

Title *District Nursing in England and Wales c.1919-1979,
in the context of the development of a Community
Health Team.*

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Abstract

The thesis views the development of District Nursing as a sub-profession or specialty within the nursing profession together with the emergence and evolution of a team approach to community care during the middle sixty years of the twentieth century (1919-1979). This takes in the period immediately following the Nurses' Registration Act (1919), through the inter-war period and Second World War, the introduction of the National Health Service, up to the reorganisation of Community Healthcare culminating with the Nurses, Midwives and Health Visitors Act of 1979. By the end-point of the thesis the district nurse can be seen to have become an established member of the primary health care team within the community. Contextualising this period of change within the development of a community health team enabled the thesis to consider the relative importance of intra- and inter- professional tensions to the development of a sub-profession – in this case, district nursing. The study has included under this remit the extended professional roles, social and political professional issues and changing power bases, and the conflict between desire for recognised autonomy and for membership of a health care team. In addition, it has been possible to address issues of gender central to a profession largely composed of women throughout the period working alongside a medical profession largely composed of men. The subject has lent itself to a consideration of the degree of influence of medically-related technologies and of developments in communications and transport on the changing role, image and work-experience of the district nurse.

The geographical focus of the research has broadly encompassed England and Wales, within which three contrasting regions have been selected for more detailed study of their comparability. These were felt to provide a varied and demographically representative cross-section of environments in England and Wales. Perhaps the most challenging, but also most innovative aspect of the thesis is the grass-roots view given of the district nurse obtained through employing the viewpoints of individual nurses based on oral history supplemented with personal communications and written, autobiographical accounts. A case study of one district nursing association in Lancashire has supplemented this 'bottom-up' view of the nurse's experience and changing role. And a study of imagery relating to district nursing, incorporating various forms of media and professional representations, examines changing cultural images and social stereotypes of district nurses. Underlying changes that were taking place in district nursing at micro and macro levels are here quantitatively illustrated, such as

- the shifting pattern of district nursing associations throughout the regions of England and Wales in the inter-war period, the changing numbers of district nurses of various grades employed, and their varying workloads. The thesis concludes with a brief forward look to consider how the changes that were to follow the 1979 reorganisation were to affect district nurses' professional relationships, roles and images in the decade to follow.

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Numerous friends and relations at home and work have been extremely supportive in a variety of ways and I would like to mention in particular my colleagues in the History of Nursing Research Colloquium, The RCN History of Nursing Society, the Oral History Group and the staff and fellow research students of the School of Humanities at Oxford Brookes University. I am also very grateful to John Stewart my second Supervisor, who has offered helpful advice and perceptive comment during the preparation of this work and to Elaine Ryder in the School of Health Care who has been an extremely helpful adviser on more recent district nursing issues and always extremely generous with her time and wealth of experience. More recently I must thank the staff and research colleagues at the Oxford Wellcome Unit,

who have supported and encouraged me through the final painful months in a multitude of ways -I look forward to the next three years working with them and thank them for making me feel so 'at home' there already!

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Working with Anne and having her as a mentor, has been a wonderful experience for which I consider myself incredibly fortunate and I thank her for always believing in me and giving me the confidence to achieve.

Finally I should like to thank my family for their loving support and encouragement throughout my studies over many years leading up to this point. Most of all my husband John, and children Jennifer and Robert, who have lived with this piece of research and have unfailingly provided much moral and intellectual support, loving understanding and encouragement throughout. I therefore dedicate this thesis to them.

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Conventions

Abbreviated Terms

BMA	British Medical Association
BMJ	British Medical Journal
CMAC	Contemporary Medical Archives Centre (Wellcome Institute for the History of Medicine)
CMB	Central Midwives Board
CSSD	Central Sterile Supply Department
DN	<u>District Nursing</u>
DNA	District Nursing Association
GMC	General Medical Council
GNC	General Nursing Council
GP	General Practitioner
HV	Health Visitor
HMSO	His/Her Majesty's Stationery Office
JHNJ	<u>International History of Nursing Journal</u>
MOH	Medical Officer of Health
NHS	National Health Service
NNMC	<u>Nursing Notes and Midwives' Chronicle</u>
NT	<u>Nursing Times</u>
QN	Queen's Nurse
QNJ/ QIDN/	Queen's Nursing Institute also Queen's Institute of District Nursing also
QVJJN	Queen Victoria's Jubilee Institute for Nurses
ONM	<u>Queen's Nurses' Magazine</u>
RCN	Royal College of Nursing
RFN	Registered Fever Nurse
RGN	Registered General Nurse (= SRN)
SCM	State Certified Midwife
SEN	State Enrolled Nurse
SHM	<u>Social History of Medicine</u>
SRN	State Registered Nurse
UKCC	United Kingdom Central Council for Nursing and Midwifery

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Part I
'Background: Contexts and Perspectives'

Chapter 1: Theory, Methodology and Critique of Literature and Sources

I Background and rationale to the research

This thesis has been inspired in particular by two previous areas of research in which I have worked. The first was my MA dissertation¹ in which I studied the relatively recent creation and development of the new specialism of intensive therapy, which included viewing the professionalisation of nursing and medicine as seen from the high-profile, technological end of the medical *institutional* spectrum. This begged the question: what was happening at the other, essentially generalist and low profile, *domiciliary* end of that spectrum which is arguably the oldest and most firmly established, professionally? That study also made use of oral history to assess different nursing, medical and paramedical viewpoints of the development of a specialism - a method I have further developed and employed in this work. The main focus of this study of the history of Intensive Care, was the question of technological influence on the development of that specialism. I felt this idea merited further study, and it has therefore been brought forward and incorporated into this thesis by for example establishing the degree of influence of medically-related technologies and of developments in drugs, materials, communications and transport technologies on the professional development of district nursing.

The second area of research that has particularly influenced this thesis was a study of general practice medicine² in which, as a research assistant I had been involved in looking at the professional evolutionary development of the medical generalist. The inter-professional dimension of this raised a number of questions which I felt could not be fully answered without an equally in-depth look at the other health professionals with whom the GP came into increasing contact as the concept of the community care team emerged. In particular this was the need to address issues of gender relationships central to a (nursing) profession largely composed of women (throughout the period of study) working alongside a (medical) profession largely composed of men. Central to this power play of institutional and occupational imperialism is an understanding of the effect of conflict and concord both intra- and inter- professionally on the development of district nursing, including extended professional roles, social and political professional issues and changing power bases, as well as the apparent conflict between a desire for recognised professional autonomy and accepted membership of a community health care team. Following the methodology used in that research project, this thesis has similarly made use of collective biography through the

¹ Sweet, H. M., (1994), To investigate the creation and subsequent development of the Intensive Care Unit in the United Oxford Hospitals. citing this in the context of British Intensive Care development; and to question to what extent this was influenced by developments in medical technology, Unpublished MA Dissertation, Oxford Brookes University.

² Digby, A., (1999), The Evolution of British General Practice 1850-1948.

prosopographical approach³ particularly through oral history. This methodology seemed particularly appropriate for application to study of the professional development of district nursing as it lends itself to a comparison of the Jives and careers of cohorts of professionals, enabling access to a Jess elite, whilst heavily gender-biased, health professional group.

In addition there has been a third, more personal influence on the choice of subject, namely that I trained and practised as a nurse and midwife in the final decade covered by this thesis, working for a short time as a district midwife, and was privileged to experience working with several of the 'old school' of district nurse-midwives who worked relatively autonomously from their homes rather than from group practices as a part of a team, and who lived within the community which they served. This has proved to be a largely positive factor in providing an informed platform from which to begin the research, - in particular an insight into the professional images of district nursing and the complexities of inter- and intra-professional relationships which have inspired a number of inquiries in this area, but also into the changing day-to-day working experiences of the district nurse at 'grass-roots' level. However, it has been my intention to minimise the subjective element as much as possible where pre-conceived notions might bias the study, a balancing act that proved especially difficult in the province of oral history as will be discussed below (see Methodology and Chapter 2).

II Historiography

Current scholarship in the area has tended to focus either upon the earlier period leading up to the founding of the Queen's Institute for District Nursing (1897)⁴ questioning the Dickensian image of the district nurses midwives as portrayed by 'Betsy Prigg' and 'Sarah Gamp'⁵ or by considering the work of William Rathbone in Liverpool,⁶ the 'mission women' of Manchester, Salford and London,⁷ or examining the rationale behind Florence Nightingale's hostility towards hospital-based health care. Alternatively the emphasis has been focused

³ See Digby, A., and Sweet, H.M., (1998). 'Collective Biography and the History of the British General Practitioner 1850-1948' in: Discussion Papers in Contemporary and Historical Issues in Health Care. J. Andrews, and J. Stewart, Oxford Brookes University: 55-62.

⁴ Stocks, M., (1960). A Hundred Years of District Nursing. London, Allen and Unwin; Baly, M., (1987), A History of the Queen's Institute: 100 years 1887-1987.

⁵ District nurses caricatured in Dickens, C., (1843-4). The Life and Adventures of Martin Chuzzlewit. In particular these have been examined by Summers, A., (1989). "The Mysterious Demise of Sarah Gamp: The Domiciliary Nurse and Her Detractors -1830-60." Journal of Victorian Studies (32(3)): 365-386. and more recently by Fenne, J. J., (2000). 'Every Woman is a nurse': Domestic nurses in nineteenth-century English popular literature (Charles Dickens. Mary Augusta Ward). PhD Thesis (English), The University of Wisconsin-Madison.

⁶ Hardy, G., (1981). William Rathbone and the Early History of District Nursing.

⁷ See for example Prochaska, F. K., (1987). "Body and Soul: Bible Nurses and The Poor in Victorian London." Historical Research 60(143): 336-348; Davies, C. (1988). "The Health Visitor as Mother's Friend: A Woman's place in Public Health 1900-14." SHM (1):39-59; Williamson, L. (1996). "Soul Sisters: The St. John and Ranyard nurses in nineteenth century London." IHNJ 2(2 (Winter)): 33-49.

either upon the District Nursing Associations prior to the N.H.S. Act (1948),⁸ or upon the contemporary rather than the historical aspects of recent community-care re-organisation following the 1993 Community Care Act with the emergence of GP fund-holding practices, changes in structure of work, pay and conditions of district nurses, and the rise of the 'practice nurse'.⁹

Other members of the community health team having received recent attention from medical historians relating to this period include GPs,¹⁰ health visitors,¹¹ and midwives,¹² whilst the historical development of the hospital nurse has also been widely researched.¹³ In comparison therefore, serious consideration of the district nurse through this period of the twentieth century was long overdue and should provide a better understanding of the evolving community care team by contextualising the historical background to developments in this field of nursing and by expanding inter-professional relationships rather than viewing individual members of that team in isolation. The tendency of nursing history has been to view nurses as if they were a homogenous group of professionals -even where these are divided into sub-groups such as district nurses or health visitors, it is difficult to see them as individuals. This thesis uses oral history and records of individual nurses in an attempt to rectify this and to address the different experiences of nursing in different regions and environments.

¹Fox, E. N., (1993). District Nursing and the work of District Nursing Associations in England and Wales, 1900-48; Fox, E. (1994). "District Nursing in England and Wales before the National Health Service: The Neglected Evidence." *Medical History* 38: 303-21; Fox, E. (1996). "Universal Health Care and Self-Help: Paying for District Nursing before the National Health Service." *Twentieth Century British History* 7(1): 83-109.

⁹Walby, S., Greenwell, J., et al. (1994). Medicine and Nursing: Professions in a changing Health Service; Davies, C., (1995). Gender and the Professional Predicament in Nursing; Littlewood, J., Ed. (1995). *Current Issues in Community Nursing*; Rafferty, A. M., (1996). *The Politics of Nursing Knowledge*.

¹⁰Donnison, J., (1977). Midwives and Medical Men: History of Interprofessional rivalries and Women's Rights; Loudon, I. (1984). "Medical Care and the Family Doctor." *Bulletin of the History of Medicine* (58).

¹¹Dingwall, R., (1980). 'Problems of teamwork in primary care', in: *Teamwork in personal social services and health care*. S. Lonsdale, A. Webb, T. Briggs; Davies, C., (1988). "The Health Visitor as Mother's Friend: A Woman's place in Public Health 1900-14." *SHM* (1): 39-59; Kelsey, A. (2000). "The making of health visitors: an historical perspective part 1." *IHNJ* 5(3 (Summer)): 44-50; Kelsey, A. (2000). "The making of health visitors: an historical perspective part 2." *IHNJ* 6(2): 66-70.

¹²Fox, E., (1993). "An Honourable Calling or a Despised Occupation: Licensed Midwifery ..." *SHM* August 6(2): 237-259; Leap, N. and Hunter B., (1993). *The Midwife's Tale: An Oral History from handywoman to professional Midwife*; Pitt, S., (1996), Midwifery and Medicine: Discourses in Childbirth 1945-1975, PhD University of Wales; Mortimer, B., (2002), *The Nurse in Edinburgh c.1760-1890: The impact of commerce and professionalisation*. PhD University of Edinburgh.

¹³Abel-Smith, B., (1960). A History of the Nursing Profession; Dingwall, et al., (1988). An Introduction to the Social History of Nursing.

In addition, Maggs'¹⁴ has criticised historians of nursing for writing very little about the actual history of 'nursing' itself -he asserts that most scholarship in this field to date has focused either upon nurses, nursing organisations, professionalisation of nursing or nursing institutions and specialisms. In this thesis oral history will be shown to have been particularly valuable in addressing this deficiency, not only highlighting changes in perception of status and inter-professional relationships, but also in revealing what the nurse actually *did*, providing detail of the daily tasks, routine and workload and personal experience. Together with some archival material from district nursing association records, the oral histories present a uniquely vivid picture both of regional variations and of the shared experience of what it meant to *be* a district nurse. This makes it possible to suggest that being a district nurse in South Wales in the 1920s might have been quite different from being a district nurse in Lancashire in the 1970s, yet both nurses would recognise certain commonalities that were essential to their work as district nurses and which, I would propose, represent an 'essence' of district nursing that transcends both time and region. The thesis therefore differs from existing scholarship in the weight it gives to establishing and understanding the changing relationships between district nurses and other members of the emerging community health care team over this sixty-year period, and in particular in understanding the diversity of experience and role that existed within the developing sub-profession of district nursing throughout this time.

The period boundaries for the thesis were initially to have been much broader but after the initial literature search revealed the potential size and scope of the study, they were narrowed down to 1919 through to 1979. This conveniently presents a sixty-year period of 30 years before and 30 years after the NHS Act of 1948 and which was marked at one end by the Nurses Registration Act (1919) and at the other by the Nurses, Midwives and Health Visitors Act (1979). In effect it therefore begins with the introduction of compulsory registration for general nursing which marks a significant point in nursing's professional development, whilst terminating at the point when all nursing statutory and non-statutory bodies, (which in the case of district nursing included the Queen's Institute for District Nursing, the General Nursing Councils and the Central Midwives' Board) were replaced by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting.¹⁵

The initial stage of research therefore focused on provision of an outline of the development of the district nurse, since the period studied covers a time of considerable change in the nursing profession and in community health provision generally. Early work suggested a number of inter-related themes and issues and it was anticipated that aspects of

¹⁴Maggs, C.,(1996). "A history of nursing: a history of caring?" Journal of Advanced Nursing 23 (3 (March)).

¹⁵Davies, C.,Beach, Abigail, (2000). Interpreting professional self-regulation :a history of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

professionalisation and legislation would provide the central focus to the thesis. Firstly this considered the transfer of Poor Law administration to local authorities in 1929 and the growth of voluntarily organised District Nursing Associations in the 1920's and 1930's questioning how this affected professional development, and how it changed following the 1948 NHS Act and subsequent Health Service reorganisation? Secondly, understanding the political complexities surrounding the establishment of District Nurse training and education nationally, which were only resolved at the very end of this period, led to questioning the extent to which local authorities adopted any form of national standard for district nurse training and whether there were rural/urban/regional differences in training provision and requirements. Research into this aspect of district nursing's professional development was based to some extent on the research carried out by a research team led by Dr. Lisbeth Hockey¹⁶ on behalf of the Queen's Institute in the 1960's and on the recommendations of subsequent parliamentary and professional reports.¹⁷ It was supplemented by oral testimony, which included several discussions with Dr. Hockey, herself.

As the research progressed other questions came to the fore. Amongst them was the need to determine the relative importance of intra- and inter-professional tensions and the concept of nursing as a sub-profession to medicine, which became a central theme running throughout the thesis and exposing a number of dichotomies:

- How accurate is the stereotypically perceived dominant, paternalistic role of GP as 'gatekeeper' and 'curer' and subordinate role of District Nurse as 'handmaiden' and 'carer'. How and why did these change over the period of study?
- How are these roles related to changes in perceived social status within the public and private spheres of the community as well as to professional status within the 'medical team' (community and hospital), and to changes in training and job-descriptions?
- Is it possible to assess changes either in public image and awareness of district nurses and in the self-images and perceived status of the district nurse during this period?
and
- Where does the idea of vocation fit in with professionalisation in the community context in which district nursing is located?

¹⁶ Hockey, L., (1966), Feeling The Pulse; Hockey, L., (1968), Care in the Balance; Hockey, L., and Buttimore, A., Ed. (1970). Co-operation in patient care: Studies of District Nurses attached to hospital and general medical practice; Hockey, L., (1971), 'The Family Care Team: Philosophy, Problems, Possibilities' in Ciba Foundation Symposium on Teamwork for World Health, G. Wolstenholme, and M. O'Connor: 103-115.

¹⁷ Ministry of Health and S. F. Armer, (Chair) et al, (1955). Report of the Working Party on the Training of District Nurses; DHSS (1970). The State of the Public Health: Report of the Chief Medical Officer; Department of Health and Social Security (1972). Cmnd. 5055: National Health Service Reorganisation; Department of Health and Social Security and P. A. Briggs, (Chair) et al (1972). Cmnd. 5115: Report of the Committee on Nursing; General Nursing Council (1977), Educational Policy 1977 Annual Report; Royal College of Nursing, (1988), Specialties in Nursing: A Report of the Working Party Investigating the Development of Specialties within the Nursing Profession.

As a result, dilemmas of professionalisation of this sub-group within the developing nursing profession came to represent the major, if not over-arching preoccupation of this thesis. Specifically these involve attainment and maintenance of an elusive professional 'status' and public respect, control of standards through recognised and autonomous regulation, control and (to a large extent) internal accountability of district nurses, autonomy of practice, and influence over conditions of service. The major theme running throughout this thesis and interlocked with that of professionalisation, is that of a developing community care team within which district nurses had to negotiate and secure their place whilst simultaneously fighting to develop an autonomous professional standing. The main preoccupation here is with inter- and intra-professional relationships, particularly with GPs and health visitors but also with their hospital colleagues. These may be seen as under-pinning both hegemonic, inter-professional influences producing a form of 'occupational imperialism'¹⁸ in the wider framework of gender-restricted and class-based citizenship. These elements contributed to the limited participation in influential professional and profession-related bodies, such as NHS planning committees and post-NHS representative bodies, to be discussed in chapters 5 and 6. However, alongside this the thesis considers the changing internal power-bases as control of many aspects of district nurses' professional and private lives moved from 'Lady Superintendents' to the 'Committee of Ladies', often under the auspices of the Queen's Institute, and eventually to transfer responsibility for employment, training and regulation to local government.

A number of minor, but inter-related themes will also be pursued, all of which may be directly linked with this precarious professional balancing-act. One recurrent issue arising throughout this study is the emergence of technologies such as pre-packaged sterile supplies, new materials, communications technologies and developments in means of transport. Issues of gender and class are also raised including those arising from tensions following the introduction of male nurses from 1947. Likewise, variations and changes in the district nursing experience including pay and conditions, workload and mobility of practice are also related to geographical location of practice throughout this thesis, shown both through the urban/ rural contrast and when comparing several regions across England and Wales.

III Criticism of sources and literature review

The primary and secondary sources used throughout this research deliberately encompass a broad range:

¹⁸Larkin, G., (1983). Occupational monopoly and modern medicine.

Primary literature:

1998 saw the launch of the Queen's Institute's Archive catalogued by the Contemporary Medical Archives Centre of the Wellcome Institute for the History of Medicine¹⁹ making easily accessible records including registers and correspondence of affiliated branches of the Institute. Although some of this material was available to earlier researchers, the acquisition and detailed cataloguing of such a wide range of material in one repository enabled a more comprehensive study than was possible previously. It could be suggested that this gave an elitist view through over-emphasis on Queen's Nurses at the expense of non-Queen's nurses, however, I would argue that a considerable amount of the material in these files related to both groups, whilst any bias has been partially offset by looking at other, non-Queen's sources. In particular, the detailed listings of district nursing associations published in Burdett's Hospital Directories and Yearbooks²⁰ were found to contain valuable and previously unexplored material relating to the district nursing associations of England and Wales. These suggested that a combined quantitative and qualitative analysis might prove particularly illuminating (see methodology, below). This had its own problems -not least, the sheer size of the lists and subtle changes of information provided in entries from year to year, and conversely, the failure of some associations to update their records regularly. Although there is no alternative means of checking the accuracy of the data, taking the information from so many associations should minimise the impact of these on the overall picture.

In addition the three editions of the Handbook for Queen's Nurses²¹ plus contemporary (non QNI) textbooks of nursing throughout the sixty-year period, provided a glimpse of the profession's view of itself and of the changing role and daily work of the Queen's District Nurse. The Journals of the Queen's Institute -Queen's Nurses' Magazine, [QNM]²² District Nursing, [DNJ]³ and the Queen's Nursing Journal, [QNJ]²⁴ provided valuable insight into the developing profession's self image, priorities, and political, economic and social outlook, whilst revealing regional differences. Again, these books and journals were produced for, and largely written by Queen's Nurses, and to gain a more balanced overview, other journals were also studied in as much depth as time allowed, including Midwife. Health Visitor and Community Nurse,²⁵ and Nursing Mirror and Midwives' Journal,²⁶ together with material gleaned from a number of other nursing, medical and public health journals. It is,

¹⁹ Dixon, S., (1998). SA/QNI The Queen's Nursing Institute. CMAC Wellcome Institute for the History of Medicine; Dixon, S., (2000). "The Archive of the Queen's Nursing Institute in the Contemporary Medical Archives Centre." Medical History 45: 251-166.

²⁰ Burdett, H., (1900-31). Burdett's Hospitals and Charities Yearbooks.

²¹ 1924, 1932 and 1943 editions.

²² QNM, 18??-1958

²³ DN, Vol. I, no. I (Apr. 1958)-v. 15, no. 12 (Mar. 1973)

²⁴ Queen's Nursing Journal, (1973-)

²⁵ Midwife. Health Visitor and Community Nurse, v. 1-27.

²⁶ Nursing Mirror and Midwives' Journal.

nevertheless, significant that the Queen's Institute represents the main producer of professional texts relating to district nursing for most of the period covered by this thesis as this serves to underline its crucial position as the mouthpiece for, and main force behind, district nursing throughout most of the twentieth century. This was a particularly important role bearing in mind the otherwise non-institutional nature of district nursing, as seen in its struggle for professional recognition set alongside its hospital counterpart. This theme will be developed in Chapter nine.

Secondary literature:

Previously published histories of district nursing²⁷ and unpublished theses²⁸ were invaluable in providing an informed background to this thesis, whilst the notes²⁹ Mary Stocks made in the preparation of her book were most helpful in pointing to areas which she felt deserved attention, but were beyond the remit laid down to her by the Queen's Institute – in particular, the changing relationship between district nurses and their supervising authorities viz. the Lady Superintendents and the ladies of the (lay) District Nursing Association Committees – these have been examined in Chapters 3 and 4. On the other hand, the histories written by Stocks³⁰ and Baly³¹ were both subject to the confines of being commissioned institutional histories for the QNI and therefore somewhat neglectful of the district nurses who were not Queen's trained. Also, neither provide more than a very limited insight into the changes in daily work and evolving role of the nurse at grass-roots level, nor into the relationships between district nurses and their professional colleagues within the community. This is particularly so where the wartime experiences of district nurses are concerned, as most secondary accounts are limited to brief references of heroic acts by midwives during the blitz with the main focus centring on the QNI's battles with the Ministry of Health in the negotiations leading to the introduction of the National Health Service.

The ground-breaking thesis in this field by Fox,³² whilst providing a well-researched administrative institutional history of district nursing presented, 'as a case-study of voluntarism'³³ concentrates on changes in social policy for the period leading up the NHS Act (1948) with particular attention given to the relationship between statutory and voluntary

²⁷ For example, Stocks, M., (1960). A Hundred Years., and Hardy, G., (1981). William Rathbone and the Early History of District Nursing.

²⁸ McIntosh, J. B., (1975). An Observation and time study of the work of domiciliary nurses. Aberdeen, PhD Thesis, University of Aberdeen; Fox, E. N. (1993). District Nursing and the work of District Nursing Associations in England and Wales. 1900-48, PhD Thesis, London.

²⁹ QNI Archives, (1956-65). SNQNI Box 114 P13/1-11: Correspondence and material used by M. Stocks for preparation of 'A Hundred Years of District Nursing'.

³⁰ Stocks, M., (1960). A Hundred Years.

³¹ Baly, M., (1987). A History of the Queen's Institute: 100 years 1887-1987.

³² Fox, E. N., (1993), District Nursing and the work of District Nursing Associations in England and Wales. 1900-48.

³³ *Ibid* p. 14

agencies, and with an emphasis on the rural rather than urban community setting. Her source for material for this was mostly the (centrally located) official records of the QNI and of the Ministry of Health. In her conclusion she notes that 'local studies are the most productive means of extending knowledge of district nursing as a service',³⁴ but that as this had not been within her remit, she had not chosen to follow that course nor to make use of oral history. Consequently her thesis does not give prominence to professionalisation nor does it attempt to define the district nurse's tasks or changing role.

There is a considerable wealth of literature on gender and professionalisation and on labour issues, which has provided extremely helpful secondary evidence. However, even where this is directed specifically at nursing as a developing profession, most studies have focused on the institutionalisation of nursing with the hospital setting rather than taking the community as focus. This is largely because this area is well resourced with data such as pay and conditions, numbers of nurses employed, training and qualifications, and duties expected of the nurses. It has been interesting to test some of the findings of these for their applicability to the district nursing profession, and similarly to elucidate comparisons where the key texts in these fields have been based on women in professions other than nursing, such as the teaching or medical professions, secretarial work, or in industries such as textiles manufacturing. It highlights the 'Cinderella' status of nursing's historiography that, at least until very recently, very little has been written about nursing as part of the labour market, particularly in the inter-war period.

IV Theory and Methodology

The thesis has incorporated a range of research methods and techniques. Firstly a search and analysis was made of a variety of primary and secondary sources including personal and professional records, District Nursing Associations' records and professional and governmental legislation, journals and textbooks of district nursing and earlier scholarship in this field. Apart from the Queen's Institute records and those of the Central Council for District Nursing in London, held by the Royal College of Nursing (henceforth RCN) Archives in Edinburgh, much of the archival material that has survived relating to Nursing Associations is scattered in County Record Offices and the archives of voluntary organisations. It has therefore been necessary to concentrate on a select, and therefore manageable number of regions in England and Wales, with the intention of creating a cross-sectional picture of rural and urban, industrial, agricultural, and coastal areas of England and Wales. These were to be points of focus rather than exclusive areas of study and were arrived at following an initial search in which the available material was assessed. This was greatly assisted by a summary of archival holdings relating to medical and nursing history held on card file by the Wellcome Unit of Oxford University. By creating a database from this it was possible to locate several

³⁴ Ibid p. 357

regions apparently presenting concentrations of primary material that were likely to be productive. In general this proved to be a very successful method in avoiding too much travel and time-wastage, but was not infallible as the disappointing visits to the Dorset Record Office and to Carditrs Record Office demonstrated. Coincidentally, it was found following a mail-shot made through the Queen's Institute to its membership list, that sufficient numbers of oral histories could be obtained in several of these 'hot-spots' to provide a useful picture of district nursing, so that the regions eventually selected were Dorset and Oxfordshire, South and mid- Wales, Lancashire with Liverpool and London. The methodology used both in selecting and obtaining oral histories will be explained and discussed in detail in Chapter 2.

As well as archival material, forty oral histories of district nurses and other members of the community health team were made in personal interviews and these were later transcribed. Copyright permission has been granted for them to be deposited with the RCN's 'Oral History Project' Archives and in the National Sound Archives 'Life-story Collection', in line with their legal and ethical requirements. In addition, the Wellcome Institute also holds a number of oral histories of general practitioners conducted by Dr. M. Bevan,³⁵ which were helpful in supplementing and comparing with my own, as were the district nursing interviews held by the Liverpool Oral History Project and Dorset Record Office and the RCN Oral History Project. Computer assisted quantitative analysis of particular data contained in these oral histories (using Microsoft Access software) was used as part of the analytical methodology. (Again, this methodology is explained in greater depth in Chapter 2). This concentrated particularly on the changes of social backgrounds of the nurses interviewed, their initial and subsequent training, places of practice and conditions of service, whilst a more qualitative approach was needed to unravel changes in role and in perceptions of image and professional identity. As mentioned above, there was some difficulty in keeping these oral histories free of bias arising from the history of the interviewer herself: it seemed futile to hide my background as a nurse from interviewees (indeed it was often positive in prompting discussion and eliciting comment which might not have been otherwise forthcoming) yet it is difficult to eliminate the effects this might have had on the respondents. Nevertheless, where it has been possible to compare oral histories carried out by non-nurse historians³⁶ with district nurses it is encouraging that the replies are strikingly similar, although sometimes less detailed or allowing for less shared medical knowledge and understanding of nursing

³ Bevan, M., Wellcome Oral History Project of the GP: 74 Life Histories, Wellcome Contemporary Medical Archives Collection.

³⁶ These were: Rona Fergusson, who has conducted a similar number of oral histories in Scotland; Francis Trees, who interviewed nurses who trained and/or worked in Liverpool, amongst whom were a small number of district nurses; and Sheila Davidson who interviewed a group of retired nurses living in a retirement home in Sussex, amongst whom were a few district nurses. I am indebted to these three for sharing their experiences with me, and it should be noted their interviews are, or soon will be, deposited with the RCN archives as part of its oral history collection.

procedures. This would suggest that contrary to early fears, bias from this angle was not a negative feature and encouraged increased rapport between interviewee and interviewer.

The material in Burdett's Hospital Directories and Yearbooks was also analysed using a Windows Microsoft Access database. This was based on data such as terms and conditions of employment of district nurses, and the patronage, administration and management of district nursing associations (henceforth referred to as DNAs) and was analysed from five-yearly listings of DNAs throughout England and Wales. Associations were also grouped into counties and regions so that distribution and patterns of change in numbers and distribution of associations might be established. The county structures chosen relate to the census geographical census classification of the inter-war period rather than present day regionalisation, that is:

London:	Surrey (Met.), Kent (Met.), Middlesex (Met.), London
S.East:	Hampshire, Berkshire, Kent, Sussex, Surrey
S. Midland:	Cambridgeshire, Bedfordshire, Northamptonshire, Oxfordshire, Huntingdonshire, Buckinghamshire, Hertfordshire, Middlesex
Eastern:	Norfolk, Suffolk, Essex
S.West:	Wiltshire, Cornwall, Devonshire, Dorsetshire, Somersetshire
W. Midland:	Staffordshire, Shropshire, Gloucestershire, Warwickshire, Herefordshire, Worcestershire
N. Midland:	Derbyshire, Lincolnshire, Leicestershire, Rutlandshire, Nottinghamshire,
N. West:	Cheshire, Lancashire
Yorks:	Yorkshire
Northern:	Northumberland, Co. Durham, Cumberland, Westmorland
Monmouth and S. Wales:	Pembrokeshire, Glamorganshire, Cardiganshire, Monmouthshire, Brecknockshire, Carmarthenshire
N. Wales:	Denbighshire, Flintshire, Montgomeryshire, Merionethshire, Caernarvonshire, Radnorshire, Anglesey

The study has therefore applied a prosopographical and institutional interdisciplinary approach to the history of District Nursing and to a wider view of the history of professions combining social, gender and political history with a more contemporary view of community health care. This methodology has therefore enabled a longitudinal as well as a cross-sectional comparative study of the selected regions of England and Wales.

World-wide, changes in patronage, perception of the patient, perceptions of illness and changing roles and tasks of the nurse and doctor as 'carer' and 'medical investigator' respectively, have produced a series of changes both in inter-professional relationships and in perceptions of what it is to be a 'professional'. In this thesis I suggest this was especially true in the case of community health care provision within an increasing emphasis towards science and technologically based medicine. Until recently in Great Britain, this focused professional status heavily on those in the hospital -especially with the introduction of specialisation and reductionism -at the expense of the generalist practitioners. Davies³⁷, and Witz³⁸ both argue that professionalisation, and the determinant factors that decide what is and what is not a profession, has its basis in gender- and class-influenced value judgements, to which Shula Marks³⁹ adds race and ethnicity where these are relevant. According to this the development of professions such as medicine, and law appears to involve establishing a 'male' (hierarchical and elitist) value-system of control of entry, training, practice and ethical codes of conduct. This value-system then becomes established as the 'orthodox'. Where this is achieved the benefits are increased status and professional power for those within, generally establishing a knowledge base and technological aspect upon which the understanding of practice is based as an alternative to that of the lay-person, whilst diminishing status and power for the 'fringe' practitioners outside that profession. Gamamikow⁴⁰ refers to the structure and working relationships that evolved between the gender-divided healthcare professions of nursing and medicine as 'inscribing patriarchy in a particularly pristine way'. Taking this theoretical stance, district nursing as a sub-group of the nursing profession is viewed here over a period of sixty years during which it underwent a number of fundamental changes in organisational structure directly affecting the way in which its professional role and status evolved. This is achieved not only by looking at the changes that took place within district nursing bringing about transformations from within, but by viewing them as a part of a larger group of healthcare professionals working within the community and focusing on the inter-and intra- professional tensions and rivalries as they affected district nursing's professional image and standing.

V Structure

The thesis is divided into three distinct parts, each containing three chapters. Part I 'Background: Contexts and Perspectives' provides the theoretical, methodological and historical contextualisation for the thesis, Part II 'Voluntary Sector to Welfare State' uses a

³⁷ Davies, C., 1995, Gender and the Professional Predicament in Nursing.

³⁸ Witz, A., 1992, Professions and Patriarchy.

³⁹ Marks, S., 1994, Divided Sisterhood: Race, Class and Gender in the South African Nursing Profession.

⁴⁰ Gamamikow, E., 1978, Sexual Division of Labour: The Case of Nursing, Feminism and Materialism. Women and Modes of Production. A. Kuhn, and A.M. Wolpe: 96-123.

chronological framework on which to pin changes in district nursing from the macro, institutional viewpoint down to the micro, individual perspective of nurses and their relationships with fellow professionals, with their employers and with their patients, whilst Part III 'Images and Identities: Cultures and Professions' presents the various faces of district nursing from visual and textual imagery of the changing stereotype or caricature to the effects of cultural and regional diversity, thereby reaching a revised understanding of a professional seen as a member of a community and of a team.

This chapter is therefore concerned with laying the foundations underpinning the thesis, by explaining the theoretical and methodological approaches applied, outlining the background rationale to the study and describing the current historiography and literature to district nursing history. Chapter two then presents the methodology used in obtaining the oral histories and discusses the use of oral history as one form of collective biography and of prosopographical analysis of the Burdett's Hospitals Directories, as another. These two approaches thus provide a comparative overview of professional change and change within a broader social context. The third and final chapter of Part I, is concerned with the thematic history of district nursing - from c 1850 to 1919 taken mostly from secondary sources, but also some primary material including *The Queen's Poor*⁴¹ and data from 1910 and 1915 editions of *Burdett's Hospitals and Charities Yearbooks*.⁴² This places district nursing within a wider context of feminist and social welfare reform movements as well as setting the scene for later discussion of its role in professionalisation and changing concepts of professional identity.

Part II moves to a more chronological approach to the subject, with Chapter four focusing on the professional development (or otherwise) of district nursing from the Nurses' Registration Act (1919) through to the outbreak of the Second World War, through use of a detailed quintennial analysis of the Burdett's Directories database from 1915 to 1931, supported by QNI archives data from the Wellcome CMAC. This enabled a multi-faceted view of the district nurses as individual nurses (particularly as seen through the Inspectors' reports) and collectively (QNI affiliation contracts for County Association and affiliated institutes' records being particularly informative, for this purpose). This chapter also considers the gradual disappearance of the 'private nurse' from domiciliary nursing and how that might relate to the loss of private general practice medicine over the same time period. It also views the nurse's position in the early development of the welfare state, and the profession's hopes and fears

⁴¹ Loane, M., (1905). *The Queen's Poor. Life as they find it in town and country*; also: Loane, M., (1905), *Outlines of Routine in District Nursing*; Loane, M., (1905), *The Incidental Opportunities of District Nursing*; Loane, M., (1905), "The Aftercare of Operation Cases in District Nursing," *Nursing Mirror* (October 28): 57; Loane, M., (1905), "Minor Surgery in District Nursing." *Nursing Mirror* (November 4): 106; Loane, M., (1905), *Simple Sanitation: The Practical Application of the Laws of Health to Small Dwellings*.

⁴² Burdett, H., (1900-31). *Burdett's Hospitals and Charities Yearbooks*.

raised by government legislation in this area, particularly perceptions of contested professional territory between the trained, semi-trained and untrained district nurse, the health visitor and the GP. A central thread running through chapters three and four is therefore the change in remit from one where the (trained) district nurse's primary duty was to provide nursing care for the 'sick poor and working classes in their own homes without distinction of creed' (i.e. as the instrument of a non-sectarian charity focussing on care and reform of the working classes), to a much wider remit through associations supported by subscription and/or public as well as private contribution and encompassing the middle classes as recipients of nursing care on a provident basis. These chapters look at the effect of the consequent rapid expansion of the QNI, and gradual 'blending' of voluntary committees of DNAs and the State through local governmental involvement, as well as the initial formation of the lay committees and how they were changed to meet new requirements. Chapter five covers the period of the Second World War, challenging previously held views that this was a static period as far as district nursing was concerned. It will be shown to have been much more of a period of transition, following which the National Health Service introduced changes in pay, conditions of employment and employing authority combining to alter the relationship between nurse and patient in a number of ways. It is also shown here to have been a period during which roles were extended and workloads dramatically increased.

The sixth chapter then covers the final, thirty year period of the thesis, from 1948 to 1979, which is presented as an era of rapid change in district nursing particularly in the full emergence of the primary care team and the professional developments that accompanied this stage of the metamorphosis from single player to team member. Using oral history this period is also seen through the eyes of those who experienced the transformation at first hand, with a focus on the role of technology in influencing the changes experienced in the day-to-day work of the district nurse such as the advent of Central Sterile Supplies Departments (henceforth 'CSSD'), a vastly expanding array of drugs and dressings, as well as widespread developments in means of transport and communication. The effects of the NHS Act (1946) and subsequent legislation in reorganising the Health Service with the move away from DNA to local authority control are evaluated by contrasting the official viewpoint with the experience at the 'grassroots' of district nursing. The chapter explains the greater perceived relevance of health service reorganisation in 1972 to the daily work of the oral history interviewees compared with changes experienced at the time of the health service introduction in 1948.

Part III represents a move from the chronological format of the previous three chapters to a closer, experiential view of the district nurse, herself. A case study, presented in Chapter seven looks in detail at one DNA where the records have survived from 1915 through to

1985, that of the Borough of Bacup, East Lancashire. The availability of the nurses' records is exceptional and has enabled a quantitative analysis of their work and caseloads throughout the inter-war period. The function of the association changed with, but survived the NHS Act (1946) and there is valuable commentary in the records of the society's 'Patients' Comforts Fund', which throws light on these changes, and on the changing relationship and role of the district nurses. The eighth chapter draws from the testimony of individuals through oral histories and autobiography combined with evidence contained within official QNI reports, to extend the picture emerging from the Bacup case study and to assess the extent to which the role and experience of district nurses diverged from this example as a result of demographic and cultural influences.

The penultimate chapter considers the professionalisation of district nursing within general nursing by comparing it both with that of general practice medicine and with other members of the community nursing team, in particular the health visitors and midwives. It also reflects on the significance of the appearance of practice nurses and specialist community nurses looking at their initial impact and the response of district nurses to their arrival on the community scene. Here the differences between the generalist and specialist, and the doctor and nurse are explored within the community context, looking at what this implies for our understanding of professions, as well as to contested roles within and between professions. The thesis subject lends itself to an unusual view of gender -that of the male nurse as a minority figure entering a 'woman's world'. This provides an interesting comparison with the reverse gender-biased situation in contemporary medicine through most of the same period and oral histories from male district nurses and female GPs are used contribute their unique support to understanding the dynamics involved.

Finally, chapter ten presents the key findings of the thesis and provides an opportunity to project these findings forward towards the later part of the twentieth century. Professional image and identity are shown to have changed according to a complex combination of internal and external influences. The conclusion also reflects on what is not covered by this particular study including areas that might benefit from a similar approach and aspects only touched upon under the remit of this thesis but offering the potential for more in-depth study. Finally the thesis takes a prospective view of developments in the decade that followed the Nurses, Midwives and Health Visitors Act of 1979, and thus offers an interesting perspective on future developments for the district nurse's role within the community care team.

Conclusion

As a piece of social history research this thesis therefore makes three key original contributions: Firstly it contextualises the evolution of district nursing within the wider

framework of an emerging community care team. In doing so the thesis transfers feminist theories relating to professionalisation from the institutional to the domestic sphere. Secondly it looks at the changing working routine, variations in caseloads, personal experiences and the changing role of district nurses from 'grass roots' level drawing upon oral history and biography as well as quantitative analysis of data. This enables the study to achieve a unique view of nursing history that reaches out to the nurses and the evolving nursing processes at all levels. The third major contribution is in presenting previously un-researched material: in particular the experiences of district nurses during World War II, the introduction of male nurses to district nursing practice, the effects of technical developments upon the daily workload of the district nurse, and the region- and area- specific aspects of district nursing practice.

Chapter 2 Oral History and the use of Prosopographical Analysis

'Errors, Inventions and Myths lead us through and beyond facts to their meaning'.¹

Tosh² cautiously describes the early use of quantitative analysis as having 'the merit of correcting the distorting effects of the 'great man' school of history' whilst he stresses the need for greater awareness of social and economic backgrounds in making an interpretation of the results than was at one time applied. Combined with recent developments in computer technology this has facilitated the systematic study of variables from a large amount of (collective) biographical data in order to explore relationships between them from a more objective, empirically-based perspective. It thus makes it possible to establish connections, patterns, trends and otherwise hidden interactive relationships, by identifying social, economic and political factors relating to a particular group, institution or a political or religious movement.³ A full prosopographical study would require a much larger data-set than the number of interviews available in my research, therefore an adaptation of this approach has been applied, to the data retrieved from the oral histories. The thesis draws upon the experience of the individual as well as the collective to demonstrate diversity of experience and thus to bypass stereotypes and provide a corrective lens to the standard or official view. Whilst retaining the unique flavour of individual testimony the combination of qualitative and quantitative analysis therefore adds an important further dimension from which to understand the lives and backgrounds of these interviewees.⁴ Oral history offers a range of biographical data incorporating both the personal (individual) and the group (institutional) aspects of collective biography, which may relate to elite or non-elite groups alike, parts of which may be broken down for quantitative analysis. This recommends it for use in accessing a less elite and still heavily gender-biased health professional group such as nurses and some para-medical professions or for obtaining the patient's view.

Methodological approach

The oral history component of this thesis comprises 40 interviews with community health professionals conducted by the author and henceforth referred to as the 'primary series'.

These are supported by a further 14 transcripts of similar interviews with district nurses held

1 Portelli, A., 1991, The death of Luigi Trastulli, and other stories: form and meaning in oral history.

2 Tosh, J., 1991, The Pursuit of History. Aims, methods and new directions in the study of modern history: 82, also in pp. 81-83 and 190-191 Tosh provides a detailed discussion of the development and role of quantitative methods in (principally political) historical studies.

3 Burke, P., 1992, History and Social Theory: 36-8 discusses the controversial use of quantitative historical methods and demonstrates the need for both 'hard' (measurable) data and 'soft data' (less easy to quantify) but which is potentially the more valuable.

4 See Lummis, T., 1998, 'Structure and Validity in Oral Evidence', in: The Oral History Reader. R. Perks and A. Thomson (eds): 273-283: 'The virtue of drawing on a number of interviews is that they provide some basis for cross-reference.'

by the Royal College of Nursing Archives and a collection of transcripts of 74 interviews with GPs held by the CMAC some of which make brief but valuable mention of the nursing members of the primary care team and of their version of inter-professional relationships. The primary series focused on the experiences of retired district nurses whose main period of district nursing work was spent in one of the four geographical areas at the centre of this study. These are a mixture of district nurses, health visitors, practice nurses and GPs, with a working experience spreading from 1927 to the present day, but with the main focus concentrated around the 1940s to 1970s.

It is worth noting that not all tape-recordings were completely satisfactory, particularly in the early stages of this research. For example, several were of poor technical quality with unavoidable background noise or unclear portions of speech making accurate transcription difficult, on one occasion the clip microphone was inadvertently switched off by the interviewee, whilst in another the microphone lead became detached from the recorder and this did not become apparent until much later. Such difficulties form part of the learning process for oral historians, and the technical skills and safeguards have to be honed and developed through experience as well as structured training.⁵ Likewise, some interviews proved to be much more fruitful than others. This may be explained in part by the unique dynamics of a two-way relationship that sometimes develops well between interviewer and interviewee whilst at other times it may not.⁶ However this may also reflect a number of variables such as the ability of some interviewees to express their feelings or to remember experiences better than others. Many of the interviewees wanted to talk about their training experiences or to reflect on present day district nursing trends and issues, neither of which fell directly within the remit of this research, but when brought back to the main area of focus they had disappointingly little to relate that could be quoted in this thesis. In contrast, some interviewees were extremely positive describing their experiences with considerable clarity of detail, valuable insight and sometimes illustrating their narrative with fascinating anecdotal material. For this reason, some have of necessity been quoted here more than others, and to avoid repetition it has been necessary to be selective in choosing quotes that articulate points most clearly where there are several saying much the same thing as was commonly the case. Nevertheless all the interviews have provided valuable data to this study, their collective viewpoints, backgrounds and professional details have contributed immensely to establishing and understanding trends and issues. Accessing the range of subjective viewpoints of a

⁵ This was a common experience shared in informal discussion by colleagues in the oral history support group at Oxford Brookes University. I attended a course in oral history run by Professor Paul Thompson at Essex University at which these problems were discussed at length, and participants again related very similar experiences in their work as was illustrated in the practical sessions.

⁶ See Morrissey, Charles T., (1998). "On Oral History Interviewing." *The Oral History Reader*. R. Perks and A. Thomson (eds.): 107-113.

professional group including insights into changing professional practice, inter and intra professional relationships, and the vividness of individual recall of personal experience represents a valuable collective professional memory. It is therefore particularly relevant for use in studying a profession in which many nursing practices, skills and experiences were handed on by oral tradition.

Sampling process:

A range of methods was used in locating potential interviewees: -the Queen's Institute for District Nursing (QNI) kindly sent on my behalf a standard letter of request to those retired nurses on their books, living in the four regions, and a similar letter was placed in local press and the appropriate nursing press, whilst a number of personal contacts were also exploited building on these through the 'snowball' method. Unfortunately, not all the respondents had worked as district nurses in the areas to which they had eventually retired, so that the addresses given were somewhat misleading, but it was felt that they nevertheless provided a valuable contribution to the study as a whole, particularly in distinguishing area-specific from generalised comment, and simultaneously providing a broad background of commonalities in practice and experiences. In addition, the intention was to include any who might recall the period immediately preceding and following the implementation of the National Health Act in 1948 and the health service structural reorganisation of 1974. The geographical location of respondents was thus more of a factor recommending their inclusion than being a strict requirement, which if it were not met, would exclude them. Similarly, a small number of other community nurses (health visitors, midwives and practice nurses) and GPs were included to provide a more rounded view of inter- and intra- professional relationships. Although a fairly representative or cross-sectional sample was achieved, it was particularly difficult to locate male district nurses, since numbers until fairly recently have been low and, with the exception of two men who were serendipitously found by the preferred 'snowball' method, these had to be deliberately sought out rather than holding rigidly to the more random method of selection outlined above. The consequence of this seemingly rather haphazard sampling process was that far more non-Queen's nurses were interviewed than had at first seemed possible -an achievement of balance and diversity of evidence that was impossible to equal through documentary sources (which heavily favour the Queen's Nurses).

Interview format:

The method used at interview was a modified version of the life-story approach, with a deliberate policy of concentrating considerably less time on early life history, than on the period of professional training, practice, relationships and attitudes. This was partly because of time and transcription constraints, but also because the interviewees were mostly senior citizens for whom an interview in excess of two hours would have been unreasonable.

It may be claimed that their reconstruction of their past will inevitably have been coloured by time, the selectivity of memory (including hindsight) together with the influence of collective professional memory, and repeated telling of popular anecdotes. In addition it is a frequent criticism of oral history sampling, that the interviewees are, by definition, volunteers and therefore cannot be assumed to be a truly 'representative' sample since those who do not offer their testimonies may represent a quite different viewpoint.

I would argue that this very method of selectivity may indicate aspects of particular significance, and that where these are repeated by a number of interviewees, a degree of consensus 'beyond facts' does indeed establish a realistic picture of their lived experience. Thompson argues that 'History is not just about events or structures, or patterns of behaviour, but also about how these are remembered in the imagination',⁷ and it is the emergence of these memories and perceptions that are collectively interpreted here to help (re)construct their history and fill in the gaps in our knowledge and understanding. Even though the interviews may not necessarily be accurate in every detail (because memory is not infallible and these narratives were being told many years after the events by nurses who were themselves aging), the conscious meanings of individuals' experiences built into the collective is at the centre of this process, including how it has been reconstructed or made meaningful to the person describing his or her experience through particular language, anecdotes or examples used to frame their narrative. One of the considerable advantages of oral history is the ability to explore the more human aspects of people's lives, an aspect of social history often inaccessible through written records - in this case to document the lives of district nurses, sometimes seen as the 'Cinderella' of the nursing profession, whilst also giving them a more direct voice with which to express some of their memories and experiences.

Considering the second problem, that of establishing a representative sample, it should be noted this does not apply only to oral history -to the contrary, memoirs and (auto)biographies represent an even more rarefied account which is often more difficult to verify. Therefore obtaining their testimonies would seem to be the only effective way in which the 'everyday experiences' of nurses in the workplace *can* be gathered. Early proponents of the oral approach to history such as George Ewart Evans and Paul Thompson saw it as a means to 'shift the focus ... by bringing recognition to substantial groups of people who had [previously] been ignored'⁸ through using a more democratic, non-elitist approach of history described as being, 'from the ground up'. Portelli⁹ notes that 'written and oral sources are not mutually exclusive. They have common as well as autonomous characteristics, and specific

7 Thompson, P., 1978, The Voice of the Past: Oral History: 139.

8 Thompson, P., 1978, Voice of the Past: 7-8.

9 Portelli, A., 1998, 'What makes Oral History Different', in: The Oral History Reader. R. Perks, and A. Thomson: 64.

functions which either one or the other can fill (or which one set of sources fills better than the other).' He goes on to note the particularities of spoken, as opposed to written language such as the expressive significance of volume, tone, pauses, changes in rhythm and velocity of speech as well as the subjective and narrative nature of oral history. This may create problems in establishing credibility, but it is for the historian to *try* to interpret and present the oral history as accurately as possible, avoiding mis-interpretation by repeatedly listening to the tape rather than purely taking text from transcripts. Where only the transcript is available, this is obviously not an option, and careful reading of the whole transcript is important, as with any other historical document. Similarly, the problem of subjectivity has, in my view, no greater challenge to the researcher than other sources such as (auto)biography, diaries or memoirs -the testimonies contained in the interviews are about district nurses' lives and experiences as they remember them. The narrative aspect presents less of a problem in most of these interviews than it might with more 'elite' subjects since most of these interviewees have never been interviewed about their lives and work experiences before, so are not presenting a 'pre-rehearsed' narrative that has been embroidered and embellished with each re-telling. Nevertheless possible flaws were occasionally revealed -these were most noticeable when the subject moved from the specific detailed account of his or her work to the anecdotal, when the same or similar story was repeated by a number of nurses.

An example of this was the narrative describing a supervised visit as a Queen's Nurse candidate (N.B. throughout the thesis oral history extracts will be written in bold type to distinguish them from other quotes):

D.M. I said to this one old lady 'I'll have plenty of paper' because you should put paper on the chair and you also covered their furniture with it so it wasn't soiled. Well we went down to this place, this particular patient, she had an ulcer on her leg I was going to dress when I walked in, My God, I thought, she had paper every where, she had it over the sideboard, over the chairs, over the floor, she was trying to do her best the poor thing! 'Oh!' I said, I told her, I said 'oh I'm sorry that this has happened' I said, 'I just told her to have plenty of paper'. She said, 'Ridiculous!' you know, that's all she said. I said, 'well she was trying hard'. I mean she didn't want me to live! - with the sideboard, the pictures, the stairs and all were covered with the paper. It was covered all over with the paper - I really died honestly when I walked in there!¹⁸

Whilst this story should perhaps be treated with some caution because it recurs in some form with remarkably frequency, it may be considered to represent part of the district nurse's folk-tradition, and must almost certainly have happened to some nurse(s) at some time. Its very

¹⁰ *DIN* 13,02/10/96, Oral History: Trained 1939-42 in Binningham before returning to Cardiff to practice and train as a district nurse.

popular telling and re-telling suggests an associated humour that was shared by many district nurses and midwives, myself included, who saw something slightly ridiculous in the emphasis on newspapers for a wide range of purposes. This pervaded the training process across many decades and came to represent the whole doctrine of ingenuity and resourcefulness which differentiated district from hospital nursing. The pretext that the newspaper provided a protective barrier for the patient, when it was, in reality, possibly more valuable as a protection for the nurse's bag and coat, added an amusing paradox, and it is likely that on some occasion(s) the patient might have mis-understood the instructions, demonstrating the inconsistencies of theoretical training with the realities of routine practice. As the chapter's opening quotation suggests, whether or not the individual actually experienced the event is less important than that the underlying significance of narratives from a collective memory be correctly interpreted, be they based on reality, invention or myth.

It has been a recent criticism of history of nursing, that it fails to address nursing's social role and the contribution of nursing to the actual process of 'caring'. The daily chores and experiences of the district nurse, fail to be expressed overtly in documentary evidence, textbook descriptions of nursing care and procedures lack the personal qualities of oral testimony, and documentary film is highly constructed and cliché-ridden. Experience would suggest that both the textbook and the documentary film represent an idealised version of the work done that frequently differed markedly from what was practically achievable by failing to recognise a number of variables of practice such as size of workload, demographics, and conditions in patients' homes (sanitary facilities, availability of informal carers etc.) In contrast the oral history offers a personal experience. Encompassing as wide a range of participants as possible, prosopography provides complexity of narratives, viewpoints and experiences, thereby revealing variety of professional experience, including the illusive 'caring' experience. Whilst these points are not intended to suggest oral history should be used as an exclusive source, they do strongly support it as a unique form of historical evidence.

An important factor that has to be noted and taken into account is the voice or influence of the interviewer in constructing the interview. Following some discussion with fellow oral historians¹¹ it was decided to avoid later embarrassment by 'admitting' my own past experience as a district midwife, prior to the interview. In comparison with others working in a similar area¹² it did not appear to produce fundamentally different responses, although it

11 I am indebted to the Oxford Wellcome Oral History Group, and fellow research students at Oxford Brookes University in the Oral History Support Group.

12 Rona Ferguson working with district nurses in Scotland, and Sheila Davidson and Frances Trees conducted excellent local oral history studies which included district nurses, but they do not have nursing backgrounds.

probably did elicit more nursing and procedural detail and encourage willingness to discuss relationships with patients and with fellow professionals 'off the record' or in greater depth and with an increased degree of openness. It also obviated difficulties with terminology. Case details were also described by respondents in greater detail, without requiring technical or medical explanations, but assumed knowledge also had drawbacks, and comments such as 'but of course you know that' had to be politely fielded with a request to explain 'for the sake of the recording'.

For example:

ES: Well, in the community, you deal with everything, don't you?

HS: Do you?

ES: Oh yes -well, you must have found that?

HS: Yes? - Well, forget that I've done any, just ••• you know, could you explain what you mean by that? What did you have to deal with?

ES: Well, I mean, you had your routine, you know, like you always done your diabetics first in the morning, so you give your diabetic injections. Now, we, in St. Helen's, only went out to see the patients ...either they were very elderly and couldn't cope with drawing up the insulin, or partially-sighted, or when new diabetics came home, we would go in and train them to give their own. But it's only a ... you know, a small minority now, in fact, where the nurses do go in. And it's for some reason, you know, it's because you're blind, or you're elderly, or just because you can't cope completely. But we did a fair amount, you know, we did a lot of training, really, of ...and wouldn't only train you, but would train a member of your family as well, so that if you weren't well, well, then, they knew exactly what to do. They would know the dose. You would have trained them as well, you know, to draw it up, so that you got the correct dose. And teaching them, you know, urine and all this business, and ...so it was a fair amount of training to do with people.¹³

As a result of the interviewer's prompt, a detailed description of the daily routine of this district nurse was provided, with considerable insight to the administration and demands of that particular district becoming apparent.

A final, but not insignificant advantage to the oral history approach should be noted in relation to this last point. This was the 'field-work' aspect of oral history that emerges from interviewing people in, or close to the communities where they worked, and which has enabled a much clearer image of the distinctively local context that gave rise to particular patient needs and professional demands. For example the strong influence of the Pilkington's

13 DIN 21, 15/05/00, Oral History: Trained 1954-57 at St. Helen's -her official district nurse's training was not undertaken until 1973.

glass-works in St. Helen's or the coal-mines in Aberdare on the particular health needs of the community, or the contrast between rural Swanage where the nurse is also the midwife and a car and telephone are necessities, compared with the inner-city experience of the Ranyard nurse on her bicycle in Forest Hill and Peckham. In particular it was possible by actually visiting the towns and villages to acquire a deeper and more vivid perception of the backgrounds in which these nurses worked.

A range of questions was formulated (for guidance and as an aide-memoir only, but not taken into the interview) that would incorporate this diversity of experience, as well as the more general concerns such as professionalisation and changes in role and workload. A letter or telephone introduction was made to each interviewee in which the purpose and intended outcome of the interview were briefly outlined,¹⁴ followed by a second contact a few days prior to meeting to confirm time and place. The interview itself almost invariably took place at the home of the interviewee in order to facilitate a relaxed atmosphere and to give the interviewee a feeling of control.

The questions related to seven areas of enquiry. These were:

1. To establish social, family and educational background;
2. To understand reason for career choice and place of training;
3. To obtain details of training, qualifications and post-registration experience;
4. To ascertain conditions of employment including primary and secondary roles;
5. To determine what, if any, factors influenced changes in job description and conditions of service;
6. To establish professional self-image and inter-/ intra-professional relationships within the community healthcare team;
7. To understand what 'district nursing' meant to practitioner and patient, including how it was perceived to have differed from other forms of nursing.

As may be seen from the listings of oral histories in Appendix A, the first 20 of my interviews with nurses in the primary series were carried out in 1996 and 1997, with none conducted in 1998, and only one in 1999, as this time was spent on archival work. The timing of the interviews with GPs was spread fairly uniformly (mostly throughout the early period of data-gathering). As a result, although the interviews remained fundamentally unchanged, it was possible to test out in the second run of interviews in 2000-2001, hypotheses that had developed in the interim. These were formulated as a combined result of a preliminary analysis of the first 20 to see what obvious trends and issues emerged, and from questions and

¹⁴ See Appendix A for draft copy of letter and questionnaire.

ideas that arose from the documentary evidence and secondary sources, as well as valuable input following the presentation of papers at conferences and seminars.

The second run of interviews therefore included new, or more searching questions, especially where it was felt earlier answers might have been inadequate, evasive or incomplete. In particular, the question of professional relationships, whether being asked of the nurses or doctors, almost invariably produced the response that 'we got on very well'. From personal experience, as well as from human nature, I knew this not to be always the case and determined to change the questioning subtly e.g. 'were there any doctors with whom you found it difficult to work?' or 'did you ever find the patient's needs and the doctor's orders presented you with a conflict of interests?' From this it emerged that there were occasional communication difficulties even in the best of partnerships, particularly in the period preceding GP attachment, but that skills were developed on both sides to avoid or minimise direct confrontation -an extension of the 'doctor-nurse game'¹⁵ in which doctors and nurses negotiate a working relationship, and usually associated with the hospital environment. It was also not until the first block of interviews had been examined as a whole, that the regional and context-dependent variations referred to above, together with issues such as professional identity as a district nurse compared to district nurse-midwife, began to emerge with any clarity, and the second block of interviews allowed for an exploration of these in greater depth. A further three district nurses entered into written correspondence -one in response to a book she had written which I had requested, and the other two by email in response to an internet search by the district nurses themselves. It is fully acknowledged that these do not possess quite the same qualities as oral history -in particular, informal face-to-face communication, a sense of immediacy and the expressive qualities of the spoken response. They have therefore been referred to throughout as 'personal testimony' to differentiate them, however they do share several commonalties with oral history such as providing interaction, making questioning and clarification possible, and giving access to biographical details otherwise almost inaccessible, so that these have been included where possible, within the prosopographical analysis.

Of the secondary series, the cohort interviewed by Frances Trees were part of a wider local history project carried out in Liverpool in 1993. The emphasis of the eight interviews, which involved district nurses is therefore directed towards the locality and tends to be more institutionally based. Their main value is in supporting the primary series interviews with Lancashire nurses. Sheila Davidson's six interviews formed a part of an Open University

¹⁵ Described in Stein, L., 1978, 'The doctor-nurse game', Readings in the Sociology of Nursing, R. Dingwall, and J. McIntosh, (eds.); Wicks, D., 1998, Nurses and Doctors at Work. Rethinking professional boundaries: 122-126; and in Sinclair, S., 1997, Making Doctors: An Institutional Apprenticeship: 291-293.

course in which I acted as adviser, and are all with nurses living at a home for retired nurses in Sussex. They have been selected from a larger collection as these were the only ones with nurses who worked in the community. Again the emphasis is a more local one and the interviewer concentrates mostly on the training and wartime experiences of the nurses. The interviews by Michael Bevan are all with GPs and have been used here to augment my own interview with GPs for their comments on inter-professional relationships. They have been drawn upon to provide a more balanced picture.

In addition to the interviews, a week was spent with a team of district nurses in Oxfordshire, during which time I was able to question various members of the team, and to shadow the team leader to see her practice at first hand. One member of the team was nearing retirement and had been a district nurse since 1970, so was able to provide valuable reflective comment on the changes she had encountered. This experience was invaluable, as it added a fieldwork dimension, and again broached new lines of enquiry and perspectives. Whilst contemporary issues affecting community health care are beyond the remit of this thesis, this opportunity provided insight into the changing role, professional and public image and relationships of the district nurse as a member of a primary care team, and as a health-care professional within a wider community. These experiences were just beginning to emerge at the end of the period being covered here, whilst also revealing those that had remained relatively unchanged. It was therefore particularly helpful in establishing the essential character that differentiates district nursing from other areas of nursing.

Retrieving and extracting data for quantitative analysis:

I have found qualitative textual analysis programmes¹⁶ less than ideal for extracting data from transcripts of oral history interviews as they work on a coding and retrieval process of 'search' words or phrases and cannot be easily used to pick up on looser associated concepts such as personal background or vocational motivation. However it is not difficult to manually extract data from a collection of oral histories particularly where the particular questions have been selected in advance of the interview process and incorporated into the interview format. Tabulating and analysing this with a number of criteria-based 'queries' may reveal insights through the simplistic structuring of data that may not be evident from the qualitative approach alone. In this way a more accurate picture of the collective group may be presented, showing, for example, how pay and working conditions affected professional and public attitudes and perceptions.

¹⁶For example the Oxford University Press 'Wordsmith', Idealist and NUD.IST software programmes will efficiently pick up on a word search of the text through a process of coding and retrieval but exclude associated words and concepts making the laborious manual search arguably still the most reliable but heavily time-consuming method of qualitative textual analysis.

Using Microsoft Access spreadsheets the interviews were transcribed and data extracted and entered into 54 possible fields interrogated through a series of constructed queries to analyse quantitatively for trends and variants. Although several of these fields were obvious from the outset (such as name, age, gender, date of birth etc.) some resulted from previous professional historical research experience¹⁷ (for example, tracing mobility through changes of place of practice, or recording take-up of technologies such as car and telephone) whilst others emerged more gradually (such as the significance of family support and social background or patterns of training and qualifications and relationships between place of birth and places of training and practice). Divided into sections these queries relate to the areas of questioning outlined above but provide some additional insights. These will not all be detailed in this chapter as some are to be used to illustrate points in chapters 4 onwards, however, some indication of the emphasis of response shown by the interviewees would seem to be appropriate at this point.

Of the forty district nurses and health visitors interviewed in the primary group, thirty-five were female and five were male. Fifteen had trained as Queen's Nurses and two were Ranyard Nurses, whilst five had health visitors' certificates. In the primary group of seven general medical practitioners, three were women GPs and two were male GPs, the other two interviewees were the daughter and the wife of deceased GPs (men). In the secondary group, all thirteen of the district nurses interviewed by F. Trees and S. Davidson (also tabulated in Appendix A) were female whilst of the transcribed forty-five GP interviews conducted by M. Bevan that I was able to view at the Wellcome CMAC (also tabulated in Appendix A), seven were females and the remaining thirty-eight were men. This balance of male to female demonstrates the very much higher ratio of women to men in district nursing, and an almost correspondingly high ratio of men to women in medicine. It was originally the intention to divide the analyses into cohorts according to the date of first qualification, however, the numbers were felt to be insufficient to justify this approach.

On enquiring into social backgrounds and possible influences and attitudes of friends and family members, a surprisingly high number of respondents (twelve out of forty) revealed lack of family support towards a career in nursing – sometimes this was actually obstructive, and in one case, prohibitive, but more often took the form of cautionary advice, with many stating that family members did not expect them to 'stick out the training'. Similarly, the attitudes towards a move from hospital to community were often felt to have been either negative seeing it as an inferior form of nursing, or lacking in knowledge or understanding of what the work entailed. Often nurses saw their move from hospital as an accidental change in

¹⁷As research assistant to Anne Digby's research into the evolution of British general practice medicine (1850-1948).

career path rather than a planned one. This exhibits marked similarities to the attitudes described by GPs when departing from hospital specialisation into general practice,¹⁸ such as Dr. H. who stated that as a student he felt GPs 'were rather second-class doctors' [...] 'and that the consultants were first-class doctors',¹⁹ and similarly Dr. R. described the relationship between hospital consultants and GPs as 'having a very strong flavour of condescension'.²⁰ Paternal occupations of district nurses provided a broad mix but comprised mostly lower-middle and skilled working class backgrounds such as collier, farmer, shopkeeper, builder or stoker in the navy. This might be contrasted with the GPs, most of whom had middle class backgrounds such as teacher, banker, civil servant or doctor.²¹ It was noticeable that thirty-two of the district nurses describe their mothers as 'housewife' whilst of the remaining eight, two mothers were described as 'nurses', one as a children's nanny, two were secretaries, one was a factory worker, one a green-grocer and one a cook and housekeeper. Comparing place of birth against main place of practice revealed that, with only a few exceptions, the region of birth was reflected in the place of practice only to the extent that those born in the north of England tended to remain there and those in the south tended to practice in southern counties. The exception to this was South Wales where all seven whose main place of practice was south Wales, were also born there, suggesting a stronger cultural attachment than elsewhere, a feature which will be explored in chapter eight. By contrast, only three out of nine nurses practising in Lancashire were born there or within the north-western region, with others coming from Scotland, Northern Ireland and Yorkshire, and similarly, of the four whose main place of practice was Dorset, only one was from the south-western region, with the remainder migrating there from Yorkshire, Worcestershire and Essex.

Educational backgrounds of the district nurses were equally varied with nine having a grammar-school education and two attending university before changing direction. Others had to overcome considerable personal difficulties, leaving school with minimal or no qualifications -one describing severe but undiagnosed dyslexia, whilst others were not supported by family and therefore had to leave school at fourteen. In addition, it is noteworthy that four of the interviewees had experienced office work as secretaries or as a cashier, prior to training as nurses and two others began training as teachers, with several others saying they had considered this as an alternative to nursing. Only nine admitted to having experienced a sense of vocation, having wanted to be a nurse for some time, five of whom had close relatives who were nurses or involved in caring and had influenced them.

18 Digby, A., 1999, *The Evolution of British General Practice 1850-1948*: 288-9.

19 CMAc/GP29/01, c1980, Oral History: John K. Hawkey.

20 CMAc/GP29/17, c1980, Oral History: Geoffrey Richman.

21 Bevan, M., 2000, 'Family and Vocation. Career choice and the life histories of general practitioners', Oral History. Health and Welfare. J. Bomat, R. Perks, P. Thompson, and J. Walmsley (eds.).

In the primary group, six nurses qualified after 1960, eleven in the 1950s, sixteen in the 1940s and just seven before 1940. The order in which qualifications were obtained emerged as a remarkably haphazard one, illustrated by two having trained in psychiatric nursing, two in some form of children's nursing and four in fever nursing before progressing to their SRNs, whilst the move to district nursing was sometimes made before and sometimes after gaining a midwifery (SCM) certificate or just Part I of midwifery training. A total of 14 of the primary group (35%) were fully qualified midwives. Health visitors' training was also obtained by six of them (15%) - sometimes immediately after qualification in midwifery, but often after some experience as a district nurse - almost as if to complete a professional rite of passage. Only eight out of forty were unmarried - this would have been in marked contrast with a pre-war cohort, where marriage would have almost invariably necessitated resignation, at least for those who were Queen's or Ranyard Nurses.

Remarks made concerning district training (post-NHS Act 1946) generally reaffirm claims of inadequate preparation and regulation made in the reports of official enquiries into training.²² There are several examples amongst the non-Queen's nurses revealing that in the 1950s and 1960s the techniques of district nursing were generally acquired 'on the job' with local authorities eventually providing 'training' courses and certification very late in the day i.e. in many cases after more than ten years of practice. This supports a discussion on the struggle to establish a national training programme presented in chapter six.

The effects of government legislation in 1946 (NHS Act) and 1972²³ reorganisation (again discussed in Chapters 5 and 6), produced a particularly interesting range of comments. The interviewees' observations concerning their patients' responses to introduction of the NHS Act are quite vivid and there are a few mentions of relief felt at no longer having to collect fees from patients. However, it is the 1972 reorganisation and changing attitudes of the public that provided most feedback. The effects of the move from patient allocation based on geographical area covered, to district nurse attachments to GP practices, cannot be overstated, and almost without exception are presented as the critical moment at which district nursing was perceived to have changed course. The other major factor that occupied the interviewees as a force for change was the introduction of CSSD and 'disposables' technology, the introduction of pre-packed dressings and certain drugs such as the antibiotics and insulins and drugs for cardiac and pulmonary diseases. Once again, it is the normally hidden culture of work, such as routines and relationships and the roles of colleagues and family members,

22 Hockey, L., 1966, Feeling The Pulse; Hockey, L., 1968, Care in the Balance.

23 Department of Health and Social Security, 1972, Cmnd. 5055: National Health Service Reorganisation; Department of Health and Social Security and P. A. Briggs, (Chair) et al, 1972, Cmnd. 5115: Report of the Committee on Nursing.

which can be more effectively exposed through oral history than through documentary sources, with perhaps the exception of (the inevitably rare) autobiography.

District nurses' perceived professional image and relationships with fellow professionals such as the pre-NHS employing committee and supervisors or with the GP and district nursing colleagues, was far more difficult to ascertain despite re-wording questions to try to elicit responses of how they saw this. Relationships with GPs seemed to become closer as the medical team emerged and the more isolated (in some cases described as 'lonely') district practice disappeared. Nurses generally welcomed this whilst simultaneously regretting some becoming 'one of the district nurses' attached to the GP's practice or health centre. The exception to this positive reaction was a marked antipathy towards health visitors, a view that was also expressed by several GPs. However, this was agreed by most to have been improving by the late 1970's as respective roles became better understood and delineated. On the other hand questions relating to the public's changing perception of the district nurse proved far more productive. Questions relating to job description were outstandingly fruitful, revealing alterations in daily workload, types of patients nursed and care typically needed (exposing regional differences), processes of patient allocation that were introduced with group practice and the practicalities of associated hierarchical structures. This line of enquiry also provided insight into relationships with patients and their families, including views of shifting public expectations of the district nurse and of the responsibilities expected of the informal carers. It also painted a vivid picture of the rural nurses' evolving role from the combined one that incorporated midwifery, and often health visiting and school nursing, demonstrating how this worked in practice. In addition, Bevan's interviews with GPs revealed widespread concepts about the work they felt was undertaken by the district nurse. This complex interweaving of relationships with public and professional colleagues will be explored in chapter nine drawing from comments in oral histories.

The interviews with male nurses were extremely enlightening in providing an understanding of gender issues rarely discussed elsewhere i.e. the relationship between the nursing majority of women and the minority of men. As men only entered this section of nursing after the war, they initially found themselves in subordinate positions to hostile women supervisors and colleagues who exploited their physical strength. Since many of these men had previously worked in a predominantly male situation (in the armed services medical corps) the tensions and solutions that were found, are of particular interest. Similarly comments made by male and female nurses regarding issues of pay and conditions of service are almost uniquely expressed through oral histories -this is particularly the case concerning the more exceptional]

demands of the Ranyard Sisterhood. in which area I was particularly fortunate in being able to interview two of the very few remaining Ranyard nurses.

Conclusion:

Taking a broad overview of these oral histories, perhaps one of the most striking features is that the interviewees perceived there to have been a very distinctive identity to district nursing compared with any other field of nursing irrespective of place or time-period of practice. This was partly felt to have been due to its professional and public image as being 'general' nursing rather than a specialised field, a concept to be explored in chapter 9, and partly due to its location in the domestic sphere rather than within the institutional environs of the hospital. The oral testimony confirms that this was also because of a unique relationship between nurse and patient. The phrase often quoted in these interviews was that, 'you had to remember you were a visitor in their home -not like in the hospital' and this combined with the sense of community, seems to be a universal concept that was cherished by those who practised as district nurses throughout the period covered by this study. Whilst there were clearly urban/ rural differences and regional differences (which will be explored throughout and particularly in chapter 8), there was nevertheless a general working routine and techniques of practice adapted to domiciliary nursing that are described in much the same way by most of those interviewed. Throughout this thesis, the oral history approach will demonstrate its unique ability to draw out the complexities of inter-and intra- professional relationships, the changing self-images of the professionals involved and evolving relationships with the public.

Chapter 3: Historical Trajectories : Background History (c.1850-1919)

*Florence Nightingale, writing to Henry Bonham Carter in 1867, referred to nursing reform and its future through hospital and community nursing: 'We were perfectly right to begin as we have done to have our aim defined ... the reform of hospital nursing was essential as a beginning ... But I would never look upon the reform of hospital nurses as an end - rather only as a beginning.'*¹

Wide open vistas

At the time Nightingale made this observation, district and hospital nursing were equally in their infancy as part of an extremely diverse, rapidly developing profession. The last twenty years of the nineteenth century and first two decades of the twentieth century saw enormous strides in development from a training and organisational viewpoint for both. However district nursing remained a service funded -and largely managed- by voluntarily run local associations, and staffed entirely by female nurses.² Whilst hospital nursing increasingly gained recognition as a profession by becoming the focus of nurse training and by skills developed directly linked to surgical and laboratory-based medicine, the district nurse retained a more vocational image associated with the domestic environment, generalist bedside medicine and a more altruistic *raison d'etre*. This chapter will concentrate on the development of district nursing up to 1919, marked by the end of the First World War and of the battle for the introduction of nurse registration. It will therefore offer a background to the thesis by providing both an historical overview and by underlining the main themes and issues.



THE WORKHOUSE MRS. GAMP.
...T Ma (III.VI) ... I U ar.I'I I.L WILS I HA\A A LEW JIUI'DI TH Tfr-

Fig.3.1 Cartoon of a 'Mrs Gamp'³

¹ Baty, M., 1991, As Miss Nightingale Said: Florence Nightingale through her savings: 106, Florence Nightingale's emphasis on sanitary reform reflected her view that it was the essential tool for achieving Victorian health and social reform to be targeted at the domestic rather than the hospital setting. e.

² Until men were admitted following demobilisation after the Second World War.

³ (1866) 'The Workhouse Mrs. Gamp' FUN March 31.

Although Dickens' gin-swilling caricature of the district nurse⁴ is powerfully evocative and not without some foundation in reality, it represented (or may be said to have misrepresented) only one image of the state of mid-nineteenth century district nursing. It is probable that this continued image of the district nurse, written as a caricature, persisted for many years in contributing to its marginalisation within nursing as a profession. In fact the nineteenth century District Nurse had a much more heterogeneous background ranging from 'Bible nurses' to 'corpse washers', and although it is not within the mandate of this chapter to do so, their history can be traced to well before the nineteenth century.'

Until the late eighteenth century, outside London there was a general reluctance to provide institutional nursing care⁶ and the (lay) nurse might offer one or several of a range of roles including a formal or informal carer as in 'attendant', a 'handywoman', 'corpse-washer' or 'village nurse' or 'parochial nurse'⁷, a private nurse or a member of the household, a midwife⁸ or 'monthly nurse', a herbalist or village 'wise woman'.⁹ Tasks undertaken would also have varied considerably, from applying dressings and poultices based on a range of folk remedies, administering herbal infusions, or applying leeches, or they might even practise 'blistering' or 'bleeding', although the latter might have intruded upon the sphere of the local surgeon or medical practitioner. A 'nurse' working in the community might carry out any one or a combination of these roles either as a self-employed (often casually employed) independent practitioner, as member of a husband and wife 'team', or under contract to the voluntary hospitals and poor law relief committee. This wide range of duties has been described collectively as the 'techniques of pre-industrial nursing'.¹⁰

4 Dickens, C., 1843-4, The Life and Adventures of Martin Chuzzlewit: Sarah Gamp and Betsy Prig, two outdoor relief district nurses caricatured by Dickens.

5 SA/QNI Box 79 H4/ 1-3: Fundraising Correspondence. The QVJIN was connected by its original charter in 1889 with St. Katherine's Royal Hospital, an ecclesiastical foundation first established near the Tower of London and endowed by Queen Matilda in 1148, chartered by Queen Eleanor in 1273 and later by Queen Phillipa in 1351, who ordained among its chief purposes "the visitation of the sick and infirm".

6 Abel-Smith, B., 1960, A History of the Nursing Profession: p.2 claims from census data that 'as late as 1851 there were only 7,619 patients [...] resident in hospitals, in the whole of England and Wales'

7 Hawker, J., 1995, 'Parish Nursing in Dorset 1700-1914' (Unpublished paper), differentiates between 'basic' and 'skilled' carers, identifying 10 skilled out of 99 carers in two parishes in Dorset in the 18th Century; similarly the parochial nurse in Hanbury, Worcestershire described in Stocks, M., 1960, A Hundred Years of District Nursing: 92-93.

8 Loudon, I., 1986, Medical Care and the General Practitioner. 1750-1850: 90 f.n.45, notes that from mid-18th century there were 'a number of lying-in charities for delivering the poor in their own homes and some dispensaries also included maternity departments for delivering the poor at their own homes', claiming these were greater in number and more successful than in-patient institutions.

9 Chamberlain, M., 1981, Old Wives Tales: Their History, Remedies and Spells; and Hutton, R., 1991, The Pagan Religions of the ancient British Isles: their nature and legacy: refers to 'village "cunning-men" and "wise-women" [...] operating freely in many places during the nineteenth century'.

10 Dingwall, R., et al., 1988, An Introduction to the Social History of Nursing: 7.

During this time first Elizabeth Fry's 'Protestant Sisters of Charity' (founded in 1840),¹¹ followed closely by other religious orders such as St. John's House (1848) and from 1857 the bible-nurses of the Bible and Domestic Mission or 'Ranyard Sisterhood' supplied trainee and trained nurses to the provincial hospitals. On their return to the community they provided nursing care to the sick poor in their own homes following the pattern established by French and German religious nursing organisations¹². Prochaska describes their duties as: 'referring patients to doctors and local hospitals, inspecting infants in mother's meetings, and encouraging medical self-help among the poor. [Mrs Ranyard] was very much aware of the degree to which the poor looked after one another in emergencies and hoped to extend and improve these traditions with nursing assistance and advice'¹³.

These recruited from the 'handywomen' to train as nurses and they later returned to their own communities to nurse the sick poor under supervision of the Lady Superintendent, whilst in many cases earning their keep by caring for private patients - as was also the case in later secular schemes. For many years the Ranyard Bible Nursing Association was the largest district nursing association in London having 47 district nurses working in 1875 compared with most other associations being still in single figures at that time¹⁴ and Ranyard Nurses continued to provide district nurses working in London into the second half of the twentieth century¹⁵. District nursing was also provided by the Church Army from 1887, and by the Nursing Sisters of the Poor (a nursing branch of the Little Sisters of the Assumption), but despite numbers of 'nurses' being considerable, they were largely untrained, in that they had received minimal, if any, hospital training although a few of the former had midwifery (C.M.B.) certificates.¹⁶ It has been argued that this 'did make an important contribution to the reconceptualization of nursing' by combining the 'secular spirit of medical modernisation' with the 'spiritual concerns of the order'¹⁷ - that is, a relationship between nurse and patient based initially on spiritual salvation gradually incorporating social and sanitary reform. It is also significant that the nurse/ superintendent system represented a two-tiered, extremely

11 Huntman, R. G., Bruin, Mary, and Holtyam, Deborah 2002, 'Twixt Candle and Lamp: The contribution of Elizabeth Fry and the Institution of Nursing Sisters to Nursing Reform', *Medical History*, 43 (3 (July)): 351-380, by 1948 these employed approximately 28 nurses undertaking 'charitable work'.

12 Prochaska, F. K., 1987, 'Body & Soul: Bible Nurses and The Poor in Victorian London', *Historical Research*, 60(143): 336-348; also Jones, C., 1989, 'Sisters of Charity and the Ailing Poor', *SHM* (Dec. 2(3)): 339-348.

13 Prochaska, F., 1988, The Voluntary Impulse. Philanthropy in modern Britain: 52.

14 Stocks, M., 1960, A Hundred Years: 25.

15 Two oral histories with Ranyard nurses : *DIN* 03, 18/07/96, Oral History: Mrs. G. C., *DIN* 20, 12/06/99, Oral History: Mrs. M.E.K. Both are mentioned in Chapter 5.

16 Burdett, H., 1900-31, Burdett's Hospitals and Charities Yearbooks. Entries for 1915 record 416 nurses working for the Church Army performing 'evangelistic and rescue work' but 'no systematic, infectious, or night nursing'.

17 Dingwall, R., et al., 1988, An Introduction to the Social History of Nursing: 29.

hierarchical, class-based system¹⁸ and this represents an important change from the independent but largely unqualified practitioner loosely described above as a 'nurse'. At this stage the changes in the Victorian economy both in costs and standards of living, together with 'a continued inability by the [medical] profession to restrict its own numbers', meant that, 'only a restricted section of the population could afford to pay for the cost of their medical treatment' and so had recourse to the Poor Law.¹⁹

Without detailing the complexities of, and variations in poor law provision of 'indoor' and 'outdoor' relief during mid-C 19th, suffice to say that pauper nurses were often recruited from within the workhouse to care for the sick in the workhouse infirmary, and sometimes outside under the 'outdoor relief system'²⁰. In 1866 an official enquiry into nursing care provision in Workhouses resulted in the Public Infirmaries Act and 1867 Metropolitan Poor Act. Abel Smith describes the workhouses at this time as 'dumps' for the patients the voluntary hospitals had 'failed to cure' or with types of illness they would not accept, and states that it was found: 'that out of a total of 157,740 indoor paupers in 1869 about a third were sick'²¹ i.e. over 50,000 patients compared with less than 20,000 in general and special hospitals recorded in the 1871 census figures. The result was a wide range of standards and duties carried out often just for token cash payments or special privileges such as improved rations and different dress, by nurses with minimal or no training under an equally variable range of supervision and management. They were frequently illiterate and often old and infirm - thus there was little to distinguish them from their fellow pauper patients. These working-class nurses were generally hired by the Board of Guardians and supervised by a lady inspector.²² Ten years later, the Poor Law Act (1879) provided for grants from Boards of Guardians 'for the nursing of those in receipt of outdoor relief'²³ marked by the founding of the Workhouse Nurses' Association which began the training of nurses for care of the sick poor, in the same year²⁴. This legislation clearly reflected some degree of public recognition of widespread developments in the organisation of nursing as a whole and more especially of district nursing in a number of urban areas.

At the other end of the spectrum it is worth noting that where surgical intervention was inappropriate or, alternatively, where introduction of sanitarian principles (of hygiene rather

18 Williamson, L. 1996, 'Soul Sisters: The St. John and Ranyard nurses in nineteenth century London', *JHJ*. 2(2 (Winter)): 33-49.

19 Digby, A., 1994, *Making a Medical Living: Doctors and Patients in the English Market for Medicine 1720-1911.*: 43-44.

20 Crowther, M. A., 1986, 'Medicine and the end of the Poor Law', *SHM*, 38: 74-6; and Anderson, G. 1948, 'An Oversight in nursing History', *Journal of History of Medicine.* (Summer): 417-26.

21 Abel-Smith, B., 1960, *A History of the Nursing Profession*: 3-4.

22 Baty, M., 1986, *Florence Nightingale and The Nursing Legacy.*

23 1929, 'Editorial', *ONM*, XXIII(S): 89-91.

24 Hardy, A., 2001, *Health and Medicine in Britain since 1860.*: 19-20.

than antiseptics) was paramount, the trained nurse was arguably of greater significance to outcome and to disease prevention than the doctor –for example, during the 1849 cholera outbreak one physician observed that 'the nurse was then of more use to the patient than the doctor'.²⁵ Although it is more likely that these 'trained' nurses would have worked as private nurses, Ackland refers to nurses hired by the Oxford Guardians to care for the sick during the 1854 cholera epidemic²⁶ and Stocks recognises the valuable role played by trained and emergency-trained district nurses and the 'Lady Superintendents' in the Liverpool epidemics of cholera in 1866 and 'relapsing fever' in 1870 as forging a 'closer link between the town's health authorities and the district nursing organisation' and particularly with the Liverpool Dispensary's doctors.²⁷ Nevertheless, for the purpose of this thesis, it is important that the distinction should be drawn between a range of carers broadly described as 'nurses' including private nurses, all of whom may have worked within the community setting, and those employed as 'district nurses', supervised and organised within clearly defined 'districts'.

Trained nurses 'for nursing the sick poor in their own homes':

It was the experience of terminal care provided by a trained private nurse, Mrs. Mary Robinson, in the home of William Rathbone (who was a Quaker and wealthy ship-builder) after his wife died of consumption in 1859, that provided the inspiration for his philanthropic establishment of district nurse training and provision for the sick poor of Liverpool from 1862 by establishing a training school and home for nurses attached to the Liverpool Royal Infirmary, and by founding the Liverpool Queen Victoria District Nursing Association. These provided trained nurses for the infirmary and district nurses for the poor as well as some private nurses and the district nurses were then supervised by a 'Lady Superintendent'. At first the Superintendent was a voluntary member of a 'committee of ladies' who ran the 'district nursing association' although this situation seems to have changed by the end of the nineteenth century in most areas (Liverpool being the exception), by which time the Lady Superintendent was employed by the association and was, herself, a trained nurse.²⁸ In 1864, within two years of the Liverpool experiment, a similar association was set up in Manchester & Salford as the 'Sick Poor & Private Nursing Institute', with the Royal Derby & Derbyshire Nursing and Sanitary Association in 1865 and Leicester District Nursing Association the following year, followed by York and Birmingham in 1870 and Glasgow in 1875. Liverpool had a second Association, the Wootton and District Nursing Society, established by 1879. The different titles would suggest a subtly different emphasis in roles may have existed

25 Summers, A., 1997, Nurses and Ancillaries in the Christian Era, Western Medicine. An illustrated history, I. Loudon (Ed.): 192-205.

26 Ackland H.W., (1856) 'Memoirs of the Cholera Epidemic in Oxford 1854' Churchill, London, quoted in Dingwall, R., et al., 1988, An Introduction to the Social History of Nursing: 174-5.

27 Stocks, M., 1960, A Hundred Years: 35-37.

28 Although prior to the 1919 Registration Act, this could mean anything from one to three years and training was not nationally regulated but varied considerably from hospital to hospital.

between these early DNAs, with some including private nursing to boost the income of the association whilst others inclined more towards sanitary reform.

Dingwall et al,²⁹ suggest that the Manchester and Salford Ladies' Sanitary Association's was a direct development from this early role of district nurse/ mission woman to become the first 'health visitors' (henceforth HVs). However this appears to have been an over-simplification of the situation as the two associations appear to have been quite independent of one another although they may have worked closely and been influenced by each other's working methods. It arose from the Manchester and Salford Sanitary Association established in 1852, as the Ladies' Branch and has more in common with the Ranyard Nursing Association, having a strong religious objective and using the same concept of the 'missing-link' between the ladies of the Association and the working-class poor, providing a role model and 'mother's friend', and employing working-class mission women living within their working districts supervised by 'lady' volunteers but with the mission women as 'sanitary visitors' rather than being trained as 'bible-nurses'.³⁰ In Foucauldian terms, the HV was a public agent of moral and social reform, used to target the working-class mother and child to create and mould a particular type of family, thereby imposing middle-class Victorian values of health, hygiene and morality on the lower classes.³¹ This might be seen to have later extended to include 'control' of middle classes by gradually widening their area of responsibility along with other public health workers.

However, there did exist very fundamental differences in the conception of district nursing organisations, between the associations set up in the north of England based on the Rathbone concept of district nursing and some of those in London founded on Miss Nightingale's principles. The former were based on provision of charity and philanthropy, often with religious overtones, and may be contrasted with the latter's emphasis on self-help and reform through education and example. There are marked similarities in this conceptual dichotomy with those discussed by Davies³² on the battle confronted by the proponents of the Women Sanitary Inspectors' Association, and this will be dealt with in more detail when considering the later development of professionalisation in Chapters 6 and 9. Nevertheless, despite this issue proving divisive in the longer term, Rathbone and Nightingale agreed on the basic idea

29 Dingwall, R., Rafferty, A.M., and Webster, C., 1988, An Introduction to the Social History of Nursing: 175.

30 See Davies, C., 1988, 'The Health Visitor as Mother's Friend: A Woman's place in Public Health 1900-14', *SHM* (1): 39-59.; Welshman, J., 1997, 'Family Visitors or Social Workers? Health visiting and public health in England and Wales 1890-1974', *IHNJ*, 3(2): 5-21.; and Kelsey, A., 2000, 'The making of health visitors: an historical perspective part I', *IHNJ*, 5(3 (Summer)): 44-50.

31 Abbott, P., and Wallace, Claire, 1998, 'Health Visiting, Social Work, Nursing and Midwifery: a History', *The Sociology of the Caring Professions*. P. Abbott, and Liz Meerabeau: 20-53.

32 Davies, C., 1988, 'The Health Visitor as Mother's Friend: A Woman's place in Public Health 1900-14', *SHM* (1): 39-59.

of employing hospital-trained nurses to care for the sick poor in their own homes, which became a key concept in district nursing organisation during the bid for the Women's Jubilee Offering for Queen Victoria's Golden Jubilee. With a few exceptions, from the end of the Nineteenth century it was gradually accepted that, instead of the work being perceived as entirely benevolent, and any grants from public bodies or employers, seen as acts of charity, it would alter 'the way in which district nursing is [sic] regarded' if a nurse's services were paid for 'in accordance with the patient's means whilst, 'efforts were made to get into close touch with Public Authorities, such as Boards of Guardians and Municipal and Urban Councils, with the object of securing the actual cost of nursing care for patients under the various bodies concerned' .³³

Apart from the religious societies mentioned above there is some contention over the claim for the first district nursing organisation in London. The London Metropolitan and National Nursing Association was an organised association founded to a certain extent on the Liverpool model by the Order of St. John of Jerusalem and supported both by Mr. Rathbone and Miss Nightingale in line with these essential principles of providing hospital-trained and well educated nurses with a specific 'professional' training to work on the district, 'rather than as a *craft*'³⁴ and it was established in 1874 with Miss Lees (who later became Mrs. Dacre Craven³⁵) as its first Superintendent. However, a report from 1864 entitled 'The Organisation of Nursing in Liverpool' stated that: "'King's College Hospital has a large number of outpatients, and encouraged by the success of the missionary nursing, were tried by the St. John's House Nurses, the Lady Superintendent has established a system of out-nursing for the outpatients reported as requiring it by the medical men"'.³⁶ These two district nurses had trained at King's College Hospital and Charing Cross Hospital for one year. Similarly, the East London Nursing Society was founded in 1868³⁷ and employed district nurses trained at the London Hospital and by 1875 had seven district nurses. Stocks describes the confrontation between Florence Lees and the East London Society³⁸ quoting her comment that 'the East London Nurses seemed to her "nothing more than district visitors or mission women"' Nevertheless, it can therefore be seen that by the 1870's there was a perceived need for an increase in skill, competence, and status of the district nurse through better training and

33 1929, 'Editorial', *ONM*, XXIII(5): 89-91.; for example: Challis, 1922, 'On Starting a District Nursing Association', *ONM*, XIX(1 & 2): 3-4, 34-35; Hughes, A., 1910, 'District Nursing on Provident Lines', *Charity Organisation Review* (July); Hurry, J. B., 1898, *District Nursing on a Provident basis*.

34 Stocks, M., 1960, *A Hundred Years*: 46.

35 Mrs. Dacre Craven (nee Florence Lees) wrote the first text-book for district nurses: Dacre Craven, F., 1889, *A Guide to District Nurses and Home Nursing*.

36 Hardy, G., 1981, *William Rathbone and the Early History of District Nursing*.

37 1933, 'East London Nursing Society', *ONM*, XXVI (2): 68-9., formed in 1868 and apart from a three year incorporation with the Metropolitan and National Association (1878-81) remained the East London Nursing Society until after WW2 and was felt to have retained its own characteristics serving 213,000 cases between 1881 and 1932 and covering boroughs of Stepney, Poplar and the Isle of Dogs.

38 Stocks, M., 1960, *A Hundred Years*: 45-48.

qualification even though there was some difference of opinion as to the level of training and class of woman needed. Taking the Nightingale stance this also implied a need for organisation and regulation and improved professional image and public status. A press comment on the founding of the National Association for the Sick Poor which failed to appreciate this fundamental concept, stated "'It will open a new profession to the large and ever increasing number of women who require an employment of more interest than that of domestic servants, but who are not sufficiently well educated to become governesses.'"³⁹

However Hallowes points out this was not the intention of the founders of the Association but instead that, 'Miss Lees greatly desired to raise the standard of nursing and the social position of the nurse' recognising the need for "'amore comprehensive education and training" 'in order to "'make it a profession fit for women of cultivation" '. To achieve this end the training received by nurses from the Metropolitan and National Nursing Association was designed to include one month's extremely tough probationary trial period, followed by one year's hospital training and finally three months of 'special district training'. This last term combined practical training on the district with lectures in anatomy, physiology and hygiene, sometimes including attendance at post-mortems, whilst incorporating reduced working hours during this final period to allow for extra study time. This opens up a second major area of difference in conceptualization of district nursing's development that later on resulted in serious tensions particularly between the Queen's Institute in London and the Liverpool (Rathbone) training association, but also between the different associations operating within London - that is should nurses be recruited from the same social class as the patients she was to nurse or should the sights be raised to aim for the emerging professional class of women? This was to erupt in 1907 when Queen's Institute was establishing the examination format in order to introduce tighter regulation and uniformity of training standards, but there is little doubt that it presented some degree of resentment before then.⁴⁰ However the conceptual division remained unresolved in that district nursing was to retain a very diverse range of trained, semi-trained and untrained nurses throughout the first half of the twentieth century, from Queen's Nurses (henceforth referred to as QNs) some holding multiple qualifications, through to Registered Nurses and to village nurse-midwives and finally the 'Gamps' or village 'handiwomen'.

39 1898, 'Mrs. Dacre Craven', The Nurses' Journal (February): 16-18; Hallowes, R. M., 1955, 'Distinguished British Nurses: 8. Mrs. Dacre Craven (Florence Lees). An organiser of District Nursing', *Nursing Mirror* (23 December).

40 Stocks, M., 1960, *A Hundred Years*: 124-130, describes a confrontation between north and south and between several members of the Rathbone family. Although Liverpool eventually conceded to accept the Queen's Institute's examination system in 1909, Stocks maintained that the resentment lingered between the 'emissaries from an arrogant metropolis' and the 'older organisation which felt that it required no outsider from the south to tell it how to manage its own business'.

It is significant that at this time a trickle of women were beginning to enter the medical profession, signifying a wider movement both towards reform in the education of women, and to women aspiring to work in the health professions. The following observation related to the employment of educated, skilled nurses in the homes of the wealthy as well as the poor:

There is no reason why the rich should not obtain for money services which are freely bestowed upon the poor. Ladies will now take fees as doctors, but they will nurse only for charity ... Invalids of the upper classes would soon feel the advantage of being tended by a lady of refinement and scientific training, and would be willing to remunerate her services at such a rate as would in time repay the expenses of her preparatory study...⁴¹.

Similar views were expressed from The Metropolitan and National Nursing Association, the forerunner of the Queen's Institute. Notes from minutes recorded in 1875 relating to the then perceived role of the district nurse state that, "Although it is intended that the Society's nurses should be mainly employed for the sick poor, the power should be reserved of sending those who have shown themselves to be specially meritorious (under certain restrictions) to the sick in the upper ranks of society"⁴². In addition the social class from which they should be recruited is recommended as not being from the workhouses, but from the 'educated classes', and Florence Nightingale is quoted in this same article as being in support of this ideal.

However, in a letter from Miss Nightingale to The Times, referring to the founding of the Metropolitan Nursing Association, Bloomsbury Square, this does not appear so clear-cut:

The present Association wants to foster the spirit of work and not relief in the district nurse, and she wants to foster the same in her sick. Nor are these district nurses without hearing and receiving evidence that this spirit is now becoming really understood among their sick. One poor old woman was heard saying to her younger neighbour: 'Them nurses is real blessings; now husbands and fathers did ought to pay a penny a week, as 'ud give us a right to call they nurses when we wants they.' This is the real spirit of the thing. So nothing is *given* by the nursing, and some day let us hope that the old woman's sensible plan will be carried out. In the meantime nurses are nurses - not cooks, nor yet almoners, nor relieving officers. But if needed, things are procured from proper agencies, and sick comforts made as well as given by these agencies.

Experience hitherto shows that, if an institution is begun 'to provide skilled nurses for rich and poor,' especially if to be self-supporting, it ends up by 'providing skilled nurses' for the 'rich' only. For the 'rich' must come first if the institution is to be

41 Haddon, C., 1871, 'Nursing as a profession for ladies', St. Paul's Monthly Magazine (August): 458. quoted in Abel-Smith, B., 1960, A History of the Nursing Profession.

42 1922, 'How the work of District Nursing in London began - and continues', ONM, XIX (3): 49-52.

'self-supporting'; or in other words, if the nurse is to support the institution. And if the rich come first they will be first and last. The present association has begun, therefore, by providing trained nurses for the *poor* alone, always in view of the Provident Dispensary System at last; also of nursing pressing, needy, middle-class cases, as has already been done. These, and indeed poorer cases, have made presents to the association; the nurses take none. But the object of the association is: *to give first-rate nursing to the sick poor at home* (which they never have had). And this costs money.⁴³

However, the alternative scenario might effectively have combined the ideals and organisation of district nursing with the more lucrative and potentially influential, private nursing so that historically, the counterfactual possibilities of such a hybridisation at that stage in Nursing's professional evolution would be interesting to consider. I believe the most likely outcome would have been a two-tiered system of general practice nursing mirroring general practice medicine with far greater influence over health care policy and nurse registration than the fragmented forms that lingered into the twentieth century. Maggs' study of the 'first generation of hospital trained general nurses in England'⁴⁴ (1881-1914) lends support to this thesis. He refers to the elite status and 'supremacy of the General [trained] Nurse' as a form of 'occupational imperialism'⁴⁵ and whilst this was particularly so within the new general hospitals, it was also the case in private practice nursing where he suggests they presented a very real threat to the livelihoods of some general medical practitioners already fearing competition from midwives and to a lesser extent district nurses presented the same threat. How much greater might this have been if the private and district nurses had been amalgamated under the Queen's Institute as their professional body?

In fact Amy Hughes, recognising the uniquely professional position of QNs when stating the case for the pro-registrationists as early as 1904, wrote:

Queen's Nurses should not forget they are the one body of nurses whose system of work includes a "register" the Roll of Queen's Nurses, in which their names, training and reports are entered, and from which they are liable to be removed if they forfeit the privilege of remaining Queen's Nurses. They are therefore specially able to weigh this question fairly, and to realise what such a register would mean to their fellow nurses, especially those who are working as private nurses, either in connection with institutions, or on their own account.⁴⁶

43 Nightingale, F., 1923, 'Trained Nursing for the Sick Poor: extracts from letter by Miss Florence Nightingale sent to The Times, April 1876', *QNM*, XX(4): 165-166.

44 Maggs, C., 1983, *The Origins of General Nursing*: 1.

45 Maggs, C., 1983, *The Origins of General Nursing*: 30-31 -this theme and the concept of 'occupational imperialism' will be explored in greater depth in subsequent chapters.

46 Hughes, A., 1904, 'Answers to Correspondents', *ONM*, 1(3 (December 31st)).

The founding of the 'Queen's Institute' - a professional rationale?

In 1874 the newly-formed National Association for Providing Trained Nurses for the Sick Poor set up a Sub-Committee of Reference and Inquiry, to be chaired by William Rathbone, and with Miss Lees as Hon. Secretary. Following extensive traveling around the UK by Miss Lees to visit existing district nursing associations, supplemented by a national questionnaire to all diocese to establish where there were district nurses, data was gathered about these, and if not, where they existed and whether one was felt to be needed. The Inquiry's Report was published in 1875 and appears to have reinforced the committee's belief in the need for an organised and regulated National Institution. The Queen Victoria Jubilee Institute for Nurses (hereinafter referred to as the 'Queen's Institute' or QNI although the simplification of the name did not come about until 1928) was set up over the following decade with the London Metropolitan and National Association as its flagship, supported by the Queen's Jubilee Fund. Almost inevitably, a prominent front-stage ambassadorial role was played in the negotiations over this by a number of eminent men -particularly Sir Henry Ponsonby, the Duke of Westminster and William Rathbone⁴⁷ but it is also important to remember the parts taken in this by a number of eminent women, most obviously Queen Victoria herself, but also considerable persuasive influence and advice received from Florence Nightingale, Mrs Dacre Craven and Mrs. Rathbone. In addition it is noteworthy that Dr. Mary Scharlieb, herself a pioneer woman doctor, was appointed as one of the first lecturers to the trainee QNs. The QNI was granted a Royal Charter in 1889⁴⁸ and in 1890 Rosalind Paget, niece to William Rathbone, was appointed as the first Inspector General. Further financial support was received at the Queen's Diamond Jubilee in 1897 and following her death in 1901 and it is noticeable in the Burdett's Directory entries that there was a sharp increase in numbers of district nursing associations established in the Jubilee year. In response, many of the local nursing associations⁴⁹ already in existence became affiliated to the Institute, with Scotland having its own separate branch and council.

47 Stocks, M., 1960, A Hundred Years: 76-77.

48 This was succeeded in 1904 by a supplementary charter granted by King Edward VII by which Queen Alexandra became patron, at which point the Institute was no longer officially connected to St. Katherine's Hospital.

49 Hallows, R. M., 1955, 'Distinguished British Nurses: 8. Mrs. Dacre Craven (Florence Lees). An organiser of District Nursing', Nursing Mirror (23 December), quotes from the Inquiry's statistics that in London alone there were a hundred district nurses (population 3 millions) and that 'only about one third of them had any training'.

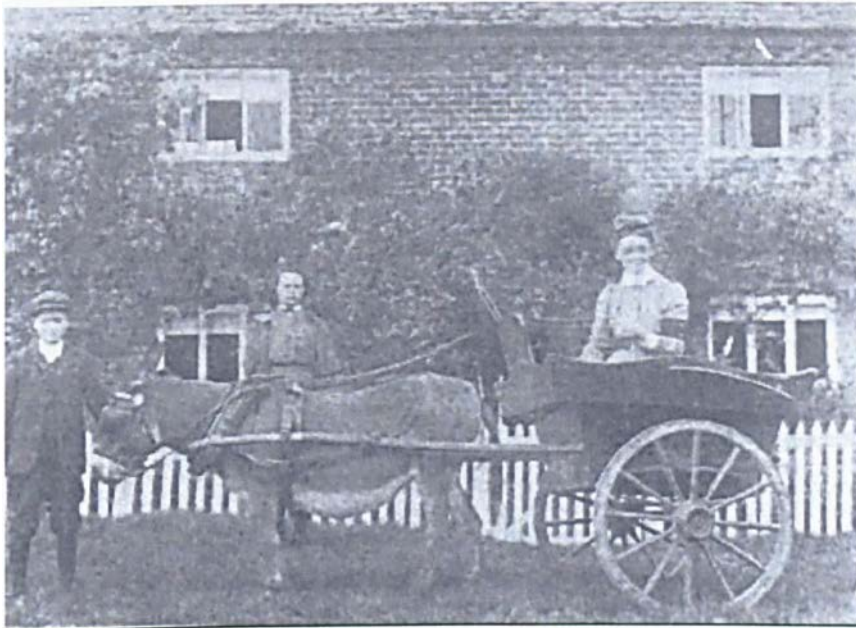


Fig. 3.2 Nurse Wolfe of Gotherington, Somerset – a rural district nurse in the donkey-cart which she used to cover her district.¹

The Rural Nursing Association, which was founded in Gloucestershire in 1889 by Mrs Elizabeth Malleon, established County Nursing Associations with Hampshire founded in 1891 and Lincolnshire in 1894. Mrs Malleon was a 'determined, radical and combative suffragist' and is quoted as saying "The work is more fitted to some of the excellent women I have known as nurses than to ladies."⁵⁰ A letter written in 1909 by a newly appointed County Superintendent of Somerset's County Nursing Association described cycling sixteen miles through heavy rain and mud to get to an inspection (carrying all her luggage for the week on her cycle), pacifying a discontented nurse and secretary and finding an emergency replacement for a nurse who had been found drunk. She refers to the shortage of nurses saying, 'We have to confer about "Gamps" for country districts. This is C.C. work. Miss E. wrote to the C.C. asking where Gamps could be got and suggesting a scheme, and I have been asked by the C.C. to talk things over and draw up a scheme.'⁵¹

By the end of the Nineteenth Century there were over 900 trained QNs on the Institute's Roll. The stipulated training had been modified to include: one year's hospital training, three months midwifery and three to six months 'training in district work'. The idea also spread throughout the Empire with the Canadian Victorian Order of Nurses being founded in 1897 and subsequently a 'Bush Nursing Service' being inaugurated in Australia in 1910 and the

⁵⁰ Ellice, G., 1989, 'A century of district nursing', *The Countryman*, 94 (2 (Summer 1989)).

⁵¹ du Sautoy, C., 1963, 'Glimpses from the Past', *DN*, 5 (11 (Feb.)): 260.

King Edward VII District Nursing Service founded in South Africa in 1912.^{s2} By 1892 the Local Government Board had authorised the appointment of district nurses by all Boards of Guardians stipulating a minimum of one year's training, a good 'moral character' and conditions of appointment similar to infirmary nurses.^{s3} This barred them from midwifery and placed them under the direction of the doctors who were to be instructed about the nurse's duties by the Guardians. The alternative was to use nurses supplied by Nursing Associations or the Queen's Institute. In addition, particularly in more rural areas, 'cottage' or 'village' untrained nurses or 'handiwomen' were employed by voluntary agencies as domiciliary nurses within the community sometimes working under the supervision of trained nurses. The Royal Commission on the Poor Laws set up in 1905 noted in two separate reports published in 1909 that there was an inadequacy in the provision of nursing for the 'outdoor' sick, particularly in remote rural areas and set this as a high priority.^{s4} In particular, the Report encouraged local Boards of Guardians to subscribe to DNAs where nursing care was provided to patients receiving poor relief in their own homes.

What then was the relationship between general practice medicine and district nursing at the end of the nineteenth century and the beginning of the twentieth? - In 1874 Maria Grey, a nineteenth century feminist and educationalist wrote:

Ladies who desire to study and practise medicine are told that it is unfeminine and unladylike, besides being too laborious for their sex, and are urged instead to become nurses ... The strains upon the nerves and physical strength, the violence done to delicacy, the necessity of witnessing painful and disgusting sights, are greater in the case of the nurse ... while many of the offices that have to be performed by her, are in themselves of so repulsive a character to anyone not bred to menial service, that only strong affection or enthusiasm could overcome the disgust attending them; but then, neither high pay nor social position are to be attained by the nurse, while both are claimed by the physician. It has, therefore, been decided that it is highly unfeminine, nay, revolting to every feeling of womanly delicacy, for a woman to be a physician, but most feminine to be a nurse. ss

s2 Searle, C., 1968, *The History of the Development of Nursing in South Africa. 1652-1960: A socio-historical Survey.*, and in CMAC: Queen's Institute Archives Box 113 extract from an article by Roberts, F.M., (c.1950) King Edward VII Order of Nurses

s3 White, R., 1978, *Social Change and the Development of the Nursing Profession: A Study of the Poor Law Nursing Service 1848-1948.*; also in Anderson, G., 1948, 'An Oversight in nursing History', *Journal of History of Medicine* (Summer): 417-26.

s4 Stocks, M., 1960, *A Hundred Years*: 139-142.

ss Grey, M., 1874, 'Idols of Society; or Gentility and Femininity', Victorian Feminism 1850-1900. P. Levine: 97-8.

The more advanced state of professionalisation within medicine (medical registration became mandatory from 1858 as part of the Medical Act (1858)⁵⁶) gave doctors a dominant and paternalistic position both in hospital and community with authority over both nurses and patients regarding patient management such as: admissions and discharges, expenditure, treatment and even nursing care decisions such as requiring medical orders prior to bathing a patient.⁵⁷ This inevitably placed nursing, including district nursing in a subordinate position to medicine despite the QNI's royal charter and patronage.

Public and professional perception of roles - a need for clarification

Whilst this was clearly appreciated by some doctors,⁵⁸ the emergence of the better-qualified and professionally supported QN must have presented the less financially secure general medical practitioners, and especially those struggling to maintain a medical living in the poorer rural and urban areas⁵⁹, with a perceived threat to their livelihood. This was particularly so in the decade before the introduction of the National Health Insurance Act (NHI) in 1911 when general practitioners were feeling particularly insecure.⁶⁰ To some extent this might be ascribed to a need for clarification of the functionally distinct roles. For example, a GP in 1899 expressed the concern that 'to all intents and purposes [a nurse was becoming] a medical practitioner'⁶¹ whilst other doctors were anxious that the new, professionalised nurse might undertake 'medical' tasks causing them to lose out on fees to her or that she might undermine their authority. Whether this was a momentary misunderstanding, or, as would seem more likely, a simmering mixture of resentment and aggravation held in check by a policy of conciliation recommended by QNI (for example, when establishing agreements of affiliation with new district nursing associations), is unclear. However, this tension came to a head when the local medical associations a few years later fiercely defended the doctors' position. This is illustrated by a case in 1908⁶² in which a problem arose between Penwith Medical Union, Cornwall and the local district nursing association in which nurses were accused of attending patients without referring them to a

56 The Medical Act (1858) contributed to the regulation of the medical profession by introducing compulsory registration -although not by 'single portal of entry' - and the creation of a medical council with disciplinary powers -see Loudon, I., Ed. 1986, Medical Care and the General Practitioner. 1750-1850:297-301.

57 Walby, S., Greenwell, J., et al., 1994, Medicine and Nursing: Professions in a changing Health Service.

58 Hallows, R. M., 1955, 'Distinguished British Nurses: 8. Mrs. Dacre Craven (Florence Lees). An organiser of District Nursing', Nursing Mirror (23 December), notes that, 'Doctors bore witness to the great value of the skilled nursing provided by the Association'.

59 Digby, A., 1994, Making a Medical Living: Doctors and Patients in the English Market for Medicine 1720-1911.: 145-147.

60 Digby, A., 1999, The Evolution of British General Practice 1850-1948: 25, refers to the number of 'young doctors, in the decades before the state national health insurance scheme of 1911 expanded demand, were forced to become low-status 'sixpenny' or 'shilling' doctors'.

61 'Country Practitioner', 1899, 'Correspondence', BMJ, 25(3):762.

62 QNI Archives, 1908-10, SA/QNI Box 79 HS/I: Correspondence and Minutes of meetings with the BMA re. proposed changes to the rules of County Nursing Associations.

medical practitioner. The British Medical Association (BMA) took this up with the QNI proposing a joint conference to discuss drawing up draft rules by governing the work of district nurse-midwives in local DNAs suggesting:

- Representation of Medical Profession on all local District Nursing Associations
- Confirmation of the position of district nurses working as auxiliaries to, and acting under instructions of, medical practitioners.
- Clarification of the situation where district nurse-midwives act as a midwife without a doctor in attendance and/or attend private persons who could pay fees.
- Clarification of the situation where district nurses might leave the employment of the District Nursing Association and set up in private practice within the area in competition with the GP.

Replying to this and other suggestions a Queen's Institute committee member, himself a medical man, Dr. Arthur Shadwell commented that:

to set up a formal or semi-formal tribunal (even if there were the power to do it) and accord the [BMA] Association a locus standing for intervention would be more likely to encourage than allay friction [...] it is no part of the Institute's functions to help bring it about. It should not be forgotten that the two bodies are not on the same plane in this matter. The sole object of the Institute is the welfare of the sick poor, whereas the aggrieved doctors are fighting for their own hand⁶³.

At this time Cornwall had a well established County Nursing Association with 63 districts in 1910 employing a total of 70 nurses all but five of whom were certificated midwives and 16 were Queen's trained.⁶⁴ In the year 1909-10 they nursed a total of 6905 patients, and it would seem most likely that it was the midwifery cases that were really at the centre of this controversy.⁶⁵ It is perhaps also significant that the Hon. Secretary of the Truro DNA was Miss Lillie Paul, who sat on a number of local committees including being a Poor Law Guardian, and she was a prominent supporter of women's suffrage⁶⁶.

Whilst it is significant that this and other examples of inter-professional rivalries took place just before the 1911 NHI Act, other instances arose later in the 1930's. (see chapter four) Although the 1911 National Health Insurance Act made considerable changes to provision of medical care, and was supported in principle by the Queen's Institute, comparatively few of the district nurse's patients fell directly under its provision. Several contemporary written

63 Ibid.

64 Palmer, J., 1994, Edwardian Truro.

65 Stocks, M., 1960, A Hundred Years. 120-121.

66 My thanks to Dr. Bradley for this information - see Bradley, K., 2000, Friends and Visitors: A first history of the women's suffrage movement in Cornwall 1870-1914: 14 and 31.

cameos of work 'on the district' give an impression of the type of work performed and the range of patients visited and these will be looked at here. Although there is little doubt that they have been modified or tempered to some degree for publication, they nevertheless provide valuable insight into work on the district at the time. In the first, the image of the Lady Superintendent as supervisor but physically remote from the actual duties of the more lowly district nurse, may be seen to be (at least in some cases) quite unjust. Hallowes cites one of Mrs. Dacre Craven's quarterly reports written whilst working as a Superintendent in London in which:

'a vivid description is given of her tackling, along with the district nurse, an old woman who had not been washed for ten years and a room which had apparently not been turned out within the memory of man. Superintendent and nurse, after beating a retreat to the passage to overcome their nausea, dealt faithfully with this situation and did not leave until both room and patient had been, in Miss Lee's favourite phrase, "put in nursing order".⁶⁷

Similarly, one patient's tribute, selected because it was 'rather quaint' is quoted: "'I didn't know there was nurses as got their living by it and weren't just missionaries, or I'd have had some of you before and been thankful"'.⁶⁸ Another article written in 1922 quotes Miss Lees speaking at Committee in 1876 about elderly bedridden patients and describing the 'nursing care' given:

The nurse daily washes them and combs their hair (once a week baths them as far as a patient can be bathed in bed). She daily makes the bed, sweeps and dusts the room, shakes the bits of carpet, empties and washes the utensils, cleans up the hearth, sifts the cinders, and carries away the ashes. Such cases we term 'cleaning cases,' and according to the number of stairs the nurse has to run up and down for these purposes, so is the case a very heavy 'cleaning' case or not. It must be remembered that the poor possess very few of the proper utensils for fetching and carrying. We have had to make several journeys to fill a heavy kettle, the only thing to fetch water in being a small tin can. Ashes and dust we often have to carry down in a newspaper, sometimes we are obliged to borrow a brush for the floor, a broom with a long handle being unheard of. After we have borrowed this brush from a neighbour she will call when we have gone and 'see how them young persons have cleaned up'⁶⁹

Similarly an Editorial written in 1924⁷⁰ looking back at the (anonymous) author's work as a district nurse in London in the late 1890s and first decade of the twentieth century, describes

67 Hallowes, R. M., 1955, 'Distinguished British Nurses: 8. Mrs. Dacre Craven (Florence Lees). An organiser of District Nursing', *Nursing Mirror* (23 December).

68 Anon., 1909, 'The morning round of a Liverpool "Queen's" Nurse', *Delegates Local Handbook of Jubilee Congress*: 31-35.

69 1922, 'How the work of District Nursing in London began - and continues', *QNM*, XIX(3): 49-52.

70 1924, 'Editorial', *QNM*, XXI(1): 176-177.

general 'improvements in the surroundings and personal condition of the patients attended', stating that in 1897, 'poverty and disease were rampant' homes visited were 'very scantily furnished' with virtually no household appliances and often 'no towels, soap or basin for toilet use, and hot water hard to get' [...] 'The difficulty of getting from case to case was great, the only vehicle available being a horse bus or tram, and these were few and far between' so entailed a great deal of walking every day. She remembers that 'with the coming of the universal use of gas cookers the work became much easier as regards hot water and sterilisation etc.' and that the formation of Infant Welfare Centres (between 1903-5) had been 'the saving of many' as had been the Minor Ailment Treatment Centres for School Children, and finally claims that notification of tuberculosis opened up 'a wide field of work for nurses, more especially district nurses'.

The Queen's Poor⁷¹ is claimed to have been largely based on the author's own first-hand experience of what she terms 'the decent poor' as a district nurse and later a superintendent of district nurses, having worked in London, Buxton Derbyshire and Portsmouth Hants. There is considerable anecdotal material,⁷² much of which is presented as if it were oral evidence, but which has to be treated with considerable caution. Nevertheless, Cohen and Fleay defend this, noting Loane's (re)assurance that 'every anecdote including the apocryphal ones to which she referred was genuine'.⁷³ There is certainly much valuable socio-historical testimony concerning health care, standards of living, and perceptions of health professionals and prevailing social attitudes. The role and professional and public images of a Queen's district nursing superintendent and district nurse are vividly revealed, and Martha Loane's first-hand experience is evident in detailed descriptions of the considerable pressures, demands and difficulties of working under the constraints of employment by a district nursing association committee in both urban and rural areas of extreme poverty. She exposes occasional abuses of the district nursing system aimed at providing nursing care specifically for the 'sick poor in their own homes' and draws attention to serious failings of the Poor Law revealing inadequacies and injustices in both institutional and outdoor relief. At the same time she strongly supported the ideas of the Eugenics movement,⁷⁴ believing many social problems were the result of uncontrolled population increase.

71 Loane, M., 1905, The Queen's Poor. Life as they find it in town and county. See especially Chapters VII and VIII

72 This would have been a style commonly used by her contemporaries and was apparently popularly received.

73 Cohen, S., and Fleay, C., 1998, 'Introduction' in: Loane, M. *The Queen's Poor. Life as they find it in town and county* (Reprint of First Edition): xxi.

74 Meetings of which were advertised in QNM throughout this period; see also Glamorgan County Archives and Records Office 1928-1958, 'D/DX 236: Private papers of District Nurse Ann Evans'. which included a small pocket-book entitled 'True morality or the Theory and Practice of Neo-Malthusianism' including details of, and advertisements for contraceptive methods and appliances.

The description of a typical day takes district nurse and supervisor to a number of routine visits and emergency calls, from false alarms and the first-aid treatment of tending to a patient's injured thumb, to the trauma of a child's death, a terminally ill young man and a victim of domestic violence. A case of pneumonia is described as 'one of the few instances when a nurse can do anything more than alleviate pain', and when the nurse is asked if she has many male patients she replies, 'not nearly so many as women. In the first place, they have better health; and in the second place, when they are ill they are generally fit cases for an hospital, and no one would wish to nurse a man in his own house if there were any satisfactory alternative.'⁷⁵

What were the conditions of service under which the district nurses worked?

Looking at the entries in Burdett's Directories⁷⁶ and the records of the QNI from 1915 onwards,⁷⁷ there were 2,100 QNs in 1914 although the number had fallen – largely as a result of nurses' contributions to wartime needs overseas and in military and civilian hospitals – to 1,989 by 1918. Mary Stocks' notes created in researching her book, include an extract from the existing rules of Durham's district nursing association at the time of affiliation with the QNI in 1913. They paint a picture of considerable regimentation and hierarchical control stating that: '"nurses may not be out in the evenings without permission from the superintendent"' – in her notes, Stocks suggests that 'this condition for nurses was general all over the country, and that 'at a later date latchkeys were provided for nurses'.⁷⁸ In reality, however, these restrictions can only have applied to the urban district nurses living in nurses' homes', whilst the rural nurse would have had rather more personal freedom, living in rooms or a tied cottage.

From the figures available in Burdett's Directory for 1915 rates of pay and emoluments offered by district nursing associations varied very considerably in England and Wales, ranging from £10 to £90 per annum, but averaging around £38 with the upper wage limit being reached usually after three years full-time employment and being approximately £5 to £10 increase on the total annual income. The lower figure at first seems highly suspect as the figures given in 1890 by the QNI⁷⁹ for the salary of a trained district nurse give a range between £25 to £50 per annum. However, the low figure of £10 may well refer to a 'village nurse' and this might have been a basic rate for nursing which may have been supplemented by payments for additional nursing and/or midwifery services or private nursing. Lincolnshire Nursing Association conveniently provides a breakdown of their salaries, QNs being paid

75 Loane, M., 1905, The Queen's Poor. Life as they find it in town and country. (reprinted edition 1998): 178-179.

76 Burdett, H., 1900-31, Burdett's Hospitals and Charities Yearbooks.

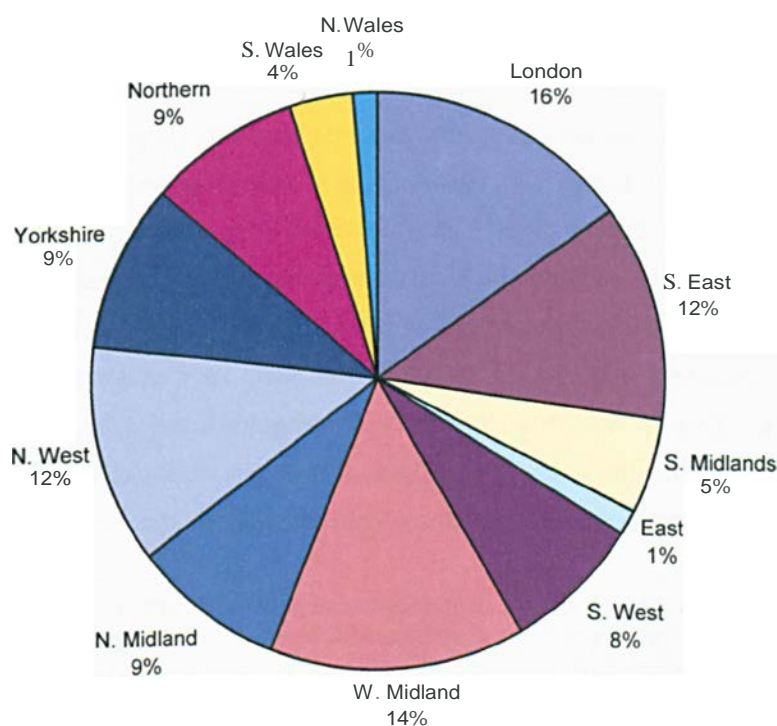
77 CMAC: SA/QNI

78 QNI Archives, C., 1956-65, SAIQNI Box 114 P13/1-11: Correspondence and material used by M. Stocks for preparation of 'A Hundred Years of District Nursing'.

79 Morten, H., 1895, How to Become a Nurse: and how to succeed.: 76-77.

£90-£100 per annum, nurses 'with some hospital and district training' paid at £60-£75, and 'rural maternity nurses' at £50-£65 indicating a considerable differential between the elite QN and the village nurse-midwife. Emoluments generally included board, lodging and laundry and occasionally covered a uniform allowance that was between £4 and £10 annually. Uniforms had not been standardized, although the Queen's Institute was nearest to introducing this through recommending a style of dress to affiliated associations and providing a badge and brassard to be worn by all QNs⁸⁰. Also by this time, some associations were making a contribution towards the nurses' pension schemes – in particular, the Royal National Pension Fund for Nurses (RNPFN). Similarly, one association recorded provision of an annuity for long service (stipulating a minimum of 10 years) whilst two others offered sickness pay (one of these gives the rate as full pay for 12 weeks). It would be reasonable to expect that others may have done the same but have omitted these details from their entry. However most indicated that they provided nursing care for the sick poor, but it is perhaps significant to note that there was no obvious standard policy concerning private nursing – some associations quite openly supplemented their income through midwifery and maternity nursing and/or private nursing. Peckham DNA, for example, recorded 'poor attended free, also attend middle class cases of sickness & operations'. More than one third (53 of the 144 entries) stated 'none but certificated & hospital trained nurses employed' or stipulated 'three years hospital training' or similar with others noting that training was provided.

Fig. 3.3 1915 Distribution of District Nursing Associations



80 Stocks, M., 1960, *A Hundred Years*: 82-83, 163-165.

Fig. 3.3 above, has been created from the data given in Burdett's Directories for 144 entries of DNAs in England and Wales in 1915. The high proportion of associations operating in London included several religious organizations (already mentioned above) and entries for these suggest something more akin to sick-visiting than nursing: 'sent at invitation of clergy' or 'the Sisters visit the sick in their own homes, in hospitals & infirmaries'. London was also unusual from an early stage both in the existence of the Central Council for District Nursing in London (CCDNL) formed in 1915 and in the extent of collaboration between district nursing and the educational and public health services of the LCC and Metropolitan Boroughs and some city hospitals.⁸¹ This may in part reflect the early tradition of two-way co-operation which was required in the establishment of district nurse training. A significant number of the London associations were under royal patronage -in particular, that of Princesses Christian and Louise, but also the Duke and the Duchess of Westminster supported the Westminster Nursing Committee and the Chelsea, Pimlico & Belgravia Nursing Associations, respectively. Only London and Liverpool associations note school nursing as a part of the nurses' regular work with the London City Council financing this service through clinics and treatment centers. It can be seen that the West Midlands region,⁸² had a surprisingly high number of Associations and the South Midlands and less surprisingly the Eastern region of Norfolk, Suffolk and Essex had very few, probably due to the very rural and sparsely populated nature of that particular region. The remainder had between 11 and 13 associations (eight or nine percent of the total) each.

Workload may be measured by looking at the number of cases (or patients) nursed over a set period, and/or by recording the number of visits made to patients over that time. For example, one case may only require one visit per week, whilst another may require twice daily visits, but the first may take up more time or require greater nursing skills, so it is prudent to view both figures. Taking these figures for England and Wales as a whole, the average number of visits per nurse per year can be calculated as 3356 attending an average of 160 cases per year. However, in reality this ranged from as few as 1490 visits (or 138 cases) in rural Liskeard, Cornwall, to as many as 5662 visits (or 183 cases) in the heavily populated city of Birmingham. In a few cases competence in maternity and fever nursing were specified as required skills, whilst others specified nursing duties were 'confined to district nursing'. Subsequent chapters will examine the changes that took place in the work and conditions of

81 Central Council for District Nursing in London, 1966, History of the Central Council for District Nursing in London. 1914-1966. It was also innovative in providing a Directory containing the names of over 20,000 streets in London together with the association by which each was served which was invaluable e.g. in improving communications between hospitals and nursing associations. Reports were also prepared by the CCDNL to review the nursing of Ophthalmia Neonatorum (1917) and infectious diseases such as measles and scarlet fever the previous year (see Central Council for District Nursing, 1916, Outline of a scheme for the district nursing of Measles, German measles, and Whooping Cough in London.

82 For regional divisions see Appendix 3.

service under which the role of the district nurse evolved, and what effect these changes may have had on her role and professional image.



Fig. 3.4 District nurse attending young child c1920⁸³

Conclusion

It may be seen from this chapter's overview of the period leading up to 1919, that there were already several indicators of an existing professional self-image within district nursing which had been established to a large extent by the Queen's Institute and its founders. Through the rules of affiliation and through the hierarchy of its internal organisational structure, this legacy included a heavy emphasis on maintaining high standards of training, examination, a system of registration and self-regulation, pressure for standardization of pay, and the relative subordination of lay committees. It has been shown that Queen's trained nurses possessed a wide range of nursing skills and received a nationally standardized programme involving theoretical and practical training followed by written and practical examination, well in advance of other areas of nursing. Although there were many associations existing outside the Queen's Institute, several of which had been alienated by its elitist stance, it is clear that its influence was considerable and that it had set a standard, at a time when the rest of nursing was still struggling to achieve these goals of professionalisation. The relationship between the general practitioner and the district nurse was an uneasy one throughout this period, with the latter being in some ways subservient to the former, yet representing a threat to the more vulnerable GPs, particularly before the National Health Insurance Act (1911). The development of this inter-professional relationship, the intra-professional relationships between district nurses and their colleagues in the evolving field of community health care, as well as with their hospital counterparts, will therefore be a central issue to the next chapter.

⁸³ Source unknown.

Part II
'Voluntary Sector to Welfare State'

Chapter 4: 'What became of the Lady?' District Nursing Development 1919 - 39

Referring to the Nurses' Registration Act (1919), Dr. Addison, Minister of Health, emphasised in a speech to district nurses in London that it was:

essential that "nurses should be adequately paid the system which paid a nurse at the rate of a scullery maid was wrong" and he implored nurses to be "citizens first and nurses second," declaring as a professional man that, "the bane of professions was that their members were professionals first and citizens second".¹

Nurses' Registration and the immediate post-war period

Having revealed the inadequacies in health care and welfare provision, the First World War is considered to have accelerated governmental intervention in this area considerably, with particular emphasis on public health being pursued by the Ministry of Health (newly-formed in 1919).² One aspect of this that had an important effect on district nursing was the Maternity and Child Welfare Act (1918) taking responsibility for the health of mothers and children, from the Board of Education, and establishing a network of local authority clinics. As such, it was therefore also largely responsible for the promotion of health visiting, numbers of HVs having more than doubled during the war.³ From 1919 the Ministry of Health also took over health responsibilities previously assigned to the Departments of Housing and Planning thereby creating a larger and politically more powerful government department dealing with a broad range of local authority services including specialist areas such as a Tuberculosis and Venereal Disease treatment centres⁴.

The war may also have served as a catalyst for an increased awareness of the need for a display of unity and awareness of the importance of professional status amongst trained nurses, and Mrs Fenwick, the leader of the Campaign for the Registration of Nurses since 1887, actually regarded the Nurses Registration Act (1919) as 'comparable to the enfranchisement of women'.⁶ This is also significant since nursing was a female occupation fighting for professional regulation, with both Parliament and the 'Professions' being male-dominated and holding the power to sanction reform. However the two are more deeply

¹ Reported in (1920), 'Editorial: State Registration.' ONM XVII(1): 1-2.

² See Marwick, A., 1965, The Deluge: British Society and The First World War; Marwick, A., 1968, Britain in The Century of Total War: war, peace and social change, 1900-1967; and Gente, M., 2001, 'The Expansion of the Nuclear Family Unit in Great Britain between 1910 and 1920', History of the Family, 6(1): 125-142.

³ Midwinter, E., (ed.) 1994, The Development of Social Welfare in Britain: 79 gives numbers rising from 600 to 1,335 during World War I.

⁴ Jones, H., 1994, Health and Society in Twentieth Century Britain: 76-77 and 84-90.

⁵ For example in bringing together those responsible for the launch of the College of Nursing in 1916 – see McGann, S., 1992, The Battle of the Nurses: 48. Granted a royal charter in 1928, the College became the Royal College of Nursing (henceforth RCN).

⁶ McGann, S., 1992, The Battle of the Nurses: 49.

correlated: the battle for enfranchisement which continued after the 1918 Representation of the People Act was to enfranchise those still disqualified from voting. Smith⁷ notes that these were typically young, educated, unmarried women, possibly those in a profession such as teaching that had a marriage bar, and would have meant they were working for insufficient pay to enable ownership of property. He also points to work by recent gender historians which suggests that the wider intentions of the campaign for suffrage was to 'empower women to alter man-made institutions to reflect women's higher moral standards'⁸ within society, rather than purely to attain equality with men.

Whilst Smith's study related these attributes to single women teachers, it can be clearly demonstrated that the district nurse would seem to fit the bill equally well. For example the changing attitude towards marriage in nursing as a whole has been described as 'an unspoken prejudice against married women'⁹ and this idea appears to be reinforced within district nursing by evidence in the QNI's Registers¹⁰ in which one of the most common reasons given for the resignation of nurses was 'for marriage'. Also it can be seen that rates of pay and conditions of service (see below) combined to make property ownership amongst district nurses very much the exception rather than the rule. In addition, preaching the 'gospels' of hygiene, sanitation, improved housing, and health education were central to the overall ethos of the majority of the campaigners for women's suffrage and equal rights. The tone and content of articles published in the QNM throughout the inter-war period certainly supports this feminist hypothesis. Bearing this in mind, this chapter will look firstly at the development of district nursing from the organizational and institutional viewpoint and then at the inter- and intra- professional difficulties encountered by these women. The title 'district nurse' might appear to have become clear-cut by 1919, but will be shown to have still been applied to a wide range of skills and abilities. Variations in work experiences and practices as well as to their terms and conditions of service, will be the focus of the second half of the chapter.

Organisational and Institutional development of district nursing

The Nurses' Registration Act of 1919 and subsequent formation of the General Nursing Council for England and Wales (GNC), imposed registration and regulation on the nursing profession as a whole, after many years of debate and division. There were three separate

⁷ Smith, H., 1998, The British Women's Suffrage Campaign, 1866-1928: 70-71, challenges the impression presented by earlier feminist historians such as Sylvia Pankhurst and Ray Strachey, that the equal franchise eventually obtained through the 1928 Representation of the People Act came 'virtually without effort', and argues instead that throughout the interim period (1919-28) the exclusion of these women was used as a political tool both by Labour and Conservative Parties.

⁸ Smith, H., 1998, British Women's Suffrage Campaign: 82 referring to discussions in Caine, B., 1997, English Feminism 1780-1980; Levine, P., 1990, Feminist Lives in Victorian England; and Lewis, J., 1991, Women and Social Action in Victorian and Edwardian England.

⁹ Abel-Smith, B., 1960, A History of the Nursing Profession: 118-119.

¹⁰ QNI Archives SA/QNI Box 115 Q6/ 11-22: Rolls of Affiliated Branches, England and Wales.

Acts of Parliament enforcing nurse registration, one each for England and Wales, Scotland, and Ireland, therefore from the outset the unity that nurses had sought from legislation was to some extent thwarted, through the formation of three separate councils, each with their own registers and educational standards. It should therefore have been of added significance to the professional status of district nursing within the wider framework of the nursing profession, that even following this Act, the Queen's Institute's district training remained unique throughout the inter-war period in being able to claim provision of truly 'national' standards of training and practice (i.e. throughout Britain), registration by qualification, and self-regulation of practice, their nurses being subject to regular inspection by the Institute's own team of Inspectors. In the wider nursing community many of these professional goals were not achieved until much later, if at all -for example, the system of registration was phased in over several years so that standards of training and practice continued to vary considerably throughout the country, and state registration by examination qualification applied only to those completing their hospital training after the Act was introduced. In addition, the GNC failed to make the recommended training syllabus compulsory and made slow progress on setting an examination syllabus.¹¹ In effect, a much wider range of abilities co-existed under the umbrella of 'Registered Nurse' than that of 'Queen's Nurse'.

A further indication of the status of district nursing within nursing might be surmised from attitudes within the nursing profession such as that of the College of Nursing. This recognised recruitment to district nursing as being a matter of prime concern, and recommended salaries to be set at £85-£120 p.a. for resident district nurses in 1920. Until this point there had been no standard rate, and although this was only a recommendation, it was seen as a step in this direction. This was promptly taken up by the QNI as a requirement for affiliated associations at the Annual Conference of the Metropolitan and Southern Counties Association of Queen's Superintendents in 1922, when national standardisation of pay and conditions was suggested with a 'salary immediately after training, should start at £30 with uniform allowance of £8, in each county' and recorded that a 'minimum salary for village nurses immediately after their training is, as a general rule, £30, with uniform provided'.¹² It should also be noted that, whilst the College of Nursing, in line with the governmental policy, placed community health care as a high priority at this time, it appointed a Public Health Advisory Committee in 1921 establishing the first full-time training centre for HVs in 1925.¹³ The existence of the QNI as a well-established training institution for district nurses makes this appear an innocuous move on the part of the College, however it may inadvertently have set an unfortunate precedent within the profession by recognizing HVs' needs for specialized training but not those of

¹¹ McGann, S., 1992, The Battle: 49-50.

¹² 1922, 'Metropolitan and Southern Counties Association of Queen's Superintendents', *QNM*, XIX(2): 2S-29.

¹³ McGann, S., 1992, The Battle: 184.

district nurses. This could be seen as indicative of a disparity that was to become increasingly disruptive as both sub-professions evolved (see chapters five and six). The underlying dilemma was that the QNI was a powerful, well-established professional body, already running a successful training programme, yet was neither controlled nor financed by local government. Its regulatory powers, therefore, could only be extended to nurses who were 'Queen's' trained, and to DNAs that were 'Queen's' affiliated. For the newly-formed College of Nursing to have attempted to usurp the QNI would have been fraught with difficulties, yet by not doing so, they essentially ignored a large number of non-Queen's district nurses.

Despite this, White notes that: 'The 1922 White Paper outlining proposals for a National Health Service mentioned only one section of nurses, the district nurses' ... ' "a full home nursing service must be one of the aims of the new organisation ... all who need nursing attention in their own homes will be able to obtain it without charge"'.¹⁴ This would suggest a high-point in the public image of organised district nursing, and more especially the recognition of its importance by the new Ministry of Health. A discussion also in 1922¹⁵ concerning the introduction of a superannuated pension scheme, noted that 'in England and Wales there were 17 Homes with staffs above 10 nurses, 123 with staffs of from 4 to 10, 49 with staffs of 3, 152 districts with 2 nurses and 391 districts with one nurse'. This gives a total of approximately 1,400 or approximately a quarter of the total district nursing workforce, as QNs. A pamphlet produced by the Queen's Institute around 1925 noted that in England and Wales:

'there are over 5,800 nurses and midwives at work visiting over half-a-million patients annually and paying over 10,000,000 visits each year, but about 25% of the population of England and Wales live in an area where there are no District Nurses and for the other 75% the existing service is not yet adequate'.¹⁶

By 1939 this situation had improved considerably, but in the 1920s some associations still experienced considerable difficulty in becoming affiliated to the QNI, not because of low standards nor their inability to pay the salary demanded for a QN, but because they failed to comply with certain rules laid down by the Institute - in particular this included non-affiliation to any religious organisation. Examples of this include the Ranyard Nurses and St. John's House, both of whom had been refused affiliation in 1891 on the grounds that they were sectarian organisations, whilst St. Helen's DNA in Lancashire was initially refused affiliation on the grounds that the religious element in the constitution was 'too prominent' as

¹⁴ White, R., 1985, The Effects of the NHS on the Nursing Profession 1948-1961: 143-144.

¹⁵ 1922, 'Association of Queen's Superintendents in the Northern Counties', QNM, XIX(2): 25-29.

¹⁶ Peterkin, A. M., c1925, The Work of the Queen's Nurses: how they minister to the needs of the sick.

it was Stamford in Lincolnshire¹⁷. Mary Stocks notes an extract from the Inspector's Report prior to affiliation in 1913 of Durham's DNA (founded 1882), which had previously included religious affiliation to the Church of England: "the old nurses who appear to have acted as almoners only, had been there 25 years ... the one rule objected to (QVJI 8) was that nourishment should not be given away". Despite this, there would appear to have been some inconsistency amongst the inspectorate of the Institute -for example, another Lancashire DNA, Preston, *was* affiliated in 1925 despite the apparently damning, preliminary report¹⁸ which noted 'a nurse has been supported for the last 15 years by St. Silas Parish Church with that committee giving £100 p.a. to Preston District Nursing Association' and went on to request that she be allowed to remain under the superintendence of the QNI 'until she resigns of her own accord'. It also recorded that the 'Roman Catholic Church who number 40,000 [approximately one-third of the town's population of 120,000 at that time] have 5 trained and 3 untrained nurses' and that 'the doctors have been asking for some time for trained help - they are practically all in favour of the [Queen's Institute] scheme'.

The more general picture of growth of DNAs (including those not affiliated to the QNI) can be seen from the Burdett's Hospital's Yearbooks database. Although this does not have a comprehensive registration of all the DNAs throughout England and Wales, it is argued here that it most probably presents a fair representation of the regional distribution and growth of the movement over a fifteen year period. Table 4.1 shows the increase in numbers registered on a 5 yearly basis from 1915-1931. In all but the East of England there is an increase in numbers, with the biggest rise in relative terms being spread across the Midlands and South East of England, although it should be noted that in North and South Wales, numbers of associations doubled. The largest increases in the sixteen-year period are reflected in 1931 coming after the Local Government Act (1929).

Year	London	South East	South East	South West	South Midlands	West Midlands	North Midlands	North West	North Yorks.	North	South North	North Wales	South Wales
1915	21	17	2	11	7	20	12	17	13	12	5	2	
1920	21	19	3	12	7	22	14	18	14	12	5	2	
1925	22	21	3	14	7	21	14	19	14	12	5	3	
1931	25	27	3	17	13	26	17	22	15	14	10	6	

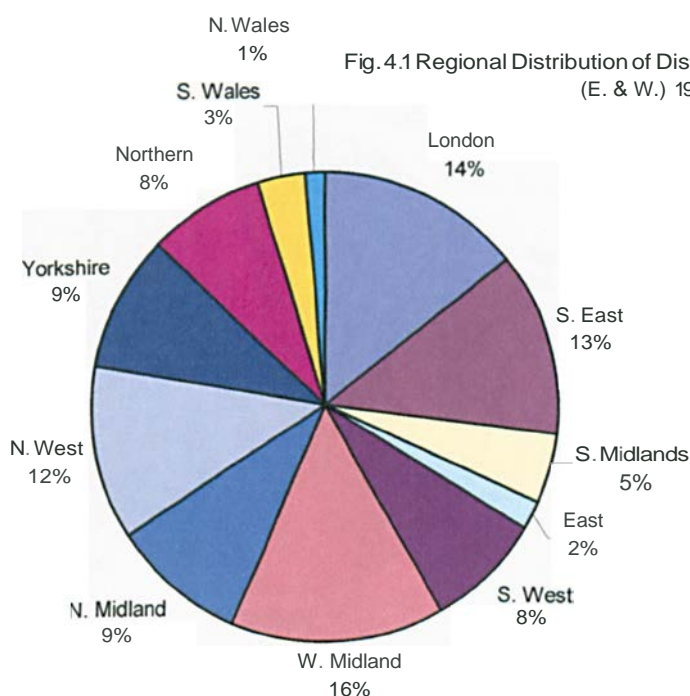
Table 4.1 Regional Distribution of District Nursing Associations (England and Wales) 1915-1931¹⁹

¹⁷ SAIQNI Box 114 P13/1-11: Correspondence and material used by M. Stocks for preparation of 'A Hundred Years of District Nursing'.

¹⁸ Ibid.

¹⁹ Data extracted from Burdett, 1900-31, Burdett's Hospitals and Charities Yearbooks.

The percentage distribution of these DNAs is shown in Figures 4.1 -4.3 and may be compared with those in Figure 3.3 (Chapter 3). This reveals a decline in relative importance of London as the metropolitan focus of the organisation of the QNI and towards the formation of a number of regional strongholds. Of particular note in this de-centralisation is the rapid expansion of the organisation throughout the West Midlands, and later still, a small but significant increase in numbers of associations in Wales and the South West of England. Effectively this reduced London from holding 16% of the total number of associations in 1915 to just 13% from 1925 onwards and by 1931 the pattern of distribution appears much more evenly spread across England and Wales. The survey²⁰ undertaken by the QNI and published in 1935, records the distribution of both QNI and non-QNI associations and of village nurse-midwives as well as QNs, noting in its conclusion that 'in England 96%, and in Wales 87% of the country is already covered'. An editorial in the Queen's Nurses' Magazine refers to the findings of this report, and in particular comments that, 'with some large towns and cities it would appear that the already existing nursing service is inadequate in number to meet the growing need' whilst 'in rural and isolated areas the problem is a different one altogether and is connected more with geographical conditions'.²¹



²⁰ Queen's Institute of District Nursing, 1935, Survey of District Nursing in England and Wales.

²¹ 1935, 'Editorial', *QNM*, XXVII(S): 232-233.

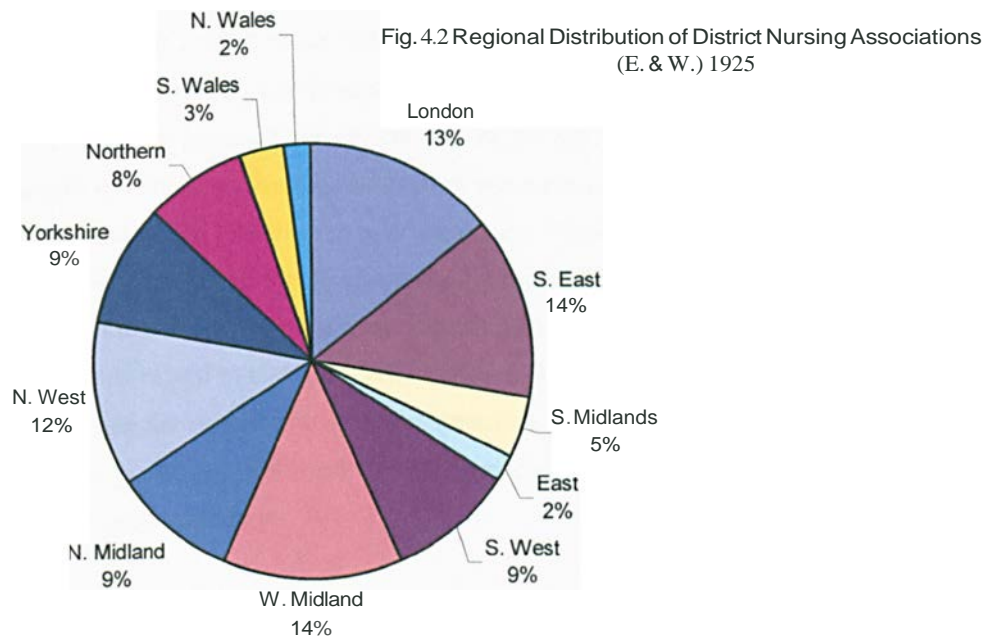
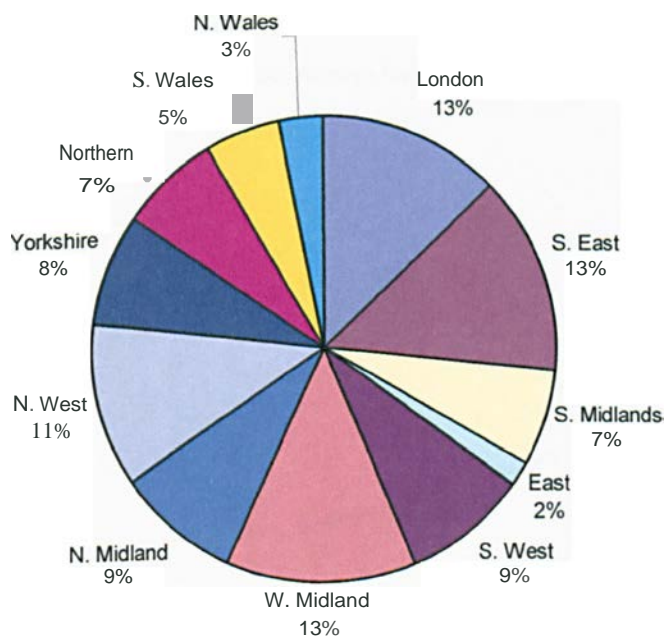


Fig. 4.3 Regional Distribution of District Nursing Associations (E. & W.) 1931



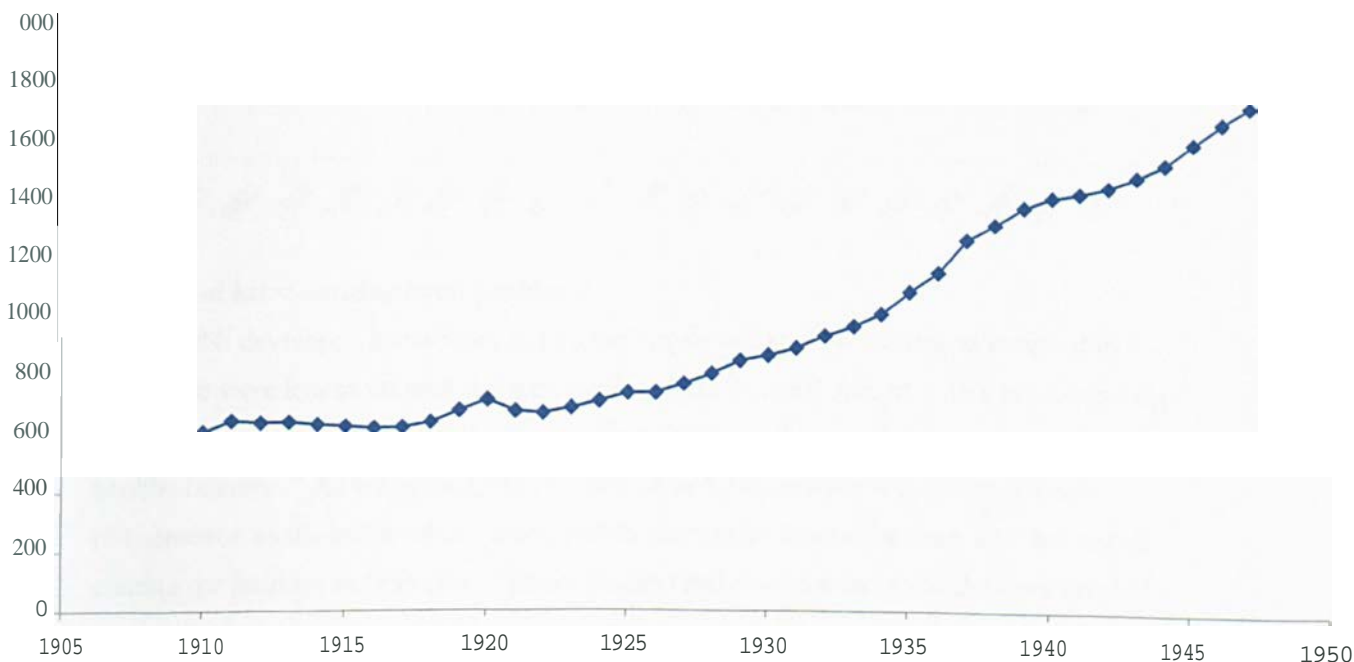
This rural 'problem' was well illustrated by an example of a Dorset DNA in the immediate post-war period.²² When the district nurse for Alderholt died at the end of 1918 there was considerable concern expressed in the association's minutes about a serious lack of funds

²² Dorset Record Office 1918-1962, '0457/5-6: Alderholt District Nursing Association: Minutes 1918-43 and 1944-1962'.

since the minimum wage to employ a new nurse was considered (by the QNI Dorset County Association to which it was affiliated) to be £90 whilst the money raised from subscriptions only totaled £70. After a number of meetings and house-to-house visiting to raise new subscribers and donations, the amount required was raised, but the village remained without a nurse for a considerable length of time as a result. Fund-raising was complicated by suggestions from the County Association that they should organize a 'Nurse's Day' in the form of a garden fete to raise money for both local and county funds, and for "training nurses and increasing their salaries" but the response to the idea was not enthusiastic - the committee felt they would need all the money raised to support the local funds. Its future was only settled and a nurse employed when the association was amalgamated with two other villages, which would have provided a larger population from which to draw subscriptions but also a wider geographical area for one nurse to cover.

With poor law institutions being transferred to local authorities in 1929, an increase in establishments of new DNAs and their affiliation agreements with the QNI suggests a response to the promise that financial support would be more readily available. This pattern was repeated with a second burst in 1936 following the Midwives Act (1936). This required provision of midwives for the whole country and enabled DNAs to provide combined nursing and midwifery services, with financial support from local government.

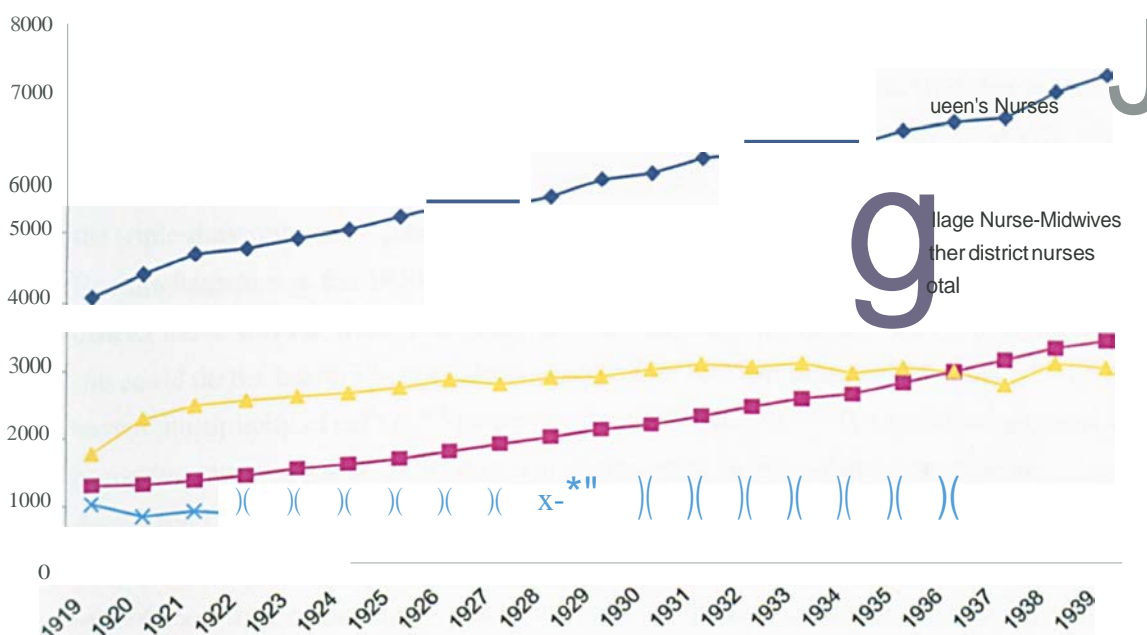
Graph 4.1 Growth of District Nursing Associations (England & Wales) 1910-1947



However, this apparent trend should be treated with some caution as although the registers of the QNI show a dramatic rise in affiliation agreements from 1927 spread over four years, the figures actually recorded in the QNI Annual Reports show that the rise after 1931 was

actually rather steeper. Graph 4.1²³ shows this rise in numbers of affiliated associations from 1910 through to 1947, - also showing a marked acceleration after 1936. The final graph in this section, Graph 4.2,²⁴ shows the change in size of the actual district nursing workforce across England and Wales. The steady growth in numbers of QNs almost parallels the overall growth in numbers and clearly reflects the result of the overall rise in numbers of affiliated associations. The numbers of village nurse-midwives and 'other' district nurses, remains relatively unchanged. The graph demonstrates a significant fall in the ratio of village district nurses to QNs over this twenty-year period from almost 2:1 in 1920 and 1921 to less than 1:1 after 1936. It does not show a sharp rise in numbers from 1936 to match that of ONAs in the previous graph, indicating a shortfall of nurses to associations in real terms.

Graph 4.2 Numbers of District Nurses (E&W) 1919-1939



Inter- and intra- professional problems

As the QNI developed its network of national organisation, its concerns, as revealed in its Magazine were less to do with the introduction of the Nurses' Act, as with a preoccupation with the very recent epidemic of influenza²⁵ and with more immediate, post-war, public health concerns.²⁶ As far as the QNs were concerned, registration was not such a new phenomenon as it was for other nurses, and its main significance for them was that nurses coming for training as QNs should (theoretically) arrive with a more standardised level of

²³ Figures taken from SA/QNI Box IB8-37, Box 2 838-45 Published Annual Reports 1910-1947: see Appendix B for full lists.

²⁴ Ibid.

²⁵ For example: Hancox, E., 1919, 'How we tackled the Influenza Epidemics: Sheffield', QNM: 31-32, and Knox Mearns, M., 1919, 'How we tackled the Influenza Epidemics: Leicester', QNM: 32-33.

²⁶ 1919, 'Conference on District Nursing at Mortimer Hall', QNM: 33-34.

training and level of competence – in practice this took rather longer to achieve. Nevertheless, concern is expressed in the pages of the QNM over the role of the district nurse within the new Ministry of Health stating that, 'on every side reform and reconstruction are in the air'.²⁷ In particular these articles referred to the rising tide of bureaucracy both for themselves and for their patients to have to cope with, as well as a confusing division of responsibilities amongst community health care providers and the 'necessity of co-ordinating existing agencies which have for their object the welfare of the community to prevent the overlapping and constant friction of the past'.²⁸

There were anticipated changes, therefore, in relationships with other health professionals working within the community. For example, an editorial as early as 1920 urged greater political awareness amongst district nurses, commenting that their, 'position ... is by no means as secure as we would wish to see' and later refers to a perceived threat to their autonomy in organisation and administration: 'It must not be possible for local inspection to be carried out over the work of fully trained nurses and midwives by Health Visitors, who themselves are neither one nor the other'.²⁹ In some rural areas the district nurse was often midwife, HV, school nurse and sometimes tubercular nurse, as well. In the more remote areas of Scotland the triple-duty remains in place at the time of writing.³⁰ A triple-duty nurse in rural Buckinghamshire in the 1930s commented: 'It gave an excellent service to patients; the district nurse was known to everybody and understood every family. While washing grandpa she could do the health visiting. She wasted neither her own time nor the patients' who now have a multiplicity of callers.'³¹ However, the relationship with HVs remained an uneasy one, becoming increasingly so in the post-war period, with their numbers more than doubling during the 1914-18 war.³² At this stage the threat from this emerging profession was probably less well perceived than later, largely because contact between the two was minimal, nevertheless their expanding public health role into the field of maternal and child health and welfare, was already threatening to infringe upon that of the district nurse.

²⁷ Barlow, K. E., 1919, 'The Evolution of the Queen's Nurse in Regard to the Ministry of Health', QNM: 49-50.

²⁸ F. Nightingale quoted in Baly, M., 1991, As Miss Nightingale Said.

²⁹ 1920, 'Editorial', QNM, XVII(4): 65-66.

³⁰ Dougall, R., 2002, "Perceptions of change. An oral history of district nursing in Scotland, 1940-1990", (Unpublished PhD Thesis), includes oral histories with several triple duty nurses still practising as district nurse, midwife and health visitor.

³¹ Williams, D., 1992-3, 'Recollections of the RCN and district nursing', IHNJ, 4((1992-93)): 25-27.

³² Hardy, A., 2001, Health and Medicine: 55, gives the numbers more than doubling during WWI 'from 600 in 1914 to 2,557 in 1918'. Discussed in detail in chapter 6.



Fig. 4.4 'Co-operating In Being' ³

However, the district nurse's main professional contact was with the GPs, whose patients she nursed, although this was by no means a regular contact in person, but more often an exchange of written notes or (increasingly from the 1930s) a telephone message. In Broughton³⁴ (Vale of Glamorgan) a report of the presentation to Nurse Pritchard on her departure for midwifery training after six years in her post, notes that over that time she 'had attended 1,500 cases, and had paid 18,900 visits' and that she was 'a willing, hard-working and painstaking nurse'. It then noted that the relationship between the two nurses working in that area, and the general practitioners 'with whom their nurses frequently came into contact' was a good one. How typical was this relationship?

Anne Digby recognises 1920 as a 'high point for the general practitioner'³⁵ as a generalist before the growth of medical specialisation became a serious threat to general medical practice. Compared with the generalist, the specialist was still perceived as having a rather narrow, less holistic and impersonal approach. Following the introduction of the Panel system of medical practice which resulted from the National Health Insurance Act (1911), earlier misgivings of GPs appears to have been subdued in the 1920s despite fears in the wider medical field concerning the introduction of nurse registration and creation of the GNC. However, in 1932 there was a series of letters by doctors to the BMJ which will be considered in full. The opening letter was from a Medical Officer of Health (henceforth MOH)³⁶ working

³³ Photograph from 1920, 'The Value of Co-operation', ONM, XVII(!): 5-6., used to illustrate article promoting 'combining preventative, supervisory and curative [nursing] care' to prevent duplication 'both of duties, expenditure and visitors in the home' particularly in rural areas.

³⁴ 1921, 'Institute News: Wales', XVIII(2 & 4): 38, 74.

³⁵ Digby, A., 1999, The Evolution of British General Practice 1850-1948: 287-289.

³⁶ 'Nest' J932, 'Letters, Notes and Answers: Doctors and Nurses in Industrial Areas', BMJ, I(March 5): 456.

in an industrial area, writing anonymously. He described the local district nursing association as 'long-established, flourishing' and, 'doing general and extensive midwifery work' and notes that his information was acquired through his HVs. This is, in itself, significant in suggesting positive contact between HV and district nurse. He described the local GPs as seriously under-utilising the fully trained nursing staff, often not going, 'beyond asking them to give an enema' and rarely seeking their help, yet 'there being no professional hostility involved, nor any lack of appreciation of nursing services on the part of patients.' Dr. Dill³⁷, from Galloway, replied the following week, commenting that this letter failed to appreciate the relative positions of doctor, nurse and patient. He pointed out that, although the doctor could recommend calling the district nurse, and if she attended, she would carry out the doctor's instructions, but 'the onus of calling her, as also the meeting of expenses incurred thereby, rests with the patient'. This might be complicated by 'the patient's omission to become a "member" (annual subscriber) of the local association, and/or may even be found to be already in debt in respect of fees due to the association for previous nursing visits or confinements.'

However, the correspondence then moved to concerns over competition and claims and counter-claims of mat-practice which are very revealing. The first, from a Devonshire GP states:

... the general practitioner has a hard job in these days to pay rents, rates and taxes, and school fees, if he can afford children. The District Nurse now takes most of his midwifery, does ante-natal and post-natal work, and, during these and other visits, is consulted on every ailment, which she diagnoses and treats. If she does not she is told they will not in future contribute their pence to the association. She is then up before her committee, who are themselves often her most exacting and troublesome patients: all use her to save a doctor's bill. She does minor surgery and sends patients to hospital for advice and treatment....She has been known to diagnose and treat a pneumonia case. In other words, she is one of the general practitioner's most dangerous opponents, and therefore he treats her as such and prefers the old "Gamp," who is under his control. •..³⁸

Several GPs then wrote in defence of 'their' nurses who were described by one as 'valuable' in dealing 'with minor ailments, and above all relieving me of routine midwifery' and he considered the district nurse 'one of my staunchest allies'.³⁹ Another declared that he was president of the two nursing associations in his area and that *his* district nurses 'have always

³⁷ Dill, G., 1932, 'Letters, Notes and Answers: Doctors and District Nurses', BMJ, I(March 19): 550.

³⁸ 'G.P.' J932, 'Letters, Notes and Answers: Doctors and District Nurses', BMJ, J(March 26): 598.

³⁹ 'Another Devonshire GP' (1932). 'Letters, Notes and Answers: Doctors and District Nurses.' BMJ 1(April 2): 642.

proved most willing and eager to do anything I have told them, and have shown themselves capable midwives. They save me many weary hours, and are always at hand to give an enema when required⁴⁰

In some areas district nurses clearly did not represent a threat to any doctor's medical living – for example an interviewee brought up in a very poor area of London, in the 1930s described her memories of a district nurse:

If anybody got ill you didn't fetch a doctor - you didn't ask for a doctor to call, you went out to find Sister Brown who ran the Queen's District Nursing Home and she either came or she sent one of her nurses on a bicycle who would come. Now if they called the doctor - oh dear - you know - not much hope, but in the normal way she would come and say what she thought and what had got to be done and somebody was dispatched to the chemist for a bottle of what the chemist made up in various sort of forms and she wore her lovely blue uniform you know as they did and her medal round her neck which always made a great impression on you. I was fascinated by this lady who appeared you know and of course everybody had their babies delivered at home which were also Queen's Nurses that came.⁴¹

Clearly, these patients were too poor to have afforded a doctor's fees and the QN felt at liberty to diagnose, nurse and treat them to the best of her ability, and to call for medical help only in the most difficult cases. This revealing correspondence also suggests that district nursing had in some ways reached a high-point in professional autonomy. They had become a threat to the more vulnerable GPs through raised public perception combined with their range of skills, with midwifery being perceived as the biggest threat of all.

Some of the professional hostility from doctors may also be explained by the rather misleading term 'district nurse' to cover several quite disparate groups: the two-tiered system of SRNs with or without district or midwifery training, and the village nurse-midwife with a midwifery qualification and just a few months of hospital nursing experience. This clearly created an impression of double-standards or lack of standardization, which is reflected in the inconsistency expressed in the experiences of doctors. Amongst these, a GP in Chichester⁴² offered examples of negligent midwifery practice and of nurses mis-diagnosing a Calles fracture and a case of diphtheria without advising the patient to seek medical help.

Subsequent letters endorsed this -one calling himself 'Country Practitioner'⁴³ gave examples

⁴⁰ Bartlett, S., 1932, 'Letters, Notes and Answers: Doctors and District Nurses', *BMJ*, 1(April 16):738.

⁴¹ DIN 18, 13/02/91, Oral History: Mrs. S.D.: trained SRN 1945-48 (London) then SCM in 1949 (Plymouth) before training as a QN in Plymouth.

⁴² Barford, A. M., 1932, 'Letters, Notes and Answers: Doctors and District Nurses', *BMJ*, 1(April 23): 784.

⁴³ 'Country Practitioner', 1932, 'Letters, Notes and Answers: Doctors and District Nurses', *BMJ*, 1(May 7):872.

of nurses attempting to diagnose, prescribe and treat with disastrous consequences, citing a child who died from meningitis and 'the nurse had been treating it for five weeks for an eruption of the face'.

However, these pockets of rivalry and distrust were not entirely one-sided. 'A Queen's Nurse'⁴⁴ wrote describing the 1918 Spanish Influenza epidemic as experienced in 'a very long, straggling and hilly district village in Yorkshire' served by two district nurses: 'During November and the early part of December there were 116 influenza patients and in one week we paid 306 visits.' The work was particularly onerous because several local GPs were away on active service and others 'found it difficult to get round to their own patients'. The writer described the resultant heavy demands on the district nurses, whilst implying a degree of negligence on the behalf of some of the doctors. In particular she cited a case of a mother who, together with two of her four children, became seriously ill. Her husband was serving in the army, but the doctor's attendance was not judged (by the nurse) to have been adequate to the severity of the case and, 'as the child did not improve, the mother, after some persuasion, got another doctor to take on the case'. She further notes that: 'there were a great many cases of a similar kind' and that 'Such difficulties as we have had throw much responsibility on the nurses, and not only cause grave anxiety and thought, but call for the exercise of great tact during such times.'

Oral histories examined in chapter six reveal this 'tact' in the form of significant 'silences' that would often appear when nursing and medical professionals are asked about these tensions, and it seems reasonable to assume that much of the time the situation of professional tolerance would also have existed in this earlier period, with only occasional outbursts reaching the correspondence columns of the respective professional journals. In theory at least, it would seem that the relationship between doctor and nurse was more clearly defined than it had been a decade earlier, in 1907 when the confrontation between BMA and QNI took place in Cornwall.⁴⁵ In a set of notes prepared by a County Superintendent in 1922, for use in guiding a village group or neighbourhood wishing to set up a DNA, the author emphasised that the district nurse's role was not as a substitute for the doctor:

'the nurse is *not* a doctor, but a worker who has been specially trained for three things: 1) To carry out the nursing treatment ordered by the doctors; 2) to assist in emergencies until the doctor arrives; 3) to make patients comfortable and show the relatives what to do, especially for the helpless patient'.⁴⁶

In fact she insisted that if called in to attend an emergency, '[the Queen's Nurse] does not continue to attend unless a doctor is called in to see the patient.'

⁴⁴ 'A Queen's Nurse', 1919, 'A Country District', ONM: 53.

⁴⁵ See previous chapter.

⁴⁶ Challis 1922, 'On Starting a District Nursing Association', QNM, XIX(1 & 2): 3-4, 34-35.

Poor communication seems to be the root cause of many misunderstandings about the role of the district nurse, not only between professional colleagues, but also with the public. In an article written in 1928, outlining the decision to set up a League for QNs, a comment from Miss Wyatt, County Superintendent East Sussex noted, 'Our status in the Nursing World is often questioned and misunderstood. Some of us have been pained by a recent article which appeared in a leading Journal giving a very misleading account of the training and work of Queen's Nurses'.⁴⁷ She then called for tighter control over tidiness of uniform and dress stating, 'the general public often judges a nurse's work by her personal appearance'. A similar comment was made to a meeting in Cardiff at which, 'Mrs. Thomas Evans ... referred to the prejudice that once existed in the minds of the public against the District Nurses, and said that that feeling had now died out largely because of the tact, efficiency, and devotion to duty shown by the Nurses themselves'.⁴⁸ In other words, the public was coming to recognise that district nurses presented a more dependable and presentable and thus more 'professional' image.

Recruitment and the hospital dilemma

What was the relationship between district and hospital nurses? That there appears to have been some failure in communication between the two is suggested in a speech made by the President of the Blackburn DNA, Lady Thom.⁴⁹ She urged closer co-operation between hospitals (particularly outpatients departments) and ONAs to avoid unnecessary patient inconvenience. Recruitment from training hospitals into the community clearly provided tensions from both sides, with a serious lack of trust and understanding between hospital and district fuelling this at times. However, the recruitment situation resulted from a combination of factors, of which lack of co-operation from the hospital was just one:

nurses did not apply as they formerly did because there were now many more professions open to women, district work was hard, the nurses objected to further training after the three years in hospital, ...the thought of another examination and the binding of a year's agreement were deterrents, as also was the knowledge that there was no pension after the term of service although many associations did build in federation to pension schemes such as the RNPFN [Royal National Pension Fund for Nurses]. The position of the district nurse was, in some localities, still not distinctly defined, and the loneliness of a single district was very trying.⁵⁰

Johnson also noted the response to a proposal from the QNI to a number of hospitals, that the probationer nurses should receive a lecture about district nursing to inform them about the

⁴⁷ 1928, 'A League for Queen's Nurses', *QNM*, XXIII(1): 7-9.

⁴⁸ Egerton, L. M., 1929, 'A Paper', *QNM*. XXIII(7): 121-123.

⁴⁹ 1932, 'Annual Meeting at Blackburn', *QNM*, XXV: 209-210.

⁵⁰ Johnson, B. M., 1922, 'Status and Future of the Village Nurse', *QNM*, XIX(2): 29-30.

work and boost recruitment: 'many [hospital] matrons did not realise the possibilities of district work' and it was agreed that 'propaganda work ...was most desirable, but the hospitals which had been approached on the subject had not been willing to receive the proposal'.⁵¹ Furthermore, changes both in the way the GP worked and in the role of the hospital, had a considerable effect on the caseload of the district nurse: with less surgery taking place in the home by the 1930s, the emphasis shifted from that of an acute facility towards one offering long-term care of chronic and terminal conditions not considered suitable for hospital care. Over time this must have been at least partially responsible for an increase inter-professionally in status differential, between hospital and district nurses.

That there appears to have been an element of credibility in the concern voiced by the GPs and the hospital nurses over the variability of standards in district nursing practice, will have increased this division. The training received by 'village nurses' was felt to have been inferior and their support and supervision, inadequate for some time. At the Annual Conference of the Metropolitan and Southern Counties Association of Queen's Superintendents in 1922 a heated discussion followed a paper entitled "Status and Future of the Village Nurse".⁵² In particular its author, B.M. Johnson, noted the difficulties for some districts in obtaining and also in paying for a QN. She admitted the main work was often midwifery and 'what general work there was, the nurse-midwife was capable of undertaking'. Whilst outlining the main reasons why village nurses would not be able to undertake formal nurse training, she also suggested how a better structured and assessed, in-service training of eighteen months, with an agreed syllabus, assessed by practical and oral examinations could be adopted as a standard.⁵³ The notes of that meeting recorded that 'one of the speakers urged that there should be a better understanding in the counties between the Village Nurse and the Queen's Nurse. It was agreed that there was confusion in the minds of the public as a general rule' and that better communication was the key to addressing many of the problems.

•A Page from an Assistant Superintendent's Diary'⁵⁴ reveals the underlying divisions and resentments that lay between the older village nurses and the more professionally powerful and assertive QNs:

I ride along a riverside lane, cross the ferry, up a very steep hill, and arrive at Mrs. Gamp Number One. ... She is over seventy and has poor sight, but is still anxious to take cases; she shows me her bag "Her ladyship gave me with my certificate," and also says "I've had no cases since you was here, Miss; is it right? They all have the

⁵¹ Ibid.

⁵² Ibid.

⁵³ See also Fox, E., 1993, 'An Honourable Calling or a Despised Occupation: Licensed Midwifery ...' *SHM* (August 6(2)): 237-259.

⁵⁴ 'Lethe', 1920, 'A Page from an Assistant Superintendent's Diary', *ONM*, XVII(3): 48-49.

District Nurse now, a young thing like she; why, I was at it before she was born, and her mother afore her."

The Superintendent visited five other women that day, all described as 'Mrs. Gamps' or 'bona tides' recording several similar complaints of loss of midwifery engagements to the 'young' district nurse, but considers, 'as they are getting beyond the work, feel it is a blessing for the prospective mothers and infants that the nurse *has* arrived'. One midwife quoted wanted to remain on the roll of practicing midwives despite being eighty-seven. The attitudes expressed towards two of these cottage nurses were slightly different, however and worth noting here. One was described as, 'about fifty, and anxious to do well', and was given a lesson on using a thermometer, although the tone was patronising whilst revealing serious professional misgivings on the part of the superintendent. Although written twelve years before the letters from the GPs, this account portrays a very similar image and suggests a strong element of continuity with the two tiered system described in the previous chapter.

A more respectful description was given by a nurse who had worked with a village nurse-midwife trained in the 1920s:

Hilda Curtis was one of the old village Midwives that had no general training but they were district trained - it was just when the Queen's Institute was beginning to - it was about 1924 Hilda Curtis was one of the people that had been trained as the village-nurse - she was the part of the Nursing Association's growing up - the pre National Health. Hilda Curtis was a large lady with false teeth and she terrified me ••• however, I learned a lot in the community from Hilda Curtis for all her teeth - or lack of them - she taught me quite a bit that I can see now that she was the rather rough and ready village midwife, trained by the Association in about 1924 or something like that.⁵⁵

I would argue that the difference in tone between the two accounts suggests a difference in relationship between the elite view of the superintendent (and by implication, of the QNI) and the non-elite view of personal experience. The latter will have seen the benefit of a life-time's experience at close quarters, whilst the former seems to judge the cottage nurses by their educational shortfalls with the probability of class prejudice adding to the negative images portrayed. Nevertheless, it is mentioned that this was a 'trained' village midwife, who would have received a token six months of general nursing training under the QNI in addition to midwifery training, unlike the elderly ladies encountered by the superintendent.

⁵⁵ *DIN* 02, 29/08/96, Oral History: Mrs J.H.: trained SRN 1958-62 (London) and SCM (Bristol and Weymouth) before becoming a district nurse in Weymouth, training 'on the job'.

District nurses, the Associations, Committees and the 'Ladies'

The professional organisation of salaried 'Queen's Superintendents' pre-dated the 1919 Registration Act by two years⁵⁶ and the disappearance of the voluntary 'Lady Superintendents', was almost complete, confined only to a few areas including Liverpool and Bournemouth. Stocks notes that in these districts, 'non-professional voluntary workers still exercised supervisory functions'.⁵⁷ The main restriction to district nurses' professional autonomy, however, probably came from their immediate employers, the local DNA, whose powers were potentially considerable. Had the lay 'committee of ladies' superseded the lay 'Lady Superintendent'? Taking the counterfactual approach, if the nurses had come from the higher educated, middle classes as had been the intention of Nightingale and Dacre Craven, would they not have been in a better position to withstand the threat from the doctors, described above, as well as from these influential 'Ladies' of the committee? That many were from a lower, albeit educated, class is suggested by the pay and conditions accepted, and by the family backgrounds of many of the oral history interviewees. One letter from a Somerset GP claims, 'breaches of professional etiquette by the district nurse' referring to treatment of his private patients without his knowledge and clearly placing himself in the preferred role of patients' gatekeeper. His concluding sentence is especially revealing: 'The district nurse is between the devil and the deep sea. She must tout for subscribers and please the public, and she must beware of the doctor, upon whose field of work she generally encroaches so unprofessionally'.^{ss}

The 'Committee of Ladies' was often referred to as the executive committee which was generally supported by a larger committee of ladies and gentlemen. Sizes varied considerably -for example, in 1925 according to the Burdett's Hospital's Yearbook. Lytham St. Anne's had a committee of 50 plus an 'executive of 14 ladies' whilst Bradford had a committee of 60 and an (unspecified) executive of ladies. In addition, the level of patronage was as formidable in 1925 as it had been in 1915 or earlier even though the names had changed, for example: H.M. The King and H.M. Queen Alexandra, Princesses Louise, Beatrice and Helena Victoria together with an impressive array of Dukes and Duchesses, Counts and Countesses, Bishops, Mayors and Mayoresses. Although it is unlikely that many (if any) of these were involved in the running of the organisations at local level, many appear to have been active at County level and must have added a degree of status to committee membership, making a formidable employer.

⁵⁶ Stocks, M., 1960, A Hundred Years: 146-147 notes 1917 'marked the first time salaried superintendents of training homes and county associations were represented on the governing body of the Queen's Institute'.

^{ss} *ibid*.

^{ss} 'Somerset GP', 1932, 'Letters, Notes and Answers: Doctors and District Nurses', BMJ, t(April 16): 738.

By the late 1930's it was estimated that there were 8,000 district nurses working in Great Britain and these were more than 40% financially supported directly by the population they served. The process of fundraising and day-to-day administration was performed by voluntarily run local associations. By this time just over half the district nurses were Queen's trained (4,566 in 1939)⁵⁹. This represents a dramatic increase both in numbers of QNs, and more generally, in all grades of district nurse throughout the inter-war period. The relationship between district nurse(s) and their committees was extremely varied, having to maintain a difficult balance between voluntary, lay employer and, increasingly, the trained, professional employee. In the case of the QNI affiliated societies, the intermediary figures of Superintendent and Inspector were intended to help facilitate this. A comment made at a conference held during the war (but equally pertinent to this inter-war period) explained, 'Members felt strongly that they were not sufficiently represented at their local Committees ... Committees sometimes had little knowledge of the qualifications of their Nurses. It was pointed out by Miss Wilmshurst that there was a great art in tackling a Committee ...'.⁶⁰ Although the number of serious instances of conflict reported in Inspectors' reports were few, when they did occur this communication gap generally featured problems not generally concerning actual nursing but the nurse's living arrangements, off-duty and holiday requests or the availability of money for purchasing equipment such as a telephone or a new nursing bag. Personality clashes obviously occurred from time to time and these were marked in minutes and QNI reports as 'found not suitable'.

for district nursing as well as for the country's economy, the 1920s were a decade marked by financial struggles. These applied both to the local nursing associations, (as will be shown later in this chapter) and to the QNI as the main body for training and administration of district nurses, nationally. Stocks⁶¹ describes the attempts made by the Institute to rectify this ranging from victory balls and garden schemes to public appeals, commenting that the greatly regretted death of Queen Alexandra ironically represented financial salvation for the QNI.⁶² With Queen Mary as the new Patron, the name of the Institute became 'The Queen's Institute of District Nursing' and in 1928 a Supplementary Charter was issued. In 1932 the QNI further benefited from a contribution from the National Birthday Trust, which enabled the acquisition of new premises for its headquarters in London. However, in local and national minute books, financial concerns never seem far from the surface.

⁵⁹Fox, E., 1994, 'District Nursing in England and Wales before the National Health Service, Medical History, 38: 303-21.

⁶⁰ 1942, 'Queen's Nurses' League Conference', QNM, :XXXI(11 (November)): 83-95.

⁶¹ Stocks, M., 1960, A Hundred Years: 149-151

⁶² Ibid. p.150

As a result of the tight financial situation, widespread adoption and implementation of the 'Provident' system of running and financing district nursing associations characterised the 1920s and 1930s as a period of change as well as consolidation - although it should be noted that this was not a new system of generating income,⁶³ its method of implementation and organisation changed significantly in the inter-war period coming to represent a rudimentary but nevertheless, more formal health-care system than had existed before the First World War. It holds significance in marking a move away from upper class philanthropic or charitable support for district nursing (albeit largely non-sectarian charity), where the remit for primary duty had been to the care of the 'sick poor and working classes in their own home without distinction of creed' (i.e. focussing on the working classes, elderly poor, and unemployed as recipients), towards much stronger links with the middle classes, both as patrons and recipients supporting associations through regular subscription and/ or contributions and functioning on a 'payment according to means' basis.

Stocks saw this as 'the Institute's readiness to exploit the growing familiarity of the British public, down to the lowest income groups, with the insurance principle, and their growing reliance on it'.⁶⁴ In fact income continued to be derived from a number of sources, principally subscriptions, direct payments or a contributory scheme, but also donations, special events (bazaars, flag days, garden fetes etc.), insurance society and public authority grants, legacies and donations. Fig 4.5 below, presents the data provided for 1915, 1920 and 1925 showing the changes in source of income by mid-1920s suggesting a move from dependence upon legacies and large donations to the provident system of subscription and midwifery as well as an increase in diversity of service provision such as school nursing, midwifery/ maternity care and T.B. nursing.⁶⁶

However, Challis's notes on starting a district nursing association referred to earlier in this chapter give the object of district nursing as: 'to provide a trained nurse for the benefit of the residents in a district, thus bringing the advantages of skilled nursing within the reach of people in their own homes'.⁶⁷ She added that associations typically charge one penny per week or between five and eight shillings as a minimum subscription, collected on a quarterly or half-yearly basis with the exceptions being, 'Persons in receipt of parish relief, also old age

⁶³ See Hughes, A., 1910, 'District Nursing on Provident Lines', Charity Organisation Review (July); Hurry, J. B., 1898, District Nursing on a Provident basis; also Stocks, M., 1960, A Hundred Years: 151 notes that the Provident system certainly predated the Queen's Institute but was being actively promoted by the Institute in the mid-1930s.

Stocks, M., 1960, A Hundred Years: 151.

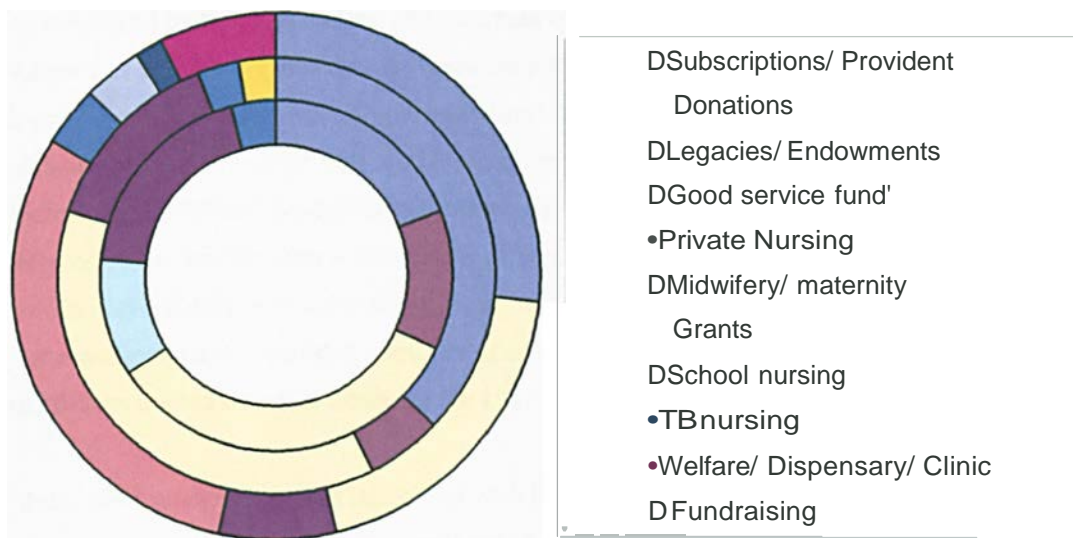
⁶⁵ These grants provided towards midwifery and maternity care, tuberculosis nursing and the nursing of notifiable diseases.

⁶⁶ Figures taken from database created from Burdett, 1900-31, Burdett's Hospitals and Charities Yearbooks.

⁶⁷ Challis, 1922, 'On Starting a District Nursing Association', ONM, XIX (1 and 2): 3-4, 34-35.

pensioners, and any necessitous cases, [who] are given free nursing'. This was to cover expenses such as: 'Nurse's salary, nurse's insurance, workman's liability insurance, general sickness insurance, equipment, ... bicycle and upkeep, printing, postage, stationery, affiliation fees to QVJIN and County Nursing Association, holiday nurse, emergency nurse.'⁶⁸

Fig. 4.5 Income Sources of District Nursing Associations
(Inner ring 1915, Middle ring 1920, Outer ring 1925)



Inter-war industrial development and urban growth in conjunction with the providential system, greatly increased the numbers of potential patients able to access district nursing care. For example, in 1930 a note from Barrow (Lancashire) on the contributory system for raising funds, explained that money was raised from 'the works' employees' enabling the nurses to pay '22,127 visits during 1929 to 854 patients, assisted at 45 operations and attended 72 Ministry of Health sessions'.⁶⁹ In Rochdale (also Lancashire) the committee were particularly aware of the need to provide cars to cope with an increasing workload in 'hitherto outlying districts, now densely populated' and it was reported that two cars had been provided as 'generous gifts' and the DNA purchased the third.⁷⁰ In Birkenhead need clearly outstripped supply and extension of the borough increased 'the difficulty of finding nurses of the right type'. In Blackburn, the following year, it was noted⁷¹ that 800 cases had been nursed including 200 cases of pneumonia, and 212 sick children under 5 years of age, together with the nurses having assisted at 94 operations, and attended to 174 'long chronic cases', - this

⁶⁸ Ibid.

⁶⁹ t 930, 'From the districts', *ONM*, XXIV(3): 38-44.

⁷⁰ t 930, 'From the districts', *ONM*, XXIV(3): 38-44.

⁷¹ t 932, 'Annual Meeting at Blackburn', *ONM*, XXV: 209-2 10.

altogether totaled 14,000 visits. For that year, Burdett's Hospital's Yearbook⁷² record there were 15 district nurses working for Blackburn DNA excluding Superintendents, and that care was 'free to poor, others 3s per week, operations 5s-10s private: daily visiting [charged at a rate of] 9s to 12s 6d, per week, maternity, £2 per case'.

It would therefore be helpful at this stage to consider how this workload was changing on a broader basis, across England and Wales. From the Microsoft Access database compiled from data in Burdett's Hospital's Yearbook, associations were selected where data gives numbers of district nurses employed by that association and numbers of cases nursed and/or visits paid by the nurses. As well as calculating an average figure from these, it was also possible to group associations according to this workload per nurse and represent this graphically using Microsoft Excel (see Graphs 4.3 and 4.4 below). However, it should be noted that these figures do not include the additional workload in some areas - for example from school visiting, midwifery or public health work - nor does it differentiate between urban/rural or large/ small districts. Nevertheless it is helpful in presenting trends and variants. Unfortunately, later editions rarely recorded numbers of cases and visits, therefore data after 1925 proved insufficient to create similar analyses for 1930 or 1935.

From the 1915 data, 104 associations were registered which provided sufficient details of numbers of *cases nursed*, whilst 107 record the numbers of *visits paid* by their nurses. From this data the average number of cases nursed per district nurse over the previous year was 125 and the average figure for visits paid was 4013 per nurse per annum. However the full range shown in Graph 4.3 suggests a wide variance with one association (Newport, Shropshire) logging less than 50 cases per nurse over that year and three associations recording less than 1,000 visits per nurse. Nevertheless it can be seen that by far the majority fall into the range of 100-149 cases per nurse over that year.

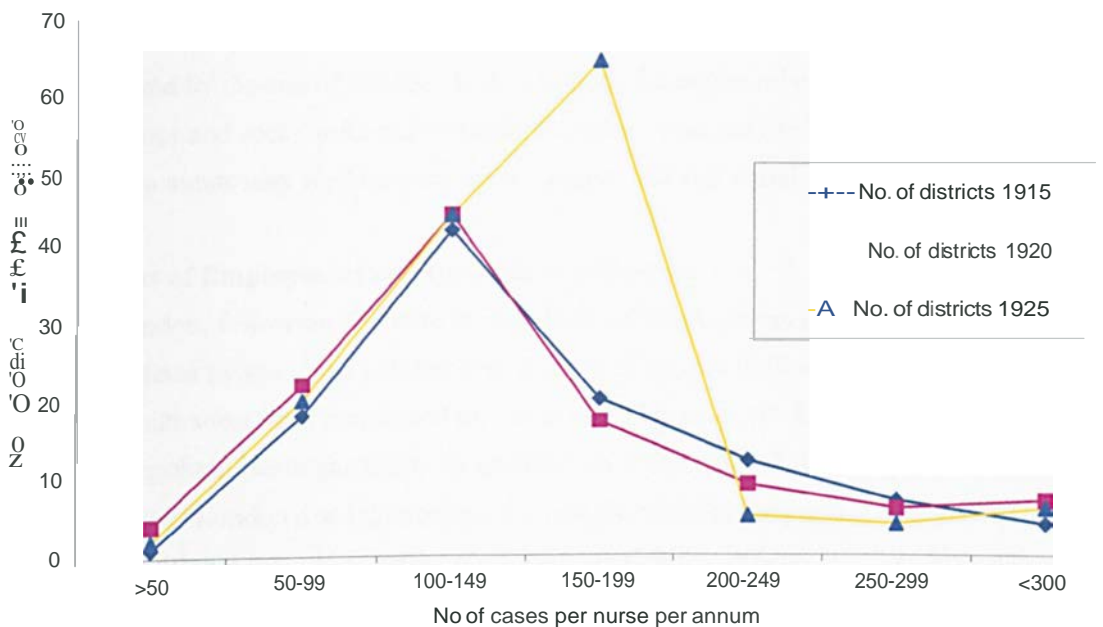
From the 1920 data the associations were those selected where data gives numbers of district nurses employed and numbers of cases nursed were slightly higher, at 109 and those entries recording visits paid by the nurses were also slightly increased, to 112. From this data the average number of cases nursed per district nurse over the previous year was 168 and the average figure for visits paid was 3716 per nurse per annum.

Similarly the 1925 data gives 105 associations where data provides numbers of district nurses employed and numbers of cases nursed with just 104 registering numbers of visits paid by the nurses. From these the average number of cases nursed per district nurse over the previous year was 153 and the average figure for visits paid was 3235 per nurse per annum.

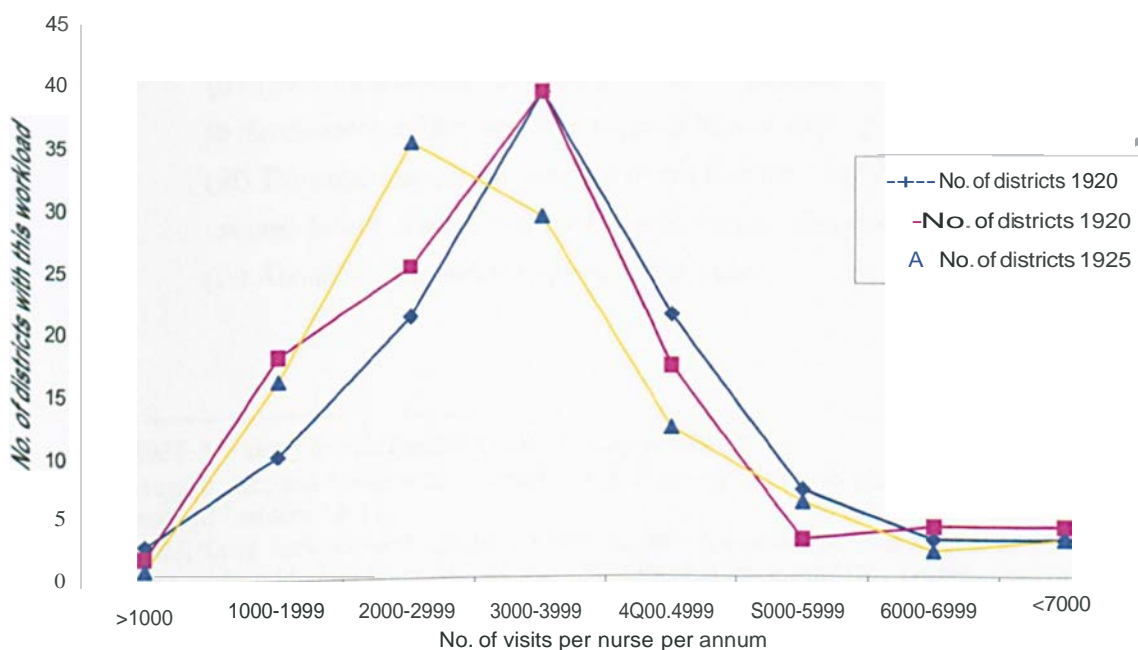
⁷² Burdett, H., 1900-31, Burdett's Hospitals and Charities Yearbooks, 1931 edition.

In the 1915 and 1920 there is, therefore, only a slight change in workload, but by 1925 the trend is more noticeable -this is towards fewer visits being paid per nurse each year (with a big increase in those paying between 2,000 and 2,999 and a fall in the numbers visiting between 3,000 – 3,999 p.a., but with a dramatic increase in the numbers of cases nursed (i.e. the 'take-up' of the service.)

Graph 4.3 Workload (1915-25): Cases per district nurse



Graph 4.4 Workload (1915-25): Visits per district nurse



This increase in patient numbers by the early 1930s would have changed the working experience of the district nurse both through these obvious pressures resulting from an increase in case-load, but also less obviously, through the changing relationships with patients. With a wider class-range of patients, some of whom might previously have employed a private nurse, expectations and attitudes on both sides, would have undergone a fundamental adjustment. For example, the data relating to patient charges differs noticeably from that in (and before) 1925 in that many record 'free or payment according to means', with many associations relying on the nurse to make that judgement or 'means-test' -incidentally very few of the 1931 entries record weekly subscriptions, although that situation would have changed by the end of the decade. In addition, the earlier relationship had often been one of educator and social reformer towards 'the poor', whereas the increasing inclusion of middle-class patients may well have called for greater tact and social skills on the part of the nurse.

Terms of Employment and Conditions of Service

In London, following abolition of the Metropolitan Asylums Board and the 25 Boards of Guardians by the Local Government Act (1929) responsibilities for public health administration were transferred to, and divided between, the London City Council, the Metropolitan Boroughs Councils and the City Corporation⁷³. Dr. Hogarth who carried out a survey of London district nursing associations, noted in the general conclusions to her report the additional roles of a district nurse compared with a private nurse, notably educational and preventative health care. It was more demanding where 'the actual necessities of life are hard to procure'.⁷⁴ For these reasons she felt it became 'more a vocation than a profession'. Set against this ideal of vocation, however, were data indicating the short-lived tenure of many district nurses. An article in the QNM⁷⁵ a few years earlier explained the proposed introduction of a Long Service Fund. The main points of its rationale were listed as:

- (i) The comparatively late age at which Queen's Nurses join the Institute - the average age of the entrants for the years 1913-1924 being 32.48.
- (ii) The comparatively early age at which the pension would have to begin, as owing to the character of the work many nurses have to give up about the age of 55.
- (iii) The large number of nurses who only remain a few years in the service. The average length of service of the Queen's Nurse is five years.
- (iv) About half the nurses left within five years.

⁷³ 1931, 'London's Public Health', QNM, XXIV(5): 104-105.

⁷⁴ Hogarth, M., and London City Council. 1931, A survey of District Nursing in the Administrative County of London: 16-17.

⁷⁵ 1925, 'Long Service Fund', QNM, XXII(3): 55-56 -A separate pension scheme was introduced for village nurse-midwives -importantly, the QNI defended its demand that contributions to these funds were to be claimed from associations rather than from the nurses' salaries.

This trend noted in points (iii) and (iv), of district nurses in many areas wishing to remain in post for a very short time, remained largely unchanged at least until the outbreak of the Second World War. A 'Long Service Fund' therefore provided some incentive to remain in district nursing, and there is evidence that in some districts the associations provided other small incentives such as coal and lighting, 'weekly attendance', a salary slightly above the standard rate, free passes on trams, railways or buses, or a pleasant furnished cottage.

Not surprisingly, bearing in mind the increasing numbers of DNAs being established after the First World War, there was a preoccupation expressed through the professional journal of the Queen's Institute, the Queen's Nurses' Magazine, with the provision of adequate nurses' accommodation particularly in urban areas but also with difficulties experienced in finding suitable rooms for district nurses in the large number of rural associations springing up. For example, Clydach-on-Tawe DNA in South Wales describes itself as an association entirely managed by the workmen, the funds being raised chiefly by a levy on wages. A letter from Hon. Sec. of that association states:

through the generosity of three donors, the District Nursing Association here has received the splendid gift of a very nice house at a cost of £1,250. It is a very nice villa, very central, and with all modern conveniences, including electric light.

Through the generosity of others the bill for furnishing will also be paid without any cost to the Association. I have put a man and his wife in as caretakers, giving them free rent, coal, light, and 10/- a week for looking after the nurses, so now I think they will be very comfortable.⁷⁶

A rise in salaries demanded by the Queen's Institute for its nurses, but not necessarily applicable to employment of non-Queen's Nurses, was held to be responsible for some disaffiliations such as Criccieth in Wales, which had been affiliated since 1905 -it was particularly notable as it was the home of the Prime Minister. Nevertheless, Mrs Lloyd George was actively supportive of district nursing and spoke at the opening ceremony of a fete and bazaar in Sketty, South Wales, 'congratulating Swansea on having begun to think seriously of the nurse's welfare'.⁷⁷ Despite this, it is clear that district nursing -and particularly Queen's Nursing, which involved the more expensive employment of a QN and affiliation costs -were to some extent casualties of firstly the brief general strike and longer (three-month) coal-miners' strike action in 1921, and later the 1926 General Strike and subsequent economic recession which hit certain areas of England and Wales particularly badly well into the 1930s. For example, lack of funds 'owing to the coal miners' strike' had

⁷⁶ 1920, 'Institute News: Wales', QNM, XVII(3): 58.

⁷⁷ 1920, 'Institute News: Wales', Queen's Nurses' Magazine. XVII(4): 79.

resulted in suspension of the Treherbert DNA in the Rhondda from affiliation to the Queen's Institute and their nurse was relocated to Swansea.⁷⁸

Table 4.2 Cases attended by district nurses in connection with Local Authorities in England and Wales (1932)⁷⁹

Disease	No. of Cases nursed	No. of Visits made
Pneumonia	13,470	13,997
Tuberculosis (all cases)	4,764	167,463
Puerperal Pyrexia and Fever	465	9,067
Influenza (uncomplicated)	4,812	43,542
Measles	2,668	26,015
Measles with Pneumonia	639	11,732
Ophthalmia Neonatorum	776	17,415
Chicken Pox	349	1,943
Whooping Cough	695	6,806
Infantile Diarrhoea	446	3,531
Pemphigus Neonatorum	145	2,003
Other diseases (Children under 5)	12,925	152,419
Other case paid by Local Authority	845	10,955

Table 4.2 suggests a very high percentage of the cases attended in connection with Local Authorities were cases with respiratory diseases and childhood infections. This was reaffirmed in 1934⁸⁰ when for the first time the figures for the previous year were published in full for maternity nursing and maternal mortality and on the nursing of patients with notifiable diseases such as tuberculosis, puerperal pyrexia and other post-natal (and ante-natal) complications, measles, chicken pox, whooping cough. These had been collected by the QNI from their nurses through a nationwide survey, and I would suggest that the editorial's forceful encouragement to nurses to study the statistics in detail, reflects the importance attached to promoting a scientised professional outlook amongst the membership. Particular attention is drawn to public health concerns such as 'undernourishment and unsatisfactory housing conditions', which the editor considers may be underlying causes of otherwise preventable deaths and should therefore be of primary concern to district nurses.

⁷⁸ (1921). "Institute News: Wales." *Queen's Nurses' Magazine* XVIII (2 and 4): 38, 74.

⁷⁹ 1933, 'Report on the Nursing of Patients in connection with Local Authorities', *QNM*, XXVI(2): 77.

⁸⁰ 1934, 'Editorial', *QNM*. XXVII(3): 93-4, 1934, 'Queen's Institute of District Nursing: Statistics for 1933', *QNM*. XXVII(3): 103-107.

The later economic situation also effected the health of the district nurse as outlined in the following report of the Queen's Institute's own Welfare fund, the '1930 Fund' which notes 'it is evident that the strain of the times has told heavily upon those who come within its scope. Breakdown in health tends to occur at an earlier age; provision for the future, adequate a few years ago, is no longer; Nursing Associations find it more difficult to raise money to help their nurses; amidst widespread unemployment those handicapped by age or weakness have less chance than ever.'⁸¹

An analysis of a list of 73 recorded resignations for the year 1933 published in the Queen's Nurses' Magazine⁸² provided the following breakdown of reasons for nurses leaving:

Table 4.3 Resignations from district nursing

Reason for resignation	Number
for marriage	17
for midwifery training	9
to return to hospital work	9
for other work	8
retirement	7
due to health reasons	6
private nursing,	5
for home duties,	4
to work abroad,	3
to work in unaffiliated district,	2
school nursing,	2
for work as health visitor,	1

Clearly further training as a midwife would be an expected reason for leaving and quite often this appears to be only a temporary resignation, according to the information in the Institute's more detailed registers and occasionally the DNA would have paid for the training.⁸³

However, numbers leaving to return to hospital work, for 'other work' and for a move into private nursing seem high, suggesting some discontent amongst the workforce and those leaving 'for marriage' confirm the belief noted earlier that resignation for marriage was an unwritten rule.⁸⁴

⁸¹ 1933, 'The 1930 Fund for the Benefit of Trained District Nurses: Report for year ending June 30th 1933', QNM, XXVI(2): 77.

⁸² 1934, Institute News: Resignations', ONM, XXVII(1): 54.

⁸³ Queen's Institute's registers (CMAC: QNI Archives, C., cl913 - 1939, SA/QNI Box 115 Q6/ 11-22: Rolls of Affiliated Branches, England and Wales.)

⁸⁴ See comment above - In the case of the Ranyard nurses and some non-affiliated associations it was built into the contract that the nurse would tender her resignation on marriage.

For all QNs,⁸⁵ off-duty consisted of a minimum of one half-day per week with 'occasional' weekends and one month's annual holiday. Welfare provision consisted of 'full salary and allowances for six weeks, less the benefit received under NHI, with half salary and allowances for a further six weeks'. The possibility of a more generous allowance was made through benefits in recognition of long service plus some grants available from the QNI or from the Tate Fund and convalescent care at the 'Home of Rest for Queen's Nurses' at Bryn-y-Menai. By the end of the 1930s this had become established as standard provision for QNs⁸⁶ by the local committee's subscription to the Long Service Fund of the Institute or the Federated Superannuation Scheme. Following enrollment, a QN would be 'recommended for work with an affiliated Association which is not in a position to give district training itself - the nurse had to sign an agreement 'to work for at least one year as a Queen's Nurse wherever her services may be required' although, 'her wishes as to the locality and the kind of post are taken into consideration' and 'on completion of her agreement she is free to choose for herself. Likewise, she might be given free midwifery training following her district training, but the agreement then stipulated that she must agree to practice as a midwife for at least a year afterwards. HV training for Q/Ns was reduced from 6 to 4 months and some scholarships were made available for supporting this.

Table 4.4 Changes in Queen's District Nurses' Pay and Allowances from 1916 to 1937⁸⁷

Year	Minimum clear Salary	Allowances
1916	£35 p.a. rising annually to £37 £40 p.a. (CMB) (Candidates at £30 p.a.)	Weekly board and laundry: 15s; Annual Uniform: £5
1918	£40	Weekly board and laundry: 15s; Annual Uniform: £6
1919	£50 (Candidates at £40 p.a.)	Unchanged
1920	£63 p.a. rising to £75 and £68 p.a. rising to £80 (CMB) (Candidates at £55 p.a.)	Weekly board and laundry: 25s; Annual Uniform: £10
1937	£70 p.a. rising annually to £100 £80 p.a. rising to £110 (CMB) with additional £5 for HV's Certificate where required. (Candidates at £55 p.a.)	Weekly board and laundry: 21s; Uniform: £8 Cost of two rooms or rent of cottage, plus fire, light, attendance, household laundry and incidental expenses to be defrayed by the Committee

⁸⁵ 1932, 'From the Districts: Annual meetings', QNM, XXV: 277-282.

⁸⁶ Queen's Institute of District Nursing, 1938, Summary of Evidence submitted to the Interdepartmental Committee on Nursing Services: 2.

⁸⁷ Data taken from Queen's Institute of District Nursing, 1938, Summary of Evidence submitted to the Interdepartmental Committee on Nursing Services.

Recruitment leaflets published by the QNI from 1931 onwards and aimed at student nurses nearing completion of training, emphasise the similarities to hospital nursing before concentrating on the more autonomous aspects of the work:

'she [the district nurse] has no appliances with which to work beyond which she carries in her bag, and no one in authority at hand to whom she can turn for help and advice. She has to work on her own initiative; to act in critical situations and frequently to carry out medical instructions under the most difficult conditions - work which calls for skill, courage, promptitude, and resource, but which is peculiarly satisfying, as all nurses will understand. There is surgical nursing, including preparation for, and attendance at, operations both major and minor; there is medical nursing; there is midwifery for those willing to practice'.⁸⁸

This goes on to outline the unique public health and educative role before explaining the training and minimum salary: 'the *clear* salary for a Queen's Nurse must not be less than £63 for the first year (£5 more if required to hold the CMB certificate) rising by £3 annually to £75, with £8 a year for uniform, after she has been provided, or has provided herself with board, lodging and laundry' [...] 'The equivalent inclusive salary is £125 - £137 with furnished rooms (or cottage), fire, light and attendance.' In the second of the three leaflets it has been added in red ink (presumably for addition by editor or publisher) that 'It is understood that a Queen's Nurse will resign her post on marriage'. However this clause has not been included in the 1938 revised version, instead it adds 'Where districts are wide a car is usually provided' together with changes to the salaries of Superintendents. By the end of this period (1939) the starting inclusive annual salary for a QN was between £180 and £200 and salaries can be seen to have doubled those offered in 1916.

Significance of developments in transport and communications technology and urban/rural differences:

In one of several articles in the QNM⁸⁹ the "Ivy" Motor Cycle was recommended by Nurse Mary W., a Q/N at Llandaff, South Wales (£50 cost compared with 22 guineas for McKenzie) describes it as 'easy to handle and most reliable' and notes that in one year she had ridden 8,000 miles although this may not have been all on district work, but that her committee paid the insurance and contributed towards running costs. By 1928, in the Gower district, two Q/Ns were reported to be riding motor bicycles 'which will be a great help in this

⁸⁸ SA/QNI Box 111 P6/8: Recruitment pamphlets, 1931, 1933, 1938, 'Queen's Institute of District Nursing' Fonn T9 (4.31, S.33, 6,38 respectively).

⁸⁹ See for example 1923, 'The "Ivy" Motor Cycle', ONM, :XX(3): 140, 1923, 'The McKenzie Motor Cycle', QNM, :XX(3): 139.

very scattered district⁹⁰ but Stocks notes that this was not evenly distributed nationwide and that 'on Exmoor a Queen's Nurse still visited her patients on horseback in the late 'thirties"'.⁹¹ From the Queen's Institute's Rolls and Registers⁹² it is apparent that some nurses worked and lived together in pairs and were provided with a small cottage and means of transport varying from a bicycle to motorbike or car depending on the size and geography of the district to be covered, whilst in towns a bicycle or mixture of pedestrian and bus or tram transportation were most common.

The QNI's National Survey⁹³ carried out in 1934-5 perceived the increased introduction of the car in rural areas as a major enabling factor in re-grouping nursing districts and thereby reducing the need for more nurses in those areas. In 1938 this was reiterated in the Institute's report to the Interdepartmental Committee on Nursing Services,⁹⁴ in which the QNI stated that 'A gradual change in public opinion has taken place in recent years owing to more general demand on the part of the public for skilled nursing care, the use of the telephone and better transport facilities. This has resulted in the requisitioning of the services of Queen's Nurses by quite small districts with populations numbering 1,000 or even less'.⁹⁵ Before telephones became widely available it was not uncommon for the nurse to leave a slate outside her house for messages, and it is obvious that this limitation also made inter-professional communication less feasible particularly in the rural setting. For example, a district nurse working in rural Hertfordshire in the late 1930s explained:

EW: I was the first nurse in that village -they'd had a 'handy-person' there before -of course she was quite good at it because she was used to it. (Prompt: You remember her do you?) Ob yes, of course -because she lived not many doors away from me.

HS: How did you get to know that a patient needed to be seen?

EW: They sent someone for you -I always had a slate outside the door and they'd leave a message, because you weren't -before they had the telephones (Prompt: Right! So it wasn't always through the doctor? -it was direct) No -they hardly ever had doctors! - they said we knew more about it than they did, you see! -They were practically your family.⁹⁶

⁹⁰ 1928, 'Notes from the Districts: Wales', QNM. XXIII(1): 37-38.

⁹¹ Stocks, M., 1960, A Hundred Years: 163.

⁹² SA/QNI Box 115 Q6/ 11-22: Rolls of Affiliated Branches, England and Wales c1913 - 1939, .

⁹³ Queen's Institute of District Nursing, 1935, Survey of District Nursing in England and Wales.

⁹⁴ Queen's Institute of District Nursing, 1938, Summary of Evidence submitted to the Interdepartmental Committee on Nursing Services.

⁹⁵ Until this point the population felt to warrant a Queen's Nurse had been fixed at 3,000, and below this figure affiliated associations were considered justified in employing a village nurse-midwife, instead.

⁹⁶ DIN 17, 16/01/97, Oral History: Mrs. E. W.: Mrs W. worked as a nurse, midwife, health visitor and school nurse, training 1928-31 (London), SCM in 1932 (Watford) and QN (Plumstead) approx. 1934.

A QNI-led campaign from 1932-1935⁹⁷ to have telephones provided to district nurses, pointed out in its report for 1935 'It would be possible for the utility of the nurses to be greatly increased by taking advantage of modern inventions'. In their view, the best way of organising ONAs was to provide a nurse with a motor-car or motor-cycle and to install the telephone in her house. It added that 'There was not enough work in some places to keep a nurse fully occupied, but she could not be moved as she must be at hand for midwifery cases. The provision of cars and telephones would enable the nurses to be centralised and would reduce the number required.' This, it claimed would be an economy of approx. £12,000 p.a. for rates of County Councils and substantial savings for Nursing Associations.' In 1935 a nurse wrote to the Queen's Institute in response to this inquiry that if she were on the telephone: 'she would be able to work much more usefully with the Doctors, since she attended cases sometimes not seeing the doctors for days, not knowing when they will call, nor they, when she will visit the patient'.⁹⁸ The Postmaster General, however, did not consider this such a necessity although a concession was granted to Associations and it was not until the post-war period that district nurses were provided with telephones and a telephone allowance.⁹⁹



Figure 4.6 'Nurse Radburn on her Motor Scooter'¹⁰⁰

By 1938 it was estimated that 1,600 cars were in use by DNAs, in some cases enabling one nurse to cover an area previously covered by two nurses. This underlines the very different experience between a nurse/ nurses working singly or in pairs in the rural environment and those living in nurses homes, working in the urban setting and traveling much shorter

⁹⁷ SNQNI Box 81 /HI 8: Correspondence, Questionnaires, Report of delegations to the Postmaster General, 1932-1935.

⁹⁸ Ibid -quoted in report but name and address not given.

⁹⁹ Central Council for District Nursing in London, 1966, History of the Central Council for District Nursing in London. 1914-1966: 10.

¹⁰⁰ Photograph from 1920, 'Swanscombe District Nursing Society', *ONM*, XVII(3):49, shows Nurse Ruby Radburn following presentation with a motor scooter by her local DNA, noting 'The district covers a large area, and the gift is a very real help. It is hoped this will be a suggestion to other Nursing Associations with over-worked nurses.'

distances either on foot, bicycle or public transport. However, this meant that the urban workload was often extremely heavy as described by a nurse who trained in London in the 1930s:

LM: Oh yes, in the mornings. must have been around eight o'clock, we congregated down the basement, round a big table, and the Supervisors were there. They took us out for a few days to get to know the area, and then you were allocated your work, well, lots of it you knew, because of previous days. And there were insulins every morning. There were so many!

HS: That was the first thing you did, was it?

LM: Yes. Yes. All the tenements, a lot of walking!

HS: You were walking? You didn't have a bicycle?

LM: No, not in London. No bicycle, no. But we trotted out with our bags, everybody going to their own area. And then we'd come in for lunch, and ...but I think It was around about five o'clock you started on the evening visits then.¹⁸¹

Rural/ urban differences also affected the way the nursing associations organized their finances. Miss Peterkin, the General Superintendent of the QNI described in a paper presented at a nursing conference in 1931¹⁰² how each local DNA was responsible for 'finding the money to support the number of nurses required for the work in the area for which it undertakes to provide nursing' and explained the 'there are, of course, nursing associations not in affiliation with the [Queen's] Institute, but they work more or less on the same lines, though not united together in any way'. She outlined the usual methods of fund raising, clearly differentiating rural from urban areas. According to this paper, the rural areas widely implemented the provident system of asking a 'penny-a-week' minimum subscription from each household, often supplemented by fund-raising events and philanthropic donations plus fees and grants for midwifery/ maternity nursing and for 'work done for Public Health Authorities and other Bodies having power to pay for nursing'. However, the more urban associations, although increasingly turning to the provident system, relied more heavily upon arrangements with Public Health Authorities,¹⁰³ together with charging fees for service given according to means, and added to this by collecting 'charitable subscriptions, house-to-house collections or whatever method of raising money is best suited to the particular locality.'

In 1934 Miss Crothers the County Superintendent for Worcestershire, was seconded from her nursing duties for a year to act as organizer of provident schemes including the appointment

¹⁰¹ *DIN* 32, 01/02/01, Oral History: Mrs. L. M.: trained SRN 1931-34 (London) and QN also in London soon afterwards before returning to Neath Valley, South Wales.

¹⁰² Peterkin, A. M., 1931, 'The Scope and Conditions of District Nursing', *ONM*, XXIV(5): 128-132.

¹⁰³ 1939, 'Editorial', *ONM*, XXVIII(9 (March)): 252-253: The extension of this public health and preventative role, was felt to be a major factor contributing to the inadequate numbers of district nursing staff by 1939.

of paid secretaries to supervise the provident funds. She also differentiated between urban practice which usually required 'general nursing only', and rural practice which was more often general nursing and midwifery and might include 'Public Health Nursing' as some combination of Health Visiting and/or School Nursing. Nurses in the urban setting usually lived together in a nurses' home, whilst the minimum accommodation provision for a rural nurse was 'two furnished rooms including fire, light and attendance' plus a minimum of 2ls. a week as board and laundry allowance. In Dorset there were, for example 71 affiliated associations employing 75 nurses, suggesting a high number of single-nurse practices, whilst in the rural counties of Cornwall, Shropshire and Cumberland some areas were reported as remaining 'unnursed'.¹⁰⁴

Conclusion

The chapter has demonstrated the difficulties faced by a professional group in promoting and advancing their interests in an economically depressed era, particularly when confronted by the professional rivalry of doctors (some of whom were also struggling at times to make a living), and the rising fortunes of the HVs employed by local government rather than reliant on fundraising and subscription. Added to this, they were handicapped in establishing their professional role and status by a confusing, three-tiered hierarchical system. This consisted of the fully trained, Queen's Nurse followed by the lesser-trained registered nurse (SRN) who learnt her district techniques 'on the job' rather than through a prescribed training, and finally the village nurse-midwives, cottage nurses and handiwomen, who represented a broad band of trained, semi-trained and untrained carers. Communication between these three groups was recognised as being far from ideal. Likewise, contact between the nurses and their superintendents was often limited to twice-yearly inspections based more on maintaining standards and discipline, than encouraging any form of constructive interaction. As a result of this and the blocking by GPs of recommendations for a team approach to community health care made in the Dawson Report, there is little evidence for any widespread co-operation between community health professionals.

Whilst the introduction of motorised transport and telephones, particularly in rural areas, was an enormous help to district nurses, communication remained arguably the greatest obstacle to district nursing as a whole. In the community, this applied to the relationships with professional colleagues, with the lay employers and with the general public in failing to create a better understanding of the particular roles and skills of district nurses. Limited face-to-face contact of District Nurses with both GPs and HVs perpetuated distrust and misunderstandings, and prevented the exchange of ideas on which a more mutually respectful

¹⁰⁴ 1932, 'From the Districts: Annual meetings', *QNM*, :XXV: 277-282.

ios Consultative Council on Medical and Allied Services, 1920, Report of the Future Provision on Medical and Allied Services (Dawson Report): see also chapter 6.

relationship might otherwise have been founded. Similarly the need for better hospital liaison was felt to have contributed to difficulties in recruiting trained nurses and created a 'them-and-us' mindset, which hampered attempts to employ nursing resources more economically. Nevertheless, real gains were made through institutional improvements such as the move towards streamlining of salaries, and conditions of service, the professionalisation of QNI superintendents, the establishment of a number of Queen's training centres across England and Wales, and a widespread introduction of subscription membership to DNAs through a determined campaign to promote the 'Provident System'. This last point was largely responsible for extending provision of district nursing care to the wider community rather than restricting it to the 'sick poor' as originally intended.

The chapter's title question 'What became of the Lady?' was intended to highlight the subtle changes and power transfers that took place in district nursing's management over this period. The move away from an untrained, voluntary 'Lady Superintendent' to a trained supervisor of nurses employed by the QNI marks a move from lay philanthropic control to a professional figure of authority. At the same time however, the 'Ladies of the Committee' of local DNAs retained this earlier philanthropic image, and as lay men and women were nevertheless able to exercise considerable control regarding the employment, payment and living and working arrangements of 'their' nurses. The social divisions between these 'Ladies' (often local dignitaries) and the nurses whom they employed, meant that the power held by them greatly diminished the true professional autonomy of the district nurse in a way never experienced by the GP or HY - especially where there was no cushion provided by QNI affiliation.

Chapter 5: War to Welfare State: District Nursing from the outbreak of World War II to the NHS Act (1948)

Writing in 1942 a Chief Superintendent of the Queen's Institute described district nursing as a "'front line" occupation and an essential war service'.¹ In addition to providing a chronological overview of the development of district nursing through this period, this chapter aims to evaluate the extent to which this 'front line' image was an accurate picture and how the district nurse's role changed during the 1939-45 world war and in the immediate post-war period. Despite the drawbacks of ideological (re)construction that inevitably surround accounts of wartime experiences, it has been possible to contextualise some of those written at the time, together with others related through oral history providing an impression of how events were seen at the time and how and why nurses' roles and responsibilities were extended and daily workloads increased in different parts of England and Wales. Through this it will also be possible to assess the part played in restructuring health care in the lead up to the NHS Act, by district nursing throughout this period and the effect this reorganisation will have had on relationships between the district nurses and other members of the emerging community health care team.

Raids and Routines: the initial disruption of the early war years

Shortly before the outbreak of war, in March 1939, a note of considerable optimism was sounding from the editorials of the QNI's official journal as a result of the recommendations of a government Inter-departmental Committee's Report. The opening paragraph of this stated that 'nursing is a service for the nation because it serves a national need, therefore the time has come when the public health authorities and the State should realise that it is a service of outstanding importance'.² At this stage, shortage of recruits to the nursing profession as a whole was a cause for concern, and the recommendations of an Interim Report were eagerly awaited, anticipating proposals for a forty-eight hour week and improved off-duty and holiday arrangements, better living conditions and an improved uniform scale of salaries. At that time the QNI's President and Chairman, the Earl of Athlone, was the chairman of this Inter-departmental Committee.³ Unfortunately no 'Final Report' was ever issued - by September 1940 he had been appointed Governor General of Canada and although the Institute were well aware of their considerable loss of political influence, they were by that stage far more focused on the immediate needs of helping their nurses cope with

¹ Irven, I., 1942, District Nursing, its scope and opportunities', *Nursing Times* (38): 469-471.
² 1939, 'Editorial', QNM, XXVIII (9 (March)): 252-253. quoting from The Rt Hon The Earl of Athlone (Chair), 1939, Ministry of Health. Board of Education: Interdepartmental Committee on Nursing Services. Interim Report: 1- Athlone Committee set up to look into arrangements for 'the recruitment, training and registration and terms and conditions of service of persons engaged in nursing the sick [...] both for institutional and domiciliary nursing' (hereafter referred to as (Interim Report).

³ Ibid: 4.

the difficulties presented by air-raids, evacuation and the exceptional conditions of wartime.⁴ One of the departing actions by the Earl of Athlone in his QNI presidential role was to send a Letter to all QNs discouraging them from volunteering for military service stating 'you will best serve your country by remaining at your post' and outlining the emergency measures to be introduced in case of war.⁵ Unlike the First World War, when district nurses were actively encouraged to volunteer for active service, during the Second World War they were therefore actively discouraged. As evacuation meant the closing of most school and welfare clinics many DNAs felt they could no longer afford to keep a nurse because of loss of income from local authorities, so 'many nurses resigned and went to other areas or began to do a different kind of work. Some were lent to air-raid shelters and first-aid posts under the control of the local authorities'⁶ whilst others left district nursing altogether, returning to hospital work or joining the Services. By 1941¹² this had resulted in an acute shortage of district nurses particularly in Central London. However, it was not until 1943 that a 'Control of Engagement Order' was introduced preventing nurses from leaving their posts -this would seem to have been a rather half-hearted attempt to keep district nurses in post and seems to have been aimed more at those with midwifery qualifications after a rise in domiciliary maternity cases⁷ suggests a substantial increase in the overall workload of many district nurses.

Graph S.1⁸ shows a slight fall in numbers of QNs and Village nurse-midwives over the period 1939-45, but a more marked drop in those labelled 'other district nurses' in the QNI Annual Reports. It would seem likely, therefore that it was mostly these women who may have been lost to other areas of war-work -the uncertainty serves to underline their obscurity, and absence from records and other primary materials and secondary literature. These were largely composed of trainee district nurses and nurses working for non-affiliated DNAs. As a result there were a number of affiliation agreements signed in 1940 and 1941 with the QNI which were probably intended to solve the problems of recruitment experienced by these independent associations. Their lack of commitment to the wider ideals of the QNI were to rebound on the Institute in post-war negotiations over the NHS as will be discussed later in this chapter. In comparison with the equivalent graph shown in Chapter 4 (Graph 4.2) looking at the inter-war period, the sharp halt from 1939/40 to the rising numbers of QNs, and in the total number of district nurses, is very striking.

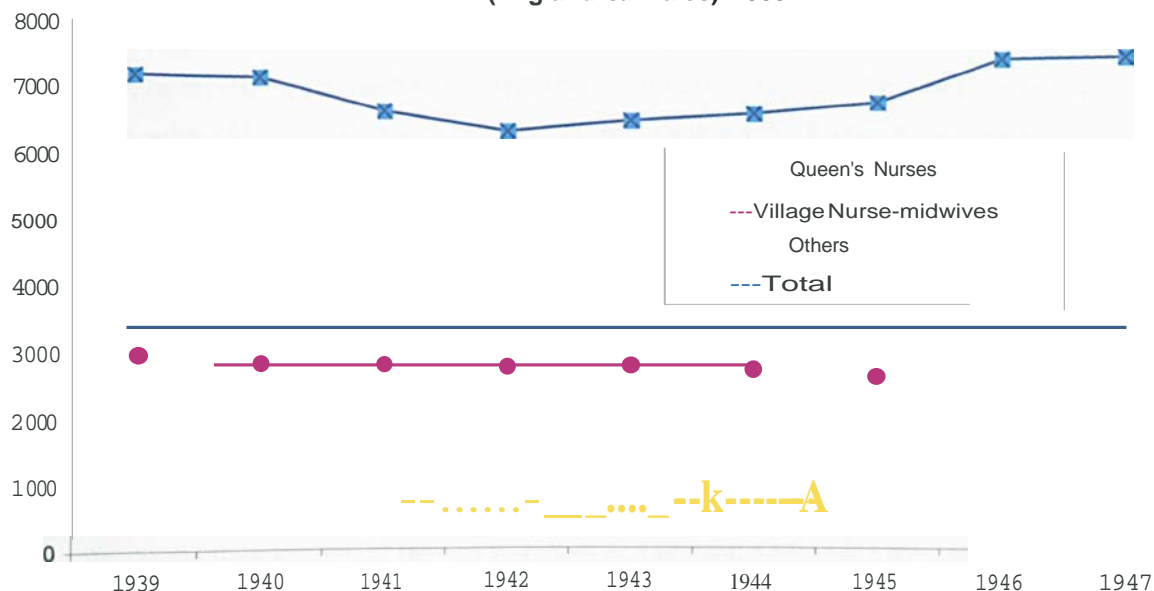
⁴ 1940, Editorial: "This was their finest hour" - Mr. Churchill', *QNM*, XXIX(3 (September)): 45-46.
⁵ Wilmshurst, M., c1946, A Record of the Work of the Queen's Nurses during the Second World War 1939-1945: 6 copy of letter dated 15th June 1939.

⁶ London, the Central Council for District Nursing in London, 1966, *A History of the Central Council for District Nursing in London 1914-66*: 11.

⁷ Wilmshurst, M., c1946, *A Record of the Work of the Queen's Nurses*: 7

• Figures taken from SNQNI Box 1 B8-37, Box 2 838-45 Published Annual Reports 1910-1947.

Graph 5.1 Queen's Nurses, 'Other' District Nurses and Village Nurse-midwives (England & Wales) 1939-47



The QNM through the first three years of the war, provides a vivid picture of district nurses living and working under a range of very difficult conditions. From the outset they were provided with steel helmets and respirators and a distinctive white strap worn across one shoulder and over the back with a metal disk in the centre of the back (so that they could be seen cycling at night during blackout). In the early months, some disregarded the call to stay at their posts, issued by the QNI and reinforced by Earl Athlone, and volunteered for the Queen Alexandra's Imperial Military Nursing Service. One wrote a remarkable description of her experience in France during the severe winter of 1939 including the difficulties of an outbreak of rubella on an overcrowded ward, and ultimately the evacuation under fire of Dunkirk and the (un-named) port at which her makeshift hospital was based.⁹ Another left her district in Preston to join the Queen Alexandra's Imperial Nursing Reserve and was made an Associate of the Royal Red Cross for attending patients during a heavy German air raid whilst serving in Italy.

However, many did remain at their posts, and some of those who did, particularly in the cities, also found themselves working under enemy fire - particularly in the heavy air-raids of 1940-41. They were expected to include new areas of work such as emergency casualty treatment at A.R.P. first-aid posts, and provision of a variety of care and attention to people at air-raid shelters, reception centres and rest homes. Much of this seems to have been taken remarkably calmly, demonstrating an apparent detachment that characterised several oral histories, but was probably part of the necessary survivalist response to such a challenging

⁹ 1940, 'Experiences of a Queen's Nurse serving in QAIMNS', *QNM*, XXIX(3 (September)): 46-47.

experience. This is demonstrated by the following description when a nurse was asked where she did her Queen's training:

EW: In Woolwich -Plumstead in Woolwich -but the war was on -we used to go up the high parts and you could watch the bombs dropping down there -you were quite safe up there you see! -well it was about a mile down because they were doing the docks and all that. you see? We used to sleep in the basement at one time, but we decided, well if we were going to be killed we might as well do it in comfort so to speak in bed!!(laughs)¹⁸

However, a QN writing at the time, in East London, described rather more soberly a particularly bad week of 'blitz' bombing when their nurses' home became a shelter for those made homeless prior to evacuation elsewhere. Despite being under bombardment themselves:

By candle light we decide that we are all right and thank him [the ARP warden] the house is still standing, though not the front door; windows out. curtains and blinds all over the road, houses down either side but no casualties. We bring in the homeless and shocked ones, and attend to them, and as soon as it is light set off for the schools and church halls to help tend and feed the homeless¹¹

Nurse T., a district nurse transferred from Llanelly, was one of several nurses awarded the George Medal for her brave action in a London air-raid in which she 'crawled through a small hole to administer injections of morphia to a man and woman trapped in debris'.¹² Later in 1941 a nurse in Plymouth described the damage done to many areas of the city rendering them uninhabitable, and a similar experience of having to turn out during an air raid:

because the call of a woman in childbirth must be answered' ... managing, to bring her baby into the world while the woman was lying in a narrow passage in the pitch dark. and high explosive and incendiary bombs were falling and nearby buildings crashing to the ground in a heap of ruins [...] Miss McCarthy arrived at one patient's house during a raid to find three incendiary bombs blazing in it. Before attending to the sick person she extinguished the bombs with the help of an elderly man, and then went on with "business as usual".¹³

¹⁰ *DIN* 17, 16/01/97, Oral History: Mrs. E. W.

¹¹ 1940, '1940 and all that', *QNM*. XXIX(4 (December)): 70-71.

¹² 1941, 'Nurse Receives Honour', *QNM*, XXX(3 (March)): 6.

¹³ 1941, 'Plymouth Nurses Carry On', *QNM*, XXX(9 (September)):47.



Figure 5.1 Plymouth Queen's Nurses Cantrill and McCarthy picking their way over the debris from a bomb raid to the house of a patient¹⁴

Comparable stories all presenting similar images of nurses 'carrying-on' despite dangers and difficulties were reported from other towns and cities such as Coventry, where they lost their nurses' home but continued to practice, living together in an air-raid shelter, from Liverpool, Hull, Southampton and Bristol.¹⁵

A noteworthy comment made in the Plymouth report quoted above, was that 'numbers of patients, potential patients and the association's voluntary collectors' had left as a result of the bombing, which 'unfortunately included many of the wealthier people, who were wont to pay more than the minimum charge per visit or to give donations on occasion.' As a result, the association was also suffering financial hardship. This must have been the case in many other areas, adding to losses incurred from withdrawal of some local authority provision such as the closure of school clinics. At the same time, district nursing was not included in the Emergency Medical Service despite the fact that early discharges from hospital forced by hospitalisation of numerous war casualties, greatly increased the district nurses' workload. Set up in 1938, this was otherwise known as the 'Emergency Hospital Scheme', and did not take domiciliary care into consideration as, unrealistically, the Civil Nursing Reserve was intended to cover all eventualities. Similarly, the nurses were expected to provide nursing cover at 'rest centres', which were makeshift areas for those bombed out of their homes but not requiring hospitalisation. This required a wide range of care, from general attention to hygiene, feeding babies and small children, dressings of minor injuries, to care of those psychologically

¹⁴ 1941, 'Plymouth Nurses Carry On', ONM, XXX(9 (September)): 47.
 is SA/QNI Box III P6/16 Pamphlet (QNI) c. 1945 'Queen's Nurses - and what they do'; Wilmshurst, M., c1946, A Record of the Work of the Queen's Nurses.

traumatised.¹⁶ In general there was no compensation payable from this type of work whereas GPs were able to claim compensation for treatment of civilian casualties not covered by national health insurance. However, the LCC did pay compensation when a nurse was taken away from her district to work at a rest centre, and the Ministry of Health provided payment at 9d per visit for 'transferred workers' (those men and women compulsorily sent to places of work away from home and therefore housed in local lodgings).¹⁷)

Not all the action was restricted to the cities, with one village nurse in Sussex reportedly killed when her cottage was bombed,¹⁸ whilst another in Kent was dug out when her cottage was bombed and then immediately went to the aid of a patient injured in the same raid.¹⁹ A greatly increased workload was also a major problem for the nurses working in the rural areas as they were expected to include duties such as inspecting child evacuees at reception centres and caring for those found not to be in good health on arrival or needing to be temporarily isolated due to infectious diseases such as scabies and respiratory infections. The subsequent increase in local population was rarely reflected in any increase in the nursing workforce, with the exception of the early period, when there was an attempt to transfer some district nurses from city to rural districts to help overworked colleagues cope with the first batch of evacuees.²⁰ They therefore had to incorporate new patients into their caseload. Although later there were attempts to move nurses according to areas of greatest need, the emphasis was on midwifery rather than domiciliary nursing support.²¹ In addition, the numbers of women as informal carers to the elderly and chronic sick substantially decreased,²² as did numbers of GPs. This loss at both ends of the age spectrum simultaneously, combined to place a far greater burden on the district nurses both in workload and in responsibility. As with the First World War, numbers of GPs were severely depleted with the older practitioners having to manage understaffed practices,²³ however in the 1939-45 war this problem was increased substantially by additional duties such as ARP and hospital casualty work.²⁴ Therefore the rise in midwifery noted above, plus the civilian casualties and a fluctuating population with all the medical, psychological and social complications that went with caring for the civilian evacuees and the homeless, provided a considerable increase to the workload of GP and

¹⁶ 1941, 'At a Rest Centre', *QNM*, XXX(3 (March)): 25. gives a description of a rest centre explaining the nurse's role.

¹⁷ 1941, 'Transferred Workers', *QNM*. XXX(9 (September)): 45.

¹⁸ 1940, 'Wartime experiences and opportunities', *QNM*, XXIX(4 (December)): 69.

¹⁹ Wilmshurst, M., c1946, *A Record of the Work of the Queen's Nurses*: 15.

²⁰ Wilmshurst, M., c1946, *A Record of the Work of the Queen's Nurses*: 7-8.

²¹ 1943, 'Editorial', *QNM*, XXXII(8 (August)): 91-92, and subsequent articles, record the setting-up of an Advisory Council by the Ministry of Labour and the issuing of the Control of Engagement Order in September 1943 which was extended in March 1944, designed to recruit and redistribute nurses and midwives to areas of greatest shortage.

²² 1942 'Editorial', *QNM*, XXXI(5 (May)).

²³ Hard, A., 2001, *Health and Medicine*: 112-113 notes that 'by the end of 1945 a total of 15,701 medical personnel had been recruited, roughly a third of the country's medical manpower.'

²⁴ Digby, A., 1999, *The Evolution of British General Practice 1850-1948*: 281.

district nurse-midwives alike. Remarkably, the figures provided by the QNI record a fall in maternal mortality from 1.64 per 1,000 births in 1939 to 1.00 per 1,000 in 1944²⁵, although there was a slight rise in the infant mortality figures over the same period. Less well documented, but equally taxing for the district nurses, was the high death-rate between 1939-1942 for those over sixty-five, and also a rise in deaths from tuberculosis.²⁶ Both of these would also have placed considerable strain on the district nurses' workload.

In the article from which the opening quotation of this chapter was taken, the author was stressing the particular public health role of the district nurse as educator (of the whole family as opposed to the restricted access available to social workers or HVs) seeing this as particularly vital to the war effort where healthy workers were badly needed. The article also addressed the urban/ rural divide already explored in the previous chapter, noting that there was, 'less continuity of health education in urban than in rural areas' since the 'rural district nurse is often nurse/midwife/HY and school nurse, thereby seeing the family through-out the formative years' as well as in later life, through her care of the elderly family members.²⁷ This certainly presents an image of a health worker with a major impact on the community at this time, compared with the more disjointed experience of the urban district nurse in which the existing system of overlapping of health services might be felt to cause confusion.

The records of the QNI provide a more quantitative testimony to some of the 'war work' done through its lists claiming payments for treatment of air raid casualties by QNs.²⁸ It can be seen that these do not refer only to care at the time of the air raid but to subsequent nursing care following initial trauma. It was the source of a long-running dispute between the QNI and the Ministry of Health starting early in 1940 when a letter was sent to the ministry requesting clarification of payments for district nurses attending air raid casualties in line with arrangements for doctors. The reply states rather ominously: 'Some of the cases may admittedly require nursing attention, but it does not seem likely that they would be numerous enough to exceed the capacity of the normal nursing agencies of the district'.²⁹ In other words, the same rules were to apply as to ordinary need for nursing care, therefore the nurse/nursing association would have to look to the patient for payment. As if to underline this, the

²⁵ Wilmshurst, M., c1946, *A Record of the Work of the Queen's Nurses*: 7. Also, Digby, A., 1999, *The Evolution of British General Practice 1850-1948*: 207 confirms that during the Second World War there was a national improvement in maternity services resulting from the Emergency Maternity Scheme, however, increased wages in the lower income bracket, together with a more nutritionally balanced diet, may also have been influencing factors.

²⁶ Hardy, A., 2001, *Health and Medicine*: 112-113

²⁷ Irvén, I., 1942, 'District Nursing, its scope and opportunities', *Nursing Times* (38): 469-471.

²⁸ QNJ Archives, C., 1940-1945, SA/QNI Box 83 H/23: Correspondence with Ministry of Health, and statistics of cases treated, lists claims for payments for treatment of air raid casualties by QNs.

²⁹ SA/QNJ/H23 Letter dated 23/01/1940 from Private Sec to the Minister of Health to Sir William Hale-White at the QNI.

Ministry of Health reclaim forms for treatment given to air-raid casualties, issued the following month, were specifically designed for use by doctors with no provision for nursing care other than in the hospital situation. A letter received from the ministry later that year⁰ in response to a second enquiry from the QNI reinforced this stance.

In May the following year when the intensive bombing was revealing the existing and potential increases in demand for nursing care of air raid casualties, a letter from the QNI general Superintendent, Miss Wilmshurst to the Minister of Health gave the total number of nursing cases following air-raid injury for England and Wales as 1206 cases and 10,365 visits.³¹ The figure for 1941 was later updated³² as 1268 cases to which 21,120 visits were paid, signifying that many of these were not 'one-off cases but some might require long-term care, and adding that the largest numbers were in the counties of Lancashire and Cheshire with the lowest in rural counties. In June she wrote again to the Minister of Health pointing out the problems of casualties returning home with serious injuries requiring long-term nursing care which would present a 'very heavy liability to the Nursing Associations in the same way that the ex-service men were after the last war and will be after this one'.³³ In this letter - perhaps hoping to appeal to the compassionate instincts of the minister to strengthen her case - she also described the heroic action of a district nurse candidate attending a midwifery case during an air-raid: 'with the flats she was in on fire she remained with her patient when a land mine had to be fired and protected her patient from the blast and as much as possible from shock'. She explained that although £4119.6d had been recovered in fees, where the liability for nursing care of these patients fell on associations running a contributory system, these schemes had not been formed with the anticipated demand from war injuries in mind, again asking that the minister urgently respond to this situation with compensatory payment to the Associations.³⁴ The eventual reply stated that the minister felt that 'the position is not such that would justify him in seeking the consent of the Treasury to any formal scheme for making payments to district nursing associations beyond the limits of the Statute, particularly as the associations are in many cases subsidised in other ways from public funds',³⁵ Miss Wilmshurst responded requesting this decision be reconsidered, pointing out that the government had promised that victims of air-raids would not incur any expense in connection with treatment, but despite private meetings and deputations, this situation remained unchanged.

³⁰ SA/QNI/H23 Letter dated 25/11/1940.

³¹ SA/QNI/H23 Letter dated 01/05/1941.

³² SA/QNI/H23 Letter dated 27/03/1942 -see also Table 5.1.

³³ SA/QNI/H23 Letter dated 20/06/1941.

³⁴ Subsequent letters asking for a response were sent in April 1942 and March and July 1943 with a reply not being received until August 1943.

³⁵ SA/QNI/H23 Letter date August 1943.

A copy of a letter received by Lady Richmond (nee Elena Rathbone), Honorary Secretary of the QNI Council, refers to this impasse shedding a little light on the background, stating:

'there was no chance of altering the decision to pay grants through the Local Authorities. The principal reason, I gathered, was that a number of small, unaffiliated associations had definitely said they were unwilling to receive payment through the Institute. She [Miss Horsbrugh at the Ministry of Health] said that district nursing was not on a par with voluntary hospitals, on account of these small associations employing a few nurses, affiliated to nobody; ... She is very anxious to see that the Queen's Institute receives every reasonable safeguard against interference by Local Authorities.'³⁶

Mrs. Beatrice Wright M.P. received a more detailed explanation of the ministry's view of the case in a letter from Henry Willing repeating that as minister he was,

limited to making payments for hospital treatment afforded to war injury and war service injury cases ... In some instances nurses have been provided by District Nursing Associations by arrangement with a number of hospitals who wish to discharge patients whilst still in need of nursing care; in others, Nursing attention has been provided at the cost of the individual Association ... on the whole, the nursing service which they have hitherto rendered is not, in my view, on a sufficient scale to justify an approach to the Treasury, especially at the present time when the level of air raid casualties is so much lower than in the first years of the war.³⁷

³⁶ SA/QNI/H23 no signature but addressed from 28 Hollycroft Ave., NW3 and dated 15th October 1943 _ this letter may possibly have been from Mrs. Beatrice Wright M.P. who seems to have taken up the case on behalf of the QNI at this time.

³⁷ SA/QNI/H23 letter dated 14/03/1945.

Table 5.1 District Nursing of Air-raid Casualties, 1941³⁸

Area	Cases	Visits	Approl. InconH
England			
Berkshire			
Bucks	4	63	£6.10.0d
Carobs	3	10	
Cheshire	12	271	£12.0.4d
Cornwall			
Cumberland	7	175	£0.18.0d
Derbyshire			
Devonshire			
Dorset	2	15	
Durham	37	757	
Essex	21	652	£1.18.0d
Glos	12	244	£0.2.6d
Hants	48	273	£0.13.0d
Herefordshire			
Herts	11	367	£0.2.6d
I of Wight	1	2	
Kent E.	20	742	£0.12.6d
Kent W.	33	516	£3.14.0
Lanes	170	1,160	£12.0.6d
Leicestershire	1	4	
Lincs K&H	13	193	£0.14.6
Lincs L			
Norfolk			
Northants & R	12	107	£1.5.0d
Notts	4	75	
Oxfordshire			
Yorks NR	1	18	
Yorks WR			
Subtotal (England)	634	9,496	£268.11.4d

³⁸ Table prepared by the QNI at the request of Mr. Infield, Ministry of Health (SNQNUBox 83 H23) – handwritten table. Unfortunately this would seem to be incomplete with entries missing for a number of counties in England, and the subtotal and total figures do not agree with the given data (neither are the figures given for individual county superintendents explained). However, it has been included here as the only retrievable data, and despite being incomplete gives a useful indication of distribution of demand for nursing care resulting from air raids at this time.

Wales			
Anglesey			
Brecon			
Caernarvon			
Carmarthen			
Denbigh	2	17	£0.6.0d
Flint			
Glamorgan	50	1,573	£8.18.4d
Merioneth			
Pemproke	3	33	£0.6.0d
Radnor			
Subtotal Wales	55	1,623	£9.10.4d
County Inspectors			
Miss Crothers	13	168	£7.0.8d
Miss Ernly	34	732	£10.15.2d
Miss Swann	12	213	£4.14.0d
Miss Lowe	71	1669	£18.6.8d
Miss Merry	151	2346	£49.9.8d
Miss Hill	123	1,498	£3.10.0d
Miss Ratcliffe	150	2,425	£29.15.4d
Miss Radcliffe (?Wales)	25	950	£9.17.4d
Subtotal County Inspectors			
Total	1268	21,120	£41 1. 10. 6d

However, in response to an enquiry from QNI headquarters for details of nursing of air raid casualties for the year ended December 1944, it was clear that this was not quite the case, and that there was still a continued demand being placed on district nurses for immediate and after care of these casualties. The details for Sussex, Essex and Kent (Table 5.2), which are all that appears to remain of this survey, demonstrate this continued demand and the anomaly between numbers of air raid cases and resultant need for nursing care, signified by numbers of nursing visits.

Table 5.2 Eastern region air raid casualties requiring district nursing (year ended Dec. 1944)

Pince	lkport	l"os of Cases	Nos of Visits
Kent County Nursing Association	Beckenham nurse helped with the hospital convoys and Penge nurses 'attended a few patients for shock at the rest centre and slept there with the people as their houses had been bombed'.	11 cases	50 visits paid: 29 to one elderly patient in Bromley, 8 to three patients in Hawkhurst and 9 to three patients in Shoveham plus 4 first aid attendances
West Sussex		25 cases	95 nursing visits
East Sussex	Most initially first aid calls, many required subsequent nursing visits. Further 2 cases not included as the nurse attended them with a doctor: 'one was removed to hospital and the other being already dead'	25 cases	285 visits
Wimbleton Nursing Association	All were elderly patients suffering from shock and bruising after air raids and fly-bombing -one had to be removed to hospital and there were a further four cases of 'Shelter legs' needing treatment.	3 cases	26 visits
Dagenham Nursing Association, Essex		3 cases	20 visits
East Kent		67 cases	390 visits
Essex		19 cases	201 visits

The debate over compensatory payment was to be superseded by the introduction of the National Health Service, which took over these responsibilities, but it is noteworthy that there were nursing associations independent of the QNI who were voicing their misgivings concerning the appropriateness in allowing the QNI to handle the proposed compensatory payments were these to have been made. This reveals a flaw in relationships creating a disunity that was about to seriously affect negotiations concerning the QNI's role in the new NHS, to be discussed later in this chapter.

In a similar way to other members of the home defence system such as ARP wardens, the fire brigade and ambulance service, district nursing can be seen to have been a 'front line' occupation, although this has subsequently been less well recognised or publicised.

Nevertheless, it would be wrong to present this situation as being consistent nation-wide or even regionally. In Bacup, Lancashire for example, which is to be the study of chapter seven, there was minimal disruption and, despite its proximity to Manchester, only one air-raid was recorded and there is no record of evacuees being received. As well as differences in demands between urban and rural situations, and at different times during the war, there were also considerable variations from one place to another. Some districts were seemingly untouched whilst others felt the full impact of war from the immediate results of bombing campaigns from death and injury to homelessness and the longer-term resultant devastation. In addition there were 'knock-on' effects from this such as early hospital discharges to make room for fresh casualties and because of the understaffed hospital service, stress-related illnesses not normally such a large part of the district nurse's workload, and having to cope with the combination of large-scale movements of patients and inadequate community staffing levels, all of which made the wartime workload far heavier than that of peacetime.

Despite this, it is striking that very few local nursing associations minute references to the war in their monthly meetings. Business appears to continue to revolve around everyday issues of collecting fees and maintaining the nurses' home, with only occasional reference to rationing or transport difficulties to remind the reader that the period is in any way exceptional. The 'business as usual' ethos seems to be all pervasive, excluding descriptions of conditions that would have been part of the common experience at the time – it is only later, in post-war discussions (including oral histories) that these details are addressed in any depth.

Interestingly, several oral history accounts similarly appear to describe relative 'normality' in their daily work - a nurse doing her Queen's training in Brighton in 1943-4 described:

A.L. It was all barbed wire along the sea front, not a lot of traffic, of course. We were 00 bikes. One or two walked. But, ob, it was wonderfuL You started the day with a prayer.'(...) 'You would do lots of diabetic injections. Blanket baths, dressings, bow the dressings were done. We used to have to boil everything, in those days - we used to have to take everything home. You'd have a biscuit tin, and in that biscuit tin, you'd have you r dressings, you'd cut you r gauze, your swabs and so forth, and you'd put it in the oven for twenty minutes, with the lid off. That was for your sterile dressings. And you took your bag with you, with your receivers, bowls and forceps and the bags contained a certain amount of disinfectant, as well, and you bad to be very particular about everything you did. You put newspaper on the table, newspaper on the floor, everything bad to be meticulously done, and you boiled all your things, you took them out, you

didn't have gloves, in those days. But it all had to be done, absolutely, as sterile as it was possible to do in those days, of course you had glass syringes, so you had to be careful in those days.³⁹

Apart from the barbed wire, this description might have been given 10 years before or after this date referring to the routine daily practice of the district nurse almost anywhere, until she adds almost as an after-thought:

A.L. I remember coming along on my autoscooter, I think we called it, and seeing the bombs coming over, the planes dropping the bombs, coming over the electric works at Portslade, you know those big chimneys -the power station, I saw them coming over the power station, and I saw the bombs coming out of the planes, and I just got under a tree, that's when I felt my knees knock a bit. (laughs.) The only time in my life I felt my knees knock. I got off my bike and got under a tree, as though that would save me from a bomb. Like getting under a parrot's cage when I was a child. Anyway, that was a major incident, and then of course we had the incidents all around, bombs dropping in Brighton and various places -we were very busy!⁴⁰

Reorganisation and Reconstruction

The minutes of a meeting of the Interdepartmental Committee on Social Insurance and Allied Services, War Cabinet, chaired by William Beveridge,⁴¹ noted that at that time there were approximately 7,200 district nurses working in the UK of which approximately 1,000 were employed by independent (non-QNI) associations, 1,000 QNs were employed in Scotland and Ireland, and between 3,000 and 4,000 in England and Wales. The contributory scheme was described to him as being carried out by voluntary collectors in rural areas with 'nearly every district having its 'penny a week' plan, and in Leicester 95,000 contributors out of 260,000 (27.3% of population) were registered as belonging to the system, mostly through direct deduction from the payroll or through groups.' The DNA representatives urged the minister to nationalise the system thereby 'making it compulsory and general' to ensure a standard rate of contribution and to remove excluded employees whose employers refused to participate, or where there are differences between place of employment and of residence'. Miss Pilkington, Honorary Secretary to St. Helen's DNA explained that having only 25,000 contributors out of a population of 107,000 was partly because 3,000 to 4,000 'worked in factories outside the town where there were no facilities for pay-roll deductions'. It was also noted that in rural areas the cost was higher (2d per week). Discussing the relationship between recruitment and pay, Mrs. Kevill-Davies, (Hon. Sec. QNI) stated 'I think in a large way it is financial, we are

³⁹SD/1, 21107/98, Oral History: Miss A. L.: trained 1931-34 in Margate, then SCM (London) I in 1936 before QN's training in Brighton in 1942.

⁴⁰ Ibid.

⁴¹ SA/QNI Box 81 H/13/7/2: notes on interview between representatives of the QNI and the Interdepartmental Committee on Social Insurance and Allied Services, dated 08/07/1942.

all waiting to know what the salaries are going to be, if they are going to be increased. The nurses want to know what their standing is going to be'. Miss Wilmshurst explained the cause was partly because of the differential that existed between pay scales for district and hospital nurses in the past, stating 'It was more so on the old scale but not the rather heterogeneous salaries that are being paid out now. There is a great deal of competition all over the country.' She also emphasised the importance of specialised training saying there were thought to be approximately 1,000 registered nurses working as district nurses, not trained QNs nor village nurse/midwives, but 'mostly older nurses'.

The comments about recruitment and pay had been articulated more strongly the previous year by a nurse writing anonymously and highlighting the inherent insecurity not only of the wartime situation in which she found herself, but also of more deep-rooted financial uncertainties:

I am hoping for a plan of reconstruction. I hope no nurse, choosing District work, will have the burden of worry I have had. Very few nurses in training know how District Nursing is financed, and it would be a shock to many working on Districts if they knew the financial outlook of many associations. Hand-to-mouth existence in many [...] The Health Visitors and School Nurses are financed by the rates, yet they only serve a section of the ratepayers; the District Nurse serves all ...⁴²

This anticipated the Rushcliffe Committee's recommendations for nurses' salaries that were published in 1943. Whilst representing a considerable improvement for the nurses these may have increased the difficult financial situation being faced by many district nursing associations at that time, although they were initially to be subsidised to cover some of the salary increase.⁴³ Now, a rise in the nurses' salaries added to the difficulties caused by wartime demographic flux, which hindered promotion of the providential system, collections of subscriptions and donations, and the National Gardens Scheme, all of which constituted important sources of income locally and nationally. However from the QNI's viewpoint the recommendations of the report from the Rushcliffe Committee were important because the pay differential recognised the extra value of a registered nurse/ nurse-midwife with district training (almost⁴⁴ synonymous with Queen's training) as well as the inferred acknowledgement that State Registration should be a standard requirement for district

⁴² Correspondence: 'Twenty Years a Queen's Nurse' 1941, *Nursing Mirror* (29 November).

⁴³ 1943 'Editorial', QNM, XXXII(8 (August)): 91-92.: notes the salaries were 'to date back to April 1st 1943 and it is earnestly hoped that all employing authorities will adopt them and so claim the 50% subsidy promised by the Ministry of Health towards the additional expenditure'.

⁴⁴ Although the Ranyard Association continued to provide their nurses with their own district training.

nursing. Nevertheless it can be seen from Table 5.2 that there were also slight financial advantages to be gained by the independent, non-QNs who could work from private premises.

Table 5.3 Rushcliffe Recommended Salaries (District Nursing)⁴⁵

District Nurse Category	Resident	Non-resident
District candidates in training	£95	Not applicable
Registered nurse and midwife with district training	£140-£200	£260-£340
Registered nurse and midwife without district training	£130-£190	£240-£310
Registered nurse with district training	£120-£180	£230-£300
Registered nurse	£110-£170	£220-£290
Village nurse-midwife	£110-£170	£210-£270

From as early as 1942, district nurses had joined general practitioners, social workers, local government officers, and central government, in planning for the public health needs of the anticipated post-war period.⁴⁶ The QNI was involved in negotiations between official bodies such as county councils, and the Ministries of Health and of Labour in providing evidence to the Rushcliffe Committee (on nurses' pay) and the Beveridge Committee (on the future role of district nursing in a National Health Service). Fox describes the unsatisfactory negotiations between the Ministry of Health and representations from the QNJ, the Ranyard Nursing Association, the London Central Council and the RCN, concentrating on the period from 1944 onwards, and stating that: 'meetings went on from 1944 to 1947 without the consultations finding common ground', and that 'In the end, compromise was forced upon it [the QNI]'.⁴⁷ Furthermore, she criticises the QNJ for claiming to represent district nursing as a whole, and for failing to take account of independent associations or consulting its own membership.

Certainly the QNJ saw themselves as the obvious (and probably only) choice to run a national district nursing service, possibly contracting this out to the Ministry of Health, whilst retaining their voluntaristic identity. There is evidence to suggest this was not popular with the independent nursing associations who remained unaffiliated to the QN^r and even with a few associations that were affiliated.⁴⁸ However, these were not numerous⁴⁹ and their hostility

⁴⁵ Lord Rushcliffe (Chair), 1943, MOH Cmd 6487 Second Report of Nurses' Salaries Committee: salaries and emoluments of male nurses, public health nurses, district nurses and state registered nurses in nurseries. This scale was updated in November 1946 together with a London additional allowance.

⁴⁶ Dunell, M. H., et al., 1943, The Domiciliary Nursing Services.

⁴⁷ Fox, E. N., 1993, District Nursing and the work of District Nursing Associations in England and Wales 1900-48: 324-332

⁴⁸ However, the associations she cites were only affiliated in 1940 prompted by problems in recruiting staff.

⁴⁹ There were just 9 or 10 counties in England and Wales not affiliated in 1943 out of 62 administrative counties, these included Rutland, Carmarthenshire, Wiltshire, Westmorland and Northumberland.

was based on a long-held and strongly-felt resentment of the monopolistic and hierarchical system run by the QNI which threatened to control and dictate, or even exclude them completely. In retrospect, it seems misguided and arrogant for the QNI to have claimed to be representative of district nursing as a whole without consulting these independent district associations, yet viewing Graph 5.1 and Table 5.4 and bearing in mind that many village nurse-midwives came under the regulation and control of the QNI, on a percentage basis⁵⁰ it could clearly be said to represent a large sector of the workforce. To have represented all its membership, let alone the entire workforce would have been an impossibility even in peacetime! In fact, Table 5.2 understates the situation, as the QNI also represented a large number of village nurse-midwives employed by affiliated associations, and was the only existing professional organisation prepared and able to represent district nurses. Taking the figures for Lancashire in 1939 as an example, there were 155 (QNI) affiliated associations employing a total of 576 nurses, of whom 507 were QNs, compared with 12 unaffiliated societies employing just 13 nurses and two private associations.⁵¹ Similar figures exist for the other 51 (out of a total of 62) counties in England and Wales, which were affiliated to the QNI. At the time that negotiations began in 1942, therefore, its claim to represent district nurses would seem a more reasonable one than Fox would suggest.

Table 54 Wartime Queen's Nurses percentages of total district nurses working in England and Wales⁵²

Dak	Number of QNs	Total of District Nurses	% QNs of Total
1939	3337	7204	46%
1942	3123	6298	50%
1945	3315	6726	49%
1947	3428	7439	46%

Despite the difficulties imposed by war restrictions, the QNI did attempt to consult their membership as far as was practicable -the Queen's Superintendents had their own society which met on an annual conference basis. In addition, the Queen's Nurses' League was formed in 1941 from the 'ordinary' membership of the QNI to provide a local forum for discussion and a mouthpiece for (Queen's) district nurses working at 'grassroots' level, 'the great aim being for the profession as a whole to be of one mind and one speaking body to the Government when the time comes, [for post-war reconstruction] *as come it will*'.⁵³ This

⁵⁰ Figures taken from QNI Archives, SA/QNI Box I B8-37, Box 2 B38-45 Published Annual Reports 1910-1947.

⁵¹ 1939, 'More Nurses for Lancashire', *ONM*, XXVIII(JO(June)): 309.

⁵² Figures taken from QNI Archives, SA/QNI Box I 88-37, Box 2 838-45 Published Annual Reports 1910-1947.

⁵³ Anderson, E., 1943, 'Queen's Nurses' League - Leeds and District branch report of lecture by Dr. H. Balme on "Post-War Reconstruction"', *ONM*, XXXII (4 (April)): 51-52.

reflected a growing concern that the RCN did not represent district nurses as a single specialist group, there being no District Nurse Section within the College at that time.⁵⁴ At that time district nursing fell under the broad banner of the RCN's Public Health Section together with HVs, school nurses and public health nurses, whilst district midwives were represented separately, by the Royal College of Midwives.

In fact, the RCN did not share the opinion voiced by the QNI, that dependency on voluntary schemes was the best way forward in raising the professional status of nurses. Without wishing to defend the QNI's decidedly blinkered vision on this particular point within these negotiations, the Labour Government's emphasis on nationalisation and regionalisation included the abolition of contributory health insurance schemes on which most DNAs were dependent for their finance.^{ss} Likewise, the transfer of power to local health authorities, presented the QNI with some impossible choices, perhaps the most difficult of which was to relinquish its powers of inspection when regular monitoring was seen by them to be fundamental in the maintenance of standards of practice and employment - without this the QNI felt a district nurse could not practice as a 'Queen's Nurse'. A compromise was eventually negotiated, which resulted in the QNI conceding to allow counties and boroughs the less expensive and restrictive 'membership' rather than full 'affiliation' to the QNI (see Chapter 6 Fig. 6.1) with all the rules and regulations this implied. Nevertheless, in 1947 a cautionary note was expressed regarding LHA responsibilities for training and supervision of nurses foreseeing fragmentation of the district nursing service. It was feared that, without imposing the safeguards of regular supervisory inspections, standards would fall and the Institute's professional ideals would be forsaken.⁵⁶ A one-off grant of £4,000 was paid to the QNI by the Ministry of Health in 1949 towards the costs of training district nurses⁵⁷ but the balance of training costs had to be found by the Institute and no further assistance could be promised (see Chapter 6).

After the war: recruitment and the public and professional image

In 1947 the QNI commented that, 'The improved conditions under which such nurses now work and the greatly increased salaries payable to them under the Rushcliffe Committee scale should do much to encourage recruitment to this most important branch of the Nation's health service'.^{ss} Staffing shortages inspired a number of recruitment appeals, which were combined

⁵⁴ D42, 'Queen's Nurses' League Conference', *ONM*, XXXI (11 (November)): 83-95.

"For a more detailed discussion on NHS negotiations, see Berridge, V., 1999, *Health and Society in Britain since 1939*; Jones, H., 1992, *The Conservative Party and the Welfare State. 1942-55*; Webster, C., 1998, *The NHS: A Political History*.

⁵⁶ QNI Archives, C., 1947, SA/QNI Box 83 H/2711-4: Introduction of the NHS.

"Rave, R. W., 1949, 'Annual Meeting Address to the Queen's Institute of District Nursing', *QNM*, XXXVIII(10 (October)): 129-133.

^{ss} SA/QNI Box 83 H/27/1-4: Introduction of the NHS, 1947.

with appeals for public financial support for the QNI at national and local branch levels, both during, and immediately after the war.⁵⁹ For recruitment purposes, the appeal leaflets contain descriptions of wartime devotion to duty shown by district nurses, coupled with the presentation of an instantly recognisable image of a respected and dependable figure within the community making an essential contribution to the nation's health. The opportunity to develop high standards whilst 'meeting emergencies' and 'reducing chaos to order' are the qualities which are most heavily stressed. The uncertainty of the approaching NHS resulted in a fall in contributions to DNAs creating a crisis in 1947 as the associations still had to fulfil their financial commitments and where patients did not belong to a contributory scheme, nurses would often have to decide what fee the patient should pay. Guidance on this was that :

If the family is necessitous and is in receipt of public assistance, or is an old age pensioner without other means, nursing will be given free of charge.

For other persons the nurse will judge what payment is appropriate. The actual cost varies from 2s. 6d. to 3s. 6d. per visit, and those who can afford it are asked to pay this amount. If this appears difficult, then a proportion of this or a weekly charge is made.....⁶⁰

This was an aspect of their work many nurses disliked intensely, finding it 'embarrassing and distasteful asking them about their income and expenditure' whilst having to issue receipts for payment and entering the information in their case books, 'the amount varying from as little as threepence to as much as two-and-six per week or per visit'.⁶¹ In the towns this money was handed to the Superintendent who kept the accounts of patient payments thereby retaining a certain degree of patient confidentiality, however in the rural situation this was less well protected, as one nurse described:

GC: you collected as much money as you could and indeed you encouraged the patients to pay a penny a week and they had a card which was marked and then once a month you took any money that you collected to this good woman who called herself the Secretary.⁶²

However, another nurse-midwife who worked in Hertfordshire before the NHS Act, when asked if she had to collect money from the patients seemed more comfortable with the situation saying:

⁵⁹ See for example SA/QNI Box 111P6/16 Pamphlet (QNI) c.1944 'Queen's Nurses - and what they do'; and 1945 'A Call to Women: The Dearth of Nurses', *QNM*, XXXIV(5 (May)): 43-45.

⁶⁰ Merry, E. J., and Irven, I. D., 1948, *District Nursing*: 65.

⁶¹ Sankey, M. I., 2001, "Thank You Miss Hunter": 52.

⁶² *DIN*03, 18/07/96, Oral History: Mrs. G. C.

EW: Oh, Yes, yes we collected money -they paid me but I couldn't keep it for myself of course. (HS Prompt: I don't suppose you can remember how much that was, can you?) I think for midwifery it was 25/-, I think that was it, and it went to, I think it was the secretary. Well, we kept them in bed for ten days and we went to see them each day. (Prompt: And did that include the delivery as well, or was that extra?) Ob no! Ob no - that was it. And you always used to carry a bag as an emergency, because people were very poor then you see, so you needed a bag of things in case of an emergency. But then of course if you are on a district for a time you get to know the people, don't you? I used to visit them in their own homes and go through the things they'd want, you see?⁶³

Conclusions

At the end of the war, the Earl of Athlone wrote another letter to all QNs thanking them for their hard work and stating "I commend you all for your steadfast service, so quietly and cheerfully carried out, and for your courage, so often unsung. I know that District Nurses can be relied upon to continue to serve during the stress and strains of post-war life which throws increasing demands on us all."⁶⁴ This echoed the first editorial written following the outbreak of war, by Miss Wilmshurst the QNI General Superintendent, who commented that many hundreds of patients were being 'discharged from hospital to be nursed at home, and in the reception areas the nurses will be looked to by mothers and the foster mothers in the billets for advice and help [...] This work may seem less spectacular than that of nursing the wounded, whether from the Services or civilian population and may not be so realised by the general public'.⁶⁵ Apart from a few surviving illustrations of the more 'spectacular' and undeniably courageous actions of district nurses, there is little record of the continuously heavy caseloads and under-staffing, nor of the increased responsibilities resulting from depleted numbers of medical colleagues, experienced on a daily basis by many district nurses throughout the country during wartime.

It would seem highly likely that the responsibility for this lack of formal recognition lies with its location in the 'unseen' female domestic sphere to be discussed in Chapter 9. However, those interviewees who did describe their war experiences outside the district sphere -either in the armed services or in hospitals, generally displayed a similarly understated attitude to their own personal contribution, so that it is possible this was symptomatic of an outlook that accepted the hardships and dangers as a wider communal experience as 'everyone was in the same boat'. War may also have been a positive experience, a means of empowerment with

⁶³ DIN 17, 16/01/97, Oral History: Mrs. E.W..

⁶⁴ Wilmshurst, M., c1946, *A Record of the Work of the Queen's Nurses*: 15.

⁶⁵ 1939, 'Editorial: A Message to Queen's Nurses', *QNM*, XXVIII(11 (September)): 312.

nursing being offered as a career to some women for whom this might not have been considered an option before. As one interviewee explained:

it was something I always wanted to do. I mean when I was fourteen, my mother... we just went into service, there was no choice, I think the war gave the opportunity to do something that you wanted to do.⁶⁶

The battle for the district nurses' role in reorganisation and reconstruction of the health service which began as early as 1942 appears to sit uneasily with this 'make the best of a bad job' philosophy, but was in fact consistent with the widely held rationale that the war was being fought for a better future for the nation as a whole. The failure of the QNI to win their case with the Ministry can be seen as the rejection of the 'old order', which in many ways it typified. Their insistence on retaining a voluntaristic support system was an anachronism that, combined with lack of support from the RCN and some apparent animosity from a section of district nursing, explained the political stance that was taken towards the QNI.

⁶⁶SD/4, 17/08/98, Oral History: Miss *LM* trained SRN 1940-43 (London) followed by QN in Brighton soon afterwards. See also, Braybon, Gail, and Summerfield. Penny, 1987, *Out of the Cage ; women's experiences in two world wars*.

Chapter 6 Challenge and response: an era of rapid change, 1949-79

The thirty-year period from 1949-1979 marks a time of rapid and wide-ranging social, demographic, economic and cultural change in Britain, all of which considerably affected urban and rural communities -not least in their attitudes towards and expectations from, community healthcare provision. Having established the rather stormy introduction of the National Health Service and the obstacles that prevented district nursing from participating in its formulation in the way the executive of the Queen's Institute would have wished, we will consider in this chapter the transfer of responsibility for the district nursing service from the Queen's Institute and other independent but nevertheless, voluntarily run and funded organisations, into the hands of local government. The effects of consequent changes in the training, supervision and employment of district nurses will be viewed alongside other changes which directly affected their role, working arrangements and consequently their professional outlook and image. A key aspect to this was the move towards a practice-based, 'community care team' and the drive for a nationally and professionally recognised, specialised district-nurse training. In particular this chapter will evaluate the role played in the changing work pattern by changing technologies such as the introduction of disposable materials and equipment, the CSSD, materials technologies, pharmaceuticals, and further developments in communications and transport. Drawing on oral histories these changes as well as the later implications of NHS reorganisation in 1972, will be explained in more practical terms to show how the nurse and patient (and informal carers) were affected and what impact this had on their inter-relationships as well as professional inter-relationships.

Post-war attitudes to district nursing: changing public and professional images

Lewis writes that the range of occupations open to women in the post-war period, 'increased substantially' but points to a 'persistence of sexual segregation of the work-force, whereby women find themselves doing different tasks from men either in the same occupational category (female teachers, male headmasters), or in different jobs (female nurses, male coalminers)'.^{1,2} This separation of roles effectively reinforced the idea that work in the 'female' domestic sphere was of lower status. Furthermore, although the marriage bars that had earlier forced women's resignation from most professions on marriage (including district nursing), had been removed during the second world war and were not widely re-instituted, 'even in the 1980s a majority of men and women considered married women's primary responsibility to be to home and family'.³ This was born out by my interviewees, most of

¹Lewis, J., 1992, *Women in Britain since 1945*: 68-69.

²Nevertheless, Wickham, A., 1982, *The state and training programmes for women, The Changing Experience of Women*. E. WhiteJegg, et al (eds.): 149-151 describes the continuing emphasis on marriage and motherhood for girls after WW2 rather than on training, which emerged from the Carr Report 'Training for Skill' (1958) and from the Crowther Report (1959).

³Ibid.

whom left nursing to look after their children by taking career breaks typically of ten to fifteen years, and returning as part-time employees, no longer having their own districts but providing relief for full-time single women. There were also a few exceptions to the removal of the ban, such as marriage during training (including post-registration training) in some hospitals, and within the Ranyard Nursing Association, a nurse could no longer practice as a Ranyard Nurse if she was married, although several were employed on a part-time basis as relief nurses.

There was also clearly some (mis)perception of district nursing by the public as not constituting 'proper nursing' - that is, not nursing of patients sufficiently (acutely) ill to warrant hospitalisation. This judgement implied an extension of home nursing as a support to the family carers thereby making the nurse seem in some way inferior to, or less skilled than her hospital counterpart. Two examples taken from the oral histories demonstrate this: both nurses worked 'on the district' in the 1950s and 60s - the first is from a nurse who worked in central London, whilst the second worked in Lancashire:

'the people who had District Nursing care worshipped the District Nurse - I mean she was absolutely wonderful. At the same time they felt she was less educated than the Hospital Nurse. I remember patients saying to me you know when are you going to qualify as a nurse, and that sort of thing. [•••] people don't perceive hands-on nursing as being skilled nursing.'

And:

have been asked, in a home, "Have you ever worked in a hospital?" And said, "Yes. district nurses have all had to do their training in hospital. And when you're in the community, you're actually being nursed by qualified nurses, whereas in the hospital, although they're supervised, you may be being nursed by a student nurse". And they look at you ••• "Oh!" And they hadn't realised ••• but think they're more aware now, because the media makes it more aware, doesn't it.⁵

It would seem likely that the continued existence of village nurse-midwives, might have contributed to this situation of confusion in the public mind. However, these examples demonstrate a clear association between hospital treatment - including hospital nursing care - as constituting 'proper' or professional nursing, whilst community-based nursing is relegated

⁴ *DIN*07, 13/08/96, Oral History: Dr. L. H.: was an Austrian refugee who had started medical training in Graz before coming to the UK. She did her Fever Nurse training in London in 1938 before SRN 1939-43, then SCM in Essex followed by QW in 1945 in London and later HY Cert. She later became the QNI's first research officer and chaired several inquiries on their behalf.

⁵ *DIN*26, 18/05/00, Oral History: Mrs. E. P.: trained SRN at St. Helen's from 1959-62 followed by QN in 1963 working for a time at St. Helen's Hospital and later becoming a practice nurse for a GP partnership in St. Helen's.

to less demanding work or 'basic care' that is not perceived as requiring the same skills. Roberts describes 'discernible changes in attitudes to welfare provision' taking place in the inter-war period which included a belief within the working classes 'that they would be better cared for in hospital',⁶ and the view that district nurses were less proficient than their hospital counterparts, may stem from this.

The term 'community care' first appeared in health policy documents in the 1950's⁷ and Berridge⁸ points to subtle changes in emphasis firstly as a rise both in dependence on professionals to advise on health issues and later to gradually encompass a range of providers of care by the 1980's and '90's with much of this retaining the voluntarism that until recently had been associated with district nursing. This may be seen as the harbinger of a change in public attitude towards rights, responsibilities and expectancies from health providers expressed by numerous interviewees as a regrettable change becoming increasingly apparent towards the end of this period and into the 1980s (discussed below).

Outcome of transfer of responsibility of district nursing to the local health authorities
In many cases the transfer of full responsibility for provision of 'home nursing' did not actually happen overnight on the 5th July 1948 (otherwise known as the 'Appointed Day', when the NHS Act officially came into effect), although much of the funding including nurses' salaries, could be immediately transferred, effectively making the provident schemes redundant. At this time there were 2,716 county and district nursing associations affiliated to the QNI nationwide, employing a total of 8,294 district nurses of whom 4,760 were QNs.⁹ Negotiations took place between the Ministry of Health, the County Councils' Association, the Association of Municipal Corporations and the Queen's Institute in 1948. The outcome of these negotiations enabled local authorities, as county and county borough councils, to opt either for direct employment of district nurses or to continue using the voluntary organisations.¹⁰ The voluntary organisations in Liverpool, for example, handed over the district service to the City's Public Health Department as late as 1959, the London Council for District Nursing was not dissolved until March 1966, although after the Local

⁶ Roberts, E., 2000, 'The Recipients' View of Welfare', in: Oral History, Health and Welfare. J. Bomat, et al (eds.): 203-226.

⁷ Berridge, V., 1999, Health and Society in Britain since 1939: 34-41 points to services such as 'Meals on Wheels', 'Help the Aged' and a large number of charitable organisations covering particular diseases or disabilities.

⁸ Ibid.

⁹ 1951, 'Memorandum on History and Work of the Q.I.D.N.' QNM, XXXX. (12 (December)): 192-193.

¹⁰ 1959, 'Editorial', DN, 2(8 (December)): 177: of 145 local authorities in England and Wales, 66 initially elected to use the existing DNAs as their agents, and by 1958 thirty-one of these had switched to direct control.

Government Act (1963) most nursing associations had been absorbed by the new London Boroughs.¹¹

St. Helen's in Lancashire was one of the last voluntarily-run associations to be handed over in the 1970s¹² and therefore retained a considerable degree of control over the service until then. A nurse working in St. Helen's in 1963 described a situation very similar to the conditions of work 30 years earlier apart from the concession that she was able to work as a married woman and live outside the nurse's home once training was completed, suggesting that those associations that remained under the old system retained many of the authoritarian constraints of the past:

Some of the nurses did live in. But when you were on duty, you were expected to have lunch at the Home. I think it was because then Matron knew where you were, or Superintendent, and you had to be in for a certain time ••• but you always got a good meal. So she was making sure you were well-fed as well. And then we finished, we had to be in for one, and you had a break till half past two, and then went out again, but you went in pairs in the afternoon, because there wasn't as much work as in the daytime. The morning was the bulk of the work. And then you were on call until eight o'clock at night.¹³

In fact, it may be seen from Fig. 6.1 (below) that many local authorities continued to sub-contract responsibility for training and inspection of district nurses to the Queen's Institute or the Ranyard Nursing Association, whilst a number of voluntary-run nursing associations continued to raise funds by subscription to provide 'patient comforts'.¹⁴ However, in other areas the local authorities placed responsibility for recruiting and managing district nurses on the department of the Medical Officer of Health, and in-service training was provided at a local level on a rather haphazard basis. In tum, he or she often devolved this task to the senior health visitor in that department adding to growing inter-professional tensions, as will be discussed later in this chapter. I would therefore argue that apart from standardisation of salaries by most local authorities, the immediate outcome of nationalisation was *less* national standardisation rather than an increase, as might have been expected.

¹¹ Central Council for District Nursing in London, 1966, History of the Central Council for District Nursing in London. 1914-1966: 15.

¹² Another was Brighton, see Gill, M. F., c.1974, District Nursing in Brighton 1877-1974: 129-130, which remained a fully affiliated member of the QNI until 1974 when it relinquished responsibility to East Sussex Area Health Authority.

¹³ *DIN*26, 18/05/00, Oral History: Mrs. E. P. (see also fu 5).

¹⁴ For example the Bacup and Wootton District Nursing Associations in Lancashire.

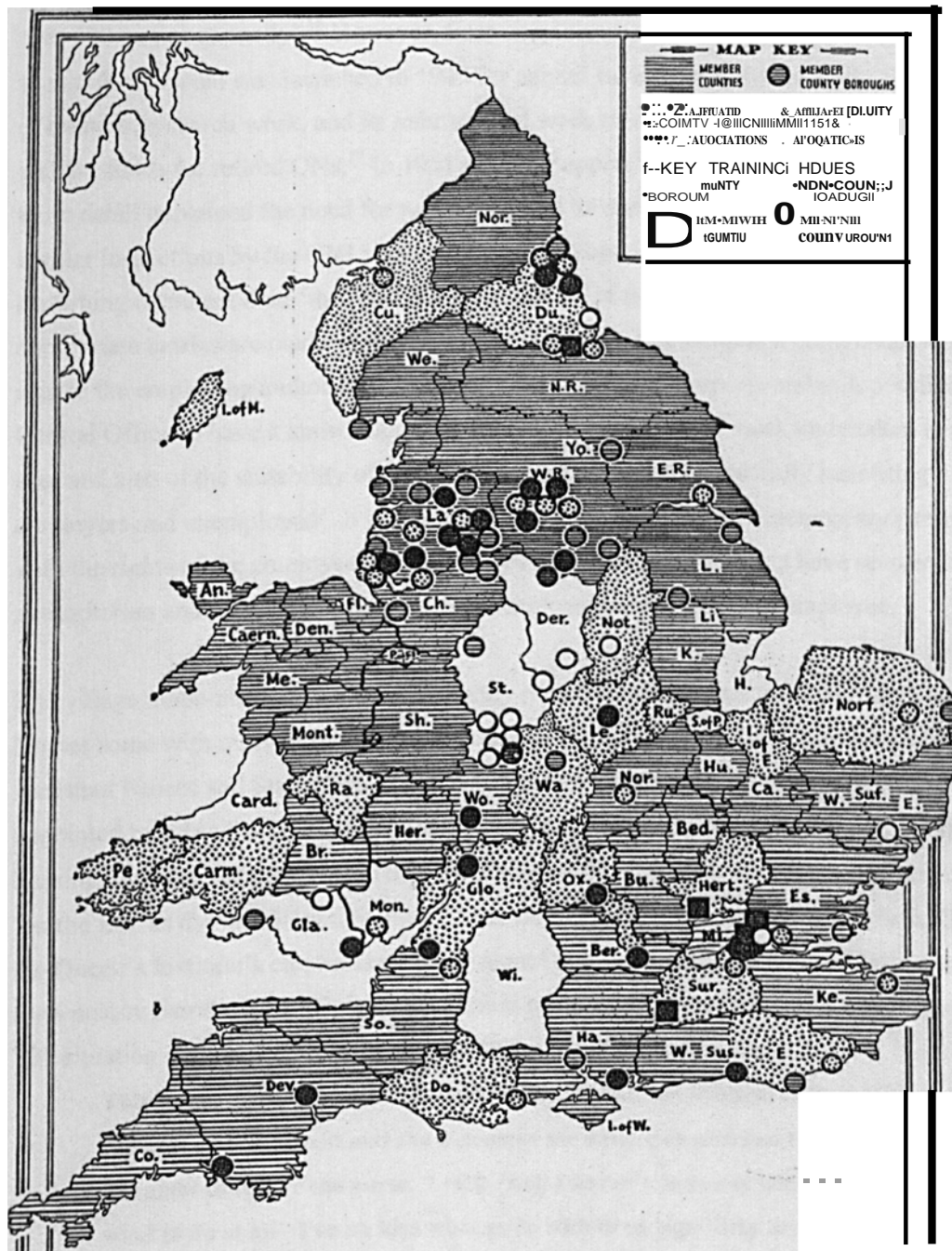


Fig. 6.1 Map of England and Wales showing allocation of QNI affiliated and member counties and boroughs following NHS reorganisation in 1949¹⁵

A recruitment article published in 1951 stated that in 1948 there were affiliated to the QNI in England and Wales, Scotland and Ireland, 2,716 County and District Associations employing nearly 9,000 district nurses and midwives of whom 4,760 were QNs, but it notes that 'the only national body providing training in district nursing is the Queen's Institute which trains

¹⁵Source: SA/QNI Box 52 o/s91 E/10 (1949).

over 600 nurses annually'.¹⁶ However, financing this training remained somewhat haphazard such that an appeal was launched in 1949 for annual subscriptions to the QNI to support costs of training, research work, and its international work together with the long-service and welfare funds for retired QNs.¹⁷ In 1951 a similar appeal¹⁸ outlining the work of the QNI in more detail explained the need for well-structured training and effective regulation through regular inspections by the QNI Visitors or County Superintendents. The appeal then added a disturbing comment that: 'the reports are considered at the Central Office of the QNI, appropriate entries are made on the nurses' record cards and suitable recommendations are sent to the employing authority. In addition, the nature of the reports makes it possible for the Central Office to have a knowledge of the standard and nature of work undertaken in each area and also of the suitability of the nurses for such work, thus mutually benefiting employers and unemployed'. It is difficult not to view this from a contemporary perspective with the rights of the employee in mind, but even at that time this must have seemed heavily authoritarian and weighing in favour of the employers and against the employee.

The village nurse-midwife was being steadily replaced by (hospital trained) State Registered Nurses some with midwifery training, but many of whom had no district training and later, by Assistant Nurses and State Enrolled Nurses. District nurses were often interviewed and appointed by a Medical Officer of Health with little knowledge of the content of nursing training, but with the expectation that the nurses could learn district practice and technique 'on the job' as did the GP at this time.¹⁹ This very casual attitude contrasts dramatically with the Queen's Institute's emphasis on professional training and regulation, and later demands for a post-registration qualification that would re-instate professional status and respectability. The situation is illustrated by a district nurse who worked in Middlesex:

This friend persuaded me to go and see the Doctor, the Medical Officer of Health, about the post and off I went and she welcomed me with open arms and said just try it for a fortnight to relieve the nurse. I said, 'well I haven't done any training, I don't know what to do at all - I've no idea what to do with dressings, dirty dressings' - I mean in a hospital everything is laid on for you. Well she said, 'You can have a week or a few days with the nurse that's going on holiday and you'll soon get used to it. It will be quite all right'. [•••] So that's what I did. I did a few days and learned the rudiments of District

¹⁶ SA/QNI Box 111 P6/20 1951 'Alphabet of Activities: Q - Queen's Institute of District Nursing' in Union of Girls Schools Record (75 (Spring)): 251-259.

¹⁷ SA/QNI Box 111 P6/18, 1949 Appeal for annual subscriptions to QNI.

¹⁸ SA/QNI Box 111 P6/19, 1951 Appeal for annual subscriptions to QNI.

¹⁹ Williams, D., 1992-93, 'Recollections of the RCN and district nursing', *IHNJ*, 4: 25-26. notes that she 'felt that GPs rather than the Medical Officer of Health understood the work of district nurses' and she had therefore been keen to include GPs onto various committees including the QNI's Committee.

Nursing with this particular nurse. At the end of the fortnight - I had quite enjoyed the work...²⁰

To train or not to train? -The dilemma.

From the viewpoint of diminished professional status, the attitude typified by this quote places district nursing at a disadvantage compared with other members of the emerging community healthcare team. This was also reflected in a lack of recognition by the wider nursing profession. For example, at a district nursing conference held during the war the regret had been expressed that no district nursing experience was included in general nurse training which inevitably was having a significant impact on recruitment: 'most delegates had experienced a lack of interest in district nursing in their hospitals, and some had taken it up against the wishes of their Matrons.'²¹ Another nurse had commented, 'many nurses on completing their hospital training ...are wishful to take up another branch of the profession, but fear to do so as they know so little about nursing outside of hospital'.²² Indeed, Dora Williams OBE remembered that the RCN branch in Plymouth to which she was appointed Chairman was run 'by what appeared ageing hospital matrons who took it in turns to be Chairman, Secretary and Treasurer for no one dared to propose lesser fry.'²³ Her appointment as a practising district nurse marked 'the first time a nurse not living in hospital had held office.' The situation was the same in the higher office of RCN College Council to which she was elected in the 1960s.

To attempt to remedy this, in 1955 a Ministry of Health Report²⁴ recommended introducing a compulsory, post-registration training for district nurses. It recorded that in England and Wales, for the year ended December 1952, there were a total of 8,884 district nurses practicing of which 4,123 were Queen's trained. A small number of the remainder (130) were Ranyard trained nurses, leaving 4631 with only minimal district training. However, the Report's working party was seriously split on accepting the length (four months) and content of the proposed training and three of the sixteen members of the working party would not agree that this was sufficient. It is perhaps not surprising to find these members were Miss Merry, General Superintendent of the QNI, Dr. Struthers, Chairman of the QNI Training Subcommittee and Miss Treleaven, Senior Superintendent of the Ranyard DNA, all three having strong opinions based on their personal experience of district nursing as well as reflecting the interests of their institutional backgrounds. They expressed their disagreement with the

²⁰ *DIN* 08, 22/08/96, Oral History: Mrs. M. V.: trained SRN 1941-44 at West Middlesex, then Part t midwifery before becoming a district nurse in Ashford, Middlesex. Her initial training was done 'on the job' but she later (after 17 years) undertook QN's training.

²¹ 1942 'Queen's Nurses' League Conference', *QNM*, XXXI(11 (November)): 83-95.

²² Gile, V. H., 1940, 'To the Hospital Nurse from a Queen's Nurse', *QNM*, XXVIII(10 (June)): 30.

²³ Williams, D., 1992-3, 'Recollections of the RCN and district nursing', *IHNJ*, 4((1992-93)): 25-27.

²⁴ Ministry of Health and S. F. Armer, (Chair) et al, 1955, Report of the Working Party on the Training of District Nurses.

majority's conclusions both through dissenting and by publishing a Minority Report which argued strongly against shortening the training, pointing to the need for supervision and guidance for practical work as well as theoretical training. The Report outlined the difficulties and poor standards of living that still existed in some rural areas for which special training was needed before a nurse could effectively apply skills learnt in the hospital environment.²⁵ A leader article in the *Lancet* in 1955 compared training for general practice medicine and for district nursing stating that a doctor entering general practice requires at least a year to learn his job 'to look after patients without the resources of the hospital behind him' together with acquiring the administrative and bureaucratic knowledge necessary to do the job and 'to gain not only the confidence of his patients, but sufficient confidence in himself'.²⁶ In comparison, the writer felt the district nurse required at least as much extra training because she had to 'learn these things too, at a more fundamental level; for it is one thing to call and give directions about the care of a patient, and another to carry them out in any and every kind of home, whether clean or squalid, well equipped or bare of the simplest amenities.' It was strongly in support of the Minority Report and noted that 'The College of General Practitioners, whose members work in close liaison with district nurses, do not think it should be shorter: on the contrary, they suggest extending it to a year.' The article noted that by 1953 'some 4000 district nurses in England and Wales - about half, that is of the SRNs in the home nursing service - had had no special district training.'²⁷ The Majority Working Party Report itself observed that 'the district nurse is no longer working in isolation: she is a member of the public-health team, and is in constant touch with colleagues working in parallel professions.'²⁸

The credence provided by this ideal surrounding national training and qualification can be explained when the wider view of the rise of the specialist is seen pervading throughout society at this time, and permeating the fields of medicine and nursing more specifically, highlighting the importance of the training system and new academic model. One of the responses to this was the setting-up and development of courses in community health run by the Queen's Institute through the William Rathbone Staff College established in 1960 in what was formerly the central home of the Liverpool Queen Victoria District Nursing Association.²⁹ These were initially intended for district nurses as refresher courses and a

²⁵ 1955, 'Editorial: Training the District Nurses', *The Lancet* (September 10): 543-544, quotes from the Minority Report that: "in one populous county, ... there are still more than 20,000 pail closets, more than 10,000 privy closets, more than 8,500 privy middens, more than 3,500 houses depending for water on springs and wells, and a further 700-odd relying on standpipes" .

²⁶ 1955, 'Editorial: Training the District Nurses', *The Lancet* (September 10): 543-544.

²⁷ *Ibid.*

²¹ Ministry of Health and S. F. Armer, (Chair) et al, 1955, Report of the Working Party on the Training of District Nurses.

²⁹ This was a valuable if short-lived contribution to post-registration professional development, closing in 1975 after just fifteen years because the QNI was experiencing considerable financial difficulties.

three-month course in administration, but later became more multi-disciplinary, to include hospital nurses, health visitors and social workers.³⁰ The latter move, which was instigated in the early 1970's, also serves to illustrate a broader acceptance of the team approach towards community healthcare from the nursing establishment. The QNI also appointed Miss Lisbeth Hockey as Nursing Research Officer in 1963 who conducted several ground-breaking information-gathering studies on the changing role of district nursing and GPs' understandings of this role,³¹ and on how hospital discharge arrangements could be improved to make more efficient use of district nurses.³² These and other reports³³ underline the extent of the lack of inter-professional communication and understanding at this time.³⁴

However, from 1968 the QNI passed all responsibilities for training and examining district nurses to local authorities. Training centres had already been established in many areas and a National Certificate in District Nursing was awarded after successful completion of courses, with the Department of Health having responsibility for overseeing training arrangements. However, concern was expressed ten years later that this was still not statutory, nor was the National Certificate a pre-requisite for service.³⁵ The QNI's correspondence with the Briggs Committee³⁶ highlighted the importance of quality teaching and support in recruiting the more highly qualified entrants as well as the importance in adequate assessment of students, recommending a national rather than a regional register for external assessment. In addition, concern was expressed that there should be strong representation of community nurses on GNC Education Boards and Committees. The Briggs Report³⁷ did stress the need for specialised training for community post-registration courses of comparable standard to other, hospital-based courses and the RCN underlined the importance of this, reporting an 80% increase in total numbers of persons nursed by the home nursing service in 1971-2 including a significant rise in the younger age group and the acutely ill. However, the failure to change the 1968 arrangements by providing district nurses with their own statutory body when health visitors and midwives had their own, independent training councils, perpetuated the

³⁰ Hardy, G., and Lemin, Brian, 1972, 'William Rathbone Staff College: past, present and future', DN (September): 120-121.

³¹ Hockey, L., 1966, Feeling The Pulse.

³² Hockey, L., 1968, Care in the Balance.

³³ See for example: Hockey, L., and Buttimore, A., (eds.) 1970, Co-operation in patient care: Studies of District Nurses attached to hospital and general medical practice; Hockey, L., 1971, 'The Family Care Team: Philosophy, Problems, Possibilities'; Ciba Foundation Symposium on Teamwork for World Health. G. Wolstenholme, and O'Connor, M. (eds.): 103-115; Skeet, M. H., 1970, Home from Hospital. e, J., 1974, 'Health Care in the Community', Nursing Mirror (May 24), reported: 'In one area in Essex the number of visits by district nurses has increased by 6,000 in one year following the appointment of a district nurse liaison officer to her local group of hospitals'.

³⁴ Carr, A., McKerrow, E., Robottom, B., and Waddicor, P., 1977, The Education and Training of District Nurses.

³⁶ SAIQNI Box 62F7/3: Correspondence with outside bodies: Briggs Committee on Nursing, 1971-72.

³⁷ Department of Health and Social Security and P. A. Briggs, (Chair) et al, 1972, Cmnd. 5115: Report of the Committee on Nursing.

professional inequality between district nurses and their colleagues in community healthcare. It was not until 1979 that legislation sanctioned the establishment of a District Nursing Joint Committee under the newly formed United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC).

Changing Inter-professional relationships

Health visitors were frequently seen as representing a major threat to the professional status and autonomy of district nurses. At the first Queen's League Conference held in 1942 several points had been raised demonstrating a growing concern together with portents of escalating intra-professional tensions. The first of these was an appeal concerning their respective pay-structures proposing that 'the salaries of Queen's Nurses should not be less than that of Health Visitors' in order to 'attract the young, the keen and the best who are in search of a profession'. Secondly, concerning training, the question was raised whether, 'it would be possible to include the Health Visitors' training for Queen's Nurses? [as] it would mean more unity with the Public Health services and establish the Queen's Institute as a complete training body.' The reply from Miss Wilmshurst, the General Superintendent of the QNI at that time, that 'A suggested scheme for combined training was at present at the Ministry of Health and it was hoped that their approval would be given'.³⁸ At this time both midwives and health visitors had their own examining bodies and to be qualified and certified in these areas did not require the SRN as a prior qualification, whilst in district nursing this was a pre-requirement. Although the QNI aspired to become the national examining body, there wasn't one for district nursing and by 1948 this represented a major professional disadvantage.

During the period following the NHS Act, and before the Nurses, Midwives and Health Visitors Act (1979) the relationship between district nurses and midwives and health visitors became undeniably uncomfortable for both members of a community 'team' in which an external harmonious professional image was projected to the public whilst the private face was often one of resentments and discord. This situation was probably rooted in the nineteenth century origins of health visitors and district nurses, described in chapter three, in which duties were not clearly demarcated and therefore overlapped particularly in the highly prized roles of public health as 'health missionaries' and the post-natal care of mothers and babies. The resultant misunderstandings and rivalries increased following 1929 when local authorities took responsibility for the employment of health visitors, providing them with far greater security than their district nursing colleagues, and enabling them to work closely with MOHs. As Baly commented, 'the older midwives and district nurses resented the new young

38 1942, 'Queen's Nurses' League Conference', *QNM*, :XXXI(11 (November)): 83-95.

women with their certificates, college training and new ideas; the better educated resented them because they wanted to extend their empire to all fields of public health'.³⁹

In addition, health visitors were themselves feeling professionally insecure and under-valued due to the perceived threat of replacement by social workers from the late 1940s until the early 1960s.⁴⁰ However this insecurity was not visible to district nurses. Miss Sankey, herself a health visitor and district nurse, expressed what many of the oral history interviewees also confirm as their perception of the problem, that is she believed the health visitors, 'felt they were a superior race and the ON was a poor relation. I remember how surprised a HV was when I told her I too was a HV!⁴¹ She found many health visitors to be 'officious' giving themselves 'airs and graces, and related how, whilst working as a trainee health visitor, 'it came as a shock when a door was slammed in my face' yet when visiting the same house dressed as a nurse the following day, she was made welcome.⁴²

A nurse in South Wales gave a similar account, describing her relationship with health visitors:

- Not a very good relationship in the very beginning because they thought they [Health Visitors] were the highly qualified people and knew exactly what was going on and this that and the other, and yet the District Nurse could prove to them that they were quite as knowledgeable too. Because a few instances occurred in the community, especially on a Saturday when Health Visitors didn't work, I could never understand why problems then ended on a Friday at five o'clock - with Health Visiting - because District Nurses took over on a weekend! [•••] It did improve when I got the job [of Nursing Officer] because I would not tolerate the fact that we were lesser than them, you know in any way at all and I think that our nurses proved it because a lot were doing diplomas, and degrees at the time⁴³

The situation was exacerbated by the fact that in some areas district nurses were now supervised by HVs fuelling this atmosphere of resentment and in 1957 an anomaly of salary awards of 5% to district nurses as opposed to 15% for HVs, increased this friction still further.⁴⁴ A letter from PJ Morland, Director of QNI (no date but c.1972) expressed concern

³⁹ Baty, M., 1987, A History of the Queen's Institute: 100 years 1887-1987: 84-85.

⁴⁰ Walker, D., 1965, 'The future public health nurse and her team', DN, 8(8 (November)): 200-203. suggests this was to some extent lessened by the setting-up of the Councils for the Training of Health Visitors and for Training in Social Work in 1962.

⁴¹ 2002, Personal Testimony: Miss M. I. Sankey MBE.

⁴² Sankey, M. I., 2001, "Thank You Miss Hunter": 58-59.

⁴³ DIN 11, 01/10/96, Oral History: Mrs. B. R.: trained SRN 1950-53 in Aberdare, where she worked for a while before taking QN's training in Bristol prior to working on the district in Hirwaun, S. Wales.

⁴⁴ 1957 'Pay settlement for district nurses', QNM, XXXLVI (12 (December)): 180.

regarding the new grading of community nursing posts -particularly noting the District Nursing Sister was to be rated as Grade II when the HV was to be a higher-paid and higher status, Grade I -this was seen as, 'a disincentive to recruitment and retention at a time when the need from the role of district nurse has never been greater'^{4s}

However, a HV who worked in St. Helen's pointed to an additional factor, left over from the previous decade which was clearly region-specific but which must have added to this feeling of acrimony and resentment to greater or lesser degrees according to the local authority under which the system operated:

When I was riding round in a car, as a Health Visitor, our District Nurses were still on bikes, because they were working for a charitable organisation. [•••] Pilkington's provided the building that they worked from, and a certain amount of money ••• I remember, in 1974, when it was ••• the whole sort of affair - District Nurses, Health Visitors, District Midwives -went under the auspices of the Health Service, rather than the County Borough Council and charity and whatever. And I remember one of the bosses telling us that the District Nurses were so short of facilities, you know ••• beds ••• walking aids, things like that."

Many felt the GP attachment system (see below) introduced in the early 1970s changed the relationship through more regular encounters and therefore improved communication:

We never bothered with Health Visitors -the District Nurse and the Health Visitor was like you know chalk and cheese, they never used to bother with. Well when the new amalgamation came round we got, we were in the clinic with them you know, and got very friendly with the Health Visitors then and then we used to - we had much more communication with them. We hadn't -in the beginning there was no communication with the Health Visitors.⁴⁷

Similarly several of the GPs expressed an antipathy towards health visitors, for example a doctor from Rotherham said he thought the HVs, 'were a bit of a useless crowd, on the whole' whereas the nurses 'were very good. I never had any fault to find with them',⁴⁸and similarly a doctor from Ulverston described the district nurses he worked with as 'very useful - taking stitches out at home that would save you a job' and 'dressing chronic leg ulcers and bathing

^{4s} SA/QNI Box 62 F/7/9: Correspondence with Department of Health and Social Security (1965 .75). "DIN 25, 17/05/00, Oral History: Mrs. C.P. trained 1944-47 at the London Hospital, followed by SCM at Liverpool and HV Cert. at Liverpool and St. Helen's working there as a Health Visitor.

⁴⁷ DIN 13, 02/10/96, Oral History: Mrs. D. M.: after fevers training she trained 1939-42 (Birmingham) before returning to Cardiff as a district nurse, training 'on the job' and becoming a district nursing officer.

⁴⁸ CMAC/GP29/08, c1980, Oral History: F.W.B.

people' but he 'didn't understand what the health visitors were meant to do and didn't get on too well with them!⁴⁹

To what extent this was a matter of communication and familiarity is not certain, but it would seem likely that this played a significant part, as things changed according to some interviewees when the 'team' began to work from offices under the same roof as a health visitor explained:

Well, we knew them better. We got to know them better. In '73, when we went out to work in the Clinics, on the area that you're working, instead of the Town Hall, you see, the District Nurse used to come in to see me there, regularly. And I got quite friendly with her.⁵⁰

Similar communication problems still existed between GP and district nurse even though the competitive element had largely been removed by the NHS Act – a situation that arose in the 1960s was described by a district nurse:

EP: I remember one night, it being very very foggy, and I was on duty, and at ten to eight, we got a call to go and give an injection. And Matron said, "Well, it's too foggy for you to drive, you'll have to walk". And I had my little black bag, and I walked all the way to ••• it would be ••• it was Lugsmore Lane, which is about, what? Four miles from here? And we walked it there, and walked it back, to give a morphia injection. Well, it had to be done. Someone had to go. Someone needed it. And, of course, in those days ... (Prompt: Couldn't the doctor have done it, though?) EP: I suppose so, but some doctors wouldn't, would they?

HS: No. I mean, I assume that the doctor had just seen the patient, to know that the patient needed the morphine and to prescribe it?

EP: Some doctors just wouldn't give the injections, that was a nursing duty. It depended on the doctor.

HS: How did you get on with the doctors, generally?

EP: Fine. Being a geographical area, of course, we weren't doctor-attached, so you went to ••• to different doctors ••• I think the majority of the doctors accepted that you were there. Still very much, I suppose, if you look back, you were the hand maiden, because what they said went. You didn't query things the same as sometimes you could now. And you still had to watch yourself, that everybody's responsible for their own practice. We had the Supervisor come round every so often, to see what you were doing.⁵¹

⁴⁹ CMAC/GP29/38, c1980, Oral History: J.J.H..

⁵⁰ *DIN 25* 17/05/00, Oral History: Mrs. C.P. (see fu 46).

⁵¹ *DIN 26: 18105100*, Oral History: Mrs. E.P. (see th 5).

Communication between members of this emerging community care team appears to have been the main stumbling-block in its effective teamwork and co-operation. Merry described contact between doctor and district nurse as largely by 'telephone or message from the doctor or through the doctor's letter handed to the patient's relative' but adds that in a country district the nurse-midwife would be more likely to meet health visitor and GP and 'know each other well.'⁵² This rural/urban difference was reiterated by a GP who described the inadequacies of contact. 'by a series of notes or telephone calls and hastily scribbled thanks' but felt the 'lucky general practitioners and district nurses in this respect are those in isolated country areas who are brought by circumstances more closely together, and, for geographical reasons, care for the same population of patients' adding 'What hospital physician would contemplate the care of patients without periodic discussion with the ward sister?'⁵³ Although most interviewees agreed if they wanted to see the doctor it could be arranged on an informal basis during surgery times or at the patient's house, having an office within the GP's practice made a big difference to work organisation. Prior to this, a typical method of communication between doctor and nurse or between central office and nurse during the daytime would be the post office or chemist:

Another way was, each nurse, in each area or district, or part of ••• a portion of it, that's her "patch" as we call it, and the males as well, we used to have a chemist's shop, local chemist, had one attached here ••• two mile away, and used to go twice a day, morning and afternoon, mid-morning and mid-afternoon, "Any messages?" you know?⁵⁴

The team approach and the medicalisation of nursing

The concept of a primary multidisciplinary healthcare team was suggested in 1920 by the Dawson Report⁵⁵ as part of its recommendations for health centres. An article written by Dr. Fisher, a GP working in Lewisham and Bromley noted the problems in inter-professional communications at that time stating that there was 'no common meeting place and communication was usually limited to the telephone.'⁵⁶ The health visitor, district nurse, midwife, almoners and other community care workers are curiously described collectively by this GP as the 'social workers'.

⁵²Merry, E. J., 1956, 'The role of the district nurse in home care', *The Practitioner*, 177(July): 54-58.

⁵³Forman, J. A. S., 1963, 'What the GP expects of the District Nurse and Midwife', *DN*, 6(July and August): 74-77; 102-104.

⁵⁴*DIN*38, 01 103/01, Oral History: Mr. A. B.: trained 1953-56 at Nottingham then QN's training 1956.

⁵⁵Consultative Council on Medical and Allied Services, 1920, Report of the Future Provision on Medical and Allied Services (Dawson Report).

⁵⁶Fisher, I., 1968, 'A Personal Review of the N.H.S. 'Midwife, Health Visitor and Community Nurse', 4 (August): 329-331; Hardy, A., 2001, *Health and Medicine in Britain since 1860*: 143-147 notes the enormous demand for false teeth and spectacles and a dramatic increase in GP-prescribed drugs.

A more enlightened view is expressed by a country doctor who wrote about the (community and rural-based) district nurses working with him a decade later:

the district nurses are to us in the villages exactly what the house staff are to the consultants in a hospital. They know the set-up, the social background, the oecology, [sic] of the people in the village very much better than we do, and it is from them that we general practitioners obtain a great deal of information that we do not get from the patients themselves. It is very often the things that the patients themselves want to gloss over and keep away from the practitioner that are the things which matter, and it is those things, such as the anxieties and difficulties in the homes of the people, that the district nurses can and do tell us. Therefore in the country villages, where the district nurse is living among the doctor's patients, she is the absolute key-point. In the country we are rung up by the district nurses and we ring them up ourselves, and we also meet them. There are six district nurses in my neighbourhood and I meet every one of them at least once a week, either because she is in the patient's house when I call there or because she comes to see me about a case, or I go to see her about a case when I am in the village.⁵⁷

Although this GP seemed to have had more interaction with the district nurses, his perception of their role continues to be as subordinate assistant. This view is consistent with that expressed by the GPs interviewed by myself and by Bevan, many of whom described the district nurse as 'very helpful'⁵⁸ or 'very useful taking stitches out at home: that would save you a job'.⁵⁹ Most also provide a very vague description of what the nurse did, such as 'dressing varicose ulcers and this, that and the other',⁶⁰ or 'Well, nursing ... seeing what people needed in their own home, reporting back ... Mainly a matter of tradition and good sense'.⁶¹ Not all saw the move to GP attachment and primary care team as a positive move. A doctor who worked in Sunderland preferred the earlier system saying he felt communication was simpler, being more direct and 'to the point': 'in the 1950s you would find a little note behind the, always behind the mantelpiece [...] from the nurse',⁶² and similarly a GP from Worcester explained there was, 'none of this ringing some office or whatever. No you just rang them up and talked to them, and said "Mrs. Jones is out, could you pop in and have a look at her?" And she 'popped in and if she was worried she rang you. And if she wasn't she got on with the job'.⁶³

⁵⁷ Barber, G. O., 1960, 'The Link to Health', *South African Nursing Journal* (February): 16-17. This article although published in South Africa was written by a British GP working in the UK.

⁵⁸ CMAC/GP29/16, c1980, Oral History: F.B..

⁵⁹ CMAC/GP29/38, c1 980, Oral History: J.J.H.. ⁶⁰

CMAC/GP29/2 1, c 1980, Oral History: J.A.H.. ⁶¹

CMAC/GP29/12, c1980, Oral History: A.S.B.

⁶² CMAC/GP29/02, c1980, Oral History: J.S.M.

⁶³ CMAC/GP29/06, c1980, Oral History: M.A.N.

Baly attributes the general recognition of the need for a much closer, 'community health team' approach, to a response to changes in the 'pattern of illness and the demands for different types of care'. She believed these to have been 'urged by reformers for over sixty years [but] they have been resisted largely because the family doctor feared loss of independence and interference with the doctor-patient relationship'.⁶⁴ Accepting this viewpoint, the removal of a significant portion of the competitive aspect afforded to GPs by the NHS Act, opened up possibilities for a closer professional relationship between the GP and the district nurse. This was enhanced by increased demands from technicalisation within medicine creating a need for increased teamwork and a widening of the nursing role to encompass some jobs previously reserved for doctors. Walby et al refer to this as: 'the glorious ideal of the ethical professional' in which 'each professional sees to the achievement of its own standards of work'⁶⁵

The establishment of the Royal College of General Practitioners in 1952 and subsequently a successful negotiation for a new pay structure for GPs in 1956 may be seen as indications of 'changes in medical education and in the organisation of practices which conferred a new professional confidence and standing' for the doctor.⁶⁶ This contrasted with the professional doldrums in which district nursing was placed during the same period. In his study of General Practice medicine published in 1954, Dr. Stephen Taylor gave considerable attention to district nursing.⁶⁷ In particular he drew attention to the 'outstandingly good' relationship between district nurses and GPs 'with very few exceptions' adding that this was not merely fortuitous. The general impression of the whole chapter is very supportive of district nursing. However, he wrote that 'she [the district nurse] and her superintendent are used to taking their marching orders from the doctors in clinical charge of the patients. This remark is evidently not intended to insult but merely reflects the wide difference in professional standing between the two at this point, with the GP confident in his 'professional ownership' of the patient. Taylor stressed that many nurses were being under-utilised particularly in towns where 'GPs fail to realize what the nurse can achieve' or 'fail to organise contact with the nurse' quoting one area where of the 48 GPs, 'only 20 were regular users of the service [of the local DNA]'.⁶⁸

⁶⁴ Baty, M., 1980, Nursing and Social Change: 121.

⁶⁵ Walby, S., Greenwell, J. et al., 1994, Medicine and Nursing: Professions in a changing Health Service: 57.

⁶⁶ Hardy, A., 2001, Health and Medicine in Britain since 1860: 142.

⁶⁷ Taylor, S. J. L. and Nuffield Provincial Hospitals Trust for Research and Policy Studies in Health Services, 1954, Good general practice: a report of a survey: 369-380.

⁶⁸ Ibid. p. 372.

Most members of the medical profession therefore welcomed the Gillie Report⁶⁹ in 1963 that revived the idea that community nurses should become attached to specific groups of doctors and their practice populations. This used similar language in explaining that the GP, 'should use the domiciliary team of workers (health visitors, district nurses etc.) as the consultant uses his ancillary staff in hospital' describing them as 'tools to do his job properly' itemised alongside equipment and premises.⁷⁰ A GP writing at the time emphasised that,

if general practitioner and district nurse are to work usefully together, loyalty to each other is essential. The GP's decisions may be right, or wrong; but he (or she) will expect support from the district nurse or midwife in carrying out the treatment or management ordered, in all her dealings with the patient or household. [...] she will do nothing but harm if she instils a suspicion in the patient's mind that the doctor has misjudged the seriousness of his condition and that hospitalisation would be safer.⁷¹

The tone of each of these examples strongly underlines the relationship that was envisaged by GPs in reducing the autonomy of the district nurse to a more subservient role. An article by a County Nursing Officer considering setting up nursing teams attached to GPs notes a few cautious words, in particular that it must be emphasised that, 'nursing staff are there to work as colleagues and not in any inferior capacity.'⁷²

By 1969 after a sprinkling of experimental attachments a wider move to GP attachment of district nurses had begun which, combined with an increase in larger purpose-built, practice premises and health centres, was felt to be, 'turning into a practical proposition the concept of the community health team, able to provide comprehensive family care. At the same time they facilitate the provision of effective nursing teams of district nurses (SRN and SEN) and health visitors with a supporting staff of auxiliary workers.'⁷³

The interviewees in my primary series emphasised the effects of change from geographical allocation of patients to attachment to GP practices as the key factor in this change of relationship. A nurse remembered working in North Kensington in the 1970s:

⁶⁹Central Health Services Council, 1963, *The Field of Work of the Family Doctor*; Report of the Subcommittee of the Standing Medical Advisory Committee (<The Gillie Report). See also Griffiths J. M. Luker, K.A., 1994, 'Intraprofessional teamwork in District Nursing: In whose Interest?' *Journal of Advanced Nursing*, 20(6 (Dec.)): 1038-1045; Hockey, L., 1971, 'The Family Care Team: Philosophy, Problems, Possibilities', in Ciba Foundation Symposium on Teamwork for World Health. G. Wolstenholme, and M. O'Connor, (eds.): 103-115.

⁷⁰Central Health Services Council, 1963, *The Field of Work of the Family Doctor*.

⁷¹Forman, J. A. S., 1963, 'What the GP expects of the District Nurse and Midwife', *ON*, 6(July and August): 74-77 and 102-104.

⁷²Walker, O., 1965, 'The future public health nurse and her team', *DN*, 8(8 (November)): 200-203.

⁷³RCN Executive Committee 1969, 'Occasional Papers: The Future of District Nursing', *NT* (March 20): 45-48.

we all met as a large group of District Nurses ... [but] an almost on a hand tell you the number of contacts actually had directly with a G.P. or who was a Health Visitor, or Social Worker, so the contacts with other health care professionals was very very limited ... [however after moving to a GP attachment in Chester] I had more contact with other health care professionals in the team and valued very much being part of that team'.⁷⁴

A health visitor who was working in St. Helen's, Lancashire in the 1960s and 70s felt there was a good working relationship at that time between herself and other members of the community team but felt the problem was more with communication between hospital and community:

JF: ... we had regular practice meetings, and the District Nurse would be there, and ... and mean, sometimes our work overlapped, but not much. Not much ...

HS: What was the relationship like between you and hospital?

JF: Well, there was no communication at all at that time. That was where the big gap was. Not the District Nurses, or the District Midwives. It was ... you very rarely went into hospital, prior to 1974. There was ... you know, the child went into hospital, the child came home. You saw it before it went, and you saw it when it came home, but you had nothing whatsoever to do with it while it was in.⁷⁵

Looking at the expanding role of the district nurse in 1989, Ann Mackenzie⁷⁶ quoted the chief nursing officer's letter from 1977:

The District Nurse is the leader of the district nursing team within the primary health care services. Working with her may be RGNs, [S]ENs and nursing auxiliaries. It is the district nurse who is professionally accountable for assessing the needs of the patients and the family, and for monitoring the quality of care. It is her responsibility to ensure that help, including financial help and social is made as appropriate. The district nurse delegates as appropriate to ENs, who can thus have their own caseload, but who remain wholly accountable to the district nurse for the care that they give to their patients. The district nurse is accountable for the work undertaken by nursing auxiliaries who carry out such tasks as bathing, dressing frail ambulant patients, and helping other members of the team with patient care.⁷⁷

⁷⁴ *DIN* 10, 27/09/96, Oral History: Mrs. E. R.: trained SRN St. George's Hospital, London 1969-72, later moved from hospital to district with minimal training in Chiswick working on several districts in London and Chester.

⁷⁵ *DIN* 24, 17/05/00, Oral History: Mrs. J.F.: trained SEN, then SRN in 1965 and Part 1 Midwifery at St. Helen's, working as a district nurse there before taking HV's cert.

⁷⁶ QNI Archives (CMAC), 1989, SA/QNI Box 112 P7/69: Mackenzie, Ann (on behalf of steering group District Nursing Association (UK)), 'Key Issues in District Nursing: Paper 1 The District Nurse within the community context': 14-15.

⁷⁷ DHSS (1977) Nursing in Primary Health Care HMSO Circular CN0(77) 8.

These roles of assessment and empowerment, co-ordination and supervision (leadership, delegation, teaching, monitoring and regular re-assessment) were all new to the pre-NHS job-description of the 'grass-roots' district nurse. In addition, the role was being extended to include more specialised areas of work such as focusing on the elderly, the mentally ill, screening and preventative work, counselling or working more closely with social services e.g. in providing high dependency care for acute, chronically or terminally ill patients and their families. Health promotion and health education continued to be seen as focal areas of district nursing, although this was (and still remains) often implicit rather than explicit practice compared with the evangelistic attitude towards health education of the early decades of the century. The separation of health visitor and midwife from district nurse, and clearer delineation of the roles of each was therefore achieved in all but the most remote areas by the mid-1970s. An interesting parallel may be drawn with the declining role of GPs in hospitals following the NHS Act⁷⁸ and this boundary-drawing creating specialist fields within community nursing. In effect, both generalists -the GP and the district nurse -had their professional 'wings' clipped by the rise of specialism in the larger medical and nursing arenas.

Bliss and While⁷⁹ argue that the arrangement agreed at the beginning of the century (see Chapter 2) between the BMA and the Queen's Institute which ensured that nurses undertook to work under the directions of the GP, together with the involvement of the medical profession in the training of district nurses, led to the understanding that 'some GPs or indeed district nurses still view the GP as the leader of care'. I would suggest that while this was almost certainly the case and is indicated by the GP oral histories referred to above, it was probably no more so than in the hospital environment, and quite possibly less obviously or universally so. Nevertheless, the nurses working during this period often described the later development of the community care team (from 1972 when GP attachment was introduced) as a mixed blessing and one that represented a move away from professional autonomy and towards shared responsibility and increased communication. On the one hand it gave them increased personal privacy, the support of a team and more regular working hours, but on the other there was to be a change in identity in their relationship with the community which included some degree of compromise to their professional autonomy.

¹¹ Digby, A., 1999, *The Evolution of British General Practice 1850-1948*: 338-339, describes a decline in numbers of hospital, public health and other public appointments held by GPs and a restriction in the range of clinical work entailed in those remaining open to them as generalists.

⁷⁹ Bliss, J., and While, Alison, (2000). "Team Work and Collaboration: The position of district nursing 1948-1974." *IHNJ* 5(3 (Summer)): 22-29.

The role of technology

In the post-war period, fever nursing was no longer so much a part of the district nurse's skill requirement, whereas before the sulphonamides and penicillin an acute case of pneumonia had been thought of as a challenge requiring intensive nursing and several visits a day through the critical phase. However this was countered by a steady rise in increasingly complicated post-surgical cases 'which, after hospital treatment, have been sent home and which often entail large dressings',⁸⁰ and demanded a different expertise. Introduction of drugs such as Mersalyl and Insulin in the late 1930s had resulted in a change in daily routine in order to administer injections before the patient's breakfast time. Although most surgery was performed in hospital by 1948, there were still some operations carried out in the home, and assisting the doctor with these was still included in the district nurse's training. 'Kitchen table' surgery included 'circumcision, tonsillectomy, incision of abscess and minor gynaecological conditions, such as curettage'.⁸¹

The equipment shown in Fig. 6.2 below, demonstrates the still considerable amount of resourcefulness and improvisation required in district nursing in the first two decades after the NHS Act. Instruments still had to be sterilised for five minutes before, and five minutes after each procedure, and swabs and dressings had to be cut up and baked in an oven. This would effectively increase the time taken per visit very considerably compared with that at the end of the 1970s by which time sterilised packs from a Central Sterilising Supply Department (CSSD), disposable sterile rubber gloves, pre-packed lotions and syringes, and a vast array of new materials and devices, changed the nurse's daily workload and nursing techniques dramatically. In addition, this represented an important modification in professional image from one which incorporated a considerable amount of time carrying out a form of culinary domestic work (cooking dressings, boiling instruments and cleaning saucepans), to one that was technicalised and medicalised through association with modern surgical practice. The contrast is suggested by the comparable requirement and layout shown in Fig. 6.3 for exactly the same nursing procedures. The system and problems were explained by many of the interviewees -for example:

Well ... in my bag, I used to have ... I used to go the day before, I mean, the first visit, and I'd say, "Now, have you got ... how are you fixed for a bowl? Separate little bowl", was a big thing. "Have you got a bucket?" "Yes, yes". "And soap and some flannels", you know, the usual things. If they hadn't, they'd go and buy something, you know. I used to go and buy it myself sometimes. [Prompt: Did you?] Ah yes. Many times. Anyway, so ... that's all geared up, and they're all kept in the corner of the room, all those things. And they'd get me a kettle boiling, there was no hot water. Got no taps,

⁸⁰ Platt, E., 1937, *The Story of the Ranyard Mission 1857-1937*: 119.

⁸¹ Merry, E. J., and Ien, L. J., 1948, *District Nursing: A Handbook for district nurses and for all concerned in the administration of a district nursing service*: 252.

from the taps, very seldom. And so you'd start off from scratch. So, in other words, you spent a lot of the time preparing, to what you did with the actual patient. And the same with dressings.(•••] Well, you see, today, Helen, it's all pre-packed. Steriles, autoclaved. Well, in them days, we had to ask for the milk saucepan to boil our syringes in. Yes! And used to get old biscuit tins, scrounged from neighbours, lining with baking paper. I'm talking about dressings now, post-ops, and ••• had to show the wife, or the patient who was capable, to ••• they used to get a prescription from the doctor for a roll of cotton wool, a big roll, and a packet of gauze, which you had to cut and do your own thing. So I'd cut them one out, to show them how to do it, and to give the patient something to do, to roll the cotton wool, cut the swabs up, pop them in the ... in the biscuit tin, and explain to the good lady, "Could you put them in your •••" they were all gas ovens in those days, "in the gas oven, for 20 minutes, with the lid off". Well, of course, when you went the next day, they'd done very well, thank you very much, but they were all black!⁸²

Similarly a description of an injection (the requirements for which are shown in the bottom half of Fig. 6.2 and contrasted in Fig. 6.3), explained:

it was all ready for you, as a rule, you'd get them all organised. But you'd use one of their little saucepans, fill it with water, put water in, and we had a bag, you know, a proper bag with all the instruments in, and syringes, glass syringes, and then came the plastic ones eventually. But needles had to be boiled, because they were used time and time again. And so you had to wait a good five minutes, five or ten minutes, boiling it, before you start. You do your injection, you clean everything out and wash the ... you dried them with the cloth that you have, put them back in your bag. So, in other words, you could be 20 minutes, or 25 minutes in a house, to give an injection. Whereas today it's in and out⁸³

This last point is contrary to the initial theory behind the development of CSSD, which was that time saved in boiling up instruments could be devoted to better bedside nursing i.e. freeing the nurse to spend more time with her patient.⁸⁴ However, these developments not only dramatically changed these more technical tasks but changes in materials available to the nurse had a considerable effect on the most basic practical work -for example, care of the incontinent and bed-bound was greatly simplified by the introduction of disposable incontinence pads at the end of the 1960's, as one nurse described:

a2 *DIN*38, OI/03/01, Oral History: Mr. A.B. (see fit 54 above).

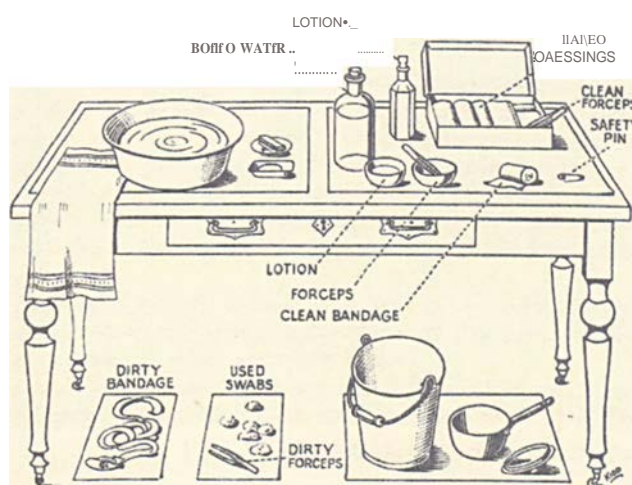
β *DIN*38, 01 103/01, Oral History: Mr. A.B.

μ Darmady, M., 1961, 'Central Sterile Supply Services and their Application to District Work', *DN*, 4(4 (July)): 83-86.

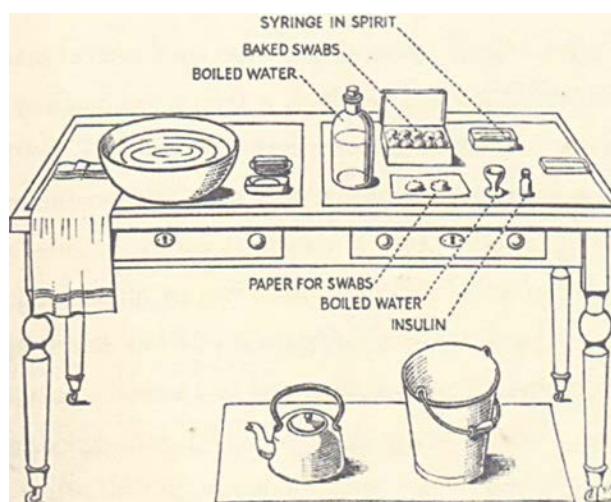
EP: We'd no disposable ... sheets ... not sheets ... they used the rubber protective sheets on the bed, which had to be washed and dried.

HS: Yes. With a draw sheet on top?

EP: With a draw sheet on top. 1●●●) Things were acquired. There were commodes, of course. And then we were just beginning using the inco sheets, and you had to say how many general nursing care you'd got, of course, Matron knew really, and we were allowed three a day for these patients, and we were told they were 3d. each! Old money! And we had to be careful how many we used. It's only these underneath them. When you think of it, three a day. But that was because they were new coming out, and before that, of course, they just used the draw sheets and they were washed. So the family were involved a lot more.⁸⁵



SETTING FOR A SURGERY DRESSING IN THE HORN



SETTING FOR MAKING AN INJECTION OF INSULIN

Fig 6.2 Equipment required for a dressing and giving an insulin injection c1948⁸⁶

⁸⁵ *DIN* 26 J 8/05/00, Oral History: Mrs. E.P. (see fn 5 above).

⁸⁶ From Merry, E. J., and Irven, LD., 1948, District Nursing: A Handbook for district nurses and for all concerned in the administration of a district nursing service: facing p. 116.



Fig. 6.3 Equipment required for a dressing and giving an insulin injection after introduction of CSSD and disposables⁸⁷

This period would seem to have been one of continuous change for the nurse's daily caseload and work routine, as outlined in the final Annual Report for the East London Nursing Society⁸⁸ written in 1968. The nursing Superintendent described in her report a heavy caseload containing a high percentage of elderly patients yet noted a general trend since 1957 towards a decrease in work which she attributed to 'tablets replacing Insulin injections and similar changes for other conditions previously requiring injections' (mercurial diuretics, antibiotics, steroids etc.) with 1967-8 showing the first significant increase in patients and visits for ten years. She commented that improvisation had become 'less part of the nurse's job than in the past' although the provision of disposables and other nursing equipment was proving more costly, whilst the disposal of dressings was 'becoming a problem for the Public Health Department as people no longer have coal fires.' Interestingly, Miss Clewes stated that

⁸⁷ My thanks to Sandra Crofts B.Sc., R.G.N., C.P.T., for these photographs and for her insightful contributions on this subject.

⁸⁸ QNI Archives, C., 1968, SA/QNI Box 102 X20/1-2 East London Nursing Society, Clewes, E.S., Ninth Annual Superintendent's Report (dated 17/06/68).

in her view responsibility for care of the elderly was 'not expected of the family to the same extent' whilst concepts of rehabilitation were becoming increasingly important but were possibly more time-consuming than bedside nursing had been. She noted that the districts of Stepney and Spitalfields had high rates of mental illness and alcoholism and an increasing drugs problem. Finally she reported the introduction of male and married nurses to the association's staff and the increase in specialised knowledge were important recent changes. According to Ramsay, infectious diseases had been the main problem encountered in this area until fairly recently and the population had more than halved, having been 579,102 in 1901 falling to 202,516 by 1968.⁸⁹ She noted that in 1933, the introduction of insulin injections the workload increased by a 22% rise in the number of visits with a corresponding fall later when self-injections were introduced. Sulphonamides and antibiotics obviously were partially responsible for the fall in infectious diseases together with (inter)national immunisation programmes⁹⁰ – tuberculosis nursing in particular was a major feature of urban district nursing before the war, yet by 1960 many of these skills were virtually no longer required.⁹¹

Many of the district nurses I interviewed referred to a fall in 'neighbourliness' and even in family shared responsibilities for care, with a simultaneous rise in expectancies from the Health Service and what was felt to be an unreasonable understanding of 'patients' rights'. Some of these changes were therefore not perceived as total and absolute progress but were viewed in a more mixed and realistic light. For example a nurse writing in 1958 claimed:

Discoveries of new drugs have done more than anything to change the aspect of nursing and in many cases injection therapy has replaced bedside care. This has also brought problems. Many nurses have suffered from dermatitis. The adequate sterilisation of syringes has been difficult to cope with and there have been many breakages ... In some areas arrangements are made whereby all syringes issued to district nurses are autoclaved.⁹²

In addition, the vast array of drugs introduced from the late 1950's onwards was seen to have increased the number of patients – particularly psychiatric patients and the elderly – who could be cared for in the community rather than requiring hospitalisation, and by 1961 most TB sanatoria were closed.⁹³ Many terminally ill patients were able to be nursed at home. This

¹⁹Ramsay, E., 1968, East London Nursing Society: The history of a hundred years.

⁹⁰From the late 1940s onwards the World Health Organisation launched successive immunization campaigns against diphtheria, tetanus, poliomyelitis, measles, whooping cough and tuberculosis focussing particularly on children and young adults.

⁹¹Baly, M., 1987, A History of the Queen's Institute: 100 years 1887-1987: 93 gives a mortality rate from TB as 992: million population in 1931, whilst Merry, E. J., and Irven, I.D., 1948, District Nursing: A Handbook. devoted several pages to 'Home Nursing of Tuberculosis' in their textbook indicating a high priority at that time.

⁹²Dixon, N. M., 1958, 'Changes in District Nursing', DN, 1(2(February)): 24.

⁹³Petty, G. F., 1961, 'Patients, Nurses and Doctors', DN, 4(4 (July)): 76-78.

therapeutic revolution in so many fields of medicine combined to increase the pressure on the community as a whole, with 'care in the community' becoming seen as an excuse to offload care onto the informal carers and under-resourced district nursing service.

Roberts describes the period 1940-1970 in Lancashire as seeing, 'a transformation in working-class housing'.⁹⁴ She notes that by the end of this period, many houses had bathrooms and inside toilets, whilst domestic appliances were becoming increasingly common with a resultant raising of (expected) standards of hygiene and cleanliness. In addition, furniture such as the old feather beds and low, deep armchairs were gradually replaced by modern designs. These changes had important implications for the district nurse in reducing the heavier and more time-consuming aspects of her work, whilst simultaneously cutting down patient-contact time.

These developments, together with increased use of cars to get around larger districts also contributed to an increased caseload, and consequently less time spent with individual patients. A superintendent of District Nursing and Midwifery training in Plymouth, remembered that by 1970, 'most [district] nurses were trained, all lived out, all had cars or use of a Council car, all had telephones.'⁹⁵ Transport technology certainly made a considerable difference - cars gradually became more readily available but several nurses mentioned the unreliability of their cars as a nurse who worked in a rural area of East Sussex in the 1950s and '60s explained:

I did have a car when I went to Lewes to begin with, but I did have to empty every night, you know the radiator, and swing it in the morning, it was good going out in the night doing that, you know! It was quite hard actually, but they did produce a new one after the snow had gone. They were very good about cars, in the South East actually, they did change them quite frequently. There came a spell, eventually, when you were allowed to have your own, but it was a bit too late for me.⁹⁶

The LCC was able to provide 25 cars as early as 1951 for nurses in the Central London Associations⁹⁷ which was remarkably early motor-car provision for urban usage, whereas in Lancashire the 'Corporation' cars were described as the 'worn out vehicles that nobody else

⁹⁴ Roberts, E., 1995, *Women and Families. An oral history. 1940-1970*: 22-44; also Hardy, A., 2001, *Health and Medicine in Britain since 1860*: 139-140 states that over the period 1945-55, three million houses were built although 'demand continued to outstrip supply'.

⁹⁵ Williams, D., 1992-3, 'Recollections of the RCN and district nursing', *IHNJ*, 4((1992-93)): 25-27.

⁹⁶ SD/2, 04/07/98, Oral History: Miss B. S.: trained SRN 1938-41 (UCH London) then SCM (Paisley) and QN London, working as a district nurse in E. Sussex before gaining HY cert in 1946.

⁹⁷ Central Council for District Nursing in London, 1966, *History of the Central Council for District Nursing in London. 1914-1966*: 13.

would, or often could, drive.⁹⁸ Presumably by 1977 most of the difficulties had been largely overcome and the car seems to have replaced the bicycle in most urban as well as rural areas, as Monica Baly described:

nowhere have changes been more marked than in the community [...] High hospital costs have promoted research into how hospital equipment can be converted into 'do-it-yourself' home kits, and machines that were once the wonder of hospitals are now found as standard portable equipment in the back of the district nurse's car. But often the district nurse will have to do treatment in cramped conditions without proper plumbing, and in an emergency there is no bell to push...⁹⁹

Male district nurses

Another major post-war change, partially in response to the recruitment crisis, was the introduction of Queen's training for male nurses in 1947. This was also partly due to the number of male nurses taking advantage of shortened (general nursing) training in lieu of war service experience received in the services' medical corps. Not all of these men wanted (nor were suited) to remain in hospital nursing. By the end of 1951, one hundred and eighty-nine male nurses had trained as QNs,¹⁰⁰ and after twenty years the figure had risen to 423 in post which was 4.9% of the total number of district nurses.¹⁰¹ For married men entering Queen's training there were a number of obstacles not normally encountered by (usually unmarried) female nurses at this time. Apart from concerns about possible prejudice from colleagues and patients, these obstacles included a reduction in salary during training, having to find and pay for lodgings in one part of the country whilst in many cases keeping a wife and family elsewhere and having to cover a larger working area than his female counterpart because he was only permitted to visit male patients.¹⁰² One of these men entered Queen's training following his marriage to a QN, herself undergoing midwifery training at the same institution. She described their subsequent difficulties:

He did Queen's and the Queen's pupils, sat on that table - all the training staff sat on the middle table and the Pupil Midwives sat on this table. So he sat over there and I sat over here. And any marriage that can last out six months because as you will appreciate I was on call most of the time, we were never allowed to lock our bedroom. There was a little cloakroom where they gave him, so that he could wash and change - the rest of it, no we were there and that door could crash open at any time (•••) And I'd been sponsored by Devonshire County Council to do my training. (•••) Anyway we said to

⁹¹ Jordan, P., 1977, *District nurse*: 47.

⁹⁹ Baly, M., 1977, *Nursing*: 91

¹⁰⁰ 1951, 'District Nurse Training for Male Nurses', *QNM*, XXXX(12 (December)): 193.

¹⁰¹ 'M.E.S.' 1968, 'John Beart district nurse', *DN*(November): 169-170.

¹⁰² 1948, 'Impressions and Experiences of a Male District Nurse', *QNM*, XXXVII(12 (December)): 146-147, the anonymous author, one of the first four male nurses to undergo Queen's training, stated that his average daily travelling distance by bicycle in Leicester was 21 miles.

Miss W. do you think they would take us both - a double post somewhere - would they take us? She said well Devon had never employed a male nurse and Devon have never had a married couple, so she said I don't offer out any hope but she said why not, you've nothing to lose, why don't you try? (•••) and we were just lucky that we applied at the right time. We went up for an interview and we were offered - but at that stage I was only offered a District Nurse's post - that was fair because in Devon Torquay was a midwifery training so it was different. But we were offered a double post in Torquay, to do District Queen's nursing and then probably you can't imagine it happening today, because I can't, but this was early 1951 and we had to sign an agreement that I would not get pregnant for three years. But three weeks before we were due to come to Torquay they rang me up and offered me Kingskerswell which is down the road here. I had become vacant - very unexpectedly it had become vacant, and they said would I like to be District Nurse/Midwife? Well and a flat went with it so of course it was a gift but Harold had an enormous problem in Torquay because the - there was of course the Queen's training home, it had a maiden lady in charge and she did not want a man, whom - she didn't see why she should have a man, he was foisted on to her and she actually went and saw people and told them! (Prompt: that they were getting a man?) No she went and told the patients that she had this man coming, only men, because of course there was no question at all of him going anywhere near women. But she went and saw the men and said if you don't like him and you don't want to be nursed by a man you tell me, we'll put in a written complaint and we shall get rid of him. But you know it was unbelievable, - he was very very skilled and within a month doctors were ringing up and saying 'I've got a man I want Mr. D. to go and see, can you please arrange for Mr. D. to see this man as soon as possible?'. But she was livid, she was furious.¹⁰³

Most male nurses described some degree of initial surprise expressed by patients on the first visit but subsequently rapid acceptance. However, similar accounts of sexual discrimination initially, emerged from most of the male nurses interviewed - for example, a nurse who worked in Lancashire explained:

AF: when we first started on the District, there was myself, and another male nurse in St. Helen's. And we couldn't do anything right. We couldn't do anything right.

HS: Was this because you were men?

AF: Yeah, I should think so! And we ••• we were careful what we did and so on. And the girls, sometimes, used to try and put on you, try and palm cases on to you that they didn't want, really. They had to get out of it. But, as time went by, we got another male nurse, and that made three of us. And after I'd been there about six, seven years,

¹⁰³ *DIN* 18, 13/02/97, Oral History: Mrs. S.D.

perhaps, the tables turned. Now, we couldn't do anything wrong. [...] They used to try and palm cases on to you. [...] And I stopped it for myself. Now, one of the other male nurses, the Matron stopped it for him, because he ended up ...he went on holiday, and be left 60-odd patients! And the boss said, "Now, where have we got all these from?" He said, "I picked them up here and there". All went back to the individual nurses. And they were told that they were not to do it anymore.¹⁶⁴

These and similar examples strongly suggest that male nurses experienced a difficult transition stage facing prejudice from some quarters before being accepted as district nurses, in many ways mirroring that experienced by women entering general practice medicine several decades earlier. For many years career development for male district nurses remained blocked, as this usually required a midwifery qualification, whether for entrance to health visiting or for promotion to supervisory level. Where women GPs had defended their right to treat male as well as female patients, so it was not until the mid-1970s that these gender barriers began to be broken down for male nurses working in the community.

Role of Welfare State: Changes in patients' needs and in nurses' relationships with patients and committees

In contrast, a change that was accepted most willingly and with immediate effect from the 'appointed day' in 1948, was the transfer from patient payment to government payment for nurses' services. 'Never again would they be required to look over their shoulders at the strivings of a hard-pressed voluntary committee to raise money for their services. Never again would they feel an obligation to assist at bazaars and local fetes, buy tickets for concerts, or function as uniformed exhibits in support of charitable appeals.' ... 'Sometimes the nurses had been required to collect or assess charges for their employing organisation'¹⁰⁶ Numerous nurses from my (primary series) interviewees described this last task as particularly unpleasant:

And in those days you also had to charge your patients for your visits, which obviously I didn't, but we had to you know officially (Prompt: Pre NHS?) pre NHS, officially you had to charge them half a crown per visit. Some patients had an insurance system which was called a Provident Scheme and they had the little yellow card on the mantelpiece so you could see it and our hearts just, you know, were very very pleased to see the little yellow card because it meant that you didn't have to ask them for half a crown. But just imagine an old lady given an enema and she could hardly afford to buy her meals and

¹⁰⁴ *DIN* 27, 18/05/00, Oral History: Mr. A. F.: left RAF medical corp and trained SRN 1946-7 (liverpool) then did QN and worked on the district at St. Helen's for many years.

Jo Digby, A., 1999, *The Evolution of British General Practice 1850-1948*: 154-186, describes the controversy over female doctors accepting male patients, and divisions amongst the medical elite and the general public, alike over, 'the suitability of women for general practice'.

¹⁰⁶ Stocks, M., 1960, *A Hundred Years of District Nursing*: 181-2.

she had to give you half a crown - you had to account for the number of visits. You had to do your accounting - number of visits money or insurance system - they had to equate and I remember more than once putting our own money in because you know if you didn't you were accused of not having done the visit. It happened relatively often, I mean those of us who were really committed and people couldn't afford to pay we just put our own half crowns in.¹⁰⁷

Another nurse described the transition as being quite confusing, especially for some elderly patients who believed non-payment to equate with charity:

....she said 'the envelope is in the hall on the hall stand', and I picked up the envelope and I went back to her, and in the envelope was half a crown, and I went back to the lady and I said 'I'm sorry but I don't know..'- 'Ob that's my, ..that's the money' - and I said 'no, no', I said, 'oh no it's all free now'. No way, no way, she wasn't going to have me if I didn't and I went back to the doctor. [...] He said 'if you can't use half a crown then' he said, 'forget it, but she must have it [her treatment] done'.¹⁰⁸

There was widespread fear of change, particularly in rural areas when the idea of re-grouping district nurses was put forward, fearing that, 'for reasons of economy of personnel and ease of administration [...] a village may find that the nurse is no longer living so near at hand.'¹⁰⁹ A nurse described the practicalities of how this relationship worked and the implications of reorganisation:

I had to live in the nurse's house, which was on a council estate and somebody was forever knocking on my door, or whatever, and if I thought they were having me on, I told them off. But nowadays the nurse does not live in the area. They have an office number, either at the surgery or otherwise. And I mean with new babies, I used to say, I don't mind when you telephone me, you know, as long as it's genuine, in the night or whatever and I will come. Well very rarely people rang me, because I had said I would come if you need me, so they felt reasonably safe, so you know what I mean.¹¹⁰

This loss of public recognition locally as *the* district nurse is a common theme noted by many when remembering the 1972 reorganisation. This was exacerbated by the almost universal move to car transport, which for many occurred around this time and meant that friendly meetings on the street were less likely to take place. In effect this increased the separation of

¹⁰¹ *DIN 01, 13/08/196*, Oral History: Dr. L. H. (see above).

^{10a} *DIN 18, 13/02/97*, Oral History: Mrs. S. D. (see above).

¹⁰⁹ Mc Master, A., 1948, "Are we to lose our nurse?" - Implications of the National Health Service Act 1948 in the Village', *Journal of the National Council of Social Services* (Autumn): 15-17.

¹¹⁰ SD/5, 17/07/98, Oral History: Miss S. A.: completed Nursery and Sick Children's Nurse training 1946 (London) then did QN training in Brighton working in Sussex as a district nurse for some time before training as HV.

the nurse from her local neighbourhood and was felt by some to be efficiency at the expense of community knowledge and personal identity:

We then went GP-attached, so you weren't actually in one area, you were all over the place ••• which had its advantages and disadvantages. Don't think you quite got to know the area, the patients in the area, the same, because you were actually specifically nursing a patient at that residence, not the whole street any more.¹¹¹

Rising numbers of public pressure groups bringing a new awareness of patients' rights, were aspects of the changing role and relationship between nurse and community in the late 1960s and 1970s that produced some of the most strongly-felt comments from the district nurses interviewed. This was felt to represent a wider social adjustment beginning some while after the NHS Act and the suggestion was made on several occasions that relatives were less willing (or able) to take such an active part in patients' nursing care and consequently co-operation had dropped noticeably. In addition there was felt to be less expression of appreciation or allowances made for flexibility of timing for visits. To what extent this is a case of remembering a 'golden age' that never really existed, is unclear. However, it was surprising to see this substantiated by one of the GPs who worked in Bolton, Lancashire, who remembered that in later years his district nurses 'had a very rough time, sometimes' as the 'irritable old people would expect them to arrive on the dot of nine o'clock [...] Oh, I've had to go on several occasions, and warn them off'.¹¹² In an address to a group of district nurses in Cardiff, a local GP described this changing public attitude: 'There is far too much demand from the public today, who grow helpless and less self-sufficient. More and more they make demands particularly in the industrial areas, on doctor and nurse. "I have a headache, doctor, is it safe for me to take an aspirin? A Sunday paper says it gives me ulcers".¹¹³

Roberts' study showed that despite popular perceptions to the contrary, there is little evidence to suggest a weakening of neighbourhood kinship attitudes in poor urban areas during this period nor that support given to elderly family members by the extended family reduced significantly before 1970.¹¹⁴ A nurse in Lancashire remembered this vividly:

Oh yes. Because I can remember ••• you'd get a patient in a street, and you'd go in, and there was no question of who would bring their dinner in. One of the neighbours would. (Prompt: there was always somebody?) Oh yeah. Or they'd come and make the bed, and they'd come and look after them, and they would ••• the only trouble was, if they

¹¹¹ *DIN*26, 18/05/00, Oral History: Mrs. E. P. (see above).

¹¹² CMAC/GP29/32, c1980, Oral History: R. H. C.

¹¹³ Petty, G. F. 1961, 'Patients, Nurses and Doctors', *DN*, 4(4 (July)): 76-78.

¹¹⁴ Roberts, E., 1995, *Women and Families. An oral history. 1940-1970*: 175-198.

knew you were a nurse, in that place ••• "Now, while you're here, nurse ..." And you'd have the whole street in!¹¹⁵

However, certain time-consuming tasks, such as bed-bathing, disappeared from the district nurse's list of duties in some areas by the late 1970s to be done either by Nursing Assistants or (more recently) by social service 'carers' whilst other 'menial' domestic tasks were done by the 'home help' service, although where these tasks overlapped, conflicts of interest could result. Indeed, Abbott claims that district nurses, in protecting their own status and professional expertise, were sometimes using a form of 'occupational closure' towards home helps in much the same way as GPs had previously done towards them by 'defining an area of expertise over which they claim a monopoly'.¹¹⁶ She recognised that there were 'grey areas' in the division of labour particularly following the introduction of home-helps and home care assistants. Her research suggested that whilst 'clients preferred nurses to perform personal care tasks' they 'expressed greater satisfaction with the home help service' largely because 'district nurses were seen to keep a professional distance and partly because of the working practices of the nurses.'¹¹⁷ Nevertheless, many of the (trained) district nurse's tasks involved much briefer visits to carry out specific procedures such as injections or dressings again resulting in a changed relationship and perceived role within the community as one of several health-workers and by several of the interviewees this was both regretted and to some extent also resented:

I think the Care Assistants have a certain training, but they can't always spot things the same as you would yourself. And to me, bathing was part of it. You got a relationship with the patient, sometimes some of them wanted too much of a relationship, should we say! But ...you noticed things. You could see whether they ...if they'd had a stroke, whether the grip was there, or whatever, or if they were covering up incontinency and things like that.¹¹⁸

This helps to explain an element of contradiction between the comments relating to changes in relationships with patients that had begun by the late 1970s and increased with the awareness of patients' rights in the 1980s and the earlier quotes claiming lack of recognition of the district nurse's professional status. According to the later comments, the patients seemed to show less respect for the nurse's authority as a detached professional, despite recognising her as a trained professional. It would seem likely that the answer to this enigma lay more in a change in the patient's self-perception as a client and with increasing access to

m *DIN27* 18/05/00, Oral History: Mr. A.F. (see above).

¹¹⁶ Abbott, P., 1998, 'Conflict Over Grey Areas': 15: District nurses and home helps providing community care', in *The Sociology of the Caring Professions*. P. Abbott, and Liz Meerabeau: 199-209.

¹¹⁷ *Ibid.*

¹¹¹ *DIN26*, 18/05/00, Oral History: Mrs. E. P. (see above).

information about his/her own care, rights and treatment, and that this change in attitude was not restricted to district nursing but applied to health care generally. In addition, by the end of the 1970s the public image of the district nurse had changed from a mixture of dedicated vocational, but familiar member of the community, to a less accessible member of a team who had abandoned some of the more 'female' roles or those traditionally associated with nursing.

The post-war period, in addition to undergoing considerable social change was also marked by rapid innovation within medicine and surgery. Elizabeth Roberts¹¹⁹ remarks on a rapid decline in infant mortality rates in England and Wales between 1900 and 1969 as signifying an overall improvement in health which accelerated in the post-world War II period and notes particularly the benefits of the NHS which had not previously been enjoyed by many women and children. She also comments that jobs previously done by older women in the community such as laying out the dead and caring for mothers and babies, were substituted in this period by 'professionals': 'there was a strong feeling that professional services were better than those provided by well-meaning amateurs [...] Increasingly, the advice of doctors and health visitors was preferred to that of older women in the family or neighbourhood.' She goes on to ascribe this to an increasing emphasis placed by government and the media on the value of expertise and professionalism. In the earlier, inter-war period, this had not been the case with the previous generation of women despite the fact that 'an increasing number of mothers had visited these [infant welfare] clinics'¹²⁰ and Roberts suggests this was responsible for a decline in self-reliance and self-confidence and towards a 'strong dependence on the professionals'.

Conclusions

1948 to 1979 was an era of numerous rapid changes affecting many aspects of district nursing and its professional standing. From within, the gradual loss of controlling influence on the part of the QNI made the first two decades of this period a low point for district nurse training and regulation, with a recognized curriculum based on just three months training only being introduced after a considerable battle. The weak position of district nursing as it fell under local authority control exposed differentials in salary scale, grading and status between district nurses and health visitors that contributed towards the creation of intra-professional rivalries standing in the way of true teamwork. On the other hand, the move away from the voluntaristic system and lay-controlled employment and into the National Health System represents a move towards professional parity with other nurses as pay and conditions of service gradually became standardized throughout England and Wales. Throughout the 1960's and '70's, changes in the nurse's role resulted from the introduction of new medically-

¹¹⁹ Roberts, E., 1984, *Women and Families. An oral history. 1940-1970*: 7. However, Hardy, A., 2001, *Health and Medicine*: 152-165, sees the impact of the therapeutic revolution since 1945 as 'variable'.

¹²⁰ *Ibid*: 146-7.

related technologies, improved transport and communications, the appearance of assistant and state enrolled nurses and male nurses to the emerging team, and the creation of the GP attachment system. The move towards more technical or sanitized tasks and equipment was accompanied by the need for nursing of more acutely ill patients in the community, due to rapid advancements in medicine and surgery throughout this period combined with changes in policy towards length of in-patient stays. Whilst this all combined to create a professional image more closely associated with medicine and the hospital it simultaneously removed the district nurse from her traditional one-to-one relationship with the community and thus from her professional autonomy.

This chapter has aimed to demonstrate that the post-war period was one embracing extensive adjustments made by district nurses in responding to the challenges presented by: evolving professional and public relationships; the changes resulting from a wide range of technological innovations; and enormous adjustments to their professional administration, organisation and training. By 1979 the primary care team had become a physical reality rather than an elusive concept, facilitating inter-professional interaction and communication. A shifting relationship with the community these nurses served also reflected wider social changes including a more critical public awareness of health issues. The difference between the ideals of the NHS and the realities of delivering a comprehensive 'cradle to grave' health service was often all too obvious in the profession of district nursing by the end of this period.

Part III
'Images and Identities: Cultures and
Professions'

Chapter 7 Bacup District Nursing Society, Lancashire - A Case Study

Section three of this thesis aims to look at the professionalisation process of district nursing over the sixty-year period of study focusing on aspects of professionalisation and their relationship to the emergence of a community care team, seen within the contexts of regionalisation and culture in several different parts of England and Wales. To begin this, a small-scale study allows detailed consideration of regional, local and personal diversities whilst testing and extending the generalised findings emerging from a wider study such as those presented in the previous chapters relating to professionalisation, working conditions, changing status and role of the district nurse. At the same time this case study presents a bridging opportunity between Parts 2 and 3 of the thesis in which principles of regional and cultural diversity as well as commonalities shared by regions or recognisable as national standards, can be explored in more detail. District nursing was essentially a 'local' service run by local volunteers and later by the local authorities. The relevance of this (albeit limited) application of community history¹ to the study of community nursing is of dual importance. Firstly it is in demonstrating the need to understand the immediacy of the effect of locality and local issues to the daily life and work of the district nurse in terms of changing social conditions, seasonal variations in patient demand and pressures of work. Secondly it is also helpful in exposing some of the underlying tensions of the pre-NHS employment relationships between the professional nurse and the lay district nursing committee that employed her.

It is therefore not intended for this case study to represent a 'typical' district nursing association, as each was at least to some extent, unique. However, there are many elements that have been found to suggest common experiences shared by other associations studied during this research, whilst some aspects may typify the more regional flavour to be discussed in the next chapter. In addition, there are valuable insights contained within committee minutes and the district nurses' and Queen's Institute Inspectors' reports, which shed light on the delicate relationship between the voluntary, lay administrators of this particular nursing association and its nursing staff. Whilst these cannot be held as typical, the problems they expose do typify the dichotomy of professional development examined in chapter nine i.e. considerable responsibilities and a large degree of autonomy of practice for trained professionals but employment and restrictive conditions of service controlled by a lay committee.

The records of the Borough of Bacup District Nursing Society were deposited with the RCN Archives in Spring 2002 and provide a comprehensive record of the underlying organisation

¹Drake, M., and Finnegan, R., Ed. 1994, *Studying Family and Community History 19th and 20th Centuries: Vol. 4 Sources and Methods: A Handbook*.

and of the work of the district nurses who practised there from 1915 to 1939, with some insight into its subsequent role as a 'Comforts Guild' following the NHS Act (1946).² Bacup is a relatively small industrial town with Stackstead as a similar, close neighbour. They are situated in Lancashire approximately halfway between Burnley and Rochdale (now served by the East Lancashire Health Authority). The nearest large town is Rawtenstall, seven miles west from Bacup, whilst the eastern boundary of Bacup is also the Lancashire/ Yorkshire boundary. The town's main industries throughout this period were textiles and footwear manufacture, with a small percentage of the population involved in coal mining, quarrying and sheep farming. The town of Bacup in 1974 had a population of 14,990³ but at the beginning of the twentieth century, this was considerably larger – over 25,000,⁴ a reflection of the fact that the Lancashire cotton industry had effectively peaked in 1914, at which point Bacup had 25 textile firms in operation, and was in decline throughout the period of this case study. The area has been described⁵ as predominantly 'poor' with mostly terraced or 'back-to-back' housing, as well as being in some ways rather insular – 'outsiders' are easily recognised as such partly because inhabitants have retained a distinct dialect (unlike much of Lancashire where this has been lost).



Fig. 7.1 Bacup town showing terraced housing⁶

The material relating to the Bacup's DNA consisted of: annual reports and accounts of, and listings of 'comforts' supplied by Bacup District Nursing Association Comforts Guild

² I am indebted to Mr. J. Hoyle LLB for his *helpful* comments concerning the town of Bacup and the organisation of the district nursing society to which his mother was Hon. Secretary for many years, whilst he is the only surviving member of the original Trustees of the Society's Patients' Comfort Fund which was finally wound up in 1985.

³ Bowden, K. F., 1994, The Book of Bacup: 86.

⁴ *Ibid*: 85.

⁵ My thanks to Dr. S. King for sharing his extensive local and demographical knowledge of the area.

⁶ Photograph reproduced by kind permission of Mr. S. Midgley of Bacup to whom I am indebted for help and advice on the history of Bacup.

following 1948, together with monthly reports of the nurses' work, assorted press-cuttings, stationery, pre-printed forms and receipts and minutes of meetings of the Borough of Bacup Sick Nursing Society spread between 1915 and 1948.

Bowden's excellent The Book of Bacup⁷ provides some vivid insights to the lives of the townspeople and the health and welfare problems encountered by the nurses on a daily basis – for example:

A typical Bacup house in the early 20th century comprised a living room/kitchen lit by a single incandescent gas mantle. All cooking was done on the coal fire or in the adjoining oven, and the kettle would often be permanently bubbling away ready for whatever meal or task was due. There was no bathroom – even in 1951 60% of Bacup's houses had no fixed bathroom; there was usually just a cold water tap downstairs over a shallow stone sink under the window.⁸

District nursing bed-ridden patients in conditions such as these would have been particularly difficult, heavy and time-consuming and emphasises the difference between hospital and community nursing. Problems such as incontinence would have been much harder to deal with, as would the observation of aseptic technique for performing dressings, for example, and advice on sanitation and diet may well have been given in the knowledge that in practical terms it was unrealistic.

The Society

The Borough of Bacup District Nursing Society was founded, as were many others, in 1897, at the time of the Queen's Diamond Jubilee and a considerable local fund-raising effort resulted in the purchase of a house at 33 Dale Street, a fairly central and mainly residential location of terraced housing, in 1906. The economic foundation of the society was based on charitable collections and fund-raising events such as concerts and proceeds from productions by the local amateur dramatic society. However there were sizeable monetary gifts from time to time, reflecting philanthropic support from local dignitaries such as Sir Henry and Lady Maden, and Mr. Alfred Edmonston, as well as the key role played by the Bacup Hospitals Charities Committee. Nothing appears to have survived relating to the work of the first nurse(s) appointed, until it is recorded that Nurse D. and Nurse A. practiced there from 1915 to 1920. From January 1915, a detailed monthly record of their work and that of their successors survives giving numbers of cases nursed and visits made, often incorporating detail of outcomes and particular problems encountered - this will be considered below.

⁷ Bowden, K. F., 1994, The Book of Bacup.

⁸ Ibid. p.47.

Minutes for The Borough of Bacup Sick Nursing Society⁹

The first minuted account available refers to a meeting held on the 16th January 1924 which notes previous minutes having been read and signed, but these have also not survived. The nurses' reports for the previous month were read as was done at every subsequent meeting, although there is never any record of any direct comment or discussion on these. In addition an agreement was reached to order a water-bed and pillow 'for the use of patients' to be paid for out of the Society's funds and it was noted that 'the Todmorden Corporation were willing to grant free bus passes to the two nurses'. As this area is extremely hilly - treacherously so in winter conditions - this would have represented a considerable relief to the nurses, who according to the society's minutes, travelled either by bicycle or public transport (bus or tram), with no other form of motorised transport until a car was bought in 1942.

However, the main discussion focused around fund-raising activities (Dramatic Society's play, 'Alexandra Day', the 'Christmas Doll Draw' etc.) and in co-opting new committee members - a process arrived at by general consensus on this and future occasions. Another aspect of the committee's work each year involved making the arrangements for a holiday relief nurse. The same nurse (Nurse H.) was appointed through the Secretary for several successive years, and was paid £2.0.0 per week with the nurses being obliged to take their whole month's annual leave at one time, according to dates largely dictated by the committee. Later on a correspondence was entered into between the QNI and the Committee agreeing to a suitable temporary appointment but it was not until 1936 that it was decided that the nurse should interview and brief the relief nurse, and advise the committee as to her professional suitability. Also at the January meeting in 1924 the proposed Pension Scheme for the nurses was discussed resulting in a decision, recorded at the January meeting in 1925, to abide by the recommendation from the QNI that £3 was to be paid per nurse by each association to give a pension of £20 per nurse after 21 years service or at the age of 55. In March 1930 a discussion centred on the proposed increases of QNs' salaries and eventually it was agreed to provide an increase to the commencing salary of £70 per annum rising £5 annually to £80 'and where midwifery is practised to £90' (a new scale came into force in 1937 by which time both nurses were on maximum salary of £100 p.a. and at which point the QNI Long Service Fund also became active). The September meeting received notification that the Public Assistance Committee of Lancashire County Council 'have decided to make a grant of £10.10.0 towards funds' of the Association for 1931 raised to £16 the following year.

In July 1931 a meeting of the County Nursing Association was reported in the society's minutes providing an explanation of the proposed superannuation scheme, which was

⁹ Bacup District Nursing Association Comforts Guild, 1915-1943, RCN Archives: C444: Monthly reports of Nurses' Work (January 1915-February 1923), (March 1923-July 1931), (September 1931-April 1943).

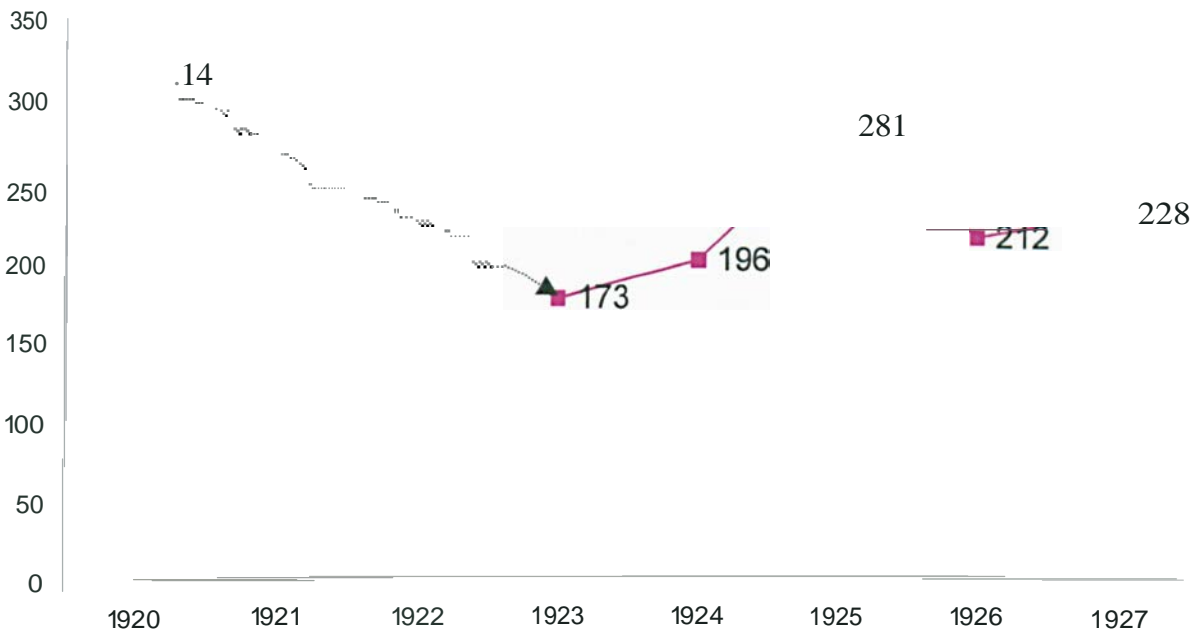
discussed and a decision arrived at to join the scheme. It was also the role of the county association to advise on purchase of new equipment - for example a sterilizer was recommended by the county advisor and its purchase was approved following this particular meeting. This seems a fairly minor piece of apparatus now, and has been superseded by pre-packaged disposables, but at the time would have made a considerable change to the daily round for the district nurses and their patients. It is perhaps significant that the nurses, in common with most other district nursing associations, did not attend these committee meetings, and there is no evidence to suggest that their views were represented. If this was the situation, they would have had little influence on the outcome of such discussions despite the fact that these and similar items would have directly affected their daily work. This did change slightly towards the end of the 1930s and during wartime, for example in 1939 on several occasions one of the nurses was invited into the committee meeting to discuss the inspection and availability of appliances supplied to patients by the association. When reporting in 1940 that their cases had become 'quite inadequate for carrying all the appliances which they needed in order to perform their duties successfully', one of the nurses was invited to demonstrate the problem resulting in a decision to purchase two new 'regulation' bags.

Other pressures impinging on the nurses from the committee were sometimes a result of national policy, for example a letter was read at the September meeting in 1924 from the Ministry of Health with regard to an application made by them for a midwifery grant that stated, 'it is regretted that on the basis already adopted for assessing such grants to Nursing Associations working in Urban Districts in England, no grant is this year payable to the Bacup District Nursing Society.' Nevertheless it was also minuted that the Queen's Institute Inspector's Report had noted that whilst there were currently no midwifery cases on the books at the date of visit, 'this branch of the work appeared to be progressing well - the patients seen were being attended with care and skill'. Immediately after this a large amount of equipment was purchased 'for the nurses bag', listed as: '1 Pelvimeter, 3 forceps, 3 probes, 2 pairs scissors, 3 clinical thermometers, 1 bath thermometer, 1 pair balances, 1 spatula, 1 kidney tray, 2 nail brushes, plus lint, gauze, cord dressing and ligature' - it would seem highly likely that this was intended to support a move to increase midwifery practice. By 1927 the annual report notes midwifery fees had risen to £104.17.6d - representing more than two-thirds of the total income (£144.13.6d) from fees and subscriptions and cases had risen from 45 recorded in 1924 to 59 in 1927. However, a special meeting was held just two years later, in 1929 'to consider discontinuing the midwifery side of the work as there are now 5 midwives in the town and the work has also been taken up by the poor law authority at 'Monlands' where a new block has recently been opened'. It was therefore decided to discontinue this aspect of the work apart from emergency cases - there is no record of any formal discussion having taken place to consult the nurses on this decision.

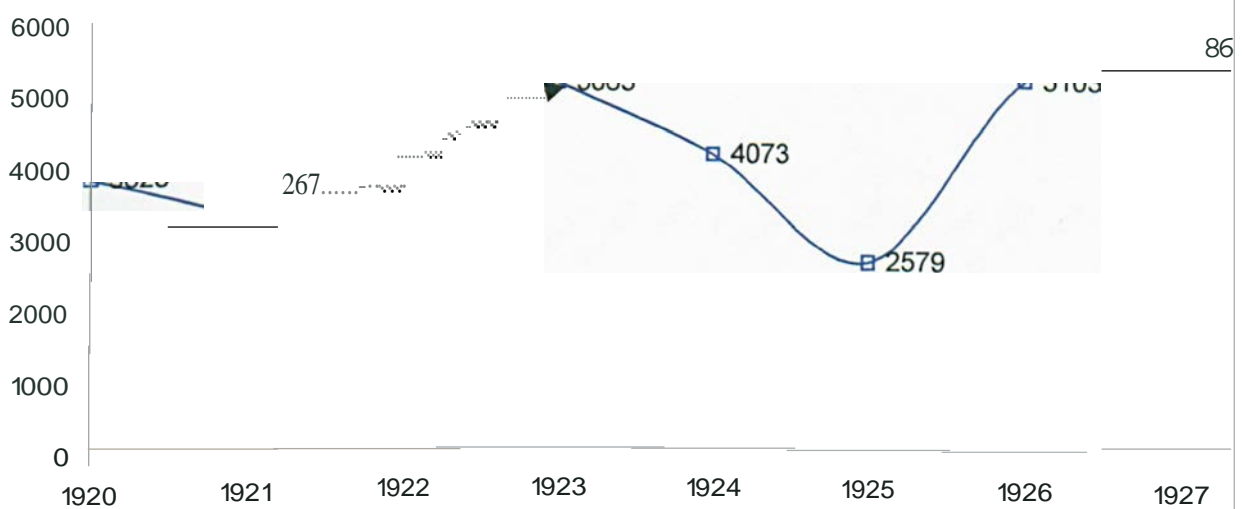
At the January meeting 1925, 'A discussion took place on the increasing work of the nurses and it was suggested that local help be obtained when necessary as in the case of illness of either nurse or rush of work'. It can be seen from Graphs 7.1 and 7.2 that although the total number of visits over the year actually decreased, and a steady fall in numbers of visits can be seen from a high point reached in 1923, nevertheless there was a significant rise in the number of cases that year, and by 1926 the numbers of visits had again risen sharply. Furthermore, monthly records kept by the nurses show this rise to have occurred over the two months of January and March both in Bacup and Stackstead, so that the nurses would have felt severely pressured by 'rush of work' - graphs 7.3 and 7.4 showing these monthly figures for Bacup plotted on a five yearly basis revealing January to April as consistently heavy when compared with Summer months. (A full table of monthly records for both Bacup and Stackstead are provided in Appendix C) If these graphs are compared with the nurses' workload graphs in Chapter four (Graphs 4.3 and 4.4) it will be seen that the Bacup nurses workload does indeed fall in the average to higher-than-average range for cases nursed and visits made. For example the 1925 national figure averages at 3235 visits per year, and whilst Bacup fits slightly below this in 1925 with 2579 visits recorded, the previous year the figure had been 4,073 and in 1926 it had risen to 5,103. Likewise, cases attended nationally in 1925 average at 153, in Bacup the nurses attended 281 cases.

Ten years later, the heavy workload became a cause for concern to the Queen's Institute's Inspector, whose report in January 1937 was noted in the committee's minutes: 'the size of the population and amount of work to be undertaken indicate the need for an additional nurse.' However, this does not appear to have been addressed at the meeting and there are no records in later minutes to suggest the committee discussed the issue and the minutes usually record that 'the nurses' report was read with no comments being made'. Interestingly, the exception to this arose in January 1940 when it was noted that numbers of visits in the Stackstead district were always greater than in Bacup although numbers of cases were less. The committee asked the nurses for clarification of this apparent anomaly and it was explained that they helped one-another with visits when one district became more busy than the other, but that the cases recorded referred only to their respective districts. This is revealing in demonstrating the lack of the committee's awareness of the nurses' daily routine, and supports the idea that in their work, district nurses possessed considerable professional autonomy through the inter-war years, yet lacked independence from the 'Committee of Ladies' in other ways. For example, in 1941 the nurses made a request to the committee that they might be allowed to sleep out on their half-day holidays and this request was referred to the County Superintendent. The verdict was that they could only take the half-day each week and one weekend per month 'except in unusual circumstances' so had to be back in the home that night.

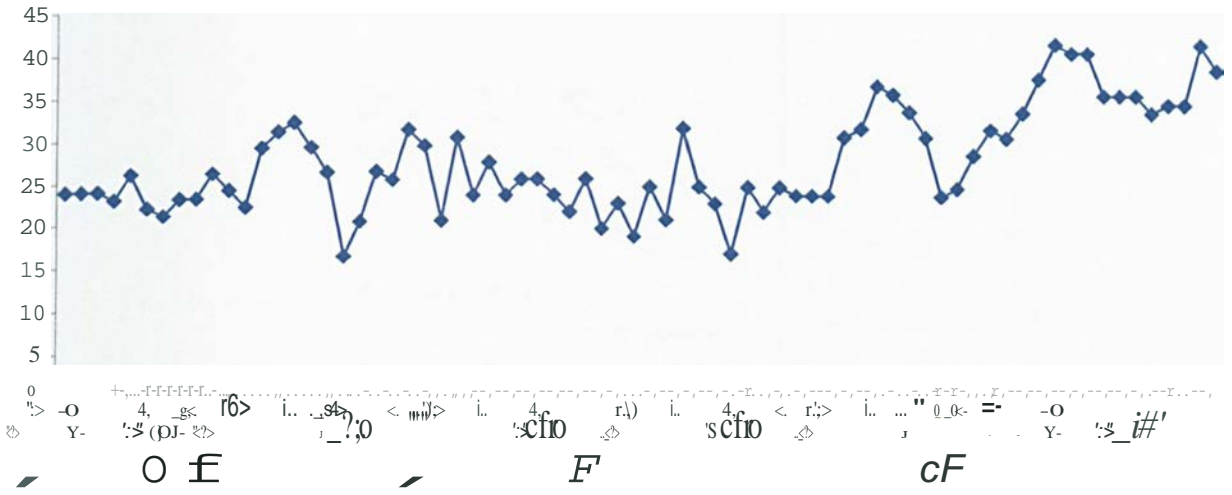
Graph 7.1 District nursing cases attended annually, Bacup (1920s)



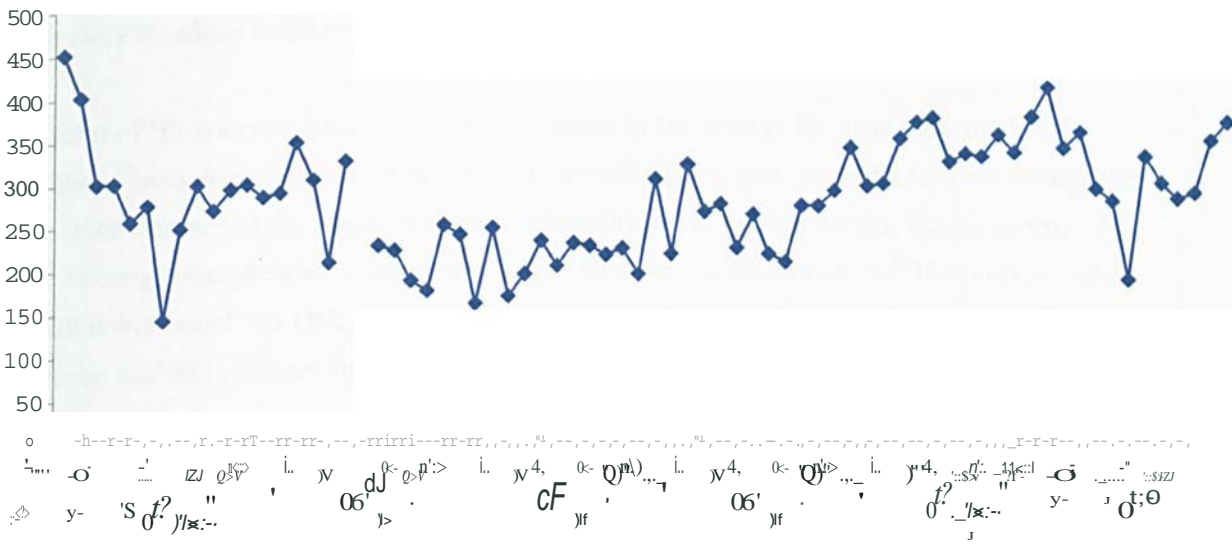
Graph 7.2 District Nurse's annual total visits, Bacup (1920s)



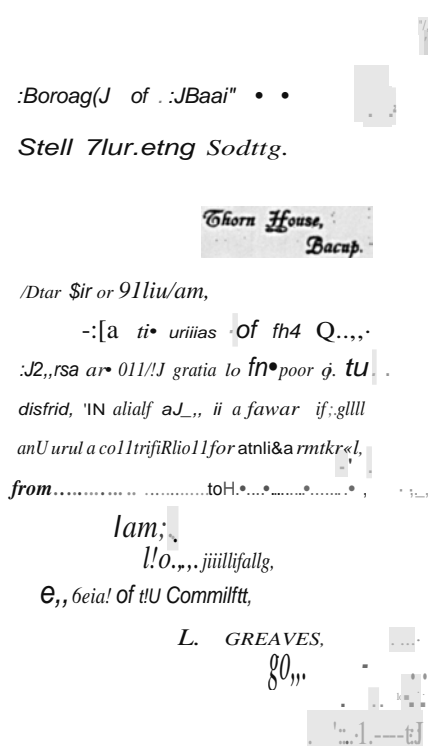
**Graph 7.3 District cases nursed at Bacup on monthly basis
(5 yearly intervals, 1915-1940)**



**Graph 7.4 District nurse's visits for Bacup, monthly figures
(5 yearly intervals, 1915-1940)**



employing QNs, the Society were committed to operating on the understanding that nursing care would be provided to the 'sick poor' without charge. However, others apparently availed themselves of this service from quite early on and, by 1915, it was felt necessary to request a financial contribution from these patients:



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Fig. 7.2 Bacup Sick Nursing Society: Request for Contribution for [District Nursing] Services Rendered c.1915 ¹⁰

A form of 'Provident system' was first introduced in 1926 under the local Hospital Fund Scheme'¹¹ and eventually the 'Penny a week' subscription system was adopted, but throughout the inter-war period the Borough Hospital Committee was responsible for a large portion of the Society's income giving grants which annually totalled £300 or more.¹² However, in July 1938 it was noted in a QNI Inspector's report read before the Committee, that a Provident scheme had still not been fully adopted and a more strongly worded recommendation was

¹⁰Bacup District Nursing Society, 1915-1948, RCN Archives: C444: Assorted press-cuttings, stationary, pre-printed forms and receipts.

¹¹ Fox, E., 1996, 'Universal Health Care and Self-Help: Paying for District Nursing before the National Health Service', *Twentieth Century British History*, 7(1): 83-109, notes that the contributory schemes developed in many urban districts, 'had much in common with the contributory schemes that were being developed by voluntary hospitals, sometimes collaborating with them but sometimes competing'.

¹² The Society's minutes for May 1928 show the grant received from the Hospitals Charities Board for the previous year was £325 and grants applied and received in subsequent years regularly compute to similar amounts.

lodged in 1939 stating that a Provident scheme should urgently be adopted 'so that everyone needing nursing care should be able to avail themselves of this service'.¹³

The ties with the Hospital Fund Scheme effectively reduced the society's allegiance to the QNI and the communication with the Queen's Institute over Queen Alexandra's memorial exemplifies this, with regret being expressed that 'owing to the state of trade in the town, it would not be possible for the committee to undertake any collecting', and two years earlier, it was decided that the Alexandra Day collection could no longer be supported by the Society 'owing to the express wish of the New Borough Hospital Committee with whom we have now to work and on whom we are now dependent for our funds'. As with many other urban district nursing societies, co-operation in payment through work-based contributory schemes was also solicited from local employers -for example, a letter was sent in 1937 to the 'Shoe and Slipper Operatives Union Insurance Society at Bacup re. payment for nursing services to their members'¹⁴ and I am assured that some local employers did co-operate in this way as well as providing generous donations to the society from time to time.¹⁵

In May 1928 it is recorded that a County Nursing Association was to be formed for Lancashire to which the Bacup Society might wish to affiliate. Advantages were presented in the minutes as, 'Providing:

1. A means of regular, frequent and common council
2. Immediate consultation with County Superintendent
3. Supply of permanent staff
4. Expert professional advice for staff in difficult or emergency matters
5. Increase of revenue from statutory grants which are now largely unapplied for [sic]
6. In general, the non-assessable strength and status to be derived from association and the benefits accruing from unity.

The advantages to be bestowed:

1. Concerned for the un-nursed areas, and participation in a County effort intimately affecting the homes and the well-being of the people of Lancashire.

¹³ from the early 1930s this had been the preferred system supported by the QNI with Miss Peterkin explaining in 1931 that the urban system differentiated from the rural provident system of 'penny-a-week' minimum subscriptions from each household, in that it relied more on arrangements with Public Health Authorities, plus charging fees for service given according to means, and 'charitable subscriptions, house-to-house collections or whatever method of raising money is best suited to the particular locality.' see Peterkin, A. M. 1931, 'The Scope and Conditions of District Nursing', QNM XXIV(5): 128-132. From 1934 a Provident Organiser was appointed to promote this concept primarily at urban areas such as Bacup.

¹⁴ Bacup District Nursing Society, 1924-1939, RCN Archives: C444: Minutes for Borough of Bacup Sick Nursing Society (January 1924 - November 1939): minutes for March 1937.

¹⁵ Personal communication, Mr. J.M.D. Hoyle. -also evidenced in a letter to 'Shoe and Slipper Operatives Union Insurance Society in 1937' re. payment for nursing services to their members'.

2. Co-operation with adjacent associations to mutually arrange nursing boundaries so that not one household is unprovided for.

3. Experience gained in health development and participation in all the Maternal Health Movements proceeding on every hand.'

After some discussion it was decided to join the proposed County Association, and at a subsequent meeting it was revealed that of the 134 nursing associations at work within the County of Lancashire, 110 had decided to affiliate. It should be noted that in this decision, as in many others concerning the membership of largely working-class subscribers or contributors, the decision was taken by the committee, which generally comprised the wives of the employing and professional classes of Bacup, with no referral to the subscribers. This was generally the practice with most district nursing associations' committees at this time.¹⁶

The nurses and their clinical work

Nurses D. and A. ran the neighbouring districts of Bacup and Stackstead jointly from 1915 to 1920 being replaced by Nurses H. and N. in 1920, who left in 1925 to become Health Visitors in Manchester - quite a common cause for resignation in many district nursing associations, nationwide, and apparently a natural step in professional development rather than signifying a permanent move across to health visiting. Nurses M. and B., both previously working in Huddersfield, replaced them. Interestingly it was only felt necessary for the Executive of the Committee to interview one of the nurses as they were friends, and the two stayed until 1938. The next two nurses to be appointed were only in post through the war years, but were followed by another pair who stayed at least fifteen years. This pattern of staff turnover was fairly average, although many nursing associations had a more rapid movement of nursing staff responding to local and regional variables, as will be seen in Chapter 8. References to the actual work carried out by the nurses is comparatively rare throughout the twenty-eight years of reports and minutes studied, however the monthly reports in 1915 and 1916 record school inspections for the second half of the year and these are quite revealing as well as confirming that at this point school nursing was included in their work.

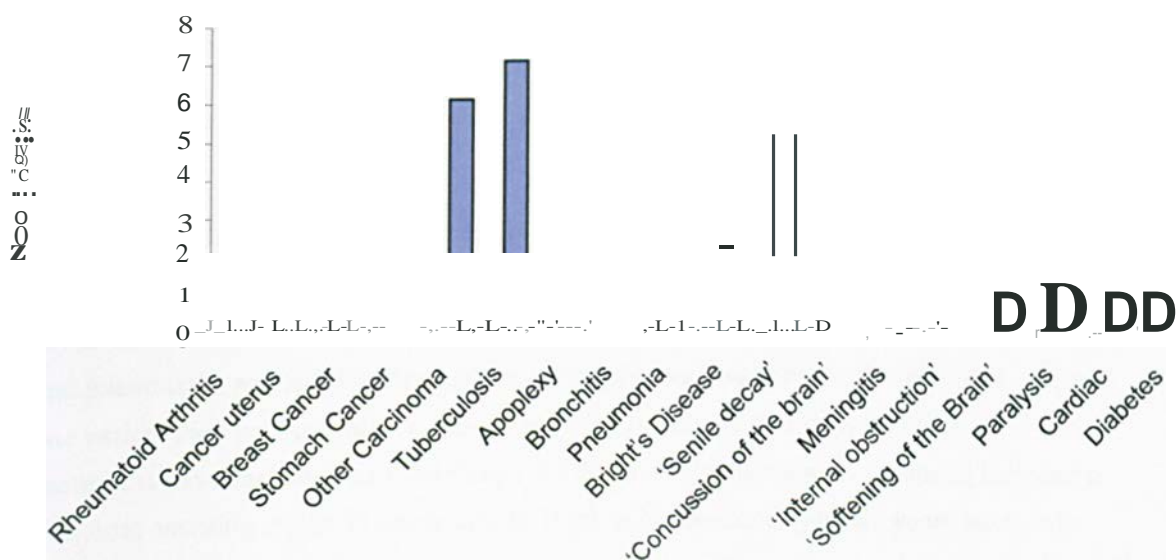
The report of June 1915 notes that the cases being treated included ringworm, sore and dirty eyes and conjunctivitis, discharging ears, 'sore and filthy heads', 'verminous bodies', sores on face '(due to dirt and neglect)'. The number of children receiving attention in June was 290 - this included 176 seen at the clinic and a further 96 who received home visits - no details are given for the remaining 12 children seen. Although numbers seen in clinic during the winter months are rather smaller (the November and December clinic attendances were

¹⁶Fox, E., 1996, 'Universal Health Care and Self-Help: Paying for District Nursing before the National Health Service', *Twentieth Century British History*, 7(1): 83-109.

down to 71 and 119 respectively) numbers of home visits rose substantially (to 66 and 78 over the same months). It is likely, therefore, that the nurses saw their role as including an educational remit, visiting the homes to advise mothers on bodily hygiene, diet and child-care.

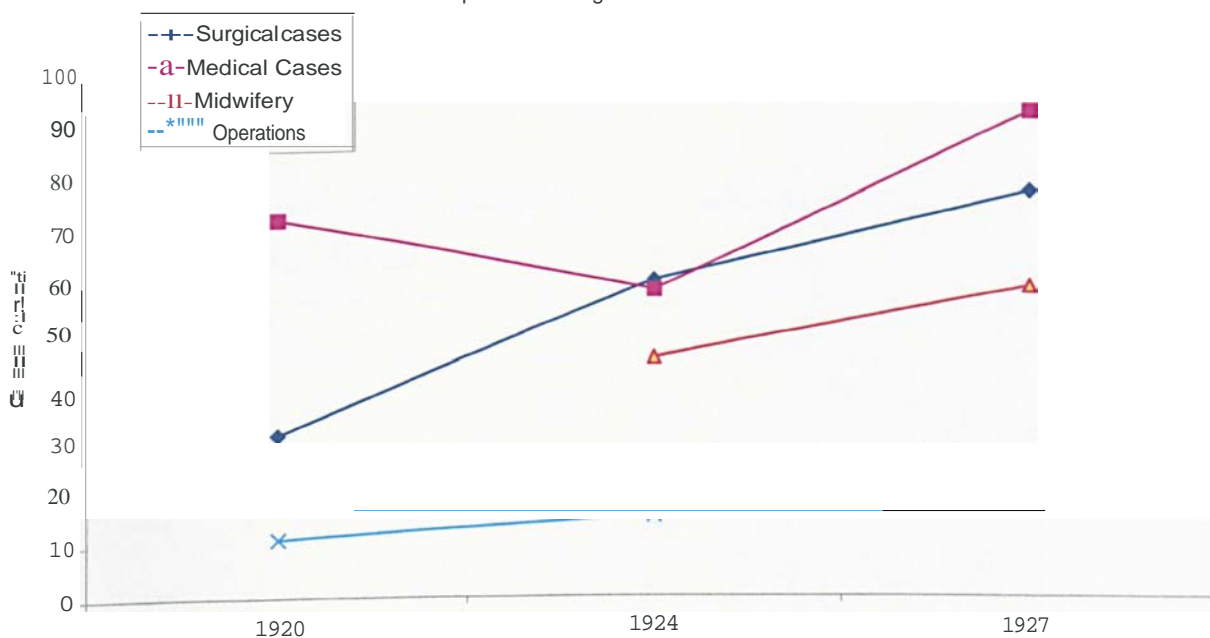
Nevertheless, the main part of their work at this time was evidently domiciliary nursing, and deaths of patients recorded by the nurses that year have been collated and are shown below (graph 4.5) with cancers, tuberculosis and 'senile decay' making up a high proportion of the terminal care nursing provided – a total of 43 that year.

Graph 7.5 Causes of death, Bacup (1915)



In 1920 the new nurses, Miss D. and Miss C., no longer recorded school visits, but causes of patients dying on the district were still recorded with a subtle change in nomenclature: Cancer of Liver (3), Cerebral Tumour (1) Sarcoma of Breast (1), other Cancers (2) Phthisis (Tuberculosis) (2), Pernicious Anaemia (1), Cardiac and/or Brights Disease (5), Cerebral Haemorrhage (4), Senile Decay (6), Abscesses of head (1), 'Double Pneumonia' (!), Injuries caused by accident (1), Pleurisy (1). The total number is 29 – almost 1/3 less than in 1915. Of the total cases for the year, 31 were surgical and 72 medical with 11 operations. The notes suggest this is a big drop in numbers compared with 1919, but the general trend in all these areas may be seen in Graph 7.6 to be an increase in workload.

Graph 7.6 Nursing work 1920-1927



From 1923, midwifery fees were recorded -the nurses in 1925 were nurses H. and N. and by this stage, midwifery seems to have become well established. Also there were fewer deaths although the prime causes of carcinoma, cardiac failure, senile decay, phthisis and pneumonia, remained unchanged. Interestingly there was one death due to malaria, and one patient died post-operatively, however unfortunately no details were given on either of these. It is nevertheless clear from Graph 7.6 that a steady increase in workload included a rise from assisting at just 11 operations in 1920 to 21 operations just six years later and a formidable increase in surgical cases nursed combined with the introduction of midwifery, (in itself very time-consuming). Medical cases remained the highest demand of all, and would probably have also presented the heaviest demands on the nurses' time and energy, since general nursing care such as bed-bathing and care of pressure areas in these, often chronically sick patients, would have been especially challenging given the domestic arrangements described above. Lack of data against which to compare these figures makes it impossible to claim this was typical, nationally, but emphasis on these aspects of nursing care in district nursing handbooks from the 1930s¹⁷ would suggest this was probably the case. This combination of factors would suggest a fairly close working relationship throughout this period between the GPs in Bacup and the district nurses, as well as with the local hospital, with which the District Nursing Society had direct financial links. It also fits the picture outlined in Chapter 4 of a situation of professional respect, albeit at a distance, between GP and QN. Nevertheless, a significant comment made at the meeting in January 1924 noted: 'It

¹⁷See for example: Merry, E. J., and Irven, I. O., 1948, *District Nursing: A Handbook for district nurses*; and 'Some Queen's Superintendents', 1932 and 1943 editions, *Handbook for Queen's Nurses*.

was resolved that stamped envelopes be provided for the doctors' use, where the communication to the Nurse is of a private character. 'Clearly the nurses did not see the GPs on a regular basis, even though their services were well recognised and used by them, suggesting a fairly autonomous mode of practice.

Queen's Institute
for Nurses.

MESSAGES AND DIRECTIONS.

Order.11

Date
Name
Address

Result Date

NIUH

This side to be used only by Doctor and Nurse for Interchange of Directions and Messages.
Dated, Signed and Mailed.

L. W. Brotherton 7th Edition, London, 1927

Figure 73 QVJ1N Nurse-Doctor Message Sheet: note comment, 'This side to be used only by Doctor and Nurse for Interchange of Directions and Messages.'¹⁸

A further note relating to professional recognition is a comment noted at the May 1926 meeting that any nursing requirements could 'now be bought at Messrs. Boots Ltd. by the nurse with a professional discount of 10% for cash'.

Regular visits from Queen's Institute Inspectors were paid on an approximately six-monthly basis and are briefly reported in the Committee's minutes – comments always stated that standards of nursing were found to be good, but a subtle change to the previously fairly standard wording was noted in the report for January 1927 which may reflect a change of emphasis on the part of the inspector. Observations such as: 'the nursing technique was good' and in addition to the usual comments concerning the nurses' books and bags being in good order, it was also noted that 'nursing appliances' were found to be 'correct and tidy', whilst in November 1929 the Inspector noted, 'Sound methods, modern technique and comprehensive

¹⁸ Bacup District Nursing Society, 1905-1948, RCN Archives :C444: Assorted press-cuttings, stationary, pre-printed forms and receipts.

individual care characterised all the work seen with the nurses' and similarly in 1939 nursing care was described as 'comprehensive and skilful'. It would seem reasonable to conclude that this change marks an adjustment to the concept of what it meant to be a professional district nurse, representing a move away from the image presented by neat and tidy uniform, bags and record books, towards a more detailed assessment of the techniques of nursing practice and familiarity with modern methods. The possible reasons for this move will be examined in Chapter nine. However, the change in professional emphasis did not appear to extend to the Jay committee recognising a responsibility to provide any support for the professional development of their nurses, as the January minutes also records that 'to attend a 5 day course of lectures in London, N. Bonham was forgoing her usual weekend holidays'.

In 1935 it was suggested that a telephone might be installed in the nurses' home as 'hitherto neighbours had kindly conveyed messages to the nurses' but that this was now becoming 'rather troublesome' because of the number of calls being made. Also comments were made in the minutes on the off-duty system in which each nurse has one day off each fortnight, taken in alternate weeks in order to provide continuous cover. A major concession appears to have been leave of absence granted for the nurses to attend the Jubilee inspection at Buckingham Palace on 16th June 1937. Interestingly, insurance certificates for the Nurses' Home for 1930 and 1935 cover two nurses and one domestic servant and public liability cover included an allowance for claims for 'compensation due to negligence of the nurses' indicating the overlapping of concerns of employment by a lay committee with the professional concerns of the nurses' practice.

However, the main concerns of the committee appeared to revolve around renovation of the nurses' home at that time - indeed, repairs and renewals for the home occupy a considerable amount of discussion at every meeting! A member of the committee who was responsible for overseeing repairs and renewals regularly inspected the Nurses' Home, which appears to have been reasonably comfortable according to QNI Inspectors' reports, but one is struck in reading these by the lack of privacy and independence given to the nurses. In fact, in 1940 the nurses requested that a change of the committee's 'Visiting day' be arranged so that both nurses could be present when their home was to be inspected.

Nurses M. and B. continued in post up to 1938 when Nurses H. and R. took over for just three months (probably temporary postings by the QNI) and were succeeded by Nurse W. and Nurse D. until 1941 i.e. just two years. There were very few midwifery cases and deaths were no longer regularly recorded in any detail although when they were the illnesses they were suffering from remained largely unchanged. The dismissal of the two nurses in May 1938 makes interesting reading and reinforces the concept of

duplicity of professional status: In April 1938 several special meetings were held to resolve a problem that had occurred concerning the two nurses. The outcome was that both nurses were requested to send in their resignations receiving one month's pay in lieu of notice -this demand was in fact supported by the QNI County Superintendent. At this time Nurse B. was seen by the doctor and pronounced unfit whilst Nurse M. was away on her annual leave! A subsequent meeting was held with Nurse M. who was 'allowed time to consider resignation'. Nurse B's resignation was received a week later, and although she wrote soon afterwards stating her health was now much better and she would like to withdraw her offer of resignation and be allowed to return to her post in Bacup, this plea was refused by the committee, and Nurse M's resignation was received at the next meeting (at the end of May). The Secretary having received two report forms from the Queen's Institute regarding Nurse M. and Nurse B., was requested to fill these in and return them to the General Superintendent for inclusion in their professional records. Both nurses were to be interviewed by Miss F., the County Superintendent. I am reliably informed¹⁹ that the main cause of this rather drastic action would appear to have been a personal rift between the two nurses over a marriage proposal made by the widower of a patient nursed by them both. Following this episode the rules of the association were updated to include a number of restrictive clauses including:

The nurse shall not talk over personal matters with patients and their friends.

The nurse shall abide by the rulings of the Lanes. County Nursing Association and the Queen's Institute

No pets shall be allowed in the home

The nurses shall take holidays in the regulation manner, a month's holiday at once, and each nurse separately

The nurses shall take duty in alternative districts

After this incident a considerable amount of renovative work was done to the nurses' home which appears to have required redecorating and some refurnishing.

Wartime and post-war changes

There were several changes of appointment during the Second World War and little can be deduced about the work and conditions of service of the nurses over that period. The area apparently only suffered one air raid and minimal war damage, however from early 1939 they were required to work with the local Medical Officer of Health Dr. McKinney, at the borough first aid posts as part of the 'Air Raid Precautions Scheme' and they received the necessary training for that work later the same year.²⁰ However the statistics of visits paid and cases nursed for the final two years leading up to the inception of the NHS, have survived and are

¹⁹Personal communication, Mr. J.M.D. Hoyle.

²⁰Bacup District Nursing Society, 1924-1942, RCN Archives: C444: Minutes for Borough of Bacup Sick Nursing Society (January 1924- April 1942): Minutes of meeting held 06/03/1939.

tabulated below (Table 7.1). These show a rise in medical and surgical cases attended in 1948 despite an actual drop in numbers of visits made. Also, comparing these figures with those for the 1920s shown in graphs 7.1 and 7.2 the rise in workload is very noticeable from 5,000 visits per year to 8,000 and between 200-300 cases annually to between 300 and 400. It is evident from this that the district nursing service was not only being fully utilised, but that the nurses were coping with an extremely heavy workload. Nevertheless 1939 appeared to mark an increased effort to raise public awareness of district nursing, firstly through the use of a 10 minute film about district nursing and the district nurses role. This was shown at the Regal Cinema for the first week of October 1939. Also it was minuted that the QNI gardens scheme posters advertising participating gardens in Lancashire were to be distributed to local mills and workshops and posted on placards throughout the district, however this would seem to be more a matter of keeping in line with the county association rather than an attempt to raise the caseload of the nurses. By 1940 holiday relief had become a problem as war work meant that relief nurses were scarce, and in April 1940 the QNI Inspector 'strongly recommended an auto-car or auto-cycle for use on long-distance cases' -after discussion with the nurses this matter was left, but re-emerged soon after the appointment of two new nurses the following year. The hospital committee felt unable to provide funding for this and money was instead raised by the mayor through public appeal, flag-days etc. In the interim, local residents provided transport on Sundays, when public transport between Bacup and Stackstead did not run.

Table 7.1 Visits paid and services rendered by Bacup District Nurses (1947 and 1948)²¹

Services Rendered	1947	1948
Visits Paid	8951	8023
Cases on books at beginning of year	49	60
New cases attended	291	327
Total cases attended during year	340	389
Number of Medical cases	112	115
Number of Surgical cases	179	212
Number of Operations	16	21
Number of cases nursed back to convalescence	217	259
Number of cases transferred to Hospital	24	29
Removed from books for other causes	2	2
Deaths	37	46
Remaining on books at end of year	60	51

²¹ Figures taken from Bacup District Nursing Association, 1931-1948, RCN Archives: C444: Annual Reports, Accounts and Insurance Policies of Bacup District Nursing Society, SOtb Annual Report (1948)

Bacup after the NHS Act: -

The report of the Annual General Meeting for 1948 notes that the two nurses were continuing to live in the nurses' home for the time being and shared a car bought by the Society in 1942, but this had been found to be unreliable causing the nurses considerable trouble and a new one had been ordered in 1946 but despite 'Medical and Nursing Services are supposed to be endowed with some degree of priority of delivery but this has not worked out in practice'. The report also notes the continuation of the 'Penny a Week Fund' stating, 'it is regrettable that just at a time when the Society has reached a stage when financial worries considerably lessened there should be a prospect of having to cease its voluntary work and hand over to a state machine which, though it may be perfectly efficient, it is felt will not provide that personal and knowledgeable contact which a voluntary service can furnish.' This voices fears that must have been felt in many district nursing associations at the prospect of a local authority taking away not only the powers of the local committee, but their distinctive local knowledge and the personal touch of the voluntary committee member.

However, the report of 1949 notes that the transfer of responsibility for district nursing took place 'in principle' but the Society continued its services until 30th September 1948 at the request of the Medical Officer of Health. It records that the Nurses' Home and two cars (one still pending delivery) are 'still to be paid for -under negotiation' -the money from the sale of these assets were then invested in the newly-formed Comforts Guild (see below). A third nurse had also been appointed since the State took over but her name does not appear in any records. Two articles published in the local press noted the continuation of the QNI's contribution to district nursing in the town, ten years after the NHS Act (1948). The first stated that the two QNs working at Bacup 'have been here for upwards of 15 years [...] The Institute is entirely responsible for the present high standard of nursing amongst those who are proud to wear the title "Queen's" on their uniform, and jealously upholds the qualification and professional integrity of its members.'²² Whilst the second refers to the QNI's Centenary District Nursing appeal for £250,000, 'largely to support training and expansion of QNI's valuable work' and referring to the work of the QNs in Bacup.²³ In fact, despite the fears expressed at the inception of the NHS, the nurses (Nurse Cummings and Nurse John) who were appointed in 1944 remained in post at least 21 years, presenting a hymn book to the Trinity Baptist Ladies' Fellowship to record this fact in 1965.²⁴ This is significantly longer than any of their predecessors, and may reflect a happier working relationship. In line with

²² Bacup District Nursing Society, 1915-1948, RCN Archives: C444: Assorted press-cuttings, stationary, pre-printed forms and receipts.: (05/09/1959) 'District Nursing -National Appeal: letter from Mrs. E. Hoyle, J.P.' The CBacup Times 3.

²³ Bacup District Nursing Society, 1915-1948, RCN Archives: C444: Assorted press-cuttings, stationary, pre-printed forms and receipts.: (05/09/1959) 'District Nursing Movement is 100 Years Old: Voluntary system still a feature' The CBacup Times 4.

²⁴ For this information I am indebted to Mrs. Sue Hargreaves, a resident of Bacup.

most other district nursing associations, the nurses would have been provided with (rented) living accommodation by the local authority, which must have been quite liberating after the somewhat restricted lifestyle of the nurses' home.

from the earliest minutes available there are mentions of regular contributions of bedding and clothing being provided through the East Lancashire Needlework Association. Likewise, larger items such as a water-bed and pillow, bought by the Bacup District Nursing Society in 1924, were provided as nursing aids and patient 'comforts'. However, the Bacup District Nursing Society Patients' Comforts fund was set up in 1948 from the 'Penny a Week' fund and the Annual report in that year and subsequently, refers to the value of the 'Comforts Fund' to patients. Examples of recipients taken from the records of the society² include:

In 1962: an old lady living alone, who was found to have 'only sheets and a cotton quilt on bed', was provided with blankets from the fund.

From 1962 to 1964: an 11 year old suffering from Muscular Dystrophy and confined to bed/ wheelchair was provided with a bed-table, Mackintosh sheet for the bed, knitting wool, a bed-pan and a mattress.

In 1965: a young woman with a premature baby detained in Fairfield Hospital for several months whilst her husband was in prison, was provided with blankets and flannelette sheets.

These examples are just three taken from a very extensive and detailed list, to illustrate the wide range of recipients of all ages, some with short-term needs whilst others needed help over a prolonged period of time. Accounts of the Comforts Guild run through to 1985 with outgoing payments covering clothing and comforts for patients. The aim was the provision of: 'Special foods and medicines, medical comforts, extra bedding, fuel and medical and surgical appliances, domestic help, money grants to enable the recipients to obtain such benefits or to defray the expense of convalescence or of obtaining change of air or special protection or treatment including the expense of any necessary transport and of obtaining domestic help during convalescence,' and was intended 'For sick and needy persons resident in the Municipal Borough of Bacup' ... 'at the recommendation of the District Nurse'.

This was a thriving society, particularly in the 1960s as may be seen from the annual report's accounts. Receipts at that time range from part-payment of beds and ripple mattresses, to Christmas food parcels, bed-rests, commodes, bed linen, blankets and urinals. From 1950 it was referred to as 'The Borough of Bacup District Nursing Society Comforts Guild', and many of the donations came from grateful patients or their relatives. The Deed of Constitution

² Bacup District Nursing Association Comforts Guild, 1964-1979, RCN Archives: C444: Listings of Comforts Supplied.

for this change was dated 1950 and refers back to the Borough of Bacup District Nursing Society formed in 1897, noting: 'whereas by virtue of the provisions of the National Health Act 1948 and the orders and regulations made thereunder the provision and maintenance of such District Nursing Service has become the responsibility of the Council for the Administrative County of the County Palatine of Lancaster AND WHEREAS the assets of the Society have been sold and the proceeds realised by such sales together with the other investments funds moneys and securities of the Society await application in manner hereinafter appearing'. The comments on a letter making enquiry about the possibility of depositing these records with the RCN archives, notes that the Comforts Guild was finally wound-up in 1985 because it was felt that 'developments of health care and extension of social services generally have, over the years, rendered the objects and purposes of the Guild increasingly less appropriate or necessary'.²⁶ The assets were transferred to the local hospice.

Conclusion

This chronologically defined case study has been able to show the complex relationship of district nurse: nursing association: Queen's Institute central and county organization, as this developed through the inter-war period. It also demonstrates the value of data in establishing statements relating to workload such as those found in the minute books of the Bacup Society. In addition, although it was not possible to obtain first hand oral histories from the nurses and committee members involved, it has been possible to augment this account with information obtained by personal communications from a number of Bacup residents, and this has been invaluable in providing a clearer and hopefully more accurate picture.

The variations in workload and in type of work undertaken have been examined, as to some extent has the relationship between the wider community and their affection for 'their' district nurse(s). Actions such as public fund-raising, donations to the home for the nurses' comfort, through to generous individual contributions such as the offers under wartime petrol restrictions to drive the nurse on a Sunday morning's round, all suggest a strong sense of loyalty and affection. Yet the relatively short lengths of stay in post appear somewhat surprising and contradictory until compared with the national picture. It was not until the post-war period that Bacup, as elsewhere, found the permanence of district nurses who came and stayed, fitting one of the popular stereotypical images of district nursing to be explored in the next chapter which will take a wider look at Lancashire as a region together with two other contrasting regions: Dorset and South Wales.

²⁶ Bacup District Nursing Association Comforts Guild, 1964-1979, RCN Archives: C444: Annual Reports (1964-1979): letter from Mr. Michael Hoyle dated 27/11/01.

A final word should be said about the records themselves: although district nursing committee minutes exist in many record offices around England and Wales, it is unusual to find the nurses' records included with them. Whilst this is very regrettable, denying the researcher the opportunity to find comparative material, from personal experience I would suggest this is probably because the nurses who kept them, chose to destroy them after a reasonable time period. This was most likely out of a sense of duty mixed with tidy-mindedness and efficiency, thinking them to be of no further value for the patient whilst possibly containing confidential information that should be disposed of. Whilst this should not infer a lack of regard for their own record keeping, it does make these records and any others that might have survived over such a long time-period, particularly precious to nursing history.

Chapter 8: Town Nurse and Country Nurse – the impact of region and culture.

This chapter will build upon the local case study of Bacup to explore the relative impact of local community, and the specific regional demography on the working experience of district nurses. A stereotypical image of the district nurse will be set against those emerging from the regional studies of district nursing associations in Lancashire, Dorset, and South Wales and from oral history, biography and registers and inspectors' reports of the QNI.¹



Fig. 8.1 1960s Recruitment leaflet, front-cover.²

Regional difference and cultural influence:

Different images have already emerged throughout this thesis separating urban from rural district nursing. The picture used on the front cover of a 1964 recruitment leaflet (see Fig. 8.1 above) depicts two quite different lifestyles: on the left, the modern, industrial urban setting with its factory chimneys and back-to-back houses, and on the right, an idyllic rural image that, with the horse and cart, appears set in the previous century, with the district nurse transcending the two. To test out these images we will now look at three case studies of district nursing in Lancashire, Dorset, and South Wales. As well as providing fascinating snapshots of the localities and the particular requirements imposed by them on the community health providers, this exposes more general aspects of evolving patient needs and problems. The particular demands of these regions will be discussed here beginning with district nursing in South Wales, which will be used to construct a comparative framework from which to view the other two regions described in less detail. London would deserve a separate study of its

¹ QNI Archives (CMAC), c1913-1939, SA/QNf Box 115Q6/11-22: Rolls of Affiliated Branches, England and Wales.

² Queen's Institute of District Nursing, 1964, The Training and Work of District Nurses.

own, and whilst it has been included in some detail in part two of this thesis, for the purpose of regional comparison, it has been excluded from this chapter.

from as early as 1900, strict conditions were imposed by the QNI (at that time the QVJIN) through the affiliation agreements governing County District Nursing Associations. Unfortunately very few of these early affiliation applications survive, but one that has, is of Coedpoeth and Minerva (North Wales) written in 1908.³ It reveals that funds were raised from public subscriptions, combined with contributions from the colliery and weekly contributions from the coal miners. The application was for one nurse to serve a population estimated at 5000. She was not required to undertake midwifery, and was to be provided with lodgings, bicycle and £30-£35 annual salary, but it stipulates that 'a welsh-speaking nurse is absolutely essential'. In 1924 a report noted, 'the population consists almost entirely of miners and their families (about 5,000) and though the collieries have gone through a very slack time lately, the last balance sheet shows £100 in hand'. It also mentions a 'Samaritan fund for helping poor patients'.⁴ A QNI inspector's report five years later, on the Liverpool-trained Coedpoeth district nurse E. W., reports 'cases nursed over last year = 198, visits paid = 4,837, with 13 cases on books at time of visit'. Of these she undertook some nursing of notifiable diseases including tuberculosis, two cases were defined as 'chronic care' requiring 'general nursing care and attention including bed-making', one had an ulcerated leg • but was reported 'out when visited!' The nurse is described as doing her work: 'conscientiously and is well liked on the district'. However there was a 'difficult undercurrent at the time' involving the secretary of the association who is described as 'an extreme Labour man, delegate for this that and the other, and has got himself on every committee he can ...He is detennined to have his own way, which is to give up the Queen's Nurse and have a cheaper one if possible'. Books, cupboard, bags and uniform were inspected and found to be 'neat on the whole' with lodging 'suitable' but the landlady is described as: 'not very satisfactory' s As this example demonstrates, once a branch was accepted by the QNI, the Institute's Rolls of Affiliated Branches⁶ present details of DNAs from 1890-1939. They often include notes on special work undertaken (or not) by the nurses specific to that particular branch together with infonnation relating to the nurses' employment, causes given for leaving, results of visits by the Institute's Inspectors and demographic information concerning the area served by that branch. Each one was created at the time of affiliation of the named association and was then updated with brief reports on nurses appointed and (occasionally) on visits made by the Inspectors. Some inevitably are far more detailed than others, therefore where possible these

³SAIQNIBox 114/QI/6: QVJIN Agreement of Affiliation approval (dated 24/03/1908) for Coedpoeth and Minerva District Nursing Association and Inspector's Report (1909).

⁴ 1924, 'Notes from the Districts: Coedpoeth, Glamorgan, Neath, Pontardawe', *ONM*.XXI(4): 273-274. 'SA/QNI Box 115 Q6/ 11-22: Rolls of Affiliated Branches c1913 - 1939, England and Wales.

⁶Ibid.

have been supplemented using data from contemporary journals and from the oral testimony of individual district nurses and other healthcare providers. In this way it has been possible to build up a picture that differentiates between the general and the region-specific roles and practice of these nurses, and how they changed over the 60 year period. However, this example also illustrates the tensions that might exist between the hierarchical organisation of the QNI which was able to remove affiliation if it felt a DNA was not complying with its rules and regulations, keeping records of supervisory visits to nurses, and the grass-roots attitudes of the local committee organisers and wider community who had to raise money to pay *their* nurse and would want to ensure that they received value for that money. The nurse can be seen to sit rather uncomfortably in the middle of this scenario trying to hold on to her professional status rather as a protective cloak of respectability, but in a precarious employment situation quite unlike any other 'professional'.



Figure 8.2 Dramatic representation of Welsh District Nurse as shown in 1980s BBC Series 'The District Nurse'⁷

Case study: South Wales

South Wales has been chosen as the prime example against which to compare the other two regions because it provides enormous demographic and cultural diversity. Maps (i) to (iii) (Appendix B) give some idea of the geography of the three regions, albeit from a twenty-first century viewpoint. The map of South Wales shows this diversity ranging from the cosmopolitan cities of Cardiff, Newport and Swansea which provides the opening focus of this case study to the mining valleys such as Neath, Rhondda, Mountain Ash and Ebbw Vale which provides a contrasting view, and finally to the rural coastal districts of Gower and South West Wales, and the mountainous region of Brecon which offer a rural alternative

⁷ Miller, H., 1984, *The District Nurse*.

nursing experience. Novels such as The Citadel⁸ and more recently District Nurse,⁹ provide particularly evocative images of nurses working in the second of these three areas of South Wales in the difficult years of the 1920s. In the latter, the title role, District Nurse R. was portrayed as a young, unmarried district nurse with a highly professional outlook, working under the watchful supervision of the GP with whom she frequently had to battle for professional recognition, whilst simultaneously having to compete with the untrained village nurse who had lived and worked in the town all her life. She travelled on foot or bicycle in mountainous terrain. She was Welsh speaking, although not a local woman, and her patients were mostly mining families, with the majority of her work apparently being public health, educational and preventative practice, nursing industrial injuries, assisting the doctor and a little school nursing. Unsurprisingly, the 'menial' nursing tasks such as the run-of-the-mill daily dressings and bed-baths, rarely (if ever) featured in the book or television series. Her relationships with village handiwomen 'nurses' often depicted open conflict between the modern and the old-fashioned styles of nursing. This portrait serves here merely to provide a useful stereotypical image or 'straw man' against which to view the realities of district nursing in South Wales and elsewhere.

In addition, several oral histories alerted me to the possibilities of wide variances within the region as a whole, particularly over rural and urban experiences. This then led me to examine the similarities and dissimilarities of the district nurse in South Wales compared with those of the other case studies, and in particular to assess the impact of regional circumstances compared with that of a general nursing culture struggling to attain professional status. In addition this enables us to see the tensions between locally run DNAs displaying the influence of regional culture - a 'bottom-up' organisational approach - against the attempts of the QNI to standardise pay and conditions of service of QNs, as well as the financing and administration of affiliated DNAs or of highly influential philanthropic figures - the 'top-down' view of organisation. These three regional studies will also contrast the different work experiences of nurses in rural dual- and triple-duty practices with those working in urban practices where duties were restricted to 'general nursing only'.

The Coedpoeth DNA cited above would have shared many similarities with associations established in the mining valleys and rural districts of South Wales (although it would have been unusual to have found a man as secretary¹⁰). Concern over the expense of employing a QN was not uncommon however, but this was usually offset by the support offered by the QNI in finding holiday or illness relief nurses and replacements when nurses stayed in post

⁸ Cronin A. J., 1937, The Citadel.

⁹ Miller, H., 1984, The District Nurse, - this was adapted to a long-running television series by the BBC.

¹⁰ This is the only example of a male secretary of a DNA I encountered in all the DNA records studied

for only short tenures of office, as was surprisingly common during the inter-war period. As far as the Welsh-speaking requirement is concerned, one nurse interviewed who worked in Ammanford in the south western sector, described a rural situation in which, as recently as 1970, most of her patients were Welsh-speaking, therefore she shared a similar cultural background to theirs. Although not deliberately chosen from the same district and social background as the early 'bible nurses' and the Liverpool district nurses (discussed in chapter three), nevertheless familiarity with the local environment, families, and particular cultural rituals concerning birth, illness and death, was a distinct advantage. She commented that 'it was much simpler if you did speak Welsh – in fact all the other nurses in that area were also local girls, so we knew the people and the place and that was a big advantage in a rural community where everyone knows everyone!'¹¹ Yet a nurse who worked in the more urban and industrial coalmining towns of Aberdare and Hiruain in the 1960's, recognised a need to be Welsh-speaking to be a fast disappearing characteristic of the old regime in her area.¹² By that time it had, in any case, ceased to be a prerequisite of the district nurse, whilst records suggest that in the cities of Cardiff and Swansea the more cosmopolitan population was reflected in the diversity of cultural backgrounds of the district nursing staff, many of whom came from elsewhere in the UK or Ireland. The details of a select number of associations will therefore be presented to demonstrate the variety of urban and rural districts and the ways in which these were managed, and the conditions under which nurses worked in each. Where possible these will be subdivided in each regional case-study into urban and rural communities, but it should be remembered that some districts which may be described as mining or industrial rather than agricultural, nevertheless fit more closely into the rural category.

District nurses were central to their communities and faced huge challenges arising from deprivation, hard physical work often combined with heavy responsibilities and consequent ill health. A GP who was working in (urban) Merthyr Tydfil in the 1930s described 'Bad Jiving and working conditions, there were many deaths from diphtheria and scarlet fever' adding that there was high unemployment and poverty.¹³ However, an obituary to QN Bridget Thomas,¹⁴ who came to Merthyr in 1912, and apart from military service during WW I, worked there until her death in December 1923, quotes from the local press that she was,

'Capable, energetic, self-reliant, but withal most kindly and sympathetic and she brought hope and comfort to hundreds of humble homes, and wherever she went she became a friend ... She passed day by day in and out of the little homes in Merthyr, carrying with her healing for body and mind, and with a sweet womanliness drew to

¹¹ RCNff/33 Oral testimony: Mrs. L.M., Brecon (see fn IOI Chapter 4).

¹² RCNff/12 Oral Testimony: Mrs B. R., Hiruian (see fn 43 Chapter 6).

¹³ CMACIGP29/59, c1980, Oral History: Samuel L. Isaacs.

¹⁴ 1924, 'In Memoriam: Miss Bridget Thomas', ONM, XXI(1): 194.

herself the confidence and love of all with whom she came in contact. ... She will be deeply mourned in these little homes - the cottages of Merthyr, amidst the sick poor, whose care is the first work of the Queen's Institute to which she was proud to belong.¹⁵

Nurse W. in Coedpoeth and Nurse T. of Merthyr seem to share some important similarities with our earlier fictitious 'straw nurse', being described as 'conscientious', 'capable' and 'well-liked', although it should be remembered that obituaries, whilst providing valuable biographical material, tend to give a very positive, slightly romanticised image, which needs to be treated with some caution.¹⁶

1) Cardiff and Urban Areas of Glamorgan:

In contrast to the single nurse in a small community, nurses in Cardiff operated in a more collective environment, made possible by the large size of the urban population there. Socio-cultural demands on a district nurse working in Cardiff would have been quite different from those in the rest of South Wales, with the possible exception of Swansea. According to the QNI Inspectors and branch officials, the population served by Cardiff and Llandaff DNA¹⁷ was given as 128,905 in 1890 and had risen to 234,670 by 1937, thus almost doubling in less than fifty years. As with Liverpool and London, Cardiff had for a long time been a richly diverse and culturally mixed city – in fact, by 1900 it was second only to London in the percentage of the population that was foreign-born. In 1919 Cardiff was the first city in the United Kingdom to experience race riots, whilst in the 1950s and 1960s it experienced a second wave of immigration from the West Indies and Asia.¹⁸ Instead, the need was to understand the problems of rapid urbanisation and of a multi-cultural mixture of people. Generally, however, the nurses in Cardiff, as in other large towns and cities, lived in a district nurses' home, with a superintendent to oversee their work, and caseload, run the nurses' home and to some extent, to keep a check on their personal lives (see Fig. 8.3).

¹⁵ Merthyr Express dated 29/12/1923.

¹⁶ Digby, A., and Sweet, H.M., 1998, 'Collective Biography and the History of the British General Practitioner 1850-1948', Discussion Papers in Contemporary and Historical Issues in Health Care. J. Andrews, and J. Stewart (eds.): 55-62.

¹⁷ Founded 1980 - see Burdett, H., 1900-31, Burdett's Hospitals and Charities Yearbooks.

¹⁸ McKenzie, R., 2001, Lifting Every Voice: A report and action programme to address institutional racism at the National Assembly of Wales: 17-18.



Fig. 8.3 Superintendent and Assistant Superintendent and (Queen's) District Nurses at the nurses' home in Cardiff (1926)¹⁹

By the 1920's the nurse's annual salary in Cardiff averaged between £63-£68 i.e. below the QNI's recommended national average of £68-£75, and marriage was a frequent given cause for resignation. Midwifery training was also a reason commonly given as dual-trained nurses could command a slightly higher salary and this was a pre-requisite for promotion. Nurses from South Wales often went over the border to Bristol, Gloucester or Cheltenham for this, although by the late 1920s this was increasingly done during an extended leave of absence. There were exceptions to this pattern such as the unusually high annual salary of Nurse F. working in Cardiff in 1924, recorded as £80 plus 2/6d weekly for coal for 7 months of the year and 5/- weekly for attendance plus 23/- weekly for board and laundry. She remained for 11 years only apparently leaving because of ill health. From 1927 the QNT salary scale was usually adopted as part of the terms of engagement nationally. However there were still individual districts that were at variance with this. The salary in 1929 of Nurse E. K. was detailed as: '£72 rising to £75 p.a. plus board and laundry allowance of 23/- weekly and fire and light allowance of 17/6d (winter)- 15/- (summer)'.²⁰ These emoluments presented attractive inducements to new recruits, as did passes on railways which had been issued to district nurses working in Cardiff since 1909 and from 1934 half-fare was charged on trams and buses to 'district nurses and midwives in uniform and candidates/ pupils.' In addition by this time, the association was participating in the federated superannuation scheme to which the QNI encouraged all associations to subscribe.

¹⁹ 1926, 'Cardiff, *QNM*, XXII(6): 135.

²⁰ SAIQNI Box 115 Q6/11-22: Rolls of Affiliated Branches, England and Wales.

During their Queen's training at the Cardiff Central Home, probationer district nurses attended various clinics in the city including those for maternity and child welfare, the school medical services and the Tuberculosis Institute of the Welsh National Memorial Association. It was noted that, 'they afterwards follow up and nurse patients from these clinics in their own homes' ²¹ Whilst this followed the basic curriculum laid down by the QNI, the high levels of respiratory diseases including tuberculosis and silicosis they would have encountered added a particular specialist dimension to this training. In 1907 there was a Superintendent and Assistant Superintendent plus eleven nurses and four Queen's probationers - by 1937 this had risen to twenty-one nurses and eleven 'candidates' plus an extra assistant. Therefore both population and number of nurses for Cardiff city doubled over this period.

County	1931 census population for county	Population in area of County DNA	% population for whom nursing is available	Number of nurses employed	Average population per nurse	Extra nurses needed	Population un-nursed
Lancashire	5,039,000	5,013,308	99	503	9,987	184	26,147
Dorset	239,000	209,870	87	80	2,623	14	29,482
London	4,389,000	4,388,645	100	335	13,100	211	-
Glamorgan	1,225,000	1,039,301	84	118	8,808	67	186,416
Monmouth	435,000	326,499	75	49	6,663	26	108,459
Caemarfon	121,000	120,209	99	54	2,226	1	620
Total across England & Wales	39,864,000	38,206,867	95	7,170	5329	1,625	1,657,317

Table 8.1 District nursing provision: selected counties (England and Wales).²²

Table 8.1 (above) shows the levels of district nursing provision for the individual counties of Lancashire, Dorset, London, Glamorgan, Monmouth and Caemarfon. The original aim of the survey from which this data was extracted was to demonstrate the need for more district nurses whilst simultaneously showing the extensive development of the service nationwide. London and Lancashire are shown as extremely well provided for in terms of availability of nursing staff, whilst Monmouth and Glamorgan were under-nursed at that time. So too was rural Dorset, but it will be seen that in Glamorgan the average population served by each nurse was almost four times that of Dorset. It was therefore to provide nurses with midwifery training to work in rural areas that much of this recruitment was aimed. However, this ignored

²¹ Ibid.

²² Constructed from data in, Queen's Institute of District Nursing, 1935, Survey of District Nursing in England and Wales.

the variations in nursing workload that resulted from differences in patients' social circumstances and does not show variations within the counties. An interviewee who had been a district nursing officer in the 1960's and 1970's explained how caring for patients in a more deprived district of a city such as Swansea who lacked amenities such as indoor bathrooms, running hot water and basic items of household equipment, combined to make the nurse's work far more onerous and time-consuming than attending the same number of patients living in better conditions in more affluent districts of the same city:

You look now, take now, down in Langland Bay, the numben - this is just hypothetical. The nurses were finishing by one o'clock. In Townhill, in the middle of Swansea, they were still working at eight o'clock at night. They had the same caseload, but there were differences in terms of •• well, ecological differences, environmental differences, ageing, poverty, all come into it. The more poverty there was, the more time it was taking. In the town, they could n't park, for example. By the time they find somewhere to park, there's half an hour gone in walking to the patient. And then down in the Mumbles, there they are, you know! You see •• so, really, we just had to see what we could do about making the workload more evenly dispersed. (••] Take, for example, if you went into a home where they had bathrooms, indoor toilets, they had trays, they had dishes, they had things •• you know, they *had* things! You know, the nurses could just go in, everything would be laid up ready. You'd go in and, say, a tray would be ready, with a cloth on it, or a pillow case, and everything that was needed was ready. But you go into some of those other homes where they had nothing •• they had nothing. They had nowhere, they had nowhere, even, for you to lay up. They didn't have a bowl for you to wash your hands. I've seen me plug in an enamel bowl, or a plastic bowl, with a piece of bandage, to put water in it, to wash a patient. (••] And again, if you go to the rich people's homes, they have the beds, they're standard size. But they've got bed linen they can change. They've got sheets that you can use as draw sheets if you wanted to, or what have you. But, I mean, you go into other places, and mattresses are sodden and wet ••²³

Nevertheless, it is worth noting that Table 8.1 does take into account the different demands of rural and urban nursing in estimating the desired ratio of population to nurses with London's density being responsible for a far greater ratio than the more sparsely populated, rural counties of Dorset, Monmouth and Caemarfon. The county ratios given for these regions in Table 8.1, whilst showing regional variance, probably mask considerable differences in nurse distribution between city, town and country, neither do they indicate areas of population growth or reduction. For example, the QNI Inspectors' reports show several towns such as Porth and Cymner, with little change in population, whilst others, such as Neath and Swansea,

²³ *DIN 33, 2910310*, Oral History: Mrs. M. H.: trained SRN c.1950-53 (Swansea) and later worked as a district nurse learning 'on the job' only training after a career break in late 1960s.

reflect large population growth between 1900 and 1931. As with Cardiff, this would have had a major impact on the demand for district nursing and associations had to work hard to keep staffing levels up to meet this demand and to raise the money to pay them and to maintain the nurses' homes provided for them.

In 1954 Taylor²⁴ detailed the further complexity of this distribution anomaly in his study. Table 8.2 (below) summarises these findings showing the disparity between the numbers of nurses serving the population and the level of GP support to these nurses, particularly in urban districts:

Type of Borough	Population	Number of district nurses	Number of GPs	Ratio of nurses to population	Ratio of nurses to doctors
mixed industrial county borough	295,000	30	180	1:10,000	1:6
mixed borough	185,000	7	66	1:26,000	1:9
rural district	9,000	3	4	1:3,000	1:1

Table 8.2 Relationship between nurses, GPs and population served²⁵

This distribution of workload was obviously further complicated by the type of caseload (chronic medical cases and care of the elderly being more time consuming than acute surgical aftercare, short visits to diabetics or hospital after-care), duality of role (as midwife and perhaps health visitor and/or school nurse) and mode of transport.

We look now at a number of examples that suggest there might have been pockets of philanthropic involvement. That there were philanthropists early in the twentieth century, who may have supported local associations is evident from an analysis of the Provisional Council of the Queen's Institute for South Wales. In 1908 it contrasts markedly with that for North Wales in including a considerable number of members of the aristocracy. These include Lady Evans and Lady Lloyd representing Cardiganshire, The Marchioness of Bute and Lady Aberdare for Glamorgan, The Lady St. David's for Pembrokeshire, Lady Dillwyn Llewelyn for the Swansea Federation and The Lady Kensington who personally supported St. Brides' district nursing association for many years.²⁶ A report of the inaugural meeting of Glamorgan County Nursing Association²⁷ similarly records attendance by a number of notary figures

²⁴ Taylor, S.J.L., and Nuffield Provincial Hospitals Trust for Research and Policy Studies in Health Services, 1954, Good general practice :a report of a survey: 369-371

"Ibid.

²⁶ SA/QNI Box 116Q/10: Report of a meeting of Provisional Councils for North and South Wales (1908).

²⁷ 1922, 'Institute News: Wales', ONM, XIX (1): 17.

including the Marchioness of Bute, Lady Mabelle Egerton and Sir Thomas Hughes and emphasises the public health role of the district nurse with Dr. Colston Williams, the MOH for Glamorgan, speaking of, 'the need for more district nurses in such a large industrial area as Glamorgan.' Penarth, for example, is listed as employing one QN covering an area of two square miles and a population of 17,719 by 1931. The nurse, Mary Warriner, was appointed in 1901 and although not undertaking midwifery as part of her nursing duties, remained in post for 29 years - an unusually long period at this time. Similarly, the smaller mining town of Treorchy DNA employed two nurses (one 'for midwifery'), who covered an area of just two square miles, charging 'no fees', and were provided with a 'comfortable little home'.²⁸ Their above-average rate of pay (£100-105 p.a.) and good conditions suggest there may also have been a wealthy benefactor or possibly the Miners' Federation, supporting this otherwise fairly poor association.²⁹

Barry, which was an urban district of busy docks and railway works, employed five QNs to cover an area of approximately six square miles. They were well provided for, with a purpose-built home and employed on the QN salary scale. Despite this apparently good support, their average stay throughout the inter-war period was just two years, often resigning for marriage, occasionally ill-health, but also several taking leave for midwifery training. Although there may have been support from Lord Bute, Barry's nursing association had close links with Barry Railway Company. Of particular interest in the association's minutes³⁰ is a report of an annual meeting held in 1927 referring to 'Insole' ward for nursing the sick poor, bequeathed by the wife of a director of Barry Railway Company, with patients on the ward being looked after by the association's district nurses before and after their rounds. Beds were also available to other patients able to pay their maintenance at a cost to the Insurance Committee of 10/- per day.³¹ In November 1927 the association was being run by the 'Lady Superintendent', with her staff of two Queens Nurses and two 'temporary nurses'. At that point it was the intention to employ another QN and there is a reference to the 1,067 visits made in the preceding month and to, 'the growing practice of the local doctors in asking for nurses to attend and assist with operations performed by specialists'. The resolution is recorded in the minutes, 'to write to the doctors bringing the claims of the association to notice, and the nurse to leave circular letters with the patients and to endeavour to receive a reply when she ceases to attend'. A temporary nurse was paid £60 p.a. and at this time the

²⁸ SA/QNI Box 115 Q6/11-22: Rolls of Affiliated Branches, England and Wales.

²⁹ The local Miners' Federations in the early post-war period provided financial support to local hospitals and libraries, therefore it is reasonable to suggest they may have contributed towards the cost of a district nurse. I am most grateful to Mr. GG Lloyd for this information.

³⁰ Glamorgan Records Office 'DIDX 287/1-4: Bany District Nursing Association annual report books: March 1891-June 1900, June 1923-Sept 1926, Oct. 1926-Nov. 1931'.

³¹ Glamorgan Records Office 1912-46, 'DIDX 111-34: Minutes Glamorganshire Insurance Committee'.

Welsh Nursing Board tried to persuade the association to accept the cost of employing two QNs to replace the temporary ones. This would have meant losing one of the temporary nurses (Nurse E.) - she was asked to train as a QN but declined - it was therefore resolved to only accept one QN and to retain Nurse E., an interesting choice of the experienced local nurse over the professionally trained 'unknown'. There is no reason given for Nurse E's decision, but it seems likely that she felt no wish to travel to Cardiff to undergo further training. This was an attitude expressed by most of my non-Queen's interviewees, who considered practical experience to be the key to good nursing and felt this could not be taught in a classroom.

2) Mining towns and villages of South Wales:

A different scenario is presented by Bridgend DNA, which also employed one QN who lived in her own cottage and similarly covered an area of two square miles and serving a population recorded as 10,000 in 1926. The entry in the QNI records at this time notes the association was supported by provident club subscriptions of 1d per week and voluntary collections. Patients who were not weekly subscribers paid, 'according to their means' from 3d to 1/- per visit but the association appears to have suffered an insecure history as it disaffiliated at some point after 1909, re-affiliating in 1926 only to disaffiliate again in June 1929. This second period of disaffiliation may well have been in response to the pressures of the severe economic depression and is consistent with experiences reported elsewhere. Oystermouth presents another fairly representative picture of urban district nursing in South Wales, having a population of 9,646 by 1931 with one nurse covering an area estimated at two to three square miles. She was provided with board, lodging, laundry and uniform and a bicycle and 'conveyance when necessary' and was paid 'according to the QVJIN scale' financed through subscriptions.³² 'General nursing' only was undertaken - this meant no midwifery and usually excluded nursing patients with infectious diseases - therefore it is likely that other 'village midwives' or 'handiwomen' may have been practising alongside her.

Other mining towns and villages in South Wales present a far more desperate socio-economic picture. For example, following the 1926 General Strike, the Society of Friends set up an organisation of poverty relief in the extremely deprived communities of the Rhondda Valleys, establishing self-help groups which rapidly grew to become a substantial centre based at Trealaw called 'Maes-yr-Haf' (see Fig. 8.4 below) combining health and welfare provision with education and re-training. From this a number of 'Unemployment Clubs', 'Sewing Groups' workshops and allotments were created. They also supported the formation of the Mid-Rhondda Nursing Association in 1931, which employed two QNs who were continuing to work there in 1933, making over 4,000 visits in their first year. The Rhondda was chosen to

³² SAIQNI Box 115 Q6/ 11-22: Rolls of Affiliated Branches, England and Wales.

represent an area of severe economic deprivation in a study of unemployment and the voluntary social service movement between 1929-36 conducted by the Pilgrim Trust.³³ This showed the area to be one of the most economically depressed areas, yet one demonstrating considerable social solidarity and supporting an unusually high number of societies such as these, as well as political and religious institutions and social clubs.³⁴ Unfortunately unemployment and resultant economic depression had resulted in large scale emigration of younger men to other parts of Britain leaving behind the elderly and a high numbers of physically disabled ex-miners suffering from chronic diseases particularly nystagmus, silicosis and dermatitis.³⁵

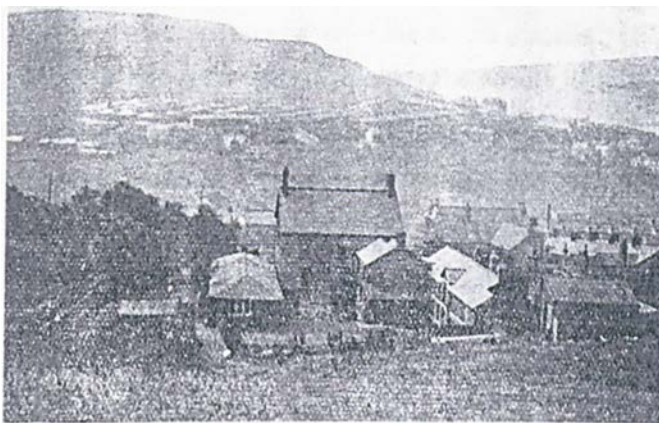


Fig. 8.4 Maes-yr-Haf -opened Spring 1927³⁶

Neath had affiliated with the QVJIN in 1897 and its population of 11,000 at that time had almost tripled by 1931³⁷. The district nursing association employed six QNs accommodated at a nurses' home in Neath but staff turnover can only be described as 'rapid' between 1919 and 1937. Although one nurse stayed for seven years leaving to get married, the average length of employment was one year or less despite the association's adherence to the QNI's recommended salary scale. The reasons given in the QNI reports for resignation are to 'return to hospital nursing', or 'marriage', whilst five out of the eighteen nurses where reasons are provided in the report, left because of ill-health. It seems highly likely that the combination of overwork resulting from this population explosion and the economic depression throughout this region resulted in the rapid turnover of district nurses and high levels of sickness amongst the staff.

³³ Temple, W., (Pilgrim Trust), 1938, *Men without work : a report made to the Pilgrim trust.*

³⁴ *Ibid:* 272-277.

³⁵ *Ibid:* 65-73.

³⁶ 1933, 'In the Rhondda Valley', *ONM*, XXVI(I): 12-17.

³⁷ Neath's population in 1931 is given in the reports as 30,480 falling slightly to 27,678 by 1936.

3) Rural and semi-rural areas of South Wales:

Turning to look at the rural areas of South Wales, Cowbridge DNA employed one QN, covering a more agricultural area of approximately six square miles, (in contrast to the average of two square miles covered by the urban district nurse) and provided with a furnished house and bicycle. She undertook midwifery as well as general nursing, as was usually the case in more rural areas and was employed on the QNI salary scale, although there were several long periods with nursing cover provided only by a temporary retired 'Village nurse' from Salop. A similar example was the district of Gower with a population of 2,000 rising to 5,172 by 1931. The two nurses (one a QN) covered an area of six square miles, their remit again including midwifery in addition to general nursing, plus 'inspection of boarded-out children'. They were provided with either a bicycle or pony and trap as necessary, the QNI salary scale had been adopted, and by 1934 the report records this as: '£17*S* p.a. plus furnished house provided'. Surprisingly, considering the beauty of this gently rural area, the good pay and conditions and the company offered by the shared practice, the records show mostly short stays in post (one or two years or even less) and there is evidence in the comments of some friction with the employing body with notes recorded by the Inspector stating, 'did not give satisfaction', and, 'left at a moment's notice though satisfactory'. This would again suggest an uneasy relationship with perhaps an over-zealous DNA managerial committee, (in 1922 it was reported as having Lady Blythswood as 'an active President and chairperson'³⁸), contrasting with the harsher conditions but happier relationship described in the obituary of Nurse Thomas, mentioned earlier.

Across the border, in rural Pembrokeshire, Haverford West employed one QN plus a village nurse covering an area of three square miles. A non-Queen's village nurse employed in 1922 was considered 'slack in many ways and did not keep good hours'. Like many others, two or three years in post was the general rule throughout the 1920's and 1930's with some leaving for school-nursing or to get married and others to work elsewhere including 'abroad' or 'missionary work'. A similar picture is presented by Cardiganshire where the Cardigan association employed two QNs providing general and midwifery care. Most stayed only one or two years between 1919 and 1938 with the exception of Nurse A. M. who worked from 1921-26 leaving for midwifery training in Gloucestershire and returning the same year, staying until 1933 when she was married. Interestingly in Ammanford, Carmarthenshire an area of collieries and tin plate works, we find, 'the committee decided to leave the district without a nurse for a time as the people did not seem to appreciate one enough' and disaffiliated from the QNI for several years, re-affiliating in 1924 only to disaffiliate again in 1931 'on account of low funds'. At the time the work did not include midwifery, however, a nurse who worked there as recently as 1960 (and did practice midwifery combined with

JB 1922, 'Institute News: Wales', *QNM*, XIX (1): 17.

general nursing) stated that even the GPs were Welsh-speaking and that the people were incredibly hospitable often giving her meals, eggs, honey and home-grown produce, but that:

Well, It's very rural, very agricultural, plenty of nice narrow roads ••• wonderful narrow roads. Welsh-speaking community, largely, 99 per cent, although there were other people that had moved in, country ••• holiday cottages and things. A few largish villages Llansawel, Llanybydder was a bit bigger. Then we went to Cwmann, which was on the outskirts of Lampeter, which was more urbanised. But apart from that village, apart from Cwmann, the rest of it was very rural, and you had probably about ••• I'm trying to think. It would be about eight miles to Llanybydder, then it would be about another six, seven miles over to Cwmann, then another 10, 12 miles via places called Powderbrenin, Pumsaint, Caeo, and back round to Talley, and then back to Llansawel again. You had about, oh, don't know, it must have been about 20/30 mile round journey (•••) Oh, of course, you had to walk miles ••• leave your car here, because you couldn't take it any further. You had to walk down all these fields, gathering mushrooms on the way! Of course, opening gates, shutting gates. Opening gates, shutting gates!³⁹

In nearby Carmarthen the affiliation record similarly notes the district requires 'one Welsh-speaking Queen's nurse for general nursing only, bicycle provided'.

As explained in Chapter 4, until the end of the 1930s a nurse would cover her district either on foot, or by bicycle or perhaps a pony and trap, often conducting midwifery in rural areas, and restricting her practice to general nursing in the more urban districts. Although in theory she worked under the direction of the GP, in practise her contact with him appears to have been minimal, throughout this period. In the rural situation this seems to have been quite an isolated professional existence, whereas the nurse living with others in the nurses' home in Neath, for example, would have been able to share the day's experiences and professional concerns with her colleagues and superintendents. A district nurse working in 'rural Wales' described the hazardous conditions in mid-winter attending a patient at a distant farm in deep snow. Although she had a telephone, contact from the patient's relative was made via the postmistress nearest to the farm, who warned that neither doctor nor ambulance could get through because of the road conditions. The nurse got a lift as near to the farm as possible in a Jorry from the local garage owner, then walked the remainder of the way 'across several fields waist-deep in snow'. She found the patient suffering from hypothermia but managed to revive her using ginger-beer bottles filled with hot water placed around the patient. The report notes the particular difficulty of the 'big oak bed on which the patient lay being very heavy and difficult to prop up at the foot.'⁴⁰ This cameo demonstrates not only the remoteness of this

³⁹ *DIN 29, 24105/01*, Oral History: Mrs. E. Morris (see above).

⁴⁰ 1941, 'Experience of a nurse in rural Wales', *QNM*, XXX(3 (March)): 5-6.

work, but the need for resourceful adaptability and for good local knowledge as a valued member of the community. In addition, the mountainous terrain made nursing in the valley towns and villages of South Wales quite physically demanding before the motorcar became a standard mode of transport for the district nurse:

I was thin as anything because I used to walk miles ... In the winter I walked up the Tram Road as a short cut and found myself up to my waist in snow - silly me! - I had to go back on to the main road which was a very mountainous road and got to the top walking in a blizzard.⁴¹

And a nurse working with a friend in the Vale of Neath in the 1930s straight out of Queen's training, commented about her colleague:

She was Welsh-speaking. Well, the lower part of the Valley, were very Welsh-speaking, so they wanted the Welsh-speaking nurse. Well, as you go up the Valley, there were more incomers, because there was work here, as you can imagine, from Merthyr and all round there. Well, they were like myself, not Welsh-speaking, and I was allocated the top part of the Valley. I had a bicycle. A lot of walking, and they said, the letter said it was a frequent bus service, which was good, very good. But having come in from London, when you could get on a bus any old time, it wasn't ...⁴²

However, this was not a requirement exclusive to the mountainous areas, as a nurse working in Cardiff described similar problems: 'most of it was general care, and general care can be very heavy especially if you are wheeling a bike up Penylan Hill ...which I did - I had all this area to do, all up Pencoed and down by the lake and part of Llanishen'. She goes on to describe how delighted she was when the GP 'pulled strings' to get her a little motorised scooter.⁴³

What, if anything, made working in South Wales different from anywhere else? – is it possible to suggest there is something unique about any particular region? Conversely, what are the commonalities? Obviously daily routine in general nursing tasks is universal -this was implicit within the (national) training and practice laid down by the QNI which (in theory) was intended to equip a district nurse for practice *anywhere* in the United Kingdom. Urban district nursing would seem to have been essentially different from rural nursing wherever it was practiced: it took place in a much more heavily populated community, did not include midwifery, often entailed nurses living together in a home, and the likelihood of knowing all the GPs was greatly reduced, compared with the rural experience. A nurse who worked in St. Helen's described her training which was divided between St. Helen's and

••DIN 11,01110/96, Oral History: Mrs. B. R. (see above).

⁴² DIN 32,01102/01, Oral History: Mrs. L. M. (see above).

⁴³ DIN 13,0210/96, Oral History: Mrs. D. M. (see above).

Liverpool with sometime spent in rural Oxenholme which could be applied equally easily to rural practice in Dorset or parts of South Wales:

EP: And we went there for a week. I remember it well, with a Miss King. And they taught us, they took us round. And, of course, they were Health Visitor trained as well, so they used to take us round. But they didn't have as many patients, that's what struck me. They didn't have as many patients as we did, because it was a more rural area.

HS: Yes. They'd be covering a larger mileage, presumably?

EP: Mmm, mmm. Much bigger. We went to the farms, and they would do, like, general nursing care, and the Health Visiting ... weighing babies and •••

HS: Were they doing midwifery as well?

EP: Yes, yes. There were all three. They were ...triple duty, I can remember her weighing the babies and that, when I was there. Yeah, very pleasant.⁴⁴

However, there are differences in the cultural backgrounds of the communities amongst whom these nurses worked, which also come through in the oral histories but apart from the obvious aspect of language or dialect, are particularly elusive. These were often attributed to a particularly strong 'sense of community' or to parochial attitudes towards 'outsiders' although the intimate relationship established through the practice of district nursing seemed to lessen this. In addition the nursing in some areas of South Wales included industrial injuries from mining accidents and respiratory diseases attributable to the coal-mining, tin-plating and steel industries. Some of these could also be found in the Lancashire mines - the same nurse described receiving the injured from a mining accident at St. Helen's at the beginning of her general training - whilst there were also many industrial injuries from the glass-works and textiles factories in Lancashire. This would have been totally outside the everyday experience of a nurse working in Dorset or other southern regions of England, where rural nursing meant working in an agricultural community.

Case Study: Dorset -the triple-duty nurse.

Dorset's County Central Home's staff comprised a superintendent and her assistant and six district nurses who initially lived in the nurses' home at Dorchester. Because of the size of the district and the rural terrain, a motorbike was provided for the superintendent from as early as 1917 to enable her to visit QNs to carry out supervisory checks and offer advice where necessary. From 1923 the superintendents were sharing a rented house, and by 1929 the senior superintendent had been provided with a 'two-seater Coupe' motorcar. Like the nurses, the assistant superintendents did not stay in post long -the first six only stayed one year each and sixteen appointments were made between 1914-24 because: 'cycling too heavy' or, 'to return to hospital' or, 'on account of health'. Several nurses who worked in Bournemouth and

⁴⁴ *DIN*26, 18/05/00, Oral History: Mrs. E. P. (see above).

Weymouth later on, in the post-war period, similarly described an increasingly heavy workload, but in their case it was of predominantly elderly patients and associated heavy 'general care'. The introduction of enrolled nurses and auxiliaries was viewed as a welcome relief by several of these interviewees. However, another comment which provides a key to the cultural flavour of the region was a reference to the comparative insularity of people in Dorset and to its attraction as a place for the elderly to enjoy their retirement:

So there was a huge difference between London, which had always been very very multi-racial, and, you know ••• certainly in Lambeth I'd grown up with a lot of racial integration there, and so I'd seen mixed families right from the start, and all the problems that that created. But in Dorset, they were really just Dorset people. And in, certainly in Bournemouth, relatively affluent. I mean, it still is a relatively affluent area. We have pockets of deprivation, certainly in terms of youngsters, young families growing up. But I suppose our main majority of elderly population are indigenous, and fairly well to do.⁴

This section will serve to highlight the role of these triple-duty rural nurses. Apart from a few small towns, much of Dorset throughout the period 1919-1979 would have required dual or triple duty nursing with, according to Table 8.1, 20% of the population remaining 'un-nursed' throughout the inter-war period. The Welsh example has already shown that rural district nursing work presented quite different demands from those required of a nurse working in a large town, and that it would therefore attract a nurse for totally contrasting reasons. One of the interviewees described the occupational hazards of visiting a patient in the rural district of Charminster when she was a county superintendent:

We opened the gate and these four geese came charging out - you know how geese are - frightened me! I was frightened to death I stood behind the nurse and said 'are they - are we safe to go in there?' - and she just marched on and said 'just walk on behind me, they won't take any notice of you - they are used to me.' And then you went in to the house, it was all dark inside, there were about six cats running around and this little old lady.⁴⁶

Ironically, the patient being visited had once been a 'handiwoman' untrained nurse herself demonstrating how recent (in historical terms) was the transfer from that informal system of local village nurses to this more formal one of professionally trained and organised district nursing. In Dorset, a largely rural and farming county, triple-duty nursing - as opposed to the dual-duty of nursing and midwifery described in the Welsh rural examples - was common

⁴ *DIN* 39, 11/04/01, Oral History: Mrs. J. F.: trained SRN partly at Weymouth and partly in the army (Queen Alexandra's) 1952-55 then SCM in London followed by QN in 1958 working in London and Weymouth as a district nurse.

⁴⁶ *DIN* 09, 29/08/96, Oral History: Miss. A. S.: trained SRN in Weymouth 1946-49 and did SCM in Southampton before returning to Weymouth as a district nurse learning 'on the job' and later becoming a district nursing officer there.

practice in many areas until the 1970s. Grants were received from the local government board for midwifery and for health visiting carried out by suitably qualified district nurses, where they were available and by superintendents where they were not. According to the Dorset County Nursing Association records (1916) the district nurse might therefore undertake health visiting which included, 'Mothers, babies, T.B., mental deficiency and school cases'.

Although Blandford was described as a small town, with a population of 3,000, which according to Table 9.2 above was the average nurse to population ratio for Dorset, although also according to this table it would seem likely that her relationship with the local GP would have been a much closer one than that of her urban counterpart. The Blandford DNA employed a 'triple-duty' QN carrying out, 'chronic medical and surgical work, midwifery and maternity care, school nursing, Infant and Maternity Welfare Centre, Health Visiting and Tuberculosis work'.⁴⁷ Her salary was £130 in 1919, but despite this high salary, nurses stayed only an average of two years until 1926 when Nurse H. stayed five years resigning for, 'home duties' by which time the annual salary had increased to a strikingly high £140 plus the attraction of a furnished house. This wide-ranging job-description of triple-duty district nursing would have demanded considerable versatility from the nurse as well as careful planning of her working day to prevent cross-infection from patient to patient. Maternity visits were always done early in the nurse's day, for example, with infectious cases coming last, and post-surgical cases were always visited and wounds dressed before attending to cases such as infected leg ulcers. Clinics would be held in the afternoons as depicted in the Ministry of Information film noted in chapter 8,⁴⁸ but the nurse would still have to carry out any outstanding nursing duties in the evenings, making her day an exceptionally long one. Similarly, the very rural districts of Charminster, Bradford Peverel and Stratton were all under the care of triple-duty QN E. J.. She also nursed 'general, maternity and midwifery, health visiting, tuberculosis, and after care, and school nursing', and was provided with a furnished cottage at 3/6d rent, and a bicycle (later a car) on an annual inclusive salary of £188.⁴⁹ However, she stayed for fifteen years, from 1922-37, so had obviously discovered this type of work suited her. It is no coincidence that Dorset was one of the counties that pioneered the provision of motorised transport and of telephones for district nurses (see chapter 4). as this was crucial in enabling small villages such as these to amalgamate and employ one nurse to cover such a remote and widespread area but relatively small population.

Case Study: Lancashire

Moving finally to Lancashire, the similarities with South Wales have already been mentioned as this also comprises a large area with mixed heavy industry (including coalmining), busy

⁴⁷ SA/QNI Box 115 Q6/ 11-22: Rolls of Affiliated Branches, England and Wales.

⁴⁸ 1942, District Nurse.

⁴⁹ SA/QNI Box 115 Q6/ 11-22: Rolls of Affiliated Branches, England and Wales.

ports and large expanses of rural countryside. On the other hand the cultural backgrounds of the people living there produced quite a different underlying lifestyle and society from that of South Wales. Elizabeth Roberts notes the diversity of Lancashire's economic base from the heavy industries of Barrow and Liverpool to the textile towns of Preston, Bolton and the broader spread of Lancaster's mixed economy. Lancashire's County Association had at least 100 QNI affiliated district nursing associations by 1939 together with Manchester, Liverpool, Lancaster, Preston, Blackburn, Blackpool and Burnley, which all had separate 'county borough' status. It is only possible here to look at a small cross-section of these, to give a taste of the way they were run and of the nurses who worked for them.

Lancashire's district nursing service was extremely proud of its contribution towards the founding of district nursing by trained nurses, and it may have been this sense of tradition that made them seem more ready to pioneer new developments in this field. Amongst these were the William Rathbone Staff College in Liverpool, which ran refresher courses for district nurses, courses in community health administration and ward management and for 'overseas nurses'.⁵⁰ Lancashire was also the first county to train students on their own districts whilst attending lecture centres at either Manchester or Liverpool. A report referring to this innovative experiment noted, 'there are a few district nurse/midwife/health visitors in the north, about sixty district nurse/midwives in the other rural areas, and general district nurses in the more urban and industrial areas'. Apart from superintendents, there were 420 district nurses working in the county in 1958⁵¹ – a fall of 16.5% since the 1930s. Table 9.1 shows Lancashire to have had a much larger population than the whole of South Wales in 1931, and only 1% of that was considered to be 'un-nursed' at that time, although it was then felt that 84 more nurses were needed to cope adequately with the heavy workload. We will look firstly at the city of Liverpool and its suburbs before considering the organisation of the DNAs serving the mill towns, ending with a brief look at the different requirements of rural north Lancashire.

1) Liverpool and suburbs

In Liverpool itself, as in Cardiff, there was a QNI training centre and nurses' home which was very proud of its long tradition, and served a similarly culturally diverse population, as Liverpool was a major port and centre for trade and commerce. The study conducted by the Pilgrim Trust described Liverpool as: 'a port with a past of great prosperity but now suffering from prolonged depression'⁵² which included heavy and long-term unemployment. Queen's nursing probationers were drawn from across the north of England and North Wales, and

so Antrobus, A., 1965, 'Pioneers Still', *Guardian* (January 29); Hardy, G., and Lemin, B., 1972, 'William Rathbone Staff College: past, present and future', *DN* 15(6 (September)): 120-121.

"Jones, L., 1958, 'Lancashire's Training Experiment', *QN*, 1(7 (October)).

s2 Temple, W., (Pilgrim Trust), 1938, *Men without work*: 29.

could be placed for one year after training wherever they were most needed. Nevertheless, concern was expressed in 1934 that: 'The population of Liverpool is about 866,013. Of that number only about 1,000 contribute to the support of the District Nursing Association, whose nurses last year attended 7,288 cases, and paid 177,393 visits'.⁵³

The Woolton DNA in Liverpool had been founded in 1879 with one nurse in lodgings in the slums, and the association's finances were boosted in 1920 when the closure of the Woolton Provident Dispensary made over stock investments to the DNA, 'with the suggestion that the income derived from it shall be applied by that Society for the purpose of providing comforts for the sick poor'. From this point three nurses were employed with almost a third of their work comprising midwifery by 1939. Minutes were generally pre-occupied with fund-raising events such as flag-days and open days at the nurses' home. Although salaries and allowances were above QNI recommendations few nurses stayed in post for more than one year in the inter-war period, several leaving under less than happy circumstances such as Nurse H. who was 'unsettled' and wished to return home but registered her 'objections to the way in which she had received notice', Nurse P. who was discharged because she refused to do extra 'relief midwifery' and Nurse R. about whom it was reported: 'this nurse is not an easy person to work with'.⁵⁴ This last remark was attributed in the minutes to the one nurse who did stay for a long time, Nurse G., who appears to have held considerable influence over the selection of nurses, and remained from 1925 until her retirement in 1950. This would suggest that personalities and power-politics played their part in retention or otherwise of newly trained district nurses, although the extent to which this applied is not known.⁵⁵

The district of Great Crosby, a suburb of Liverpool⁵⁶ covered a 'residential and agricultural area of twelve square miles, the DNA of which was managed by a committee, financially supported by a mixture of subscriptions, donations, fees and grants. One QN was employed to cover this district until 1929 when a second was appointed, (rising to three in 1934 but returning to two in 1938). The nurses covered general nursing and midwifery and their salaries were recorded as, '£69 rising to £75 plus £8 uniform allowance' gradually increasing to '£80 plus board (£1.10s) and laundry plus £8 uniform' by 1935 in line with the national average for QNs with midwifery. However, of the thirteen nurses recorded on the register as

⁵³ Liverpool Record Office: 352 WOO Woolton District Nursing Society, Liverpool: 352 W00/1/3-5 Minutes 1925-50.

., Ibid.

⁵⁴ My personal experience of wrk?tg amonst a similar grop of older, firmly entrenched nurses supports this hypothesis, and a sImllar expe lence was descnbed by (DINI I, 01/10/96, Oral History) Mrs. B. R. in South Wales, who expenenced resentment and resistance to change from the 'older nurses'.

⁵⁶ Founded 1921 with a rising population of 16,00 at that time and 20,015 ten years later, this actually comprised Great and Little Crosby and Blundellsands.

working on this district over the years 1922-1939, three resigned to get married and four to go abroad. A similar picture emerges from Bootle, a coastal district on the outskirts of the Liverpool which has a mixed pattern of lengths of stay in post suggesting that at least some of these nurses were sent to the suburbs from the Liverpool QNI training centre for their compulsory first year but did not wish to stay longer.

2) Industrial towns of Lancashire

Of the three regions, Lancashire shows the most direct and open participation by philanthropists and employers in providing nursing care for their employees. An example of this is Summerseat, a district in many respects similar to Bacup, affiliated to the QNI in 1914. Their nurse covered a small area (one square mile) succinctly described in the QNI inspector's affiliation report as: 'Industrial, cotton mills', and a population that was fluctuating between one and three thousand.⁵⁷ The association was managed initially by 'Messrs. Hoyle Bros. with a small committee', and from 1919 this became just two trustees: Horace Hall Esq. and Mrs. Sydney Whitehead, with the 'Nurse paid by Mill owners for the benefit of their employees'. The QN performed 'general, monthly and midwifery cases' and by 1923 undertook infant welfare work, receiving 'usual salary and allowances' whilst renting a furnished cottage. Initially this work also included health visiting but that appears to have been discontinued by 1918. The first nurse left within the first year, 'for military reasons' and her replacement, Nurse P. who stayed until 1923, was paid a generous annual salary of £115 inclusive rising to £150, being replaced by Nurse S. who was paid £155 yearly rising in annual increments to £164, and the record notes that even her gas bill was paid by the DNA.

A second example is the town of Littleborough, which covered an industrial area just north-east of Rochdale, of approximately three square miles and a growing population.⁵⁸ In this case the DNA was managed by a general and executive committee, and unlike Summerseat, this supported two nurses through house-to-house collections and paying patients. In 1917 the records note midwifery was having to be undertaken, 'owing to shortage of doctors',⁵⁹ But this work was discontinued in 1921 after which it was felt just one nurse was needed 'for general work only' until 1932, this suggesting that midwifery had accounted for a large part of the workload. Whilst there were two nurses, a furnished cottage and bicycles were provided, but this changed to 'rooms' in 1921 and at some later point a car was provided.

⁵⁷ QNI Inspector's reports record populations in 1914 estimated at 2,000, falling to 1,000 in 1923 but back up to 2,559 in 1931.

⁵⁸ According to QNI Inspectors' reports, rising from 13,000 in 1917 to 16,821 by 1931.

⁵⁹ This was a relatively common problem during the First World War and lasted for a little while afterwards - see also Chapter 4.

Unusually, terms are included for the early period noting that 'The nursing of better class patients is undertaken and reasonable fees charged' these being:

1 daily visit (according to time occupied) from	7/- to 10/- per week
2 " " (" " " ") "	10/- to 20/- per week
Assistance at an operation	5/6 to 10/6
Single visit	1/- to 2/6
chronic cases requiring 3 or 3 visits per week	10/6 to 15/6 per month ⁶⁰

In 1919 the records note that annual Grants were received (£10.10s) from the Cooperative Society, (£6) from Gatside's charity and (£21) from Board of Guardians, together with income from midwifery undertaken. This example serves to demonstrate the very business-like way in which many of these DNAs were run, particularly following the move towards a more inclusive nursing care provision for the whole community. The care provided by the nurses was the same whatever the social background of the patient, but it is clear from this and similar examples elsewhere,⁶¹ that a means-related system existed (see also discussion of the role of the welfare state, chapter 6). Nurses came to and left the district in pairs until 1921, rather as in Bacup, consistently staying about three years. From 1921 an unusually high starting salary was provided of £150 p.a. plus furnished rooms with the addition of 'fire, light and attendance'. These two examples suggest areas in some ways similar to the mining towns of South Wales, but the salaries and living conditions offered to the nurses were considerably better and I would argue that, as a direct consequence their length of stay averages at four years, rather than one or two noted in the Welsh examples. It may be that higher female wage rates being paid to textiles workers in Lancashire dictated these higher salaries for trained nurses.

There are numerous similar examples of privately-financed or works-funded ONAs such as Ashton in Makerfield, largely funded by The Lady Gerrard but with £100 support from the Colliery owners, and Irlam and Cadishead, an 'Industrial and agricultural' district located between Manchester and Warrington, the nursing association of which was managed by a committee and supported:

'by all large works. The employees have consented to a levy of Yld per week' which brought in a total of £300 annually, together with grants from Barton and Irlam and Cadishead Boards of Guardians'.⁶²

However perhaps the ultimate example was the district nursing association at St. Helen's which was supported by the Pilkington family, a large family-owned glass-making company. This included the provision of a purpose-built nurses' home opened in 1927 and enlarged

⁶⁰ SAIQNI Box 115 Q6/11-22: Rolls of Affiliated Branches, England and Wales.

⁶¹ Burdett, H., 1900-31, Burdett's Hospitals and Charities Yearbooks.

⁶² SA/QNI Box 115 Q6/11 22: Rolls of Affiliated Branches, England and Wales.

considerably in 1935,⁶³ as well as a tradition of committee membership by a member of the family and private donations. The Nursing Association was established in 1884 and was originally run by six 'ladies' including Mrs. R.A. and Mrs. W.W. Pilkington. By 1935 they employed a staff of 25 district nurses supported through a contributory scheme. This was felt to be so successful, that Mrs. Pilkington gave evidence to explain and defend the voluntary system in 1942 to Sir William Beveridge (see chapter 5).⁶⁴ A district nurse who trained at St. Helen's in the 1950's described the positive and negative aspects of this 'top-down' organisation:

Oh yes. Each ...what happened, when we first started on the District, our District In St. Helens, was run by a private Committee. It was St. Helen's District Nursing Association. Lady Pilkington was the Chairman ...Chairwoman. And Mrs. Greaves was on the Committee, and Mr. Laylum, and so on. And it was run by this private Committee. It wasn't attached (controlled by the local authorities] ... you know. I think we were like a little service on our own. And we had a Matron, an Assistant Matron, and a Chief Nurse. And the Matron was Miss R. She came from Yorkshire. She just came there at the same time as me. And the Assistant Matron was a lady called Miss Y. Now, she taught me a lot. Wasn't so much ... theoretical work, because I knew all that, but it was the communication between people, and that ... did me more good than anything, really. I used to enjoy ...we used to go out together three times a week. (...) She used to come out with me. They would give you a District, and you had a set area, and we used to cover about ... 20125 patients a day. (Prompt: That's a lot!) Oh yeah. Now, they were mixed. So many injections, so many general care, so many dressings, and all that. A mixed bunch like that. And the numbers used to go up or down, depending on what you'd got. But ...she taught us a lot. And we used to do the "Inner Circle". The Districts were all split up into areas, now, the inner areas, around the centre of the town •• we used to go out on the cycle, of course, on the push-bike. And they were the teaching areas, really, because then the tutors used to come out on cycles and so on. Now, outside of that, is other areas, that people used to go to in cars.⁶⁵

However, this study would not be complete without reference to the prolonged depression of parts of this region, and the effects this must have had on the health of its inhabitants and the consequent heavy workload on community health workers. A nurse who worked in Oldham, Lancashire in the late 1920's and early 1930's described the prevalence of diseases related to poverty particularly malnutrition, rickets and high maternal and infant mortality rates, and to

⁶³ 1927, 'The New District Nurses' Home at St Helen's', *QNM*, XXII(9): 205, 1935, 'Enlargement of the Home at St. Helen's', *QNM*, XXV11(8): 242-243.

⁶⁴ "SAIQNI Box 81 *W/3n/2*: notes on interview dated 08/07/1942, between representatives of the QNI and the Interdepartmental Committee on Social Insurance and Allied Services.

⁶⁵ *DIN* 27, 18/05/00, Oral History: Mr. A. F. (see above).

the hardship of work in the cotton mills, including high levels of respiratory diseases and cancers of the mouth from handling and spinning the raw materials.⁶⁶ She vividly described attending an emergency confinement in a dirty and very poorly-lit home with no electricity or running water, and with the mother lying on two orange boxes in an otherwise bare room and having nothing in which to wrap the baby, (this had to be borrowed from a neighbour). She commented on the widespread ignorance of effective contraceptive methods, which she felt exacerbated many of these hardships. Similarly, Blackburn which in the 1930s was considered 'typical for the whole cotton area' was described as 'grim ... everywhere is a forest of tall brick chimneys, against a sky that seems always drab, everywhere cobbled streets, with the unrelieved black of the mill girls' overalls and the clatter of wooden clogs.'⁶⁷ Unemployment amongst women was considered to be a major problem in these areas, and signs of stress and malnutrition were also most evident in the women.⁶⁸ Nurses interviewed in a BBC documentary set in Lancashire,⁶⁹ commented that the ill health of women often contributed an additional burden to their heavy workload as district nurses and midwives, as GPs fees before the NHS were prohibitively expensive for those excluded from national health insurance. Both commented on the problems of infestation with lice, fleas and house mites, and in providing a layette for new babies, before describing the problems in procuring abortions and getting family planning advice, commenting that home versions were used such as Epsom's Salts. The community they served clearly depended heavily on the nurse and midwife. Similar experiences were described by several Liverpool district nurses interviewed in my own primary series and by Frances Trees. For example, one my interviewees describing her experience whilst training as a health visitor in Liverpool in the 1950s noted:

(The Wash houses) were in ... you see, most of the houses in Liverpool, that we went to, had no facilities for ... for washing, and hanging the washing out. They just had yards, didn't they, you know, and ... and a brown sink in the back kitchen, and a cold water tap. But the Wash Houses, they had in various areas round Liverpool, and for the women, it was a day out, really. They used to put all their dirty washing in a pram, and push it up to the nearest Wash House, take their own soap powder with them, and ... J think ... I can't remember how many sinks there were, they took us on a visit there, probably about ... there might have been as many as 14 or 15 sinks, and they had the hot water and everything, and they took their own powder. And I remember, Tide had just come in at that time, and they wouldn't let them use it, because they thought it was wrong for the sinks. But they were there most of the day, you see, and they all knew one

⁶⁶ *DIN* 19, 13/02/97, Oral History: Miss K.L. trained 192-27 in Oldham, Lanes. and SCM in Edinburgh some time before taking a district nursing post in Wiltshire which for she received no official training.

⁶⁷ Temple, W., (Pilgrim Trust), 1938, *Men without work*: 82.

⁶⁸ *Ibid*: 133-143.

⁶⁹ 1989, No. 4 'Mustn't Grumble', *Out of the Doll's House*.

another, and it was a ••• a social outing. (LAUGHS) Because, you see, people didn't have washing machines then. They were just beginning to come out at that time. And I remember the Tide, because when I came on the District, as a Health Visitor, an awful lot of women had dermatitis on their hands then, and they all said it was due to the washing powder, the new ones that were just coming out.⁷⁰

She also commented that two of the major problems she encountered when first working in Liverpool and St Helen's in the 1950s were infestation of the heads with lice and impetigo in children, as had been the experience of the nurses in Bacup thirty years earlier.

3) Rural Lancashire

We look finally at district nursing provision in rural Lancashire. Hawkshead and District is now part of Cumbria but was included in Lancashire until the boundaries were changed in the 1970s. This has been included as the experiences of nurses in this remote, rural setting would have been quite different from those described so far. Like the rural nurses in South Wales and Dorset they covered a particularly large area recorded in 1924 as: '6x2 miles' and increased to '25 square miles' in 1934. It was described as a 'country district, rather hilly' adding 'cyclist necessary' but from as early as September 1925 a Morris Cowley, two-seater car was provided. A committee who ran a provident system of subscriptions and donations, managed the DNA which employed just one QN who covered both general nursing and midwifery. The first, Nurse F stayed from 1919-24 and was paid £75 annually, plus 21/- board and laundry weekly, and £8 uniform allowance, having 'two furnished rooms with fire, light and attendance provided' -later a furnished cottage was provided. Nurse E who stayed fourteen years from 1924-38 and who, very unusually, took three months out in 1930 for a 'hospital post-graduate course' (although unfortunately there are no details of where this was undertaken or what it entailed), succeeded her. The role of health visitor is not mentioned although it is probable that this work was undertaken if somewhat informally. Rather more typical was Camforth district nursing association, founded in 1920 and covering an area of one mile radius, described as a 'small town, slightly hilly', situated just North of Lancaster and with a population of just 3000. A small committee ran it using the 'Provident system' employing one QN for, 'general and midwifery and monthly nursing'. She was provided with lodgings and a bicycle, and her salary started at £75 rising to £80 plus an £8 uniform allowance. Over the period 1922-38 there were four different nurses averaging a stay of four years each.

The particular combination of varied topography together with unique cultural backgrounds, present a distinctive scenario for each region - and arguably, for each district. In addition,

⁷⁰ *DIN25, 17105100*, Oral History: Mrs. C. P.: trained SRN at the London Hospital from 1944-47 before moving to Liverpool to complete her midwifery training, later becoming a district nurse and health visitor.

socio-economic contexts also had a considerable impact whether this was unemployment throughout Lancashire in the inter-war period,⁷¹ the miners' strikes and subsequent depression in the South Wales valleys or the 'Blitz' in cities such as Liverpool. In each case the knock-on effects would have been felt acutely by the district nurses through increased workload, the types of disease or injuries resulting from poverty or war, or even occasionally affecting them directly by making their employment unsustainable. As a result, although nursing associations were theoretically set up and run on formulaic lines and Queen's district nurses were all trained to the same standards and with the same basic techniques, nevertheless the formulas had to be adapted to meet the special needs of each particular community. Terms and conditions of employment varied until a national standard was imposed in 1948, and even then, variations in emoluments offered by individual associations may have been used to entice nurses and persuade them to stay in post. Even after 1948 it has been shown that different local authorities responded differently to the options open to them regarding district nurse organisation and training, some handing over full responsibilities immediately whilst others, such as St. Helen's resisted the local authorities for a further 25 years.

The nostalgic image of a district nurse who lived in, and felt part of her community, would also seem to be of only limited reality. These case studies have revealed far greater mobility between district placements amongst nurses than this image would suggest. Although some of these may be explained by the QNI's policy of compulsory one-year postings immediately following qualification as a QN, it would seem likely that these first placements were often used to staff positions that were otherwise difficult to fill. The idea of the district nurse staying for most of her life in one post -certainly before 1948 - seems to be a popular stereotype with little foundation in reality, although there were certainly a few who did. This may be compared with a similar pattern discovered amongst GPs, again refuting the popular image of the 'family doctor' staying in one practice throughout his professional lifetime. In fact it has been shown that they, too, usually moved several times during their careers, and like the nurses, sometimes returned to hospital work or went abroad to practice after a period of time, particularly during the inter-war period.⁷²

⁷¹Roberts, E., 2000, The Recipients' View of Welfare, Oral History. Health and Welfare. J. Bomat et al: 203-226, notes variations across the county in this respect such as Barrow-in-Furness suffering 49% unemployment in the Depression of 1922 in which ship-building was badly hit, compared with only 7% in Wigan and 10% in Bolton, whilst 1931 and 1932 were more uniformly bad years throughout the County with levels ranging between 27% (Barrow) to 47% (Blackburn).

⁷²Digby, A., 1999, The Evolution of British General Practice 1850-1948: 75-78.

Conclusion

The work and experiences of district nurses has been shown here to be subject to several layers of cultural influence.⁷³ Firstly, the local and regional culture which must include the more individual elements that might have made one town or village distinct from another, together with the individual characters of the nurses and of the association's committee. These influences, whilst evident from these studies, are difficult to evaluate and appear to some extent masked by the more obvious urban or rural factor. This dictated for example whether a nurse was also the midwife and the health visitor covering a large, and often lonely, district on her own or with only one other nurse, or whether she was one of a community of nurses in a town or city, living together and practicing general nursing only, under the much tighter supervision of a home superintendent. However, I would argue that the topmost layer in this model was the over-riding one of nursing culture. The heavily gendered 'culture' of nursing can be seen to consist of a common language, methods of practice, educational background, and even recognisable rituals and traditions. It seems evident from the oral histories that the district nurses would have experienced their specific brand of this culture including a particular set of jargon, distinctive skills involving ingenuity and their own folk memory in the form of shared anecdotes, together with a common daily ritual which is related in much the same way throughout all the interviews conducted. In effect this would have meant that a district nurse might have found working in Lancashire, different from Dorset or South Wales, and might have found it easier to fit in to the local community in one area rather than in others. However, the work she would have done, and her place in society, would have been substantially similar and familiar to her, wherever she practiced.

⁷³For the purpose of this thesis this is simply taking 'culture' as relating to a system of interrelated values and customs representing the collective experience of a particular group of people.

Chapter 9: 'Generalists and Generals': District Nursing Professionalisation

*'Professional society is based on merit, but some acquire merit more easily than others'*¹

District nursing has been referred to throughout this thesis as a sub-profession of nursing with frequent reference to the complex intra- and inter-professional relationships - in particular, those with other members of the community care team - the health visitors, the midwives and village nurse-midwives and the GPs. This chapter seeks to examine the meaning and implications of 'profession' and 'professional' as applied to district nursing and the district nurse working in the community health-care context, and how this might relate to a wider field. It will explore the contested roles that have been outlined chronologically in chapters three to six before going on to highlight what this suggests about the changing perceptions that differentiate the generalist and specialist, and about the hierarchy of related professions.

Whilst hospital nursing increasingly gained recognition as a *profession*, particularly after the Nurses' Act (1919), the district nurse to a considerable extent appears to have retained a more *vocational* image for at least the subsequent thirty years. In contrast, over this same period the GP was most commonly a male practitioner and until the NHS Act came into force his practice was owned and managed by him as a business having moved away from being perceived as 'trade' in the early nineteenth century to a 'respectable', autonomous and professional status².

Why did the professional image become so highly prized above other descriptions such as 'vocation', 'trade' or 'occupation'? - Possibly these last two imply elements of lower status, combined with subservience or submissiveness, which tend to be associated with skilled but traditionally lower class-based, work. Occupations may be differentiated from professions by looking at the method of regulation - that is the self-regulation through peer review and an internal control mechanism of the latter as opposed to external controls used in regulating the former. Freidson amongst others, refers to the professional system as 'collegiality',³ 'Vocation', on the other hand, implies a quasi-religious calling often associated with amateur enterprise in which material gain and organisation as a recognised body have low priorities compared with the sense of spiritual fulfilment.⁴ A paper presented by the Deputy Medical

¹Perkin, H., 1989, The Rise of Professional Society: England Since 1880.

²Digby, A., 1994, Making a Medical Living: 37.

³Freidson, E., 1988, Profession of Medicine: a study of the sociology of applied knowledge; and Wilding, P., 1982, Professional Power and Social Welfare.

⁴For example: Crouch, M., 1950, 'The Future - Profession or Vocation', QNM, XXXIX (9 (September)): 130-133 and 19, was written in a quasi-religious style with biblical quotations urging a more vocational outlook and self-renunciation in contrast to the concerns about professional status pay and conditions of service which she felt were damaging to the underlying ethos of district nursing. However, similar concerns were expressed by Mackay, L., 1998, 'Nursing: will the idea of a vocation survive?' The Sociology of the Caring Professions. P. Abbott, and Liz Meerabeau, : 54-72, referring to

Director, Central Council for Health Education⁵ in 1957 attempted to establish the meaning of 'profession' and the reason and need for professional organisations with particular reference to those involved in medicine and nursing. He based this initially on the need for a contractual relationship that would create confidence in the practitioner, stating that this must include possession of 'qualifications obtained after recognised training, which will be a guarantee to a client' whilst taking personal responsibility to the client as an essential to this. In his view it followed that this also involved the need for a professional organisation that was neither a guild nor trade union, and yet involved maintenance and promotion of professional 'status' (presumably from within), through provision of a service to that part of the community which needed it. Therefore he claimed that a 'profession exists primarily to serve the community' and 'should not further its own interests for its own sake, but only in so far as this is necessary in order to serve the community'. This is rather an altruistic definition compared with the more self-interested rationale put forward in this, and previous chapters, however, the boundaries between altruism and enlightened self-interest can prove difficult to define in reality.

However, being a professional may be measured using alternative or additional criteria. Society often recognises a person as having professional rather than occupational status, but the criteria used to make this distinction are quite obscure and amorphous. In 1937, Miss Wilmshurst, the General Superintendent of the QNI referred to the freedom and independence experienced by a (Queen's) district nurse, and particularly to the possibilities for district nurses to,

'have homes of their own, for instance. It is a joy to every woman to have her own home. [...] "This freedom" is not, to her, a catch phrase: it is an ever-present condition of her life. Frequently she has a car. What other working woman dependent on her earnings can have a car so early in her career? Of course her car is for working purposes, but the office clerk, clinging to her strap, will probably never know the joys of handling a car at all.'⁶

These were the standards against which she was measuring district nursing as a professional career for a single woman, for whom the opportunities were largely limited to office work or teaching. Several oral history interviewees similarly offered office work or teaching as the main alternatives they saw for themselves in the 1940s and 1950s with three having actually worked as secretaries together with one as a cashier and another as a teacher, prior to training

the view of the 'new nurse' that 'nursing is a job like any other' combined with transfer of patient to customer status and associated 'righteous' attitudes referred to in Chapter 6 of this thesis.

⁵Dalzell-Ward, A. J., 1957, 'The Reason and Need for Professional Organisations', *Nursing Mirror*, 53(November 8): 431-432.

⁶Wilmshurst, M., 1937, 'Fifty Years an Institute', *Nursing Times*, XXXIII(1677 (June 19)).

as nurses. For those who reached supervisory or nursing officer status, the pay and conditions of work that might appear unfair and male dominated over half a century later, appear to have been accepted with little question, whilst the potential opportunities of travel, managerial experience, independence, public respect, and material things such as a car and telephone and possibly home ownership, marked the district nurse out as a professional person. As more women were able to aspire to these symbols of status, it seems reasonable to see a fall in prominence, particularly if the district nurse's standing within the nursing profession as a whole had dropped, as was seen to happen for a while following the NHS Act (1948).

What is a Profession?

'Profession', can be seen to imply a set of values and judgements recognised both nationally and internationally. Identified by Giddens⁷ these may be summarised as:

- Autonomous regulation and control and (to a large extent) internal accountability - this incorporates training which has become increasingly focused on higher education, rather than apprenticeship; qualification; registration; and policing 'professional' behaviour of registrants -i.e. accountability to a self-regulating body (GMC for medicine, Bar Council for Law, Chartered Society of Physiotherapists, General Nursing Council etc.). Unlike the professions of clergy, law and military, medicine and nursing have no heads such as Lord Chief Justice, Archbishop or Commander in Chief and were/are not bound by an oath of loyalty to the monarch -rather to themselves through the (resurrected) 'Hippocratic Oath' or 'Professional Code of Conduct'.
- Autonomous Practice -taking Medicine as our example, this includes 'ownership' of the client, particularly in the public sector, and control of positions of social and economic power in the market e.g. keeping 'irregulars' out of public offices⁸ such as appointments in public health, hospital consultancies, the colonial medical service or prison service, and a large degree of control over regulating ethical practice and malpractice. To this end the regulating body defended the rights of its members to exclusive medical practice using the title 'Doctor' in the latter part of the C19th. Although autonomy of practice applies in a similar way to most professions, nursing and other health-related professions inevitably have a watered-down version with medicine being the 'lead' profession. Larkin refers to this as 'occupational imperialism'⁹ .This will be discussed in more detail later.
- Public recognition and respect -the 'professional' is perceived as the gatekeeper or bridge between elite knowledge and skill base, and the lay public -it is this that is marketed rather than *trading* in visible consumables such as medicines - in turn this

⁷Giddens, A., 1997, Sociology.

• 1921 'Editorial', Queen's Nurses' Magazine, XVIII(4): 62-63., urges nurses to comply with registration sooner rather than leaving it too late: despite being given 'two years of grace' and record the expectation of professional satisfaction that 'The day is not far distant when Public Health and other State appointments will go to nurses who are registered rather than to those who have not registered.'

⁹Larkin, G., 1983, Occupational monopoly and modern medicine.

creates a 'professional' relationship with the patient or client that combines authoritative power and a strict code of confidentiality and ethics, with 'professional' distance that, with reference to medicine, Sinclair¹⁰ refers to as entering a ritually 'scientised' and 'pathologised' world which becomes a 'nosophony' or representation of disease. According to Foucault¹¹, medical discourse came to represent an authoritative body of knowledge that has permeated society both through ideas and beliefs and through a powerful set of social and political institutions.

- Inter/ Intra professional recognition and respect -power and status linked with specialisation rather than generalisation -Larson¹² refers to this as 'exclusive cognitive identity' necessary both for creation and subsequently for exploitation of the market (see paragraph above). Whilst a common educational experience created group solidarity within the medical profession, beneath this there lay a complex professional hierarchical system of 'co-operative competition'¹³ and prestige of specialties, teams and institutions.

Both Davies and Witz¹⁴ add a sixth characteristic, which is that a profession is traditionally male-dominated -the medical, legal and clerical professions all have this tradition which despite Twentieth Century inroads by women remains top-heavy with men at the beginning of the Twenty-first century. As a result, Nursing and Midwifery sit uneasily here and might have been perceived more as 'vocations' or 'occupations' (see above) or as 'semi-professions' throughout the period under discussion here. Stacey writes of the inadequacy in trying to express concepts for understanding how women fit into the workplace and has led to the categorization of semi-profession. She sees these as encompassing:

tasks which, like nursing, are undertaken in both the private domain (unpaid) and in the public domain, where they are paid at market rates depressed because they are 'women's work'. The confusions which abound in the analysis of professions can be related to this conceptual lacuna and result in such awkward notions as the 'semi-professions', not only an unhelpful concept but insulting to those (mostly women) in the occupations so labelled.¹⁵

The notion of a continuum ranging from manual occupations to recognised professions such as law and medicine, as proffered by Wilensky¹⁶ implies that there is no definite division

¹⁰ Sinclair, S., 1997, Making Doctors: An Institutional Apprenticeship.

¹¹ Foucault, M., 1973, The Birth of the Clinic: An Archaeology of Medical Perception.

¹² Larson, M. S., 1977, The Rise of Professionalism: a Sociological Analysis: 15.

¹³ Sinclair, S., 1997, Making Doctors: An Institutional Apprenticeship: 151.

¹⁴ Davies, C., 1995, Gender and the Professional Predicament in Nursing; Witz, A., 1992, Professions and Patriarchy.

¹⁵ Stacey, M., 1983, 'Social Sciences and the State: Fighting like a Woman', in The Public and the Private, E. Gamarnikow et al (eds.).

¹⁶ Wilensky, H., 1964, 'The Professionalisation Of Everyone', American Journal of Sociology, LXX(2 (September)): 143-144.

between an occupation and profession, and that an occupation can be more developed professionally in one area than another. In reality, many of these values and judgements which in theory could differentiate between nursing as vocation, occupation or profession, have been continuously changing their parameters in relation to variables such as relationships to other fields or specialisms within nursing and medical practice, developments in medical and surgical technology, social and economic change and the bureaucratic control of power. Nevertheless it is possible for all three to co-exist rather as a three-sided pyramid presenting a greater or lesser degree of altruism depending upon which facet is most evident. Bellaby and Oribabor discussing the 'contradictions within professionalism' apply Johnson's approach to understand the position of nursing within the health professions. This approach places 'professionalism within the relation between the producer of a service or goods and the consumer' and they consider that 'the establishment of a profession depends upon external factors - breaking loose from the patronage of consumers, gaining a monopoly over a sphere of practice and establishing the means to defend it (usually a law), freedom from intervention by third parties - and internal factors - means of socialising and disciplining members.'¹⁷

Their discussion is predominantly centred on the professional development of the hospital nurse and points to the fact that the framework within which nurses worked had been established and was largely controlled by the medical profession, whose ideology dominated the hospital including defining the needs of patients through the role of gatekeeper. Burrough explains that "In the process of emerging as a profession, an occupational group tends to delegate many of the more mundane tasks to other groups or individuals."¹⁸ This concept can be applied both to occupational imperialism demonstrated by doctors delegating downwards to nurses, and to sub-groups of nursing seen within its hierarchical construct, particularly with the emergence of the 'Enrolled' and 'Auxiliary' nurses. Similarly Jewson¹⁹ describes the process of medicalisation from person-orientated to object-orientated through institutionalisation and the development of an authoritarian medical profession. This is described as being multi-causal, citing changes: in medical patronage, perception of the patient, perceptions of illness and changing roles and tasks of the doctor as 'medical investigator' in a science-based medicine (based on research, diagnostics and therapy) with the introduction of specialisation and reductionism through anatomy and pathology and later through the development of laboratory science - in particular, cellular biology. The

¹⁷Bellaby, P., and Oribabor, P., 1982, "The History of the Present" - Contradiction and Struggle in nursing', in *Rewriting Nursing History*, C. Davies (ed.): 159-161.

¹¹Bullough, V. L., 1966, The Development of Medicine as a Profession: The contribution of the medieval university to modern medicine, quoted in Burnham, H. C. 1998, 'How the idea of profession changed the writing of medical history', *Medical History* (Supplement No. 18): 105.

¹⁹ Jewson, N. D., 1976, 'The Disappearance of the Sick-Man from Medical Cosmology, 1770-1870', *Sociology*, 10.

professional distance between practitioner and patient was therefore increased as 'a ritual mode of differentiation between the established and the outsiders'²⁰.

However, it was not quite so dear-cut within community nursing i.e. outside the hospital's medical domain, where an increasing degree of perceived autonomy was attainable and where the more rural or remote the practice, the less apparent might be the medical or nursing supervision. In addition, where the district nurse covered a more holistic form of caring encompassing a wider range of roles, the 'mundane' tasks would have been less clearly differentiated from the more glamorous or challenging ones than might have been the case in hospital nursing. Therefore where the practitioner and the patient were outside the institutional setting, many of these object-orientated aspects were either greatly reduced or made virtually irrelevant.

Why was professionalisation so desirable to nurses and where did district nursing fit in the struggle to attain professional status?

As society became increasingly secular and consumer-orientated the development of a 'profession' may be seen to have been the means by which the market might be controlled by restricting competition. Anne Digby²¹ considering the financial relationship between doctors and patients in the process of professionalisation, points to medical professionalisation as more than a 'simple power relationship in which doctors increasingly dominated their clients'. Medicine's struggle for autonomous control of the market and of the patient him/herself through the nineteenth century may be perceived as one against all 'unqualified' practitioners with scientisation of medicine as a central theme. The characteristics of the profession that promoted exclusivity and protection of status through a 'closed-door' society supports this concept, effectively replacing a diffuse range of approaches to sickness and healing, with this dominant biomedical approach. This located both professions within a social- and consequently gender- structured, hierarchical and patriarchal system -both professions being at their most sensitive formative stages at a time when Jack of female suffrage and internal professional disunity weakened the nurses' position still further. In addition, this placed greater value on the treatment and cure of acute illnesses and less on longer-term management and cure of the elderly, chronic sick or mentally ill.

This early clash of views is documented and discussed in detail by Katherine Williams²² who bases a chapter upon references from an article published in the BMA by an unknown author

²⁰ Ibid.

²¹ Digby, A., 1994, Making a Medical Living: 6

²² Williams, K., 1982, 'From Sarah Gampt to Florence Nightingale: A Critical Study of Hospital Nursing Systems from 1840 to 1897', Rewriting Nursing History. C. Davies: 41-75.

which is then compared with one by Margaret Breay²³ published in the Nursing Record and Hospital World, (both articles published in 1897 on the occasion of Queen Victoria's Jubilee). In this comparative study Williams makes an important point concerning professionalisation appear clear-cut: that to the section of the nursing community supporting registration which Miss Breay would appear to represent, selective recruitment of suitable – and by implication, female – students, combined with a 'modern system of [hospital, apprentice-style] training and educating' are the essential 'first principles' which will raise the professional status of the nurse and "it is upon the principle of Profession that the public identity of nursing should be settled". In contrast, the medical view expressed in the BMA article cited, suggests that some doctors would prefer nursing reform and a 'skilled profession' to be limited to reform of selection procedures only, with the aim to increase the 'womanly character' or feminine attributes associated with caring for the sick, whilst retaining the position of employment as 'ward-maid'.

In my opinion this represents an over-simplistic view of medical and nurse-theorists at the end of the nineteenth century whereas in reality this just represents two poles of opinion. For example, Mortimer²⁴ argues that the private nurse was in quite a different position, possessing far greater autonomy of practice in some circumstances whilst working in close proximity with doctors in others, and as colleagues rather than as competitors. It would be reasonable to assume that other nurses working outside the constraints of the hospital, might also have experienced a similar, albeit diluted, feeling of independence. It would also seem reasonable to believe that some more enlightened doctors would have welcomed skilled and educated nurses rather than 'ward-maids', appreciating that they could be trusted both to care for, and to educate their patients, as discussed in chapter three, albeit under their own terms. Nevertheless, this discussion is important in underlining the recognised significance of skilled independent practice by both nursing and medical profession, despite the fact that professional autonomy was not highlighted as an important characteristic of professionalisation until 1933, when Carr-Saunders and Wilson wrote The Professions²⁵.

In 1943 in a lecture explaining of the possibilities of an NHS in the post-war reconstructing of health care provision, Dr. Balme explained how he saw the problems of nursing in not being a

²³ Margaret Breay was a close colleague of Mrs Bedford Fenwick over a 40 year partnership, she became assistant editor of Nursing Record (British Journal of Nursing) in 1902 and was secretary and treasurer of all the various societies founded by Mrs. Bedford Fenwick including the ICN as well as being joint author with her of first history of ICN - I am indebted to Susan McGann, Archivist RCN, for this information.

²⁴ Mortimer, B., (2002). 'The Nurse in Edinburgh c. 1760-1860: The impact of commerce and professionalisation' PhD University of Edinburgh (unpublished): 271-286.

²⁵ Carr Saunders, A. M., and Wilson, P. A., 1933, The Professions, refers to both the Association of Hospital Matrons and the College of Nursing as 'professional associations' (pp. 120, 321). See also discussion in Chapter 3 on the counterfactual possibilities had distinct nursing and private nursing amalgamated.

'closed' profession -that is, one in which training centres set a fixed high standard and the title 'nurse' would have been reserved for those whose qualifications admitted them to the Register. He described five categories of 'nurse' practising in the community from the SRN (who might be a QN or district or private nurse), a partially trained nurse or nurse-midwife, a school-leaver prior to starting general training, acting as a Probationer at the local cottage hospital, untrained village women who 'specialised' in the care of bedridden folk, being referred to as "good practical Nurses", and finally children's nurses or 'nannies'. With the war there was the addition of Auxilliary Nurses, British Red Cross and St. John's Ambulance Nurses²⁶ and Assistant Nurses who later were given a recognised training and became State Enrolled Nurses.²⁷ This situation was not the case with medicine, where use of the title 'doctor' was jealously defended by the medical profession following the Medical Registration Act (1858).

In the community situation few would openly question the GP and it is more obvious that from being relatively independent practitioners in mid C 19th, despite their royal charter and patronage and the powerful backing of the Queen's Institute, district nurses were answerable to, and under the direction of, GPs by 1900, - a position fiercely defended in some instances by local branches of the BMA²⁸. However, it is perhaps significant that it was the Health Visitor rather than the district nurse who eventually managed to establish a far more equal and autonomous professional relationship despite their apparent marginalisation and the later threat from social workers. Hart²⁹ partly ascribes this to the lack of a past public image -the women Sanitary Inspectors' Association which preceded the Health Visitors' Association, was formed as early as 1896 but unlike district or hospital nurses, health visitors did not have an earlier public image to hamper their professional development.³⁰

The doctor/nurse relationship has been compared to the 'power relations of the archetypal Victorian family: [using] the analogies of father-doctor, mother-matron/ 'lady nurse', servant-

²⁶ Anderson, E., 1943, 'Queen's Nurses' League - Leeds and District branch report of lecture by Dr. H. Balme on "Post-War Reconstruction", *QNM*, XXXII (4 (April)): 51-52.

²⁷ 1943, 'The Assistant Nurse', *QNM*, XXXII (I (January)): 1-2, recommended a scheme of training and enrolment for 'such work as she will be permitted to undertake' would best 'safeguard the Registered Nurse from the unfair competition from which she has suffered in the past'. This expression of professional concern is perhaps explained by the concern expressed in the same article that, 'when the war ends all sorts of women who have been doing nursing work of various kinds will be let loose on the general public and if allowed to practice as "nurses" with no supervision and no control the lot of the SRN will be pitiable indeed.' The question of supervision remained a headache within community nursing for some time - see also Editorial 1945, 'The Assistant Nurse', *Queen's Nurses' Magazine*, XXXIV (4 (April)): 33.

²⁸ See chapters 3 and 4 with the particular example in, SA/QNI Box 79 H8/1: 1908-19 Correspondence and Minutes of meetings with the BMA re. proposed changes to the rules of County Nursing Associations. Correspondence between QNI and BMA following protests from Penwith Medical Union, Cornwall.

²⁹ Hart, C., 1994, *Behind the mask. Nurses. their Unions and Nursing Policy*: 24-6.

³⁰ See also Chapters 3 and 6 of this thesis.

paid nurse, child-patient'³¹ i.e. ideas based on stereotypes of features of masculinity and femininity projected onto the professions of curing and caring. The invisibility of men in nursing in South Africa is viewed by Marks as being accentuated by racial identities with caring seen as women's work -and extension of their 'essential' natures. The attitudes towards male district nurses described in Chapter 6 suggest they were similarly underrated – if only temporarily so - in the mid-twentieth century -not in the male environment of the services or in the psychiatric institutions, but in the more domestic sphere of community nursing, and by female nurses in particular.

The resultant 'separate spheres' doctrine was undoubtedly used to advantage by some women in establishing their positions in a heavily class influenced nursing hierarchy, yet nurses were nevertheless professionally subordinate to the monopolistic male medical authority and control over their discipline, instruction, economic power and social status until mid-twentieth century (and arguably beyond). Bynum³² describes how the emergence of nursing as a 'profession' in the late C19th, despite becoming increasingly diverse, had, at its focus, 'the hospital' where nurse training-schools were located and younger trainees were 'initiated' into particular duties and skills, rather than in the community. Walby et al.,³³ conveniently present the relative perceived importance of these three models of professional autonomy as:

- a) having complete professional autonomy,
- b) having only partial autonomy but representing the patient's advocate³⁴ in a symbiotic yet subservient relationship with the doctor, or
- c) as totally subservient and obedient 'handmaidens of medicine'

but in actuality they reject either the idea of subservient or of complementary professions, pointing to there being two possibly gender generated or culturally differentiated models of professionalism reflected in their distinctive modes of professional organisation particularly evident in the pre-1972 situation, and these continued in a modified form well after this date.³⁵ For a GP this would have implied taking *direct* responsibility for his or her own actions. Even within a medical team where a patient might be referred to a senior colleague this does not bow to the bureaucratic model, and was increasingly so in General Practice. For a district nurse, however, being professional suggested accountability to others for his or her practice under guidance of rules and hierarchical monitoring procedures. This did not mean that doctors were not to be held accountable to their professional body, more that there was a

³¹ Marks, S., 1994, Divided Sisterhood: 4-7.

³² Bynum, W. F., 1994, Science and the Practice of Medicine in the Nineteenth Century: 188.

³³ Walby, S., J. Greenwell, et al., 1994, Medicine and Nursing: Professions in a changing Health Service: 52.

³⁴ See also Snowball, J., 'Asking Nurses about advocating for patients: 'reactive' and 'proactive' accounts' in Journal of Advanced Nursing, 24 (1996): 67-75; and Digby, A., and Sweet, H., 2001, Nurses as culture brokers in twentieth-century South Africa, Plural Medicine. Tradition and Modernity. 1800-2000. W. Ