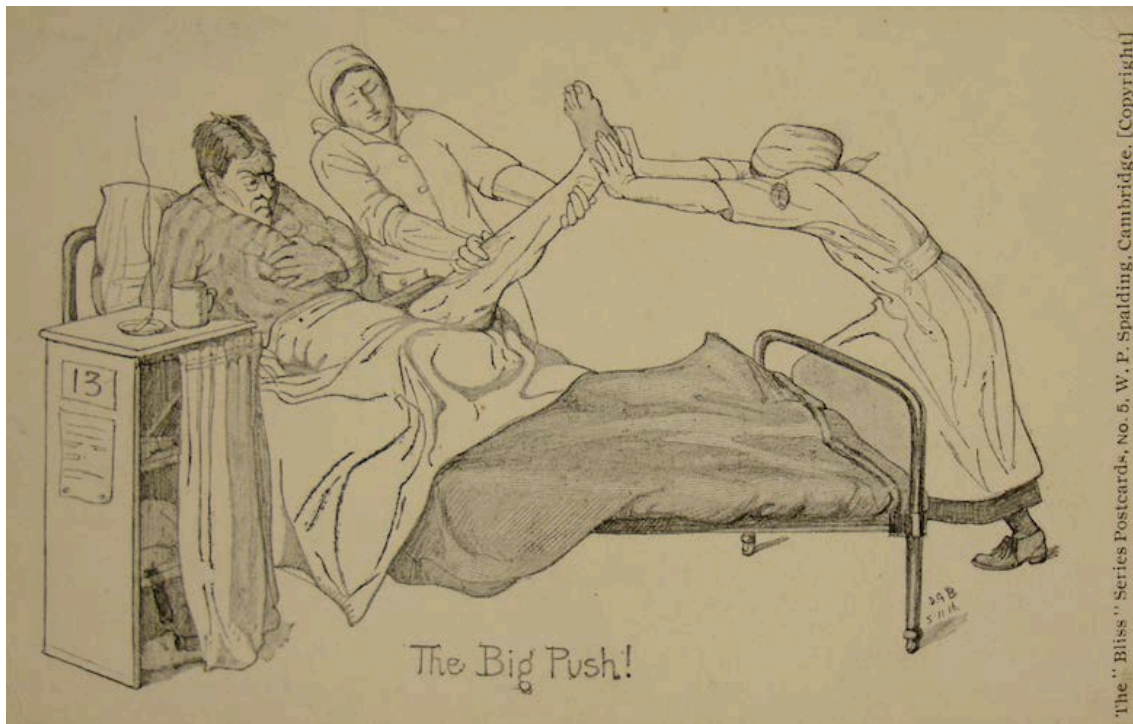


Figure 9 - 'The Big Push', (1916), WL, SA/CSP/Q.1/16a.

Physical therapy was not only used as a 'last resort' to fix impairments, however. As shown, with the development of military orthopaedics it became more established as a surgical auxiliary. Writing in 1917, Jones described 'massage may be successfully employed as a preliminary to, as a concomitant with, and as a sequel to active surgical treatment'.²¹⁴ Orthopaedic surgeons displayed a clear appreciation of the interdependence between surgery and after-treatment for successful rehabilitation. Describing this, orthopaedic surgeon Rowley Bristow, wrote that:

The work of the surgeon is to repair and refashion the structure; the work of the physico-therapy department is to re-establish the function. The interdependence of the surgical and after-treatment departments is nowhere more closely connected than in orthopaedics. The extreme importance and close relationship is not always fully recognised.²¹⁵

²¹⁴ Jones, 'Introduction to the First Edition', p.xii.

²¹⁵ Walter Rowley Bristow, 'Deformities of the Feet', *JISTM* (February, 1918), 181-186, (p.181).

Within orthopaedics, rather than being used to correct residual dysfunction, physical therapy was viewed as part of a holistic approach to rehabilitation that circumvented residual impairments altogether.

An example of this interdependence was the wartime treatment of nerve injuries. As a result of compound fractures, bullet and shrapnel wounds, there was a high volume of peripheral nerve injuries during the First World War.²¹⁶ While not traditionally considered within the remit of orthopaedics, the importance of pre- and post-operative treatment for these cases, brought nerve injuries into the scope of military orthopaedics.²¹⁷ Untreated, peripheral nerve injuries and paralysis resulted in muscle atrophy and contractures that could permanently inhibit nerve restoration and cause permanent paralysis and disability. Surgeon of the Norfolk War Hospital C. Noon complained that '[o]ne often sees hopelessly contracted limbs with paralytic deformities, and with muscles the seat of degenerated changes, sent to the massage and electrical department as a last resource'.²¹⁸ In contrast, he continued '[t]hese cases should have been sent to this department for the prevention of these calamities, not for their relief'.²¹⁹

In these cases massage and physical therapy was considered crucial preventive and restorative methods. Writing in 1918, Noon argued that:

the operative treatment in these cases should be looked upon merely as an incident in the treatment of the case. The most skilfully performed operation on an injured nerve is doomed to failure, and can accomplish little if the pre-operative and post-operative treatment is insufficient or neglected.²²⁰

²¹⁶ Major H.S. Souttar, 'Some Points Arising in Nerve Injuries', *JISTM* (March 1918), 204-211, (p.204).

²¹⁷ Jones, 'Military Orthopaedic Surgery', 116.

²¹⁸ C. Noon, 'Gunshot Wounds of the Peripheral Nerves', *The Lancet* (27 July 1918), 100-101, (p.100).

²¹⁹ Noon, 'Gunshot Wounds of the Peripheral Nerves', 100.

²²⁰ Noon, 'Gunshot Wounds of the Peripheral Nerves', 100.

Massage and physical therapy were used to prevent joint stiffness, muscular atrophy and contractions and to keep the paralysed limbs in a healthy condition for the restoration of nerve and function.²²¹ Without the masseuse, H.S. Souttar wrote:

the muscles would waste beyond repair, the joints would stiffen and consolidate, the skin would become unhealthy and covered with sores, and the whole limb a useless encumbrance she has to perform outside all that the nerve would do from within.²²²

Massage treatment often extended over many months, and once the nerve had regenerated, the masseuse then worked to restore function, gradually re-educating and strengthening the patient's limb.²²³ While there were great advances in the treatment of nerve injuries during the war, the long-established principle of using massage to prevent the negative effects of paralysis and prolonged immobilisation remained central. As outlined in previous chapters, the massage profession was familiar with this type of work and drew from such experience, for example in the rest cure treatment for neurasthenic women and infantile paralysis, adapting it to new wartime conditions.²²⁴ The close relationship between physical therapy and orthopaedics was not limited to the treatment of peripheral nerve injuries; as surgeon Walter Rowley Bristow

²²¹ Noon, 'Gunshot Wounds of the Peripheral Nerves', 100.

²²² H.S. Souttar, 'War Injuries of the Nerves, from the Standpoint of the Masseuse', *JISTM* (May 1919), 257-266, (p.257).

²²³ For a description of the process of muscular 're-education' see, Mennell, 'Massage in Orthopaedic Surgery', pp.549-554.

²²⁴ Robert Jones noted that 'it is well, in view of the enormous number of injuries to nerves occurring in this war, to emphasise the fact that principles applicable in poliomyelitis are applicable here', in Robert Jones, *Notes on Military Orthopaedics* (London, Cassell and Company, Ltd., 1917), p.12.

commented, '[t]he interdependence is clear in this case and it is equally true for most orthopaedic work'.²²⁵

The development of massage and physical therapy as a surgical auxiliary was a mutually beneficial relationship. As orthopaedics harnessed physical therapy for its own professional advancement, it also opened up a space for the massage profession to develop. The tight hierarchy and division of labour that enabled the orthopaedic surgeon to control and direct treatment meant that there was far less ambiguity surrounding treatment and masseuses received more direction than in other institutions. Describing the contrast of 'massage work in orthopaedic hospitals' in October 1917, Barrie Lambert wrote:

What to me is the most outstanding feature is that the doctors in charge of the Departments, who are specialists in the work, are not only willing but anxious to teach and train those working under them. The history of the case and necessary treatment are explained fully to the masseuse, in many cases the X-ray photograph and report being shown to her. I have even known of the masseuse being allowed to be present at any operation on her patient.²²⁶

Positioned as an integral part of the medical approach to rehabilitation, the massage profession gained further integration within medicine and alignment with a powerful ideological commitment. This demonstrates how the massage profession adapted old methods and principles not only to a new medico-military context, but also burgeoning interests within medicine.

Combined Physical Treatment

The final part of this chapter looks at how the wartime medical emphasis on 'combined physical treatment' shaped the parameters of the massage

²²⁵ W. Rowley Bristow, 'Deformities of the Feet', 181.

²²⁶ Florence Barrie Lambert, 'Massage Work in Orthopaedic Hospitals', *JISTM* (November 1917), 112.

profession. As the first half of this chapter showed, there was an emphasis from within medicine towards the use of physical treatments alongside one another. The ultimate goal of combining physical treatment was to speed up convalescence and restore men to productivity as quickly as possible. Illustrating the military and political ideology underpinning this approach, Fortescue Fox wrote:

The aim and object of physical treatment is the preparation of the wounded and mutilated soldier for work in the large acceptance of that term. And for this governing purpose all physical agencies – massage, electricity, medical gymnastics, mechanical treatment, baths and douches – not one or two of these remedies in isolation, but all of them in a natural and harmonious association, can operate with powerful effect.²²⁷

As highlighted in previous chapters, the concept of combining physical treatments had been familiar to the massage profession for over twenty years; the terms ‘massage’, ‘massage department’ and ‘masseur’ had long encompassed a variety of treatments and expertise. During the war, however, the massage profession became increasingly defined by the ‘combined treatment’ approach and rehabilitation.

Although used widely, massage was rarely used alone. While in the late-nineteenth century, general massage dominated as a popular tonic to soothe nervous disorders, the wartime concentration on injuries meant that the majority of massage was applied locally with the aim of restoring function.²²⁸ Towards this goal, the use of massage alone declined and it was frequently used alongside remedial exercise, mechano-, electro-, and hydro-therapy. Much like the fitness of soldiers these physical treatments were categorised during the

²²⁷ Fortescue Fox, *Physical Remedies*, p.234.

²²⁸ Lucy Robinson, ‘General Massage’, *JISTM Special Conference Edition* (June 1918), 7-8, (p.7).

war. The Lingian 'passive', 'active', and 'resistive' terminology long used to categorise massage and gymnastic movements were applied to these methods representing their relationship to, and the physical condition of, the patient. As Carden-Coyne has argued, this therapeutic terminology was reinforced by socio-cultural, military and political expectations of masculinity and 'overcoming' disability.²²⁹ 'Passive' treatments such as massage were associated with the body in a passive and injured state, whereas 'active' treatments such as remedial exercise represented active and self-directed bodily movements. Within the context of rehabilitation, a 're-gendering process' underpinned physical therapy, which aimed to progress patients from passive to active treatments, signalling a restoration of physical integrity and masculinity.²³⁰

Despite the widespread use of massage, wartime discourses on rehabilitation had an impact upon its status and reputation as a treatment. The military and political emphasis on restoring manpower meant that 'active' treatments were considered more important than 'passive' ones. As Jones wrote in July 1918, '[t]he governing principle in regard to curative work is founded on the well-grounded belief that active movements are of infinitely greater value than passive movements'.²³¹ This was because, as masseuse Guthrie-Smith noted, 'all treatment should aim at restoration to the normal. The sooner he will start active movement, the sooner he will get better'.²³² The emphasis on active treatment complied with the greater vision of the rehabilitation project and reflected the desire to progress the patient as soon as possible.

²²⁹ Carden-Coyne, discusses the discourse of 'overcoming' disability generated by rehabilitation in, *Politics of Wounds*, p.113.

²³⁰ Carden-Coyne, 'Painful Bodies', 144.

²³¹ Jones, 'Military Orthopaedic Surgery', 115.

²³² Guthrie-Smith, 'Apparatus for Stiff Joints', 19.

It was in this context that a critique of massage therapy began to emerge. Speaking at an STM conference in October 1917, Guthrie-Smith observed:

As you are probably all aware, a great deal of criticism has been going on about massage. It is claimed by the critics that massage is becoming too passive, and that patients are inclined to become neurotic. There is just now a revulsion against massage, and it is said that "Massage is massage; movement is gymnastics. All massage is bad; gymnastics are good." You will all see a great danger in this.²³³

Medical men, in particular, started to complain that massage was being 'overdone' and slowing down the rehabilitation process. For Carl Westman, medical officer in charge of massage and electro-therapeutics at the Great Northern Central Hospital, '[w]e see far too much of the nice, comfortable and soothing of a limb, and far too little of the brisk and encouraging kind of treatment which compels the patient to try his utmost in executing a movement'.²³⁴ For Westman and other critics, 'too much active work on the part of the masseuse and too little on the part of the patient', slowed the re-education process.²³⁵

Medical critics also argued that injudicious massage made patients hysterical. Speaking to the STM in March 1919, Arthur Hurst of the R.A.M.C., warned that '[i]n your work you must remember that when you try to rub something *out* of a patient's limb you must not inadvertently rub it *into* his mind'.²³⁶

He does not think that he is being massaged for fun, he thinks there is a reason, and the reason, he believes, is because it is impossible

²³³ Guthrie-Smith, 'Apparatus for Stiff Joints', 19.

²³⁴ Carl Westman, 'Massage and Medical Reconstruction', *JISTM* (June 1919) 296-300, (p.299).

²³⁵ Westman, 'Massage and Medical Reconstruction', 299.

²³⁶ Arthur Hurst, 'Massage and the Mind', *JISTM* (June 1919) 289-295, (p.291).

for him to move his limb, so that if the treatment is continued too long it helps to keep up this idea in his mind.²³⁷

There was a fear that too much passive treatment was psychologically detrimental to recovery and reinforced disability psychosomatically. As Westman believed, 'I am convinced that in many cases positive harm is done, in that what was originally an organic disability is converted into a hysterical one by too much passive treatment, which to a receptive mind is suggestive of great disability'.²³⁸ As the decline of massage and the rise of 'active' treatment suggests, the practical dimensions of the massage profession were inherently shaped by military and political discourses of willpower and 'overcoming' disability generated by rehabilitation in the First World War.

Professionally, the way in which the massage therapist dealt with patients was considered important to their recovery. As physician Hurst, who made documentaries of shell shocked patients at the Royal Victoria Hospital, Netley and at Seale Hayne in Devon,²³⁹ complained:

I have visited well-run massage and electrical institutions, where I have seen large numbers of patients undergoing treatment, and among them I have seen many holding *The Daily Mail* in one hand, whilst massage or electricity was being applied to the other, just as if it did not belong to the patient at all.²⁴⁰

The massage profession was encouraged to engage the patient's attention and will them to be self-supporting. Scholarship has shown how the force with which medicine, charities and the state emphasised the importance of a patient's attitude to his recovery was part of broader political concerns to limit pensions

²³⁷ Hurst, 'Massage and the Mind', 291.

²³⁸ Westman, 'Massage and Medical Reconstruction', 299.

²³⁹ Edgar Jones, 'War Neuroses and Arthur Hurst: A Pioneering Medical Film about the Treatment of Psychiatric Battle Casualties', *Journal of the History of Medicine and Allied Sciences* (2011), 1-29, (p.1).

²⁴⁰ Hurst, 'Massage and the Mind', 289.

and dependence.²⁴¹ Massage and physical therapy was informed by this preoccupation; for example, at St Thomas's massage department during the war, Mennell proclaimed that the 'keynote' of treatment 'W.O.O.S.', meaning that each patient was to be taught how to "work out his own salvation", and the motto "THE LORD HELPS THOSE WHO HELP THEMSELVES", was hung on one of the pillars in the Department.²⁴²

Masseuses were increasingly called to consider the 'psychological element' of treatment.²⁴³ The sympathetic healing touch and 'rapport' considered so important in pre-war years gave way to a more disciplinarian demeanour.²⁴⁴ As Robert McKenzie wrote, 'conversation with the patient should be limited to the giving of directions, and the treatment must not degenerate into a social visit'.²⁴⁵ McKenzie advised the massage profession to be wary of 'false' pain, and that tactfully 'distracting' the patient could help distinguish the false from real, as well as get 'a fuller range of movement'.²⁴⁶ The masseuse was called to continually encourage patients to progress; as McKenzie wrote 'suggestion, encouragement, scolding, or even bullying, all have their uses'.²⁴⁷

Underpinning this professional shift was the broader atmosphere of discipline and distrust pervading wartime medicine. Pressure was placed upon medical staff to identify malingerers and to discriminate between 'shamming and actual illness'.²⁴⁸ Masseuse at the Shoreham Command Depot, Hazel Blandy wrote that 'the masseuse may meet with the conscious or unconscious attitude of unwillingness on the part of the patient to get well, for he knows that

²⁴¹ Carden-Coyne, *Politics of Wounds*, p.113.

²⁴² 'St. Thomas' Hospital, School of Physiotherapy, World War 1914-1918', LMA, HI/ST/PS/Y/04/002, p.4.

²⁴³ Jones, 'Introduction to the First Edition', p.xiii.

²⁴⁴ Robinson, 'General Massage', 7.

²⁴⁵ McKenzie, 'Massage, Passive Movement', p.92.

²⁴⁶ McKenzie, 'Massage, Passive Movement', p.94.

²⁴⁷ McKenzie, 'Massage, Passive Movement', p.94.

²⁴⁸ Carden-Coyne, *Politics of Wounds*, p.297.

every stage of improvement, every group dropped, is a step nearer “the other side.”²⁴⁹ The soldier, she wrote, needed to be ‘cheered, and encouraged to wish to become healthy, able members of society, whether as soldiers or civilians’.²⁵⁰ The masseuse and physical treatment played a particularly important role in distinguishing between ‘false’ and ‘real’ impairment, and were often used to identify and treat cases of ‘functional’ or ‘hysterical’ disability. The term ‘functional disability’ applied to impairments such as paralysis or contractions for which no organic cause could be found.²⁵¹ In the main, functional disability was thought to be a psychological problem and a symptom of shell shock. Physical treatment was applied to these patients not always as a therapeutic measure, but combined with, as McKenzie noted above, ‘distraction’, ‘suggestion’, and even force and coercion to prove that disability was false.

Part of the wartime use of massage, then, was as a treatment by ‘suggestion’. Discussing the treatment of ‘functional’ cases, medical officer in charge of massage and electro-therapy at the 4th London General Hospital, E. Bellis Clayton, wrote in February 1918 that ‘the masseuse must make the patient interested in his treatment and persuade him that he is going to be cured’.²⁵² ‘The success of the whole treatment’, he continued, depended upon ‘whether one can really make the patient believe that he is improving’.²⁵³ Writing of two treatments given in the massage department for functional cases, Mennell described that repeated forceful manipulation was used to ‘secure fatigue’ in a patient’s limb. Of the first method he wrote: ‘hysterical contraction

²⁴⁹ Blandy, ‘Shoreham’, 80.

²⁵⁰ Blandy, ‘Shoreham’, 80.

²⁵¹ Anderson, ‘Jumpy Stump’, 15.

²⁵² E. Bellis Clayton, ‘Massage Treatment for Shell Shock’, *JISTM* (February 1918), 187-190, (p.188).

²⁵³ Bellis Clayton, ‘Massage Treatment for Shell Shock’, 188.

can be overcome by the simple, if somewhat exhausting and painful, process of gradually undoing the contracture, by means of manual pressure, as often as it recurs'.²⁵⁴ The second method, he wrote, 'amounts to scientific bullying' and was often used in cases of hysterical paralysis:

The patient is taken into a separate room and is then told that he will go out cured. He is invited to give voluntary acquiescence in the treatment and is warned that it may be protracted. It is then proved to him – this is always quite simple – that some muscle or another is in contraction and therefore not paralysed. [...] Few patients are able to maintain true flaccidity under all circumstances throughout a whole limb or even a small portion of it.²⁵⁵

Hurst's documentaries of shell-shocked patients demonstrate how they were cured by 'vigorous persuasion and manipulation'.²⁵⁶ While the actual methods used are unclear in the documentaries,²⁵⁷ it is likely they involved elements of 'scientific bullying', 'suggestion' and manipulation to fatigue, like those described by Mennell. These accounts suggest that remedial massage, physical treatment and the massage profession, became part of, and were shaped by, a military and political agenda that eclipsed the humanity of the individual for the benefit of the nation.

There were a number of forces, then, crystallising the massage profession's role as a multi-skilled specialism. The medical emphasis upon rehabilitation by 'combined physical treatment' meant that it was no longer enough for the masseuse to be trained in massage alone. The broad turn away from massage and the increasing use of 'suggestion' in massage treatment only stimulated the profession further to branch out into other expertise. During the war it is possible to see that the massage profession became defined by

²⁵⁴ Mennell, 'Massage in Orthopaedic Surgery', p.521.

²⁵⁵ Mennell, 'Massage in Orthopaedic Surgery', p.521.

²⁵⁶ Reid, *Medicine in First World War Europe*, p.92.

²⁵⁷ Reid, *Medicine in First World War Europe*, p.92.

rehabilitation and combined physical methods. Demonstrating this link, Beth Linker's work shows that the auxiliary service trained for rehabilitation work in America during the war were called 'physiotherapy aides' from the outset; while assuming the same role in Britain they retained the pre-war professional title of 'masseur'.²⁵⁸

Exercise and Mechano-therapy

As scholarship shows, exercise, mechano-, hydro- and electro-therapy each developed as separate specialisms before 1914. As this thesis has indicated, each of these methods was used by the massage profession before the war in some capacity. This final section considers how the war affected the evolution of the masseur's skill-set. Exercise had long been viewed as inseparable from massage in the correction of deformities and the rehabilitation of injuries. As the war magnified this field of work massage was rarely used without remedial exercise. Mennell wrote that massage, '[r]arely, if ever, is it all-sufficient as a method of treatment, unless combined with movement – active, passive, or reflex'.²⁵⁹ Massage and passive movement were often given to patients while still in bed to hasten repair, loosen scars and prevent adhesions. As patients gradually recovered, more activity was entered into and as they improved progressed to more difficult exercises and eventually sports and games.²⁶⁰

Despite the emphasis on getting men fit as quickly as possible, physical therapy was a finely coordinated process. Medical doctrine emphasised a 'graduated' recovery. For Mennell at Shepherd's Bush, 'restoration of function

²⁵⁸ Linker, *War's Waste*, p.61. Suggests that the American physiotherapy profession was influenced by Robert Jones model of physical therapy, see p.62.

²⁵⁹ James Mennell, 'The Administration of Massage', in *Physical Remedies for Disabled Soldiers*, by Robert Fortescue Fox (London: Baillière, Tindall and Cox, 1917), pp.122-134, (p.122).

²⁶⁰ Mennell, 'The Administration of Massage', p.125.

[...] cannot be reached in one fell swoop', and progressing a patient too quickly could result in other impairments as a consequence. Remedial exercise was used to both re-educate and strengthen muscles after long periods of immobility in preparation for normal function. Wartime remedial exercise was strongly influenced by Lingian principles such as arranging class exercises in 'table' form. Exercise tables were a series of movements tailored by the gymnast to treat specific disabilities and ensure that muscle groups were strengthened in proportion.²⁶¹ At the Shoreham Command Depot, masseuse Hazel Blandy noted that approximately 350 patients were treated in the gymnasium per day.²⁶² Eighteen classes, each taking 20-25 minutes, were conducted each day, including 'breathing classes' for those gassed or with chest and neck wounds, and classes for 'patients with flat or trench feet'.²⁶³

The Command Depot was an institution that organised its regime according to the principle of graduated recovery. As previously noted, upon entry patients were grouped according to their fitness and the different groups were prescribed treatments corresponding to their ability. As patients improved and became fitter, remedial exercise progressed to become physical training. Describing this process, McKenzie wrote:

As massage progresses it is followed by passive manipulation, either by the hand of the operator or by machines designed to stretch shortened ligaments, break down slight adhesions, and restore the normal movement in joints [...] When a patient is able to perform these movements he must be thrown still more on his own resources by free gymnastics in which there is no guidance from the machine or operator, and cases are then sent to the gymnastic instructor, who begins with three tables of carefully compiled exercises [...] When they are able to do all these movements they are promoted to full

²⁶¹ For an extensive discussion of remedial exercise and exercise tables, see: George Murray Levick, 'The Ling System of Exercises', in *Orthopaedic Surgery of Injuries* Vol. 2, ed. by Robert Jones (London: Hodder & Stoughton, 1921), pp.561-578, (p.562).

²⁶² Blandy, 'Shoreham', 77.

²⁶³ Blandy, 'Shoreham', 77-78.

physical training, which introduces quick and active movements, running, jumping, and gymnastic games teaching alertness, control and agility [...] The patient who can do his full physical training and route march is ready for the final stage of hardening in which he does the full table of exercises required of trained soldiers, and a twelve or fifteen miles march in full kit.²⁶⁴

McKenzie also laid emphasis on the importance of open-air exercises and games as part of convalescence. 'Games that involve running, like soccer, ballee, basket-ball, rugby, and field hockey, will serve as most valuable and interesting accompaniments to this training for endurance, and serve to make the final test for active service in the field complete'.²⁶⁵ Julie Anderson has looked extensively at the place of sport as physical and mental therapy. Sport, like work, was important for rehabilitation for a number of reasons, not only did it provide a diversion from prolonged and monotonous hospitalisation, but also offered a way of demonstrating masculinity.²⁶⁶

The emphasis on exercise led to the development of an extensive array of 'mechano-therapeutic' equipment. As Fortescue Fox pointed out, while apparatus had been used in Britain before 1914, the war 'bringing in its train many thousands of wounded and stiffened limbs, became the great opportunity for instrumental treatment'.²⁶⁷ Much of the equipment developed during the war was modelled on Swedish Zander technology that became popular across Europe during the late-nineteenth century. Zander apparatus was commonly constructed on the 'pendulum principle' whereby, as described by Souttar at Netley, 'the patient does gentle work on a machine which includes either a pendulum or a flywheel, the inertia of which always tends to carry the

²⁶⁴ McKenzie, 'The Treatment of Convalescent Soldiers', 217-218.

²⁶⁵ McKenzie, 'Massage, Passive Movement', p.121.

²⁶⁶ Anderson, 'Soul of a Nation', p.56.

²⁶⁷ Fortescue Fox, *Physical Remedies*, p.70.

movement a little further'.²⁶⁸ Mechano-therapy was used to imitate the passive and active movements given manually by the masseuse, to break down stiffness and exercise muscles.²⁶⁹

While the War Office supplied military hospitals, Convalescent Camps and Depots with standard mechano-therapeutic apparatus, such as 'pulley weight machines',²⁷⁰ increasingly institutions engineered their own equipment. Often machines were designed by staff and built by patients, making them more economically accessible.²⁷¹ Head masseuse at Seaford Command Depot, Guthrie-Smith designed a number of apparatus, which she showcased at the first annual conference of the STM in October 1917.²⁷² One piece of equipment designed to mobilise the elbow joint was nicknamed the 'elbow "strafe"' by patients, after the German catchphrase 'Gott Strafe England' (God punish England) (Figure 10).²⁷³

²⁶⁸ Souttar, 'Some Points Arising in Nerve Injuries', 208.

²⁶⁹ Souttar, 'Some Points Arising in Nerve Injuries', 208.

²⁷⁰ Macpherson, *Medical Services General History*, p.176.

²⁷¹ McKenzie, 'The Treatment of Convalescent Soldiers', 217.

²⁷² Guthrie-Smith, 'Apparatus for Stiff Joints', 19-23.

²⁷³ Guthrie-Smith, 'Apparatus for Stiff Joints', 21-22.

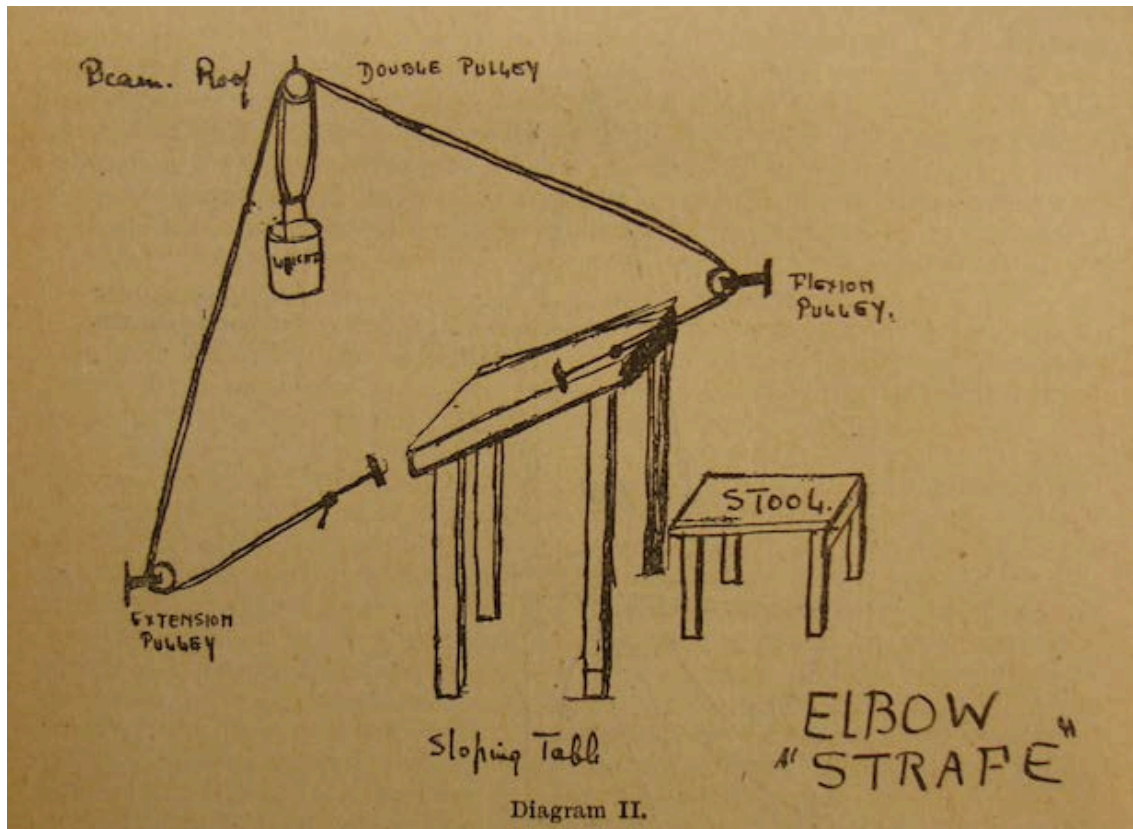


Figure 10 - Diagram of the 'Elbow "Strafe"', in Guthrie-Smith, 'Simple and Easily Made Apparatus', *JISTM* (June 1918), p.22.

For Guthrie-Smith, as for many other masseuses, mechano-therapy supplemented rather than replaced manual work. Apparatus was used for a number of reasons, of which the first was efficiency. Apparatus was used to replicate manual movements without reliance upon the availability, strength and endurance of a workforce; therefore exercises could be given to a higher volume of patients, more often, speeding up convalescence. This, according to Fortescue Fox, was particularly important during the war when '[t]he vast amount and urgency of the work to be accomplished made it necessary to utilize every available means in order to deal promptly with the wounded'.²⁷⁴ Mechano-therapy not only made convalescence more efficient but also the

²⁷⁴ Fortescue Fox, *Physical Remedies*, p.70.

masseuse as a worker. McKenzie wrote that '[b]y multiplying the apparatus, cases can be grouped in classes, thus economising both time and supervision'.²⁷⁵ In this way, he estimated that one masseuse 'should be able to supervise the work of a dozen patients, and so should be able to treat 100 to 150 a day'.²⁷⁶ The practice of supervising multiple treatments at one time was called 'dovetailing', as described by one masseuse: 'for example, two might be having heat, a third ionisation or interrupted current with a metronome, and a fourth massage'.²⁷⁷ By using a range of different apparatus and technology the masseuse was able to treat a higher volume of patients and 'work for a considerably longer period without fatigue'.²⁷⁸

Mechano-therapy was also used to make repetitive remedial exercises more interesting, therefore removing the patient's focus away from their condition and pain of treatment. For example, at Summerdown Convalescent Hospital, masseuses used many 'ingenious' devices, the 'chief object being to fix the patient's mind on some purposive exercise and so distract his attention from the damaged muscle group'.²⁷⁹ Comic representations of mechano-therapy as 'punishment' highlights, however, that it was often a painful and intimidating experience. In one cartoon entitled 'Getting them well', a soldier-patient is depicted as trapped using formidable looking Guthrie-Smith suspension apparatus, calling out 'Please Mam, I think I am fit for group I now!' (Figure 11). Mechano-therapy was not the only way that remedial exercise was made more interesting.²⁸⁰ Sport, games and work were all used as more

²⁷⁵ McKenzie, 'Massage, Passive Movement', p.106.

²⁷⁶ McKenzie, 'Massage, Passive Movement', p.106.

²⁷⁷ Smith, 'Summerdown', 262.

²⁷⁸ Guthrie-Smith, 'Apparatus for Stiff Joints', 19.

²⁷⁹ Smith, 'Summerdown', 264.

²⁸⁰ Jeffrey Reznick examines the therapeutic functions of the curative workshop at Shepherd's Bush, see *Healing the Nation*, (Manchester: Manchester University Press, 2004) pp.124-125; Jones, 'Military Orthopaedic Surgery', 115.

interesting forms of remedial exercise. It was also partly for this reason that orthopaedic centres developed 'curative workshops'. Aside from economic expediency and occupational retraining, the workshops were described as a 'priceless therapeutic boon', where soldiers were given work that aimed to mobilise stiff limbs and unconsciously aid rehabilitation.²⁸¹

²⁸¹ Jones, 'Military Orthopaedic Surgery', 115.



Figure 11 - 'Getting them well', (c.1917), WL, SA/CSP/P/4/1/13/8.

Hydro- and Electro-therapy

Like mechano-therapeutics, a wide range hydro- and electro-therapeutic technology was developed during the war. Hydro-therapy was defined by expert Fortescue Fox as 'the application of energy of *heat and cold and movement*, through the medium of water and vapour, as well as by direct radiation – both to

the whole body and to parts of the body'.²⁸² In the treatment of injuries hydrotherapy was used to promote the healing of wounds, improve circulation, reduce swelling, increase mobility, reduce pain and stimulate the nervous system.²⁸³ Types of cases included 'deformities, fractures, dislocations, wounds of joints, contusions, arthritis, myalgia, neuritis, nerve injuries, trench foot and neurasthenia'.²⁸⁴ Hydrotherapy could have a stimulating or sedative effect dependent upon the application, temperature and motion of the water. It could be given to a patient generally, such as with the sedative pool bath used to treat nervous shock and strain, or locally, such as with the 'schnee bath', which treated poor circulation in a specific extremity (Figures 12 and 13).



Figure 12 - The Sedative Pool Bath at the Bellahouston War Hospital, in Fortescue Fox, 'Hydrotherapy', p.595.

²⁸² Robert Fortescue Fox, 'Hydrotherapy', in *Orthopaedic Surgery of Injuries* Vol. 2, ed. by Robert Jones (London: Hodder & Stoughton, 1921), pp.581-597, (p.581).

²⁸³ Fortescue Fox, 'Hydrotherapy', p.581.

²⁸⁴ Fortescue Fox, 'Hydrotherapy', p.582.



Figure 13 – APMC member administering treatment and ‘Schnee Bath Treatment for Poor Circulation’, (1917), WL, SA/CSP/ Q.1/11.

British spas and other health-resorts were some of the first places that injured soldiers received hydrological and other physical treatments during the war and David Cantor has noted that British spas saw an influx of between 50,000-75,000 wounded and invalided soldiers.²⁸⁵ Fortescue Fox commented that the demographic of the spas transformed dramatically: ‘instead of a few scores of invalids of the wealthier classes’, he wrote, the spas were filled now with ‘many hundreds of disabled soldiers’.²⁸⁶ While the transformation of British spas into rehabilitation centres remains to be fully explored, it suggests that they, like the massage profession, represent pre-war hubs of physical therapeutic expertise.²⁸⁷ Hydrotherapy was not limited to the spas, however,

²⁸⁵ David Cantor, ‘The Contradictions of Specialization: Rheumatism and the Decline of the Spa in Inter-War Britain’, *Medical History*, 34 (January, 1990), 127-144, (p.130).

²⁸⁶ Fortescue Fox, *Physical Remedies*, p.237.

²⁸⁷ Fortescue Fox, *Physical Remedies*, p.178.

and equipment was installed in a variety of military hospitals, depots, camps and orthopaedic centres, as well as smaller institutions such as The Red Cross Clinic and Portland Place.²⁸⁸ As a model institution, the hydrotherapy department at Shepherd's Bush, opened in July 1917, was equipped with a range of modern technology including the whirlpool bath, hot and cold douches, contrast baths, radiant heat baths, aeration baths, massage douches, sitz and paraffin baths, showers, and pools.²⁸⁹

Like massage, hydrotherapy was considered a passive treatment and often used alongside other methods. As pain was an inhibitor to movement, it was frequently used for its anaesthetic properties, to relieve and loosen painful joints and scars. Reducing pain with heat baths meant that subsequent treatment by massage and mobilisation could be progressed quicker and further. For example, McKenzie used the whirlpool bath at Heaton Park to treat 'limbs with painful scars or frostbitten feet', as '[i]t makes an ideal preparation for the necessary massage and manipulation that would not be tolerated without it'.²⁹⁰ Describing experimentation with the whirlpool bath at the Red Cross Auxiliary Hospital for Officers in Brighton, medical officer in charge F.P. Nunnely wrote that:

The masseurs said that the tissues and joints were more easily manipulated, and the patients that the manipulations were less painful [...] Adhesions are frequently broken down, and function seems to be restored more rapidly.²⁹¹

Quite plainly, then, hydrotherapy was used as a tool to circumvent pain in order hasten recovery. Like mechano-therapy, hydrotherapy was also considered a

²⁸⁸ Fortescue Fox, 'Hydrotherapy', p.581.

²⁸⁹ Fortescue Fox, 'Hydrotherapy', p.582.

²⁹⁰ McKenzie, 'The Treatment of Convalescent Soldiers', 217.

²⁹¹ F.P.Nunnely, 'The Whirlpool Bath', *BMJ* (25 November 1916), 721-722, (p.721).

way to maximise the masseuse's working economy. According to Souttar writing in 1919, '20 minutes in the Whirlpool Bath, followed by 10 minutes massage, is better in its results than 30 minutes devoted to the older form of treatment'.²⁹² 'The economy in skilled work', he continued, 'can be seen at a glance, and as a matter of fact the capacity of our massage department has by this simple means been trebled'.²⁹³

Electrotherapeutics was another method widely developed for the treatment of injuries during the First World War.²⁹⁴ Injuries treated with electricity included nerve damage, paralysis, functional disability, hysteria, scars, trench foot and neuritis, and it was also used for diagnostic purposes to test nerve and muscle stimulus.²⁹⁵ A range of equipment was manufactured to give faradic and galvanic stimulation, diathermy, tungsten and ultra-violet rays, and was often designed as simply as possible so that masseuses and other technicians could apply it without medical supervision. For example, the electrical department at the Eastbourne Convalescent Camp comprised of: '14 wall switchboards, worked from 50 accumulators, each of two volts, and furnishing galvanic, faradic, and combined currents as required [...] local radiant heat, and Schnee four-cell baths, and vibrators worked from the main'.²⁹⁶ As, Barrie Lambert noted, it was 'difficult to supervise in detail', the 'great number of assistants' necessary to work the department, it was decided to 'keep the apparatus as simple as possible [...] the simpler the apparatus the better the result'.²⁹⁷

²⁹² Souttar, 'War Injuries of the Nerves', 264.

²⁹³ Souttar, 'War Injuries of the Nerves', 264.

²⁹⁴ Bristow, 'Electrical Department', p.491.

²⁹⁵ Bristow, 'Electrical Department', pp.492-493.

²⁹⁶ Barrie Lambert, 'Massage and Medical Electricity', 789.

²⁹⁷ Barrie Lambert, 'Massage and Medical Electricity', 789.

Although at the war's outset there were relatively few masseuses trained in electricity, very quickly it became clear that this would be an essential part of her work. At Convalescent Camps, Barrie Lambert described that 'we were faced with the problem that although a fair number of masseuses and remedial gymnasts were available, the supply of electricians was very limited'.²⁹⁸ To overcome this difficulty the Eastbourne camp split the staff of 25 masseuses into 'squads' of five, placing in charge of each squad a masseuse with expertise in electrotherapy, 'making her responsible for the work and tuition of those under her'.²⁹⁹ This plan was consequently adopted at other camps so by the time the Command Depots were opened there was 'a nucleus of experienced and practical electricians to draw upon'.³⁰⁰ By April 1915, the STM responded to the demand for electrical expertise by inaugurating a medical electricity examination, which was held several times per year.

Massage and electricity worked 'hand in hand' in the rehabilitation of disabled soldiers. For Mennell, '[t]he maintenance of circulation is the work of the Massage Department', and '[t]he maintenance of contractibility is the function of the Electrical Department'.³⁰¹ Electricity was another treatment considered as 'passive' and one of its uses was to contract muscles involuntarily to keep them healthy during periods of inactivity. Electricity was not only applied to paralysed muscles, but also because 'voluntary effort on the part of the patient [...] is not always forthcoming'.³⁰² Electricity, then, was used to

²⁹⁸ Barrie Lambert, 'Massage and Medical Electricity', 789.

²⁹⁹ Barrie Lambert, 'Massage and Medical Electricity', 789.

³⁰⁰ Barrie Lambert, 'Massage and Medical Electricity', 789.

³⁰¹ Mennell, 'Massage in Orthopaedic Surgery', p.510.

³⁰² Mennell, 'Massage in Orthopaedic Surgery', p.510.

exercise weak muscles 'independently of the goodwill of the patient',³⁰³ to hasten their restoration:

The number of voluntary contractions that an enfeebled muscle is capable of performing at any given time is often limited, and, for restoration to be rapid, it is essential that frequent repetition of contraction throughout the day should be ordered. If this is not carried out – and it is impossible to ensure that it is – electrical stimulation can at least enforce that a considerable number of contractions are performed.³⁰⁴

As this section has sought to demonstrate, while the use of physical treatments independently and together was not new, they were extensively developed and inherently intertwined in the context of rehabilitation during the First World War. The evolution of physical therapy was defined by the drive to restore injured soldiers as quickly as possible, and treatments were often used to push men beyond their physical and psychological limits. The combined physical treatment approach to rehabilitation was a platform for the massage profession to define itself by an approach and ideological commitment rather than any one specialty, an important factor given the unstable status of massage.

Conclusion

This chapter has shown how the massage profession contributed to and was shaped by the First World War. The first half explored some of the key locations in which massage was used. It argues that in the context of a military manpower crisis the state invested in the pre-war expertise of the massage profession to rehabilitate its injured soldiers. It highlights how the massage profession was instrumental in the deployment and development of wartime rehabilitation, as a service in and of itself and in the development of physical medicine and

³⁰³ Mennell, 'Massage in Orthopaedic Surgery', p.510.

³⁰⁴ Mennell, 'Massage in Orthopaedic Surgery', p.510.

orthopaedics with which it shared its territory. This chapter reminds us that the history of rehabilitation within medicine is not limited to orthopaedics and the work of Jones, but also includes a range of marginalised places, practices and people.

The second half of this chapter looked in more detail at the type of work that the massage profession carried out during the war. It was a moment when the profession adapted 'old rules and familiar principles',³⁰⁵ to unfamiliar bodies, wounds and the military culture of rehabilitation. The massage profession extended its practical scope to become authorities on combined physical therapy, an approach that was underpinned by an ideological commitment and political momentum. This considerably shaped the trajectory of the profession and the evolution of physiotherapy as a specialism. The final chapter of this thesis follows this theme, examining some of the ways in which the war impacted the profession.

³⁰⁵ 'Massage and the Wounded', *JISTM* (December 1915), 10.

Chapter 6

The First World War and the Professionalisation of Massage

The Incorporated Society of Massage and Medical Gymnastics is about to die; but Phoenix-like from its ashes [...] will rise the Chartered Society of Massage and Medical Gymnastics, which will aim at improving “the status and public usefulness of the profession of persons practising treatment by Massage, Medical Gymnastics, and Electricity.”¹

On 11th June 1920, the Society of Trained Masseuses (STM) was granted Chartered status, indicating its position as Britain’s leading organisation for training in physical therapy. The Royal Charter marked the considerable progress of the STM during the war, and how the massage profession had become firmly integrated into medical, social and political aspirations. By 1920 the Queen had become an official patron of the STM, the APMC was recognised by the War Office, Admiralty, and other public authorities, and leading medical men offered their support. It was the drive for rehabilitation during the First World War that enabled the massage profession to demonstrate the value of its expertise and experience in the treatment of injuries and disability. This opened up an opportunity for the profession to extend its activities, influence and gain independence. While an extension of its pre-war territory, the STM’s Chartered status also represented a transformation of practical and professional boundaries. The newly constituted Chartered Society represented male as well as female membership; included ‘manipulative, gymnastic, electro-therapeutic, and kindred forms of treatment’ as well as massage; and for the first time was under the chairmanship of a member of the medical profession. This transformation was a product of challenges and

¹ ‘Editorial’, *Journal of the Incorporated Society of Trained Masseuses* (henceforth *JISTM*) (May 1919), 254-256, (p.255).

negotiations that the massage profession faced to both its identity and territory throughout the war. The aim of this chapter is to examine how the First World War shaped the professionalisation of massage. It argues that, while by 1920 the massage profession had gained independence and represented a specialty embryonic of modern physiotherapy, embedded within its reconfigured professional boundaries were on-going disputes and debates about massage that can be traced back into the late-nineteenth century, renegotiated in a new set of circumstances.

To explore the professionalisation of massage during the war, this chapter focuses upon three different areas. Firstly it looks at how, amid unprecedented growth and public status, the massage profession continued to be challenged by debates about training and qualifications. Secondly, it examines how the war affected the relationship between the massage profession, men and the medical profession, exploring how gender, intimacy, and massage remained significant. Finally, it considers the changing status of the massage profession in relation to Swedish gymnastics and nursing, and how independence brought new challenges to its status. To investigate these debates and the profession's changing borders, this chapter uses material including the STM's committee minutes and journal, medical journals and texts, and public records. By examining the impact of the First World War on the professionalisation of massage this chapter aims to contribute more widely to the medical history of the First World War and its impact upon the development of auxiliary services.

War Work, Training and Qualifications

During the war years, the massage profession grew dramatically in terms of numbers entering the occupation and in terms of public status. As Chapter 5 indicated, the popularity of massage and physical treatment reached a zenith as a result of its use in rehabilitating hundreds of thousands of injured and disabled servicemen. The massage profession offered thousands of women with an opportunity to contribute to the war effort and to establish a career. Membership of the STM increased from 1000 in 1914 to 3641 by the end of 1918;² while many masseuses gave their services on a voluntary basis (out of the first 100 APMC recruits, approximately 60 were voluntary),³ increasingly women took up the work as paid employment. The profile and reputation of the profession was also elevated as it gained public recognition for its war work, including Queen Mary becoming an official patron of the STM in 1916,⁴ and representation on state bodies such as the War Office, Admiralty,⁵ and later the Ministry of Pensions.⁶

While the majority of those entering the profession did so through the STM's examination, there was an influx of personnel with a variety of trainings and certificates. Apart from trained nurses and medical orderlies, VADs and Red Cross staff were amongst the voluntary workers that undertook massage during the war. As Christine Hallett has shown, thousands of women

² Jean Barclay, *In Good Hands: The History of the Chartered Society of Physiotherapy 1894-1994* (Oxford: Butterworth-Heinemann Ltd, 1994), p.50.

³ Jane H. Wicksteed, *The Growth of a Profession: Being the History of the Chartered Society of Physiotherapy, 1894-1945* (London: Edward Arnold & Co., 1948), p.89.

⁴ Barclay, *In Good Hands*, p.50.

⁵ For information showing the development of massage in the Navy, see: 'Electro-Therapeutic and Massage Methods. Proposals to Obtain a Higher Standard of Treatment in HM Navy', (1917), The National Archives (henceforth TNA), ADM 1/8483/55.

⁶ A Pensions Massage Service attached to the Ministry of Pensions was established after the War, see Barclay, *In Good Hands*, p.83.

volunteered for the AMS as nurses and other auxiliaries during the war,⁷ and many of these women, 'desirous of being useful',⁸ chose to take up massage. Demonstrating the diversity of persons engaged in massage work during the war, is that English writer and editor of *Reveille*, a 'landmark' wartime journal devoted to disabled servicemen, John Galsworthy,⁹ did massage at an English hospital for French soldiers in Martouret.¹⁰ During an interview he said, 'I learned massage some years ago', and desirous to give war service, "brushed it up' before I went out', treating around ten cases per day.¹¹

It was common for volunteer massage staff to receive a shortened form of training. Florence Barrie Lambert noted in October 1915 that, at the beginning of the war 'all training schools were flooded by applicants wanting to train for three weeks or a month, who openly said that they did not want to take up massage seriously, they only wanted to know enough to treat the wounded'.¹² Writing in October 1915, James Mennell complained that '[t]here are people doing it in hospital after only 12 lessons'.¹³ Similarly the STM council continually struggled against 'short courses' in massage. For example, in November 1914, the STM supported one member who was 'threatened with trouble from the authorities' for her refusal to 'teach Red X nurses the massage treatment for recent fracture in one lesson'.¹⁴ The Council firmly 'deprecate[d]

⁷ Christine Hallett, *Containing Trauma: Nursing Work in the First World War* (Manchester: Manchester University Press, 2009), p.8.

⁸ 'Where Women Can Help', *Nursing Notes and Midwives' Chronicle* (henceforth *NNMC*) (March 1915), p.iii.

⁹ Jeffrey Reznick, *John Galsworthy and Disabled Soldiers of the Great War*, (Manchester: Manchester University Press, 2009), p.4.

¹⁰ 'Notes by the Way', *JISTM* (June 1917), 342.

¹¹ 'Notes by the Way', *JISTM* (June 1917), 342.

¹² Florence Barrie Lambert, 'Massage', *Summerdown Camp Journal: Representative Organ of Summerdown Military Convalescent Hospital* (2 October 1915), 31-32, *Trench Journals and Unit Magazines of the First World War*, Imperial War Museum (henceforth *IWM*), 32.

¹³ James Mennell, 'Massage in the After-treatment of the Wounded', *The Lancet* (2 October 1915), 755-757, (p.755).

¹⁴ 'Council Meeting', (13 November 1914), *Chartered Society of Physiotherapy: Council Minutes* (7 April 1913-12 March 1915), Wellcome Library (henceforth *WL*), SA/CSP/B.1/1/9.

this method of training',¹⁵ arguing it was 'inadequate preparation for work amongst the wounded'.¹⁶ As Barrie Lambert argued, 'surely our men after all they have gone through deserve the best and not the worst we can give them in the way of treatment'.¹⁷

'Untrained' massage workers, or more accurately those without an STM certificate, were widely employed and accepted during the war.¹⁸ While the War Office required all military institutions to engage staff through the APMC, to ensure a certain standard of training, this was only mandated from September 1915,¹⁹ before which they had been 'allowed to appoint their own workers, without restrictions to qualifications'.²⁰ The War Office's 1915 instruction, however, did not apply to other hospitals and smaller private homes, which meant that throughout the war voluntary hospitals, Red Cross Hospitals, and auxiliary hospitals were free to employ staff according to their own requirements and much work was undertaken by 'unqualified workers'.²¹ Limited financial resources meant that these institutions often could not 'afford to pay a staff of fully trained masseuses', and the demand for physical therapy overshadowed any preoccupation with specific qualifications.²² Writing to the *Lancet* in 1915, E. Bellis Clayton, head of the massage and electrical department at Kings College Hospital, complained that 'many members of the medical profession do not take the trouble, when engaging a masseuse, to make inquiries as to her

¹⁵ 'Council Meeting', (10 May 1918), Chartered Society of Physiotherapy: Council Minutes (16 March 1918-27 June 1919), WL, SA/CSP/B.1/1/13.

¹⁶ 'Examination Committee', (2 July 1915), Chartered Society of Physiotherapy: Council Minutes (26 March 1915-19 April 1916), WL, SA/CSP/B.1/1/10.

¹⁷ Barrie Lambert, 'Massage', IWM, 32.

¹⁸ Barrie Lambert uses the term 'untrained worker' in 'Massage', IWM 32. This chapter uses the term 'untrained worker' to denote training 'unrecognised' by the STM, which does not necessarily mean persons were 'untrained', but rather did not have the STM certificate.

¹⁹ W.G. Macpherson, *Medical Services General History* Vol.1 (London: HMSO, 1921), p.143.

²⁰ 'Advisory Board Sub-Committee', (10 December 1915), WL, SA/CSP/B.1/1/10.

²¹ 'Much of the work at Red X. hospitals was carried out by unqualified workers', 'Council Meeting', (26 October 1917), Chartered Society of Physiotherapy: Council Minutes (16 March 1917-16 March 1918), WL, SA/CSP/B.1/1/12.

²² E. Bellis Clayton, 'Massage and the War', *The Lancet* (18 December 1915), 1369, (p.1369).

training and diplomas'.²³ While economy and demand were two primary considerations, the widespread acceptability of lay massage workers also reflects the enduring opinion that massage therapy posed little risk and could be applied almost universally. As Chapter 5 suggested, it was considered that practically every patient group, medical and surgical, could derive some benefit from massage, and was often used because at the very least it could do no harm.

Amidst widespread acceptance and employment of 'untrained' massage therapists, came complaints from those who had interests in the field. Medical men with special interest in physical treatment regularly protested against lay workers and short training. For Bellis Clayton in December 1915, '[t]he greatest handicap to efficient treatment up to the present has been employment haphazard of all sorts and conditions of so-called masseuses'.²⁴ Similarly, Mennell complained that '[c]onstantly we are told of the inefficiency of massage and other forms of physical treatment; but no less often do we hear that medical men make no inquiries as to the qualifications of those to whom the work is entrusted'.²⁵ These medical men blamed the poor reputation of physical treatment on their peers who employed 'inefficient' practitioners. For them, handing over physical treatment to untrained workers undermined its scientific status and diminished its reputation as a potent medical remedy, which was the basis of their specialist claims.

²³ Bellis Clayton, 'Massage and the War', 1369.

²⁴ Bellis Clayton, 'Massage and the War', 1369.

²⁵ James Mennell, 'Treatment of Scoliosis by Remedial Exercises: The Skilled and the Quack "Rubber"', *The Lancet* (8 April 1922), 716, (p.716); the complaint at the employment of unqualified assistants continued into the interwar years, see James Mennell, 'The C.S.M.M.G. and Loyalty', *The Lancet* (5 December 1931), 1268-1269; James Mennell, 'Osteopathy', *The Lancet* (6 January 1934), 49-51.

These views formed part of on-going debates about the expertise necessary to practice massage that can be traced from the late-nineteenth century. For Bellis Clayton:

one hears of patients being treated by ladies who have had only a few lessons, or by those who actually say that they are natural masseuses and require none; and it seems that the general public is still unable to distinguish between a masseuse and a Turkish bath attendant.²⁶

Similarly, head of the massage and electricity department at the Great Northern Hospital, Carl Westman wrote, '[w]ho can fail to see the difference between the work of the painter-artist and the house-painter though both use the same instruments – paint and brush?'.²⁷ 'Equally great', he continued, was 'the distinction between the work of the skilful, intelligent masseuse and her imitator, though they both do their work solely with their hands'.²⁸ These types of analogies differentiating the 'empiric' from the 'skilled, 'intelligent' worker echoed the discourses of medical men who sought to raise the status of and distinguish massage as part of medical orthodoxy in the late-nineteenth century. As scholarship shows, disparaging the skills of untrained workers and marginalising them as 'empirical', 'quacks' and 'charlatans' was a common strategy of professionalisation and specialisation within medicine more widely.²⁹

The 'untrained worker' was also considered to be 'a very real danger' to the massage profession.³⁰ As highlighted in Chapter 2, the threat of the untrained worker was not new and the formation of the STM in 1895 had attempted to establish standard 'professional' training to bring order and

²⁶ Bellis Clayton, 'Massage and the War', 1369.

²⁷ Carl Westman, 'Massage and Medical Reconstruction', *JISTM* (June 1919), 286-300, (p.300).

²⁸ Westman, 'Massage and Medical Reconstruction', 300.

²⁹ For example, see W.F. Bynum and Roy Porter (eds.), *Medical Fringe and Medical Orthodoxy 1750-1850* (London: Croom Helm, 1987).

³⁰ Barrie Lambert, 'Massage', *IWM*, 32.

meaning to the multiplicity of trainings and certificates on the market. Like the aspirational medical specialists in physical medicine and orthopaedics, the legitimacy of the massage profession also depended upon the status of massage. A cornerstone of professionalisation was the claim that massage therapy was based on medical science and therefore required certain knowledge, gained through a standard education and training, to practice. For the STM, education and training clearly delineated the legitimate from the illegitimate, rational from the empirical, moral from the immoral, and their qualification gave them immunity from charges of empiricism and unethical practice that overshadowed massage work. The influx and general acceptance of untrained workers, therefore, threatened the profession on two fronts, as competition for work, and in undermining claims to professional status.

Throughout the war and often in the face of great pressure, the STM remained against any relaxation of examination standards.³¹ By lowering the standard of training, they argued, 'the profession is brought into abuse and disrepute'.³² The STM responded to demands made by the War Office by announcing in October 1915 that it would be increasing its annual number of examinations, but that all candidates must 'show proof of not less than six months' training in an accepted school'.³³ Although at the beginning of the war the authority and status of the STM was upheld by the Almeric Paget Massage Corps (APMC), as initially the STM certificate was mandatory for membership, this was undermined as they became unable to supply the military demand for practitioners. Despite holding five examinations in 1916 alone, with 'several hundred candidates at each examination', there was still a shortage of workers

³¹ Barclay, *In Good Hands*, p.62.

³² 'Where Women Can Help', *NNMC* (March 1915), iii.

³³ 'Examination Notices', *JISTM* (October 1915), 18-19.

for the APMC.³⁴ Two months after the War Office officially sanctioned the APMC as the sole source of military massage personnel in September 1915, it issued an order that the APMC would accept for work certificates granted by organisations other than the STM, even including private schools struck off the STM's roll of approved institutions for not conforming to training standards.³⁵

By giving public recognition to other forms of training, the War Office rendered ambiguous the boundaries of the massage profession once again, and challenged the position of the STM as its leading regulatory body. The Council complained that the 'acceptance of private certificates without standard training or examination was a menace to the future of the profession'.³⁶ Multiple portal entries into the profession, they argued, meant 'no guarantee as to training'; without such 'the standard of massage must be lowered and this must be detrimental to the interests of the wounded and the profession'.³⁷ The STM felt that the actions of War Office had rendered 'null and void the work of the Society for 22 years past', to establish massage as a profession.³⁸

Aggrieved, the STM petitioned Alfred Keogh and the War Office for 'recognition and representation for the Society and its members and the massage profession generally which was now by War Office arrangements for war purposes entirely in the hands of a private organisation'.³⁹ In response, the War Office formed a 'massage committee' in December 1915, to settle questions regarding status and pay and to regulate recruitment to, and

³⁴ 'Advisory Board Meeting', (10 January 1917), Advisory Board Minutes (December 1915-March 1918), WL, SA/CSP/B.1/2/2.

³⁵ 'Massage for the Wounded', [leaflet], Almeric Paget Massage Corps (December 1915-January 1916), WL, SA/CSP/F.1.

³⁶ 'Special Council Meeting', (10 November 1915), WL, SA/CSP/B.1/1/10.

³⁷ 'Massage for the Wounded', WL, SA/CSP/F.1.

³⁸ 'Council Meeting', (14 January 1916), WL, SA/CSP/B.1/1/10.

³⁹ 'Council Meeting', (12 November 1915), WL, SA/CSP/B.1/1/10.

deployment of the APMC.⁴⁰ The Committee consisted of three medical practitioners, Eleonora Essex French, the matron of University College Hospital, Miss Finch, and STM council member, Lucy Robinson, but only in her capacity 'as an expert on massage and in no way represented the Society'.⁴¹ The STM felt that Keogh had ignored their petition and that the newly established Committee was not representative of the profession and disregarded the Society.⁴² With little power to negotiate, they were, however, forced to accept the situation and look for other ways to support their position.

The War Office controversy highlights a number of points. Firstly, bringing the massage profession under state control in order to supply its requirements indicates the military and political significance of massage personnel and physical therapy during the war. It also demonstrates the importance of state policy to the professionalisation of massage in this period, highlighting that the profession's shifting boundaries were not simply a result of the agency and initiative of the STM. The rest of this chapter shows how more external challenges and negotiations stimulated the massage profession to change and reform.

One of the first ways that the STM responded to the challenge of untrained workers and rival certificating bodies was to form a Medical Advisory Board. While the suggestion to form such a body had arisen throughout the year, by the end of 1915 it was considered imperative for the STM's survival. In a Council meeting on 10th March 1916, council member and head masseuse at

⁴⁰ 'Exam Committee', (7 January 1916), WL, SA/CSP/B.1/1/10.

⁴¹ 'Council Meeting', (14 January 1916), WL, SA/CSP/B.1/1/10.

⁴² 'Council Meeting', (14 January 1916), WL, SA/CSP/B.1/1/10.

St. Thomas's Hospital, Minnie Randell, called 'for the attention of the meeting on an urgent matter which must be treated with confidence':⁴³

She had been informed that in order to maintain the position now held by the Society it was imperative that members of the medical profession be closely in touch with the government and general working of the Society, and that steps to secure their *active* co-operation in the objects of the Society should be taken without delay.⁴⁴

'Without this active support from the medical profession', she argued, difficulties might arise in attaining further development for the Society'.⁴⁵ While we cannot be certain of Randell's source of advice, it is likely to have come from Mennell with whom she worked closely at St. Thomas's Hospital. Mennell was at the forefront of the Medical Advisory Board's organisation, advising the STM to seek the support of 'well-known members of the profession', such as Sir Seymour Sharkey, Sir Frederick Treves, and Sir William Osler.⁴⁶

While the STM had always relied upon medical patronage and approval to legitimise its professional aspirations, they increasingly looked to strengthen their relationship with the medical profession. As STM council chairman Sarah Grafton said at a meeting,⁴⁷ '[t]he very fact that an Advisory Board had been called into existence shewed [sic] that the Council had not been slow to recognise the advantage of outside help in dealing with the difficulties the Society had to face both in its relations to other Bodies'.⁴⁸ The Society felt it had little authority or leverage when dealing with powerful public bodies and needed

⁴³ 'Council Meeting', (10 March 1916), WL, SA/CSP/B.1/1/10.

⁴⁴ 'Council Meeting', (10 March 1916), WL, SA/CSP/B.1/1/10. (Authors emphasis).

⁴⁵ 'Council Meeting', (10 March 1916), WL, SA/CSP/B.1/1/10.

⁴⁶ 'Examination Committee', (5 November 1915), WL, SA/CSP/B.1/1/10.

⁴⁷ STM chairwomen included Rosalind Paget (1895-1905); Florence Dove (1905-1910); Lucy Robinson (1911-16); Sarah Grafton (1916-1918).

⁴⁸ 'The Incorporated Society of Trained Masseuses and the Institute of Massage and Remedial Gymnastics: Notes of the Conference and Proposals', (20 March 1917), pp.1-4, Advisory Board: Minutes and Correspondence Re. Amalgamation with IMRG (May 1916-June 1917), WL, SA/CSP/B.1/2/3, p.2.

representation from the medical profession. In order to strengthen its position, the STM considered whether the role of the Medical Advisory Committee should be 'to advise only' and final governance left with the STM council, or if the Committee 'was to stand more or less as a governing body for the Society'.⁴⁹ While the Medical Advisory Committee decided that 'the Council was the governing body of the Society' and that its role was to '*advise*, not dictate',⁵⁰ the willingness of the council to relinquish governance to the medical profession suggests the powerlessness it experienced during the war.

Alongside its partnership with medicine, the STM sought professional uplift in a number of other ways. For example, in August 1916 Barrie Lambert of the Medical Advisory Committee suggested that the STM approach the British College of Nursing or the Physical Training Colleges with a view to merging forces.⁵¹ By December 1916, the STM had joined with the Dartford Union, members of the Physical Training Colleges and the Ling Association to approach the Board of Education for state recognition.⁵² Again, while negotiations with the remedial gymnasts had collapsed by July 1917, and 'the Physical Training Colleges intended to proceed alone with their scheme for obtaining state recognition',⁵³ the Society's negotiations with other bodies shows how they creatively seized opportunities at different moments to assert the massage profession. It is also suggestive of the multiple directions that professionalisation may have followed at any one moment.

⁴⁹ 'Council Meeting', (14 April 1916), WL, SA/CSP/B.1/1/10.

⁵⁰ 'Council Meeting', (5 May 1916), Chartered Society of Physiotherapy: Council Minutes (28 April 1916-9 March 1917), WL, SA/CSP/B.1/1/11.

⁵¹ 'Meeting of Professional and Business Committees', (2 August 1916), WL, SA/CSP/B.1/2/2.

⁵² 'Rough Copy of Dr. Barrie Lambert's Reports', [loose notes, n.d.] pp.1-4, WL, SA/CSP/B.1/2/2, p.1. For the suggested scheme see 'Special Council', (25 May 1917), WL, SA/CSP/B.1/1/12.

⁵³ 'Council Meeting', (13 July 1917), WL, SA/CSP/B.1/1/12.

Another opportunity, which proved successful, was to apply for Royal Charter. The Charter was sought to elevate the STM above rival organisations and 'prevent any other massage society achieving such ascendancy'.⁵⁴ Although when first suggested by the Society's solicitor Mr Hegg in 1911, they did 'not think they would experience much difficulty in the matter',⁵⁵ the transformed profile of the massage profession and the weakened position of the STM as a result of the war made this a far more complicated process.

Manchester Institute, Men and Medicine

It was in this weakened position that the STM faced the emergence of a rival organisation, the Manchester Institute of Massage and Remedial Gymnastics (MIRG). The MIRG had been formed in early 1916, to examine, certify and represent 'persons engaged in medical gymnastics, massage, electro-therapeutics, and kindred subjects'.⁵⁶ While a newly established and small organisation, the MIRG threatened the STM because it represented a number of key interests that had emerged within the profession during the war that the STM did not. It was a society governed by medical men rather than women highlighting the development of medical interest in the field; it represented men and provincial members indicative of the expansion of the massage profession, and it also represented the profession's diverse skill-set. The MIRG quickly received Incorporated status in July 1916,⁵⁷ and was welcomed by the *Lancet* as 'founded upon lines with which the medical

⁵⁴ 'Council Meeting', (22 September 1911), Chartered Society of Physiotherapy: Council Minutes (15 January 1909-14 February 1913), WL, SA/CSP/B.1/1/8.

⁵⁵ 'Council Meeting', (22 September 1911), WL, SA/CSP/B.1/1/8.

⁵⁶ 'Institute of Massage and Remedial Gymnastics', *BMJ* (1 February 1919), 141, (p.141).

⁵⁷ 'Council Meeting', (28 July 1916), WL, SA/CSP/B.1/1/11.

profession can cordially agree'.⁵⁸ The STM's initial response was to strengthen its own position in Manchester, starting with the organisation of a massage examination in October 1916 and establishing a centre for members.⁵⁹ They also petitioned the Board of Trade against the MIRG receiving Incorporated status,⁶⁰ arguing 'against the multiplying of examining bodies in massage',⁶¹ and the 'privilege of incorporation [...] to an untried body, with no definite standard'.⁶² Both efforts, however, proved unsuccessful, but after negotiations with the Physical Training Colleges collapsed in July 1917, the STM sought consolidation and 'one portal entry'⁶³ into the profession through amalgamation and Charter application with the MIRG in the autumn.⁶⁴

The emergence of the Manchester Institute highlighted the significant changes to the profession brought about by the war, and that it had outgrown the STM's constitution. Presenting the case for reconstitution and amalgamation to members at the STM's Annual Meeting in March 1918, chair and M.P., Sir Charles Nicholson said that: 'the Incorporated Society has, over twenty-two years of work, outgrown its original constitution [...] and it has become absolutely necessary to enlarge the scope of the Society which can be best effected by re-incorporation under a Royal Charter'.⁶⁵ Amalgamation with the MIRG required reconstitution of the Society to reflect the profession's changing borders. The remainder of this section considers how the changing status of men and the medical profession shaped the massage profession.

⁵⁸ 'The Practice of Massage', *The Lancet* (27 January 1917), 158.

⁵⁹ Barclay, *In Good Hands*, p.52.

⁶⁰ 'Council Meeting', (3 April 1916), WL, SA/CSP/B.1/1/10.

⁶¹ 'Annual Meeting', (24 March 1917), WL, SA/CSP/B.1/1/12.

⁶² 'Council Meeting', (26 May 1916), WL, SA/CSP/B.1/1/11.

⁶³ 'Annual Report, 1917-1918', (March 1918), WL, SA/CSP/B.1/1/13.

⁶⁴ 'Council Meeting', (7 September 1917), WL, SA/CSP/B.1/1/12. The minutes and journal of the STM contain a full account of negotiations with the Manchester Institute regarding amalgamation and reconstitution.

⁶⁵ 'Annual Report, 1917-1918', WL, SA/CSP/B.1/1/13.

The war transformed the relationship between the massage profession and men, both as patients and as workers. Before the First World War, very few masseuses had any experience of massaging men as practice had been largely sex segregated in both private and hospital practice. As Chapter 2 showed, sex segregation was central to the STM's professionalisation project and a measure to decouple the link between massage therapy and associations with sexuality and prostitution. While it allowed women to practice massage with impunity, it also meant that the Victorian massage profession was familiar with female bodies in environments that contrasted sharply with the masculine culture of the military hospital. Allowing women to massage men was, therefore, a radical departure from normal practice. While as Chapter 5 shows, the massage profession was very quickly 'accepted without question almost as part of the hospital equipment',⁶⁶ connections between massage, sexuality and intimacy were not eliminated by the military context.

Women giving massage therapy to injured men was an encounter that created a new set of social-gender relations. Masseuses frequently gave sensitive, intimate and painful treatments to men who often felt emasculated as a result of their injuries. As Ana Carden-Coyne and Fiona Reid have shown, this experience generated a significant amount of commentary, much of which featured the sexualisation of the masseuse and massage work. Their studies have shown that sexual humour, innuendo and fantasy were ways that patients regained agency and dealt with the embarrassment of physical exposure, the vulnerability of pain, and the crossing of gender boundaries where the male body was considered passive and the female therapist in a position of power.⁶⁷

⁶⁶ Barrie Lambert, 'Massage', IWM, 31.

⁶⁷ Ana Carden-Coyne, *The Politics of Wounds: Military Patients and Medical Power in the First World War* (Oxford: Oxford University Press, 2014), Ana Carden-Coyne, 'Painful Bodies and

Explicit poems satirised manipulations as arousing or even sado-masochistic. One example includes, 'A painful parody', published in the *Summerdown Camp Journal* in February 1918:

Pale Hands which rubbed/ Inside the Massage Hut
Where are you now? Who squirms beneath your touch
Do you recall my face with rapture fled
Those limping days before I shed my crutch
Pale hands I loved/ Beneath the massage roof
Whom do you punch and pummel 'stead of me?
I have had dreams of thumbscrews and the rack
Since that first day you kneaded on my knee
And yet pale ministering hands-on looking back
How much I needed thee!⁶⁸

Rewriting a painful and humiliating experience into a sexual fantasy was one way that intimacy, gender and pain were re-negotiated, and masculine agency asserted.

While historians have investigated this encounter to give insight into the experience of the injured soldier, the impact this had on the massage profession has not been explored. While the war gave authority to the massage profession, to move from an exclusively female sphere to a new, politically charged masculine therapeutic arena wherein they were viewed as experts in rehabilitation, masseuses were also subjects of derision and disempowerment. The sexualisation of masseuses undermined their status as professional women and the seriousness of massage as a treatment. As Beth Linker suggests, efforts to diffuse the sexualised associations of massage work and neutralise intimate encounters fed into the masseuses' professional identity and practice. One way that masseuses asserted their professional reputation was by

Brutal Women: Remedial Massage, Gender Relations and Cultural Agency in Military Hospitals, 1914-18', *Journal of War and Culture Studies*, 1:2 (2008), 139-158; Fiona Reid, *Medicine in First World War Europe: Soldiers, Medics, Pacifists* (New York: Bloomsbury Academic, 2017).
⁶⁸ 'A Painful Parody', *Summerdown Camp Journal* (13 February 1918), 2., in Carden-Coyne, *Politics of Wounds*, p.290.

inflicting pain rather than pleasure. As Chapter 5 indicated, evidence suggests that enduring pain was an inherent part of remedial massage and physical therapy; feeding into this was the professionalisation of massage.

During the war there was strong opinion amongst the massage profession that, as Mennell put it, 'massage become painless ceases to be massage and is merely treatment by suggestion'.⁶⁹ Giving a patient 'all he can stand',⁷⁰ as opposed to painless massage, protected the masseuse's professional reputation from both charges of impropriety or incompetency. This is demonstrated in another of A.G. Bliss's wartime postcards, whereby a belittled masseuse characterised as 'a little bit of fluff?' on Monday, is transformed into a fearsome authority figure on Tuesday, when it is time to get treatment. In this context, the tables have turned; the soldier presented as small and belittled cries 'kamarad!', the word used by German soldiers giving themselves up for capture and pleading for mercy (Figure 14).

It is not fair, however, to portray masseuses as sadists, using their empowered position as an opportunity to cause pain to patients. Pain, rather, was built into fabric of physical therapy; fed by views about efficacious massage and the aims of the greater rehabilitation project. As previous chapters have shown, the belief that 'Swedish' methods of massage were more effectual and scientific than their 'English' equivalents were longstanding, and this view was magnified during the war. As the *JISTM* noted in 1915, '[t]he Swedes argue that the chief point is to cure the patient as quickly as possible, and, in so doing, the patient may rightly be called upon to bear a little pain'.⁷¹ Another STM examiner wrote that '[a]t examination times I have been struck by the rough work of

⁶⁹ Mennell, 'Massage in the After-treatment of the Wounded', 757.

⁷⁰ Mennell, 'Massage in the After-treatment of the Wounded', 757.

⁷¹ 'A.M.R.' 'Swedish and English Massage', *JISTM* (December 1916), 163-165, (p.164).

candidates who are attempting so-called Swedish movements'.⁷² Emulating perceived 'Swedish-style' massage was a way that masseuses asserted their professional status demonstrating how many debates and perceptions shaped the practice of remedial massage.



Figure 14 - 'A Little Bit of Fluff', (1916), WL, SA/CSP/Q.1/15.

Another way that masseuses neutralised the intimacy of the massage encounter was by distancing themselves from massage practice. Increasingly, masseuses had opportunity to identify themselves as multi-skilled practitioners with expertise in an array of physical treatments and modern technologies. As Chapter 5 noted, the war saw a 'revulsion against massage',⁷³ and Lucy Robinson noted in June 1918 that young members of the profession had started

⁷² 'A.M.R.' 'Swedish and English Massage', 164.

⁷³ Olive Guthrie-Smith, 'Simple and Easily Made Apparatus for Stiff Joints and other Injuries', *JISTM* (June 1918) (Special Conference Number), 19-23, (p.19).

to 'despise it as less scientific and less important', than other treatments.⁷⁴ Assuming a mantle of scientific and technical ability enabled the masseuse to distance herself from the intimacy of massage and its sexualised associations. As this demonstrates, although by 1920 mixed-sex massage was routine practice, debates about gender and sexuality had not been resolved but rather renegotiated in a different context

The status of men as masseurs was another issue that continued to challenge the STM's professional conventions. While men practised massage before the war, for example Swedish gymnasts, medical orderlies, male nurses and others worked privately and in hospitals, due to the fact the massage profession grew out of a nursing movement there was relatively few masseurs (Figure 15). The principle of sex segregation not only governed the practice of massage, but also the STM's principles regarding training, examination and membership. It was considered inappropriate for women – unless medically trained – to teach or examine male candidates anything involving physical contact, or vice versa. As the STM's minutes show, however, this rule proved difficult to implement in practice, and there are many examples of the Council making exceptions while continuing to hold steadfast to their Victorian conventions.

⁷⁴ Lucy Robinson, 'General Massage', *JISTM* (June 1918) (Special Conference Number), 7-8, (pp.7-8).



Figure 15 - RAMC Masseurs Class Royal Victoria Hospital Netley, (April 1912). The Army nurse is H. Wolsey who was the tutor. Courtesy of The Museum of Military Medicine.

The STM had examined men from 1905. As Chapter 3 pointed out, following a request from Keogh in that year the STM altered its articles of Association, which had provided only for the examination and enrolment of masseuses, in order to examine RAMC nursing orderlies.⁷⁵ By 1914 'male nurses from mental hospitals',⁷⁶ and Naval sick berth attendants,⁷⁷ were also eligible for the STM's certificate, and from 1911, civilian male candidates were required to have a medical or nursing certificate to enter the examination.⁷⁸ As women were not allowed to examine men in practical work, however, Council

⁷⁵ 'Extraordinary General Meeting', (15 May 1905), Chartered Society of Physiotherapy: Council Minutes (13 January 1905-14 December 1906), WL, SA/CSP/B.1/1/6.

⁷⁶ 'Council Meeting', (8 October 1909), WL, SA/CSP/B.1/1/8.

⁷⁷ 'Council Meeting', (10 November 1911), WL, SA/CSP/B.1/1/8.

⁷⁸ 'Executive Committee', (9 June 1911), WL, SA/CSP/B.1/1/8.

member Margaret Palmer's son who was a masseur Jackson Palmer; available Swedish gymnasts and medical men who were trained in massage had to be engaged to conduct that part of the examination.⁷⁹ These sex-segregated restrictions to training did not apply within the armed forces; here the STM was forced to acquiesce in the established custom of training being given under the direction of the Nursing Sisters.⁸⁰

The STM examination and membership also proved challenging. From 1909 successful male candidates were eligible for the Society's register and were subject, like female members, to its byelaws; required to work under medical direction and prohibited to give massage to the opposite sex.⁸¹ While they were certificate holders, however, they could not become members of the Society and therefore did not receive representation or other benefits. The reason for this was that membership of the STM carried with it membership of the Trained Nurses' Club, and the admission of men to a Nurses' social club would have created a major scandal.⁸²

During and immediately after the war there was an influx of men who sought to train in massage. As the majority of men were conscripted to fight in the armed forces, the majority of men entering the profession did so upon their return as ex-servicemen; one particularly notable group of masseurs were those blinded in battle (Figure 16). Training the blind in massage was not new; records of the British and Foreign Blind Association refer to blind masseurs as early as 1891, and from 1900 Dr J. Fletcher Little of the London School of Massage began to accept blind students for training and later that year

⁷⁹ 'Council Meeting', (14 September 1917), WL, SA/CSP/B.1/1/12; 'Council Meeting', (4 October 1918), WL, SA/CSP/B.1/1/13.

⁸⁰ Wicksteed, *The Growth of a Profession*, p.96.

⁸¹ 'Executive Committee', (14 May 1909), WL, SA/CSP/B.1/1/8.

⁸² Wicksteed, *The Growth of a Profession*, p.61.

launched the London Institute of Massage by the Blind.⁸³ During the war, however, blind masseurs became a significant group due to the efforts of Arthur Pearson who headed the National Institute of the Blind (NIB) and established St Dunstan's in Regents Park, a rehabilitation centre for war-blinded soldiers. At St Dunstan's, men were given re-education and training for civilian life and given an option to learn trades such as cobbling, mat- and basket- making, joinery and farming, as well as other occupations such as shorthand, type-writing, telephone operating, and massage.⁸⁴

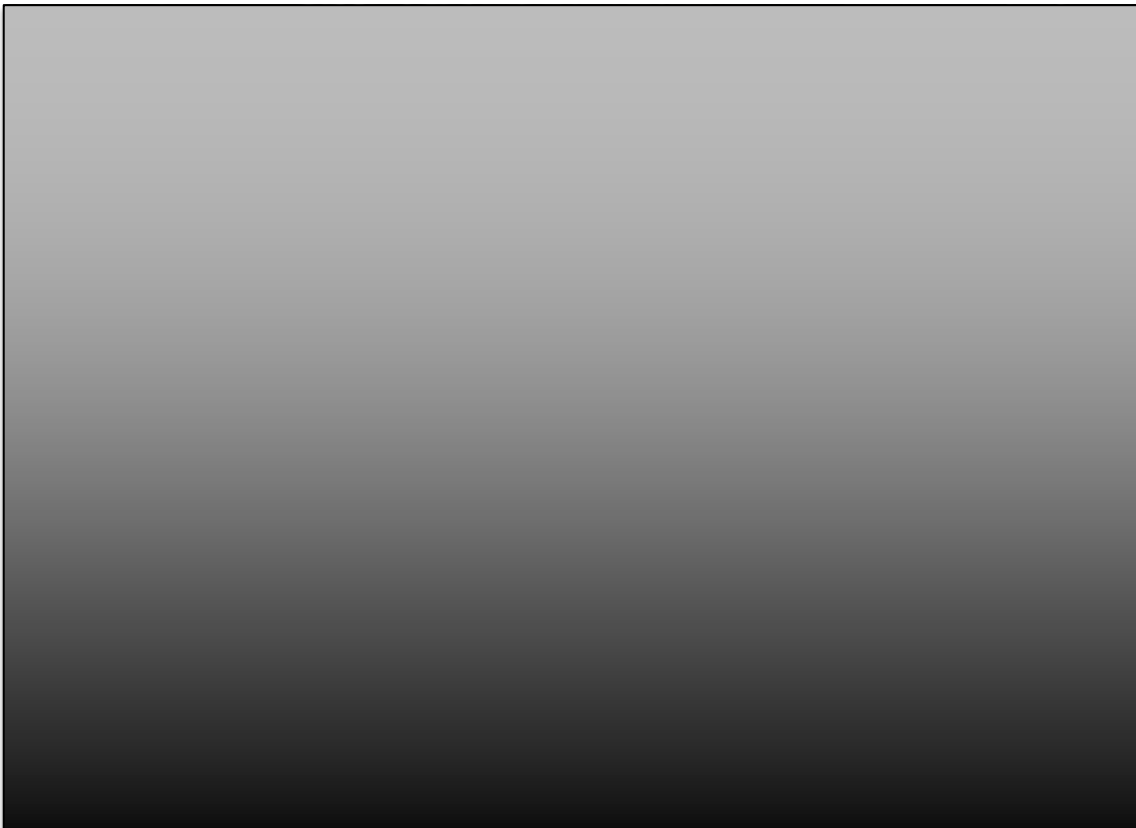


Figure 16 - Photograph of a blind APMC member at work, in McKenzie, 'Massage, Passive Movement, Mechanical Treatment and Exercise', p.90.

⁸³ Barclay, *In Good Hands*, p.45.

⁸⁴ 'Life At St. Dunstan's Hospital For Blinded Soldiers and Sailors', [n.d] pp.1-9, IWM, B.R.C.S.18/12.

Massage was considered to be an occupation that the blind could excel at. As a pamphlet for St Dunstan's wrote, massage was 'one occupation which a thoroughly well-trained blind man is able to follow, not merely as well as but even better than a man with sight'.⁸⁵ Students were given lessons in anatomy, physiology and pathology at St Dunstan's itself; undertook practical lessons at the NIB's massage school, and work experience at Middlesex, Hampstead and St. Bartholomew's hospitals.⁸⁶ The first candidates were examined by the STM in 1916; Percy Way was one of three men to receive a distinction and in 1917 he gained the highest marks in the country for SRE.⁸⁷ The work of blind masseurs was widely approved. In July 1919 the STM council received a letter from the War Office 'expressing appreciation of the work of the blind masseur many of whom were carrying out massage treatments at hospitals and centres under the War Office [...] there was no doubt that the blind workers were doing excellent work as masseurs'.⁸⁸ Similarly, it was noted that the medical officer of one large Command Depot with a staff of thirty-two, stated that 'the four blind men from St. Dunstan's who worked there [were] the most competent members of the Massage staff'.⁸⁹ Many blind masseurs joined the APMC and by 1918 there were 60 working across Britain in training schools, private practice, civilian and military hospitals, Depots and Camps.⁹⁰ During the de-mobilisation period, massage was considered one of the 'higher professions' in which 'ex-officers

⁸⁵ 'Life At St. Dunstan's', IWM, B.R.C.S.18/12, p.5.

⁸⁶ 'Life At St. Dunstan's', IWM, B.R.C.S.18/12, p.5.

⁸⁷ Barclay, *In Good Hands*, p.59.

⁸⁸ 'Council Meeting', (25 July 1919), Chartered Society of Physiotherapy: Council Minutes (11 July 1919-9 July 1920), WL, SA/CSP/B.1/1/14.

⁸⁹ 'Life At St. Dunstan's', IWM, B.R.C.S.18/12, p.6.

⁹⁰ Barclay, *In Good Hands*, p.59.

and men of similar educational attainments' could retrain, and there was a government grants scheme for this purpose.⁹¹

The wartime influx of men into the profession, however, did not occur without debate. The STM held steadfast to the principle of same-sex instruction,⁹² and on a number of occasions reprimanded female members who taught mixed-sex classes. One example includes that of Mrs Penfold who taught blinded soldiers SRE in 1918, the STM wrote to her that 'the principle of the training was wrong' and '[t]he Council could not sanction this mixed sex class and strongly deprecated the training of women by men and vice versa, unless of course the teacher were a doctor'.⁹³ As highlighted above, an exception was made for the military, and women instructed both army orderlies and naval sick berth attendants. It was not, however, a decision that the STM was entirely comfortable with. As late as April 1919, the Council approached War Office and Admiralty authorities 'asking for their support in the endeavour to regulate training for men [...] [p]ressing the point of a male instructor for demonstration and practical work'.⁹⁴ The War Office refused on account of the 'dearth' of male teachers, 'the strict discipline under which the classes in the services were carried out', and 'the fact that all the work was under the supervision of an officer of the medical services'.⁹⁵

Membership of the Society also remained a contentious issue. Despite increasing pressure on the STM to admit male certificate holders to full membership, they remained resistant towards any amendment and this was not

⁹¹ 'Letter to Secretary of the CSMMG', (18 December 1921), Appointments Department: Correspondence from the Incorporated Society of Trained Masseuses Regarding Training in Massage and Medical Gymnastics, (1919), TNA, LAB 2/1505/AD1426/1919.

⁹² 'Council Meeting', (25 April 1919), WL, SA/CSP/B.1/1/13.

⁹³ 'Council Meeting', (22 March 1918), WL, SA/CSP/B.1/1/13, for another example see 'Miss McColl', 'Council Meeting', (8 February 1918), WL, SA/CSP/B.1/1/12.

⁹⁴ 'Council Meeting' (25 April 1919), WL, SA/CSP/B.1/1/13.

⁹⁵ 'Council Meeting', (13 June 1919), WL, SA/CSP/B.1/1/13.

reformed until the Society's amalgamation and reconstitution with the MIRC in 1920.⁹⁶ The minutes for October 1915, for example, show that general feeling amongst the Council was that male membership 'was inadvisable' because, it considered, 'the education and social position of masseurs being, as yet, not of the same standing as masseuses'.⁹⁷ Evidence here shows that external forces were transforming the massage profession, and it was a process resisted in many ways by the STM.

Examining the changing relationship between massage and the medical profession during the war indicates both change and continuity. As shown in previous chapters, before 1914 very few medical men were interested in the field of physical medicine. Recalling the situation before the war, Mennell wrote:

To give an idea of the uphill fight of physical treatment in this country, I may say that 15 years ago, when I first began to take an active interest in the subject, a deputation of my fellow house officers at hospital waited upon me to request me not to degrade my profession by studying such a very doubtful branch of medical practice.⁹⁸

A combination of scepticism, prejudice, unfamiliarity and disinterest meant that the field of physical treatment and the work of the massage profession were not central to the interests of the medical profession. This changed during the war; as casualties mounted and rehabilitation became central to medical practice, the medical profession became more familiar with the field of physical treatment in general and specialist interests emerged in particular.

⁹⁶ Barclay, *In Good Hands*, p.53.

⁹⁷ 'Examination Committee', (1 October 1915), WL, SA/CSP/B.1/1/10.

⁹⁸ James Mennell, 'The Use and Abuse of Physical Treatment', *The Lancet* (19 January 1924), 160-163, (p.160).

A number of competing interests emerged within the territory of rehabilitation and physical treatment during the First World War.⁹⁹ Although this section focuses upon the relations between medical specialists and the massage profession, there was an array of professional negotiations occurring within this territory during the war. There was struggle amongst and between lay and medical workers to assert themselves and define their spheres of interest in relation to one another. For example, in 1917 a group of medical men established the British Association for the Advancement of Radiology and Physiotherapy (BARP) to sponsor the teaching for a new medical Diploma in Medical Radiology and Electrology (DMRE) to be started at University of Cambridge, the first examination being held in 1920.¹⁰⁰ Also in 1920, the Society of Radiographers was founded with help from the Institute of Electrical Engineers and BARP, to give professional status to certified non-medical assistants in X-ray and electrotherapeutic departments.¹⁰¹ The dimensions of this burgeoning field, and the place of the massage profession within it (many of the massage profession practised electrotherapy and radiology), remains to be fully explored.

Pertinent for this chapter, however, was that with the advance of specialist medical interests came increasing regulation and control of the massage profession. Emergent medical specialisms had much to gain from establishing a working relationship with the massage profession. Both physical

⁹⁹ Although there are no any detailed studies, this phenomena is recorded by scholars including: G. Larkin, 'Health Workers', in *Companion Encyclopedia of Medicine in the Twentieth Century*, ed. by R. Cooter and J. Pickstone (Amsterdam: Harwood Academic Publishers, 2000), pp.531-543, (p.537); Rosemary Stevens, *Medical Practice in Modern England; the Impact of Specialization and State Medicine* (New Haven, Yale Univ. Press, 1966), pp.46-47; Roger Cooter, *Surgery and Society in Peace and War: Orthopaedics and the Organization of Modern Medicine, 1880-1948* (London: Macmillan Press, 1993), p.135; and David Cantor, 'The Contradictions of Specialization: Rheumatism and the Decline of the Spa in Inter-War Britain', *Medical History*, 34 (January, 1990), 127-144, (p.139).

¹⁰⁰ Stevens, *Medical Practice in Modern England*, p.46.

¹⁰¹ Stevens, *Medical Practice in Modern England*, p.46.

medicine and orthopaedics relied upon trained support staff to undertake routine work and ensure successful treatment outcomes. While they supported the employment of trained personnel, however, specialists did not advocate their professional autonomy. In contrast, they defined roles for themselves and the masseuse within a clear division of labour. Mennell, for example, wrote in 1917: '[t]he responsibility for the treatment of a patient rests entirely on the medical man. The only responsibility of the masseur is to see that orders are carried out implicitly'.¹⁰² While, he believed, staff must be highly trained to administer treatments accurately,¹⁰³ it was the responsibility of the medically trained to decide, prescribe and supervise treatment. 'The masseuse is no diagnostician', he wrote, and '[n]o masseuse, however efficient and fully trained, can properly be left in sole control of the treatment'.¹⁰⁴ Amid continued scepticism amongst doctors about the scientific basis and therapeutic benefits of physical remedies, it was critical for aspirant specialists to assert the scientific validity of such treatments. Mennell often described that massage was like a drug with a specific chemical or pharmacological action and therefore needed to be regulated: 'When a medical man orders massage he should not try to hand over his responsibility to the masseur', he wrote, '[h]e should consider the prescription of massage treatment in the same light as he would consider that of a potent drug and watch its effects no less closely'.¹⁰⁵

Mennell was not the only one to emphasise this division of labour. As highlighted in Chapter 5, Robert Fortescue Fox and the Section of Balneology and Climatology (SBC) carved out a specialist role by arguing that 'in order to

¹⁰² James Mennell, *Massage: Its Principles and Practice* (London: J.A. Churchill, 1917), p.107.

¹⁰³ For a description of how Mennell ranked the training of massage staff see, James Mennell, 'Massage in Orthopaedic Surgery', in *Orthopaedic Surgery of Injuries* Vol.2, ed. by Robert Jones (London: Hodder & Stoughton, 1921), pp.505-559, (pp.506-507).

¹⁰⁴ Mennell, 'Massage in Orthopaedic Surgery', p.505.

¹⁰⁵ Mennell, *Massage: Its Principles and Practice*, pp.v.vi.

produce their proper effect', physical treatment had to be 'judiciously' combined under medical direction.¹⁰⁶ Orthopaedic surgeons also supported these views. In an introduction to Mennell's 1917, *Massage: Its Principles and Practice*, Robert Jones emphasised the importance of 'loyalty' and teamwork, arguing: '[t]he responsibility rests on the surgeon, not on the masseuse':¹⁰⁷

Success in treatment depends on loyalty between surgeon and masseur or masseuse: loyalty on the part of the surgeon in giving precise explanations of what he wishes, loyalty on the part of the masseuse in faithfully carrying out those instructions.¹⁰⁸

Only, '[w]hen this close alliance is maintained', he concluded, was massage 'successfully employed'.¹⁰⁹ The emergence of medical specialists in this arena, then, can be viewed as a process corresponding to the entrenchment of the massage profession as an auxiliary service. It shows that the aspirations of medical specialists were invested in establishing a working relationship with the massage profession that guaranteed labour, successful clinical outcomes and upheld their professional position.

As medical specialists sought to assert their authority over the massage profession there was increasing criticism at the lack of medical supervision over physical treatment more widely. As Mennell noted, in regular practice, the masseuse was rarely given sufficient, if any, clinical information or directions for treatment, frequently receiving patients with an indistinct prescription such as 'massage required for this case'.¹¹⁰ Noting a typical example, Bellis Clayton complained that when 'a case of fracture is sent [...] for massage treatment.

¹⁰⁶ Robert Fortescue Fox, *Physical Remedies for Disabled Soldiers* (London: Baillière, Tindall and Cox, 1917), p.183.

¹⁰⁷ Robert Jones, 'Introduction to the First Edition', in James Mennell, *Massage: Its Principles and Practice*, 2nd edn. (London: J.A. Churchill, 1920), pp.xi-xiii, (p.xi).

¹⁰⁸ Jones, 'Introduction to the First Edition', pp.xi-xii.

¹⁰⁹ Jones, 'Introduction to the First Edition', p.xii.

¹¹⁰ Mennell, 'Massage in the After-treatment of the Wounded', 755.

The masseuse is given no further directions, and she does not see the Xray plate. It is left to her to decide what massage to give and what movements'.¹¹¹ Ambiguous prescriptions compounded by debates about the uses of massage and meanings of pain demonstrate the difficulties that masseuses faced in practice.

Specialists felt that the negligence of their colleagues was to blame for lay practitioners assuming responsibility for physical treatment, and for ineffective results. Mennell fulminated '[c]onstantly we are told of the inefficiency of massage and other forms of physical treatment',¹¹² and likewise, Bellis Clayton wrote '[i]s it surprising [...] that so many of these cases end in disaster?'¹¹³ They called upon the medical practitioner to have a 'definite idea as to what progress he expects to see in his patient' and to examine patients at regular intervals 'to insure that his scheme is progressing favourably'.¹¹⁴ 'Otherwise', Mennell concluded, 'disappointment is almost inevitable. He alone is responsible for failure or success, as he cannot shift his responsibility in the event of failure, and retain it only in successful cases'.¹¹⁵ Medical direction mattered to these specialists, both in upholding their professional position as well as the reputation of physical treatment upon which their interests were based.

Specialists argued that it was not just a matter of medical negligence but want of knowledge that inhibited the proper direction of physical treatment.

¹¹¹ Bellis Clayton, 'Massage and the War', 1369.

¹¹² Mennell, 'Treatment of Scoliosis by Remedial Exercises', 716.

¹¹³ Bellis Clayton, 'Massage and the War', 1369.

¹¹⁴ James Mennell, 'The Administration of Massage', in *Physical Remedies for Disabled Soldiers*, by Robert Fortescue Fox (London: Baillière, Tindall and Cox, 1917), pp.122-134, (p.122).

¹¹⁵ Mennell, 'The Administration of Massage', p.122.

Medical men were called to educate themselves in physical treatment in order to give better prescriptions. Jones observed in 1925 that:

few [...] are able to give intelligent instruction to a masseuse, or to direct a masseuse in treating deformity, or show an electrotherapist the muscles he should stimulate in order to overcome weakness. The instruction generally given is, "Have your arm massaged," or "Use the faradic current," or "Give exercises to this man." We blame the physiotherapists if they do not carry out the doctor's instructions; we do not dwell on the fact that the doctors-with few exceptions - do not possess the knowledge to instruct.¹¹⁶

Texts such as Mennell's, *Massage: Its Principles and Practice*, and Robert Fortescue Fox's, *Physical Remedies for Disabled Soldiers*, were efforts by aspirant specialists to educate colleagues in what was described as 'rather unfamiliar ground'.¹¹⁷ It was not only specialists who called medical practitioners to assume more responsibility for treatment and other commentators within medicine started to identify the professional importance of harnessing control of this territory. In January 1917 *The Lancet* wrote:

All has not been done when the patient has been handed over for so long every day to a professional rubber. The indications for massage must be a matter of exact study, and skilled massage may be largely wasted when the surgeon has not been able to prescribe it correctly.¹¹⁸

'There is room - urgent need indeed', they concluded, 'for the accurate scientific study of the indications for massage'.¹¹⁹ Encompassing physical remedies into the regular practitioner's scope of knowledge, it was believed, was crucial to maintain medical authority over the field and undercut competing lay-practitioners. As *The Lancet* wrote in September 1918, '[t]he ignorance of our

¹¹⁶ Robert Jones, 'Lady Jones Lecture on Crippling due to Fractures: its Prevention and Remedy' *BMJ* (16 May 1925), 909-913, (p.911).

¹¹⁷ Fortescue Fox, *Physical Remedies for Disabled Soldiers*, p.ix.

¹¹⁸ 'The Practice of Massage', 158.

¹¹⁹ 'The Practice of Massage', 158.

own medical men as a whole of physico-therapeutical work has enabled self-advertisement to be its own reward'.¹²⁰ The result, they argued, was that 'good and bad masseurs alike have flourished; in fact, there is reason to fear that the inferior grade has obtained the better positions'.¹²¹

Complaints about lack of medical direction, however, as we know, were not new and long heard from the massage profession. Masseuses continued to note that while 'officially' working 'under medical direction', in practice they were often compelled to exercise a considerable amount of autonomy. At St Thomas's hospital, one report investigating 'the grave defects' of the massage department noted 'lack of medical supervision', and wrote 'masseuses complain that doctors never even bother to explain the nature of disease [or] wound'.¹²² Masseuses started to contrast the guidance they received when working under the supervision of specialists to regular working situations. For example, one STM member working in Canada reported that, '[o]ne surgeon visits us a good deal; but, as in England, much is left to us; and we often wish we had *more* of the doctor's advice and help and interest, just as at home we wished for more'.¹²³ 'All cannot be Mennells or Bristows though' she concluded.¹²⁴ This description demonstrates that although becoming more recognised and embedded within medicine, much was still left to the masseuse. It reflects the liminal status of the profession during the war and how it worked in two distinct ways, as a modality in and of itself, as it had done for over twenty years, but also increasingly as a surgical auxiliary.

¹²⁰ 'Remedial Gymnastics', *The Lancet* (21 September 1918), 398, (p.398).

¹²¹ 'Remedial Gymnastics', *The Lancet* (21 September 1918), 398.

¹²² 'The Physical Exercises Department', [n.d], pp.1-4, Records of St Thomas' Hospital, Miscellaneous Papers: History of the School, London Metropolitan Archives (LMA), HI/ST/PS/Y/04/001, p.3.

¹²³ 'Notes from Canada', *JISTM* (July 1919), 14-15, (p.14).

¹²⁴ 'Notes from Canada', *JISTM* (July 1919), 14.

Accounts by masseuses suggest that higher levels of direction and supervision were welcomed and sought. This was because the relationship between the medical and massage profession was mutually supporting. The massage profession embraced a closer partnership with medicine, division of labour and mutual loyalty as it allowed them to further establish themselves as medically related professionals. For example, describing massage in orthopaedic centres in November 1917, Barrie Lambert wrote:

What to me is the most outstanding feature is that the doctors in charge of the Departments, who are specialists in the work are not only willing but anxious to teach and train those working under them. The history of the case and necessary treatment are explained fully to the masseuse, in many cases the X ray photograph and report being shown to her. I have even known of the masseuse being allowed to be present at any operation on her patient.¹²⁵

Similarly, head masseuse of Alder Hey orthopaedic centre noted that: 'the masseuses are instructed in the special methods adopted for treatment of orthopaedic cases, and weekly tutorial classes are held by the officer in charge of the Massage Department'.¹²⁶ This shows that the relationship between the massage profession and medicine does not fit into a traditional medical control narrative. While the massage profession relinquished some of the practical autonomy it had exercised from the late-nineteenth century, from their perspective, the division of labour was an act of loyalty that secured their professional claims and a place within medicine.

Although increasingly subject to medical hierarchy, the massage profession gained professional confidence and assertiveness. During the war the massage profession became authorities in rehabilitation and physical

¹²⁵ Florence Barrie Lambert, 'Massage Work in Orthopaedic Hospitals', *JISTM* (November 1917), 112, (p.112).

¹²⁶ Sarah Chuck, 'Account of the Massage and Electrical Treatment at Alder Hey Hospital, Liverpool', (23 September 1918), pp.1-2, IWM, B.R.C.S.25.6/3, p.1.

treatment and asserted their unique expertise in this territory. Two STM members wrote, for example, that while medical students should be encouraged to undertake 'a course of instruction in the therapeutic uses of massage and allied treatments', that it should be understood 'this in no way qualifies him to undertake the practical treatment of patients'.¹²⁷ 'Should the medical student desire to *specialise* in this branch of work', they continued, 'it should be made compulsory for him to undergo a definite course of training, and pass an examination in the theory and practice of massage and exercises before he can qualify'.¹²⁸ While subordinating their practice, therefore, the massage profession maintained its distinctiveness and indispensability.

Complaints about the lack of medical direction, from both medical men and masseuses, serve to highlight that while physical treatments and the massage profession became more accepted during the war, the majority of medical practitioners remained 'unfamiliar with', physical therapy.¹²⁹ Although pockets of specialists emerged within medicine, these were exceptions as opposed to the rule, and physical therapy continued to be used as a last resort.

Writing in 1924, Mennell described this transitional status:

The uses of physical treatment are, I think, fairly universally admitted, though unfortunately the variety of its uses are still unknown [...] Those of us who practise physical treatment are mainly regarded as a last resource; patients come to us when every other known means of helping them has failed, to find, even after suffering pain and disability for 20 years, that in physical treatment they are able to secure relief.¹³⁰

¹²⁷ 'Correspondence: Massage and Medical Reconstruction', *JISTM* (July 1919), 15-16, (p.16).

¹²⁸ 'Correspondence: Massage and Medical Reconstruction', 16.

¹²⁹ 'Chartered Society of Massage and Medical Gymnastics', *BMJ* (26 October 1929), 767, (p.767).

¹³⁰ Mennell, 'The Use and Abuse of Physical Treatment', 160.

Mennell repeated these sentiments throughout the interwar years, writing that '[s]till medical practitioners of the older generation find it hard to recommend physical treatment. They know little or nothing about its possibilities'.¹³¹ This shows that while the war engendered the transformation of the massage profession, its changing status within medicine was more an evolution than revolution.

The changing status of massage and physical treatment within medicine was also reflected in the governance of the STM. As highlighted earlier, as the Medical Advisory Board came to replace the informal medical patronage of earlier years, the medical profession increasingly directed the Council's decision making. It is also interesting to note that in 1916 the British Medical Association (BMA) demanded representation on the STM council for medical practitioners with massage schools, and argued they should not be subject to inspection.¹³² Although negotiations with the BMA were postponed in light of on-going discussions with the MIRG, when the STM was reconstituted under Charter in 1920, its governing body would represent the medical profession. In addition to the Founders and an elected masseur, the Council was to be two-thirds elected and one-third co-opted; two-thirds of the co-opted portion made up of medical men and women.¹³³

The attainment of the Royal Charter in 1920, then, represented a transformation of the massage professions' practical and professional boundaries. When the Council of the new Chartered Society met for the first time on 16th July 1920, it was under a new gender-neutral name 'The

¹³¹ Mennell, 'Osteopathy', 50.

¹³² 'Professional Committee Meeting', (28 June 1916), WL, SA/CSP/B.1/2/2; also see 'Council Meeting', (11 May 1916), WL, SA/CSP/B.1/1/11; 'Council Meeting', (9 November 1917), WL, SA/CSP/B.1/1/12. The STM introduced the inspection of massage schools in 1916.

¹³³ Barclay, *In Good Hands*, p.53.

Chartered Society of Massage and Medical Gymnastics', both men and women were permitted membership, and men were represented on the council. It reflected the multiple skills 'massage, medical gymnastics, electro-therapy and other kindred methods of treatment' that the profession encompassed.¹³⁴ The Society was also, for the first time, under the Chairmanship of a member of the medical profession rather than one of its own female members, and in addition the Council included seven members of the medical profession.¹³⁵ Rather than a linear trajectory, however, as this section shows, this transformation was resisted, contested and piecemeal, occurring as continued debates about gender, intimacy and expertise were renegotiated in dramatically different sets of circumstances.

Swedish Gymnastics, Nursing and Independence

Like massage, the war made remedial gymnastics a highly valuable therapeutic and it was deployed widely in a number of different forms by a variety of practitioners. As Chapter 5 showed, the wartime use of remedial exercise for rehabilitation was heavily influenced by Swedish doctrine, for example, drawing upon terminology such as 'passive' and 'active', principles such as graduated recovery and exercise 'tables', and the Zander-pattern of apparatus. As we know, the kinship between massage and exercise, particularly in the treatment of disability, was not new and the massage profession had long viewed it as part of its professional scope, demonstrated by the inauguration of the STM's examination in Swedish Remedial Exercises (SRE) in 1909.

Wartime rehabilitation work, however, cemented the link between massage and remedial exercise for the massage profession. While before 1914

¹³⁴ 'The Annual Meeting', *JISTM* (May 1919), 267-271, (p.268).

¹³⁵ Wicksteed, *Growth of a Profession*, p.120.

massage had been the central focus of the profession, increasing was the view that massage alone had limited use. As a 'passive' method, practitioners feared that it threatened to stunt a patient's progress if not combined as soon as possible with active treatments. Describing the 'general principles of massage treatment', Mennell wrote that 'we must consider it entirely as a means to an end, the end being restoration of function',¹³⁶ which was achieved by mobilisation, passive and active exercise. Massage was combined with remedial exercise within a progressive treatment approach to physical restoration.

Masseuses were encouraged to extend their training into SRE. Mennell, for example, wrote that '[w]hen training for the massage examination, students are taught a method of treatment by which they are enabled to assist in the cure of a patient; whereas in the S.R.E course they learn [...] how to teach patients to assist in curing themselves by their own exertions'.¹³⁷ 'The two methods of treatment', he continued:

are really supplementary one to the other. But whereas it is only in exceptional cases that massage treatment alone suffices to cure in orthopaedic work, it often happens that S.R.E training can effect a cure in the total absence of treatment by massage proper.¹³⁸

In order for the massage profession to engage in and define itself by rehabilitation work and not massage alone, SRE was embraced as a central element of the profession's skillset. Writing in 1919, the STM Council observed that '[t]he war has taught many what some of us knew before, that massage alone will not carry us far, and in many cases its real value can only be

¹³⁶ Mennell, *Massage: Its Principles and Practice*, p.4.

¹³⁷ Mennell, 'Massage in Orthopaedic Surgery', p.507.

¹³⁸ Mennell, 'Massage in Orthopaedic Surgery', p.507.

appreciated in connection with allied treatments'.¹³⁹ As early as 1916 the number of candidates for the SRE examination rivalled that of massage,¹⁴⁰ and it was increasingly felt that such expertise should not be an optional extra. By 1920 the STM Council were finalising plans for a conjoint examination of massage and remedial exercise as the basis of entry to the profession.¹⁴¹

As Swedish expertise was incorporated into the massage profession, interests overlapped with Swedish gymnasts of the Ling Association and Physical Training Colleges. As the STM's failed negotiations with these bodies to apply for state recognition in 1917 suggests, while they had mutual interests there were difficulties in defining their distinctiveness.¹⁴² For example, the initial 'suggested scheme' forwarded by the STM in May 1917 sought to distinguish two separate spheres, the 'educational' from 'remedial' gymnastics.¹⁴³ By the end of the war, however, Swedish remedial gymnasts and professional masseuses were very similar in terms of expertise and therapeutic practice. Both engaged in wartime rehabilitation work, were employed by the APMC, and Mennell even wrote that he considered the fully-trained gymnast to be the 'highest grade of staff' in the massage department, 'the only direction in which she is likely to found lacking is in actual hospital experience'.¹⁴⁴

Though they have received limited study, there is evidence to suggest that there were also a notable presence of foreign remedial therapists, including Swedish gymnasts and masseurs, working in Britain during the war. Evidence

¹³⁹ 'The Report of Chairman of Council', *JISTM* (May 1919), 272-275, (p.274).

¹⁴⁰ 'Swedish Remedial Exercises Examination', *JISTM* (May 1916), 128.

¹⁴¹ The first conjoint examination was in June 1922, but minutes indicate that schools started a conjoint training from 1920, to find details see Chartered Society of Physiotherapy: Council Minutes, (11 July 1919-9 July 1920), WL, SA/CSP/B.1/1/14.

¹⁴² This debate continued into the interwar years, see Steve Bailey and Wray Vamplew, *100 Years of Physical Education, 1899-1999* (Warwick: Warwick Printing Company Limited, 1999), pp.29-30.

¹⁴³ 'Special Council', (25 May 1917), WL, SA/CSP/B.1/1/12.

¹⁴⁴ Mennell, 'Massage in Orthopaedic Surgery', p.506.

of them can be found in complaints arising from both the medical and massage profession. As this chapter argues, a multitude of practitioners emerged within the field of rehabilitation and physical treatment during the war, each competing for a place in this newly prestigious territory. By 1918, signs of inter-occupational rivalry between Swedish remedial gymnasts and the medical profession emerged in the medical press. In September 1918 for example, *The Lancet* reported that: '[r]emedial gymnastics, including massage and electrical therapeutics, have obtained a definite place in the practice of medicine, and one that is growing daily in importance by reason of the injuries and mutilations of war'.¹⁴⁵ But, they continued, 'much depends on the instruments through which the treatment is applied, and the traditional instrument in this country, the Swedish masseur, is not of constant quality'.¹⁴⁶

While Swedish gymnasts represented the same expertise as the massage profession, they were not professionally obligated to practice under medical direction and therefore presented a challenge to medical authority. As *The Lancet* continued:

the Swedish masseur, as we meet him in practice, can be placed in one of two groups. Those in the first are serious and unostentatious in mien, anxious for medical help and advice, delicate in their treatment – in short, a good type of physico-therapeutic expert. The second group comprises persons, self-possessed and self-sufficient, who seek out medical men, not to solicit help or advice, but as a means of securing employment, and of using well-known names in specious advertisement.¹⁴⁷

As one STM member complained in 1919, 'Swedes come here and practise, doubtless with skill, but also on their own authority and diagnosis'.¹⁴⁸ Medical

¹⁴⁵ 'Remedial Gymnastics', *The Lancet*, (21 September 1918), 398.

¹⁴⁶ 'Remedial Gymnastics', *The Lancet*, (21 September 1918), 398.

¹⁴⁷ 'Remedial Gymnastics', *The Lancet* (21 September 1918), 398.

¹⁴⁸ 'Correspondence: Massage and Medical Reconstruction', 16.

practitioners feared that the proliferation of lay therapists outside of medical control threatened their position in the field. The medical and massage profession alike, therefore, had mutual interests in curtailing the competing practice of Swedish gymnasts. Steadfast in their loyalty to the medical hierarchy, the massage profession offered medicine a way to undercut competitors and assert its interests. As *The Lancet* concluded, '[i]t is hoped that amalgamation between the Incorporated Society of Trained Masseuses and the Institute of Massage and Remedial Gymnastics in Manchester will help solve the difficulties ahead', by exposing 'the presence of many foreigners' amongst whom 'persons from Sweden, who [...] are not masseurs but quacks'.¹⁴⁹

The increasing acceptance of the massage profession into medicine, therefore, was a professional strategy. Establishing a working relationship with the massage profession was a way for medicine to extend the scope of its activities into the field of rehabilitation and physical treatment while maintaining its professional interests and marginalising marketplace competition. As Chapter 4 suggested with the ousting of 'Herr Koch' from the London Hospital, however, inter-occupational rivalry can be identified from the late-nineteenth century, demonstrating this territory had been growing in importance to the medical profession before the war. There may have also been nationalist sentiment in this process. As Jane Wicksteed notes, while the STM's examination was called Swedish Remedial Exercises and curriculum based on Swedish doctrine, there was a strong nationalist element against the use of the word 'Swedish' resulting in it being dropped from the new title the 'Chartered Society of Massage and Remedial Gymnastics', in 1920. This reflects more broadly how SRE was adopted into British medical practice, whereby Swedish

¹⁴⁹ 'Remedial Gymnastics', *The Lancet*, (21 September 1918), 398.

expertise was emulated and absorbed by the massage profession enabling the marginalisation of foreign practitioners.

Like Swedish remedial gymnastics, nursing had been an important platform for the professionalisation of massage before the war. The First World War offered an opportunity for massage to separate and distinguish itself from the nursing profession. While the majority of those in the massage profession before the war were nurses, the proportion of those entering the profession via a preliminary training in nursing rapidly diminished.¹⁵⁰ Furthermore, the wartime demand for both nurses and masseuses meant that there was less overlap between the roles. These factors strengthened the massage profession enabling it to outgrow its dependence upon nursing. This professional separation was demonstrated by the changing relationship between the STM and the Midwives' Institute and Trained Nurses Club, with which it was closely linked. For example, growth led the STM in January 1915 to move premises from the headquarters it shared with the Trained Nurses Club at Buckingham Street to its own at Great Portland Place in January 1915,¹⁵¹ and in August 1915 the STM established its own professional journal apart from *Nursing Notes* called the *Journal of the Incorporated Society of Trained Masseuses*.¹⁵²

The war was also an opportunity for the massage profession to construct an identity distinct from nursing. They engaged in conventional methods of identity formation such as establishing an independent journal, a professional membership badge bearing the Society's motto 'digna sequens' ('following worthy aims'),¹⁵³ and specific uniform regulations distinct from nurses. In

¹⁵⁰ Winifred McAllister, 'The Training of the Physiotherapist', in *Recent Advances in Physical Medicine*, ed. by Francis Bach (London, J & A Churchill, 1950), pp.455-466, (p.455).

¹⁵¹ 'Editorial', *JISTM* (December 1915), 4.

¹⁵² 'Editorial', *JISTM* (August 1915), 5-6.

¹⁵³ 'Membership Badge', *JISTM* (July 1916), 20.

contrast to the white apron, long skirt and high-necked blouse that the STM encouraged members to wear before the war, the APMC wore a long dark-blue coat and skirt with shoulder straps and the badge of the corps of the left sleeve, white shirt and dark blue tie, and white regulation overalls and cap for work (Figure 17).¹⁵⁴



Figure 17 - Member of the APMC at work wearing regulation uniform and badge. 'Massage for Our Wounded Soldiers: Tommy has the Best of Everything', *Daily Sketch* (5 December 1914), IWM, B.R.C.S.25.6/25.

The war also enabled the profession to distinguish itself more clearly by training, expertise and methods of practice. As shown, the war enabled the massage profession to establish itself as a multi-skilled discipline as opposed to

¹⁵⁴ 'Uniform Regulations of the Massage Corps', [n.d], IWM, B.R.C.S.25.6/18.

massage in isolation. Writing in 1919 the STM described the discipline as a 'science':

We begin with Massage, the subject from which all the others have sprang - the root of all our work; and as a root cannot reach perfection until it bursts into leaf and flower, so Massage is only part of a science until its students branch out into Medical Electricity, Remedial Gymnastics, and so forth.¹⁵⁵

As specialists in rehabilitation and experts in a range of physical treatments outside the scope of ordinary nursing practice, the profession could no longer be considered as a part of general nursing work, or a 'department' of nursing. Opinion amongst the profession grew throughout the war that no training concessions should be made for nurses despite prior training, it being felt that 'the nurse required as full a course as those who were not nurses if she was to attain the same standard'.¹⁵⁶ By 1920 training for the massage profession had been extended from a few weeks in 1894 to twelve months for the conjoint training, with a further three months for medical electricity.¹⁵⁷

Professional alignment with the ideology of rehabilitation was another way for the massage profession to identify itself as separate from nursing. Their professional imagery drew from a range of factors including methods of practice, the masculine and military aims of rehabilitation, as well as social representations of their work. By the nature of the work it undertook, the massage profession could not identify with the traditional nursing imagery of the sympathetic female healer, as demonstrated by another of A.G. Bliss's cartoons that ironically describes the masseuse as a 'ministering angel', a common nursing trope (Figure 18). As Fiona Reid shows, female medical staff in the First

¹⁵⁵ 'The Report of the Director of Examinations', *JISTM* (May 1919), 275-277, (p.275).

¹⁵⁶ 'Council Minutes', (25 July 1919), WL, SA/CSP/B.1/1/14.

¹⁵⁷ 'Council Meeting', (20 January 1920), WL, SA/CSP/B.1/1/14.

World War were assumed to be naturally 'tender' and idealised as a 'perfect counterpoint to the essentially masculine, fighting soldier'.¹⁵⁸ The massage profession as it evolved during the war, however, challenged conventional gender-based assumptions. Masseuses elicited pain, used strength, force, a range of scientific technologies, and worked in gymnasiums as opposed to the bedside. As Beth Linker points out, physical therapists 'resembled drill sergeants more than bedside nurturers'.¹⁵⁹



Figure 18 - A.G.Bliss, 'The Ministering Angel', (1916), WL, SA/CSP/Q.1/17a.

As shown in Chapter 5, to be sympathetic or sentimental to patients was viewed as counter-productive to rehabilitation. To restore injured soldiers, the massage profession had to identify with patients in a different way, using

¹⁵⁸ Reid, *Medicine in First World War Europe: Soldiers, Medics, Pacifists*, p.14.

¹⁵⁹ Beth Linker, 'Strength and Science: Gender, Physiotherapy, and Medicine in Early-Twentieth-Century America', *Journal of Women's History*, 17:3 (Fall 2005), 105-132, (p.116).

inspiration, encouragement, suggestion and even discipline to mobilise them physically and mentally. As masseuse Hazel Blandy of Shoreham Command Depot wrote: '[d]o not tell your pupils to hold their head up: make them *want* to hold them up'.¹⁶⁰ It was 'just this spirit', she continued, that was 'needed in both the ward and gymnasium where the men need to be cheered, and encouraged to wish to become healthy, able members of society, whether as soldiers or civilians'.¹⁶¹ By aligning with the ideology of rehabilitation the massage profession was able to detach from nursing whilst retaining the self-sacrificing, public-service rhetoric they had emulated. The massage profession was inherently shaped by discourses of rehabilitation during the war and it became a professional commitment to which it aligned its future. As Blandy concluded, the spirit of the massage profession 'carried far and wide into all classes of society – both at home and overseas – will become a tremendous factor in building up the life of both present and future generations'.¹⁶²

With increasing independence also came a number of challenges. No longer protected under the umbrella of nursing, the massage profession had to negotiate its new position in relation to other healthcare workers and the state. The status of the massage profession troubled many and led 900 members of the APMC to unionise in January 1919 forming the Almeric Paget Massage Club.¹⁶³ Part of a broad wave of industrial assertiveness at the close of the war,¹⁶⁴ the Almeric Paget Massage Club displayed professional confidence in its demands. The position of the masseuse in relation to other health workers

¹⁶⁰ Hazel Blandy, 'The London Command Depot, Shoreham', *JISTM* (October 1918), 76-80, (p.80).

¹⁶¹ Blandy, 'The London Command Depot, Shoreham', 80.

¹⁶² Blandy, 'The London Command Depot, Shoreham', 80.

¹⁶³ 'Council Meeting', (10 January 1919), WL, SA/CSP/B.1/1/13. In July 1919, the Almeric Paget Massage Club changed its name to United Services Massage League, 'Council Minutes', (11 July 1919), WL, SA/CSP/B.1/1/14.

¹⁶⁴ Anne Marie Rafferty, 'Nurses' in *Companion to Medicine in the Twentieth Century*, ed. by R. Cooter and J. Pickstone (London: Routledge, 2003), pp.519- 529, (p.522).

proved difficult to negotiate throughout the war. As one masseuse, Florence Sullivan complained in December 1918, 'the time has come when the position and pay of the masseuse should be improved'. '[A]t present', she wrote, 'her position is very ill-defined as in many hospitals she is regarded neither as Sister nor V.A.D, and is quite the Cinderella of the nursing world. She does not even hold a title'.¹⁶⁵ As noted, the STM and APMC badge was one method used to distinguish the profession from nurses and the other volunteer or 'untrained' health-care workers in the field. The Council encouraged members to wear it continually to highlight their qualifications, 'both in their own interests and those of the Society to which they are proud to belong'.¹⁶⁶

The ill-defined status of the masseuse vis-à-vis other health-care workers was compounded by their similar position in relation to the state. While official bodies such as the War Office offered the profession recognition and support by using their services, masseuses often complained that they did not receive recognition and were being exploited. Controversy surrounding the formation of the Military Massage Service demonstrates this point. In January 1919 the APMC was demobilised and replaced by the Military Massage Service (MMS), an organisation under the auspices of the Army and Pensions Massage Association and controlled by the War Office and Ministry of Pensions.¹⁶⁷ As the STM proclaimed at its Annual Meeting, the formation of the MMS was a landmark for the future of the profession:

¹⁶⁵ Florence Sullivan, 'Correspondence: The Position and Pay of the Masseuse', *JISTM* (December 1918), 138.

¹⁶⁶ 'Editorial', *JISTM* (November 1916), 122. Rosalind Paget was a wartime Inspector of Red Cross and V.A.D hospitals under Sarah Swift for the British Red Cross. Her personal papers show that she was constantly checking the qualifications of the masseuses employed at these institutions, and encouraged STM members to wear their badges for identification. For example see 'Letter to Miss Templeton', (20 March 1919), Personal Papers: Rosalind Paget, WL, SA/CSP/P/4/1/17.

¹⁶⁷ 'Army Council Instruction, No.65', (29 Jan 1919), pp.1-8, IWM, B.R.C.S.25.6/14, p.1.

To some that name *Army and Pensions Massage Association* may be new – it means much to us as a profession. It means what we have so long wished for has come about, and that we now have a *National Service of Massage*, a most important step has thus been taken, and I believe it will do more to establish the professional status of the masseuse than anything else could have done.¹⁶⁸

Within the Army Council Instruction detailing the conditions of the MMS, however, was a clause that identified two categories of masseuse. The ‘category A’ masseuse referred to those with recognised training, while ‘category B’ gave recognition to ‘those who were not fully qualified [...] but who show evidence of having received a *bone fide* training’.¹⁶⁹ Categorising massage personnel was a way that administrators sought to give structure to the influx of workers being redistributed to civilian employment. Grading staff as Category A or B sought to match skills to demand, as the War Office hoped to supply rural and outlying districts with category B masseuses, which lacked skilled personnel.¹⁷⁰ The STM argued, however, ‘the employment of unqualified masseuses [...] must tend to a lowering of the whole profession and consequently the status of the trained worker’.¹⁷¹ The STM joined forces with the Almeric Paget Massage Club in March 1919 to make a deputation to the War Office petitioning for the removal of Category B. The deputation was a success suggestive of the political leverage of the massage profession, but also highlights continued debates about expertise, the untrained worker and the importance of state support for the profession’s future.

Poor rates of pay, working conditions and the rank of civilian worker were amongst the other issues that the profession sought to negotiate during the war. In a letter to *The Times* in April 1919, members of the Military Massage Service

¹⁶⁸ ‘The Report of Chairman of Council’, *JISTM* (March 1919), 272-275, (p.273).

¹⁶⁹ ‘ACI, No.65’, IWM, B.R.C.S.25.6/14, p.1.

¹⁷⁰ ‘Special Meeting of Council’, (7 March 1919), WL, SA/CSP/B.1/1/13.

¹⁷¹ ‘Council Meeting’, (14 February 1919), WL, SA/CSP/B.1/1/13.

complained at the way 'Army masseuses have been treated during the whole of the war':¹⁷²

There are some 1,500 masseuses employed by the War Office; we are a body of fully trained professional women, but have never been granted any sort of rank or status, as have the nursing sisters and V.A.D's. We have repeatedly begged to receive some definite place in the hospital staff, but such has never been accorded us, we are merely ranked as civilian subordinates, and as such classed with the orderlies and scrubbers. Our pay is such that we can barely exist on it; we do not live in as the nurses, but have to provide for ourselves.¹⁷³

The profession's industrial assertiveness highlights that the profile of the profession was very different by the end of the war. Before 1914 many entered the profession as a voluntary occupation and the STM had continually encouraged members to work voluntarily. This was a way that the STM distinguished massage as a profession as opposed to a trade. In contrast, by 1920, unpaid work was strongly discouraged as undermining the status of professional work. As the STM wrote in 1918, 'we wish "pocket money" labour, at least in so far as it tends to reduce the rate of remuneration for the genuine woman worker and makes her burden heavier, could be abolished'.¹⁷⁴ This demonstrates that in 1920 the massage profession represented a group of confident professional women who were part of a wider surplus million women dependent upon their careers.

¹⁷² 'Army Masseuses', *The Times* (1 April 1919), IWM, B.R.C.S.25.6/27.

¹⁷³ 'Army Masseuses', IWM, B.R.C.S.25.6/27.

¹⁷⁴ 'Editorial', *JISTM* (November 1918) 97-99 (p.99), There are interesting correspondences about the changing position of voluntary work for the profession, see 'Notes by the Way', *JISTM* (January 1919), 164; 'Correspondence: Voluntary Work', *JISTM* (February 1919), 180.

Conclusion

This chapter has explored some of the ways in which the First World War shaped the massage profession. By 1920 the massage profession was in an unprecedented position of public, political and medical importance, and its practical and professional boundaries were entirely transformed. Through its war work and alignment with the ideology of rehabilitation the massage profession established itself as a multi-skilled discipline and authority in the reconstruction of disabled bodies. This distinctiveness enabled it to sever ties with nursing, claim independence and work more closely with medicine. This chapter has argued that a linear narrative of progress does not capture the complexity of the massage profession's wartime transformation. Rather, the reconstitution of professional boundaries involved the renegotiation of continued debates about expertise, gender and intimacy within a complex web of wider military, political and professional interests. It argues that professionalisation was a resisted, contested and piecemeal process contingent upon broad forces as much as individual agency.

Conclusion

This study has investigated the professionalisation of massage in Britain from the late-nineteenth century up to 1920. This research sought to step away from institutional teleologies and narratives of 'medical control', which foreground leading individuals and institutions, and broaden the lens through which we consider this process. By tracing massage practice to a variety of different locations, this research gave agency to a wide range of people, practices and forces, showing that the evolution of 'massage' to 'physiotherapy' must be understood as part of and participant in, broader developments within society and medicine in this period.

Long before its professionalisation in 1895, massage, alongside other physical therapies including remedial gymnastics, mechano-, electro-, and hydro-therapy, had been of interest to orthodox medicine. In a climate of cultural pessimism towards modernity, anxieties of physical and mental decline, and apprehensions about scientific medicine, these modes of treatment, which harnessed nature and promised to restore the body, mind and promote fitness, gained broad appeal. Customarily the province of lay-practitioners, however, in order to be incorporated into medicine these practices were put upon a 'scientific' basis. Chapter 1 began by tracing massage to the discourses of medical men in the late-nineteenth century, examining how the practice was reworked within orthodox medicine. Heavily influenced by Swedish doctrine, these men literally re-wrote the history and status of massage in the language of medical science. Many historians have studied the shifting borders of medical orthodoxy and this thesis positioned the adoption of massage into medicine as part of this wider phenomenon. While Chapter 1 showed medicalisation 'in

action', evidence shows that this was an on-going process. The argument that massage was analogous to a 'dose' of medicine, which required special medical knowledge to administer, provided the basis for medical specialisation as well as the professionalisation of massage throughout the period. By tracing massage 'before' its professionalisation in 1894, therefore, this study offers insights into the translation of massage into medical science, which was a key process upon which all further practical and professional developments were based.

As Chapter 1 also showed, however, that the medical status of massage was fiercely contested and its adoption into British medical practice faced many challenges. Although it received a new *bona fide* scientific basis in the late-nineteenth century, the exact therapeutic properties of massage remained ambiguous and largely based on anecdotal and experiential evidence. Massage continued to be imperfectly understood and a topic of debate throughout the period as demonstrated by disputes about painful treatment in the First World War. With such tenuous medical status, a manual profile, and strong associations with 'empiric' lay 'rubbers' and 'shampooers', adopting massage *in corpore* was inconceivable for the majority of medical men before 1914. As Chapter 1 showed, the adoption of massage into British medical practice was dependent upon it being harnessed as a division of labour. This required a specification of skills: while, medical men argued, only the medically trained had authority over diagnosis and prescription, the labour-intensive manual work could be passed on to others to whom status was less of a problem. When massage erupted onto the British medical scene in the 1880s and 1890s, therefore, made popular by the introduction of Weir Mitchell rest-cure treatment,

it did so through the work of women - nursing professionals and others aspirant for careers.

While medical men agreed that massage was a division of labour, the expertise of the operator - whether it was a skill to be 'learnt in six lessons' or a profession that required prolonged training – however, was a topic of debate. Definitions of expertise mattered and they were articulated around professional interests in massage. Claims that massage required specialist training was a cornerstone of the STM's professional project, but something that was continually challenged by untrained workers, by medical men, the public and the state throughout the period. As the *BMJ's* 1894 massage scandals attest, it was not only the medical status of massage that caused anxiety. Chapter 2 showed that amid a broad movement for social purity in the late-nineteenth century mixed-sex massage proved altogether too explosive for the socio-medical imagination.

Nurse historians have long identified the importance of gender for female professional projects and the professionalisation of massage offers an opportunity to examine these forces at play. For the pioneering nurse-midwives of the Midwives' Institute and Trained Nurses Club who practised massage in the late-nineteenth century, professional status and reputation were of paramount importance. Subordination to the medical profession and prohibiting mixed-sex massage were two ways that the STM diffused the untenable intimacy of massage, rendering it a 'safe, clean and honourable profession' that 'respectable' women could undertake with impunity.¹ Negotiating intimacy stimulated the professionalisation of massage in 1895 and continued to shape its professional boundaries into the First World War, as evidenced by anxieties

¹ Quote from Jane H. Wicksteed, *The Growth of a Profession: Being the History of the Chartered Society of Physiotherapy, 1894-1945* (London: Edward Arnold & Co., 1948), p.26.

surrounding the treatment of injured soldiers. A contextualised study of the professionalisation of massage suggests that it does not fit comfortably within prevailing narratives of the 'medical control' of women. It shows that the development of the massage profession cannot be abstracted from its historical context and must be understood in light of the power relations that it negotiated. Chapters 2, 4 and 6 sought to highlight the agency of the massage profession and how through their actions they carved out a profession for women allied to nursing and medicine, becoming authorities in the arena of rehabilitation and physical treatment.

Despite important breakthroughs, scientific medicine remained relatively powerless in the face of many diseases and disabilities throughout the late-nineteenth and early-twentieth centuries. Tracing massage before the First World War led this project to a number of places that conventional medical practice was weak or ineffective. Chapter 3 showed that massage was an important part of, and indeed sometimes the only source of, relief for common musculo-skeletal conditions such as deformity, paralysis and rheumatic pain. Furthermore, it offered a therapeutic that promised to reform the disabling consequences and inefficiencies of conventional injury and fracture treatment. While historians have highlighted the limited scope of medical rehabilitation before the First World War, the use of massage in these arenas signals a nascent conscience within medicine towards restoring physical function. This was part and product of a wider emergent culture of rehabilitation and drive for efficiency that expressed itself in a variety of different ways throughout society and politics in the late-nineteenth century. Chapter 3 showed that massage was an important instrument of medical rehabilitation before the First World War, and that its assimilation into medical practice supported the medical

profession's entry into the unfamiliar therapeutic territory of physical treatment and disability. However irrelevant massage practice may seem to medicine, therefore, this study illuminates that medical developments occurred not only through individual agency and surgical breakthroughs, but also practices, traditions and practitioners often historically and historiographically marginalised.

As Chapter 3 also showed, however, the majority of medical practitioners in Britain remained distant from physical remedies and the treatment of disability. Evidence of haphazard, vague prescriptions for 'massage' as a last resort of treatment feature throughout the period and signal a broad professional disinterest in this territory as well as the dismissal of many patient groups considered 'hopeless'. As Chapter 4 showed, the absence of medical interest in specialising in this arena opened up a window of opportunity for the immigration of foreign expertise as well as the professionalisation of massage. As such, the massage profession found that it exercised a considerable amount of practical autonomy over its work, a fact which enjoined it to develop specialist expertise in the field of rehabilitation and physical treatment. Professionalisation did not develop *de novo*, however, and rather, as Chapter 4 showed, in a dual process the massage profession emulated the training and expertise of the Swedish gymnast whilst also drawing upon established nursing skills, etiquette and imagery. This was a strategy that carved the massage profession out as purveyors of an expertise indispensable, but also loyal, to the medical profession. Tracing massage before the war, therefore, offers a broader lens through which to consider the early professionalisation of massage than a focus on the massage scandals alone allows. It shows how the massage profession was a vehicle through which mechanical expertise was integrated into British

medicine without medical men having to adopt the practice themselves or relinquish authority to competing foreign professionals.

With a broader view of professionalisation, then, we can understand why on the outbreak of the First World War the massage profession was of the first provision mobilised for the restoration of injured soldiers. As studies show, in the context of urgent demand for manpower the military and political value of restoring the disabled dramatically increased. As such, physical remedies that were, before 1914, marginal to medical practice became central, and the work of the massage profession gained unprecedented importance. Chapter 5 examined massage during the war, showing that the pre-war expertise of the massage profession was mobilised on a vast scale through the APMC, Convalescent Camps and Command Depots. As the value of medical rehabilitation increased, a range of competing lay and medical practitioners interested in this territory also proliferated. Chapter 5 showed that the rise of military orthopaedics and physical medicine engendered the eclipse and control of the massage profession. While historians have highlighted the importance of these specialisms for medical advances during the First World War, this study sought to illuminate the contribution of the massage profession to the development and deployment of rehabilitation, as a service in and of itself and as an auxiliary that supported medical specialisation.

A study that considers professionalisation during the First World War invariably touches on the debate as to whether war has been 'good' for medicine.² Studies have shown that by providing large groups of patients, specialised facilities and financial resources, war offers a positive environment for specialty formation. As Chapter 6 indicated, the war certainly had a

² Roger Cooter, 'Medicine and the Goodness of War', *Canadian Bulletin of Medical History*, 7 (1990), 147-59.

transformative impact upon the massage profession - by 1920 it had become practically and professionally embryonic of modern physiotherapy and achieved unprecedented public, medical and state support for its activities. By aligning itself to the ideology of rehabilitation and a combined physical treatment approach both foregrounded by the war, the massage profession was able to separate from nursing and establish an independent role coherent with social, medical and political aspirations. As Chapter 6 showed, however, the impact of the war upon the professionalisation of massage has to be assessed in light of its historical context rather than in abstraction. Such analysis highlights a more nuanced picture embracing both continuity and change; the war provided fertile conditions for a magnification and adaption of the massage profession's pre-war work. While the practical and professional boundaries of massage were transformed, this was not a linear process but rather the result of continuing debates about intimacy, medical status and expertise renegotiated in a different set of historical circumstances.

Future Directions

Potential directions for the development of this research are numerous. The most immediate avenue that arises is an assessment of the full significance of other physical methods to the professionalisation of physiotherapy as well as the development of rehabilitation more broadly. While this study highlighted the significance of massage for the history of physiotherapy, physiotherapy has constituted a broad-based specialism that incorporates a number of methods including remedial exercise, hydro-, electro- and actino-therapy, each with their own histories. As such, this study is only partial and would stand alongside further research in these other areas to map a broader picture of the history of

physiotherapy. Using a similar approach, tracing these practices to consider how they operated in the context of rehabilitation in and of themselves and how and why they were assimilated into medicine through the expertise of the physiotherapist offers a potential area for inquiry.

This study touched on many of these areas as they came into contact with the early massage profession. In particular, this research highlighted the importance of Swedish doctrine to the development of physical therapy and rehabilitation in Britain. The immigration of Swedish gymnasts in the late-nineteenth century had a considerable impact upon physical culture in Britain. While their significance as physical educators has been studied, their role as physical therapists has not.³ Yet, as this research points out, the lack-of medical specialisation in the field of mechanical therapy before 1914 served as a magnet for Swedish gymnasts who introduced their expertise in hospitals and private clinics throughout the country. Furthermore, Lingian doctrine pervaded medical discourse on rehabilitation long after the marginalisation of Swedish practitioners. Evidence shows that Swedish gymnasts participated as physical therapists in the First World War and, like that of the masseuse, their pre-war expertise in this field was highly sought after by medicine and the state. This thesis has but highlighted the significance of this group; their full practical and ideological contribution remains to be explored.

Another direction this study points to is British spas. Like the massage profession, British spas and other health resorts were immediately mobilised during First World War to rehabilitate injured soldiers, representing their pre-war expertise in the field of rehabilitation and physical treatment. While their

³ Studies that examine Swedish gymnasts as physical educators includes, Steve Bailey and Wray Vamplew, *100 Years of Physical Education, 1899-1999* (Warwick: Warwick Printing Company Limited, 1999); Jennifer Hargreaves, *Sporting Females: Critical Issues in the History and Sociology of Women's Sports*, 3rd edn. (London: Routledge, 1997); Kathleen E. McCrone, *Sport and the Physical Emancipation of English Women* (London: Routledge, 1988).

activities had been limited to 'a few scores of invalids of the wealthy classes', however, in 1914 these institutions were transformed and undertook a great amount of work with injured men.⁴ The contribution of British spas to the War effort and their significance as pre-war hubs of physical therapy expertise is another potential focus for further research.

In tracing massage to a variety of locations in the late-nineteenth century, this research came across the presence of lay-practitioners often called 'rubbers' or 'shampooers'. While medical men and professional masseuses frequently cast their activities as 'empiric', 'ignorant' and 'quack' in order to assert their professional interests, rubbers were popular practitioners. Their presence was a key part of the professionalisation of physiotherapy as it was 'ignorant rubbers' that professionals defined themselves against and sought to marginalise. Focussed research into the activities of these lay-practitioners could offer a valuable perspective on the broader history of physiotherapy and medical professionalisation as well as a lens to explore little studied areas such as Turkish baths and massage establishments which were a part of Victorian urban culture.

Finally, this study is limited chronologically. While this research has argued that a specialism embryonic of physiotherapy can be traced to the beginning of the century, it was not until 1943 that the massage profession officially switched its title to 'physiotherapy'. How the massage profession adapted and developed to the dramatic changes within society and medicine in the interwar years and Second World War would be a valuable extension of this work. A fully contextualised history of massage, gender and disability after the First World War remains to be written.

⁴ Robert Fortescue Fox, 'Physical Remedies at the British Spas', in *Physical Remedies for Disabled Soldiers*, ed. by Robert Fortescue Fox (London: Baillière, Tindall and Cox, 1917), pp.237-270, (p.237).

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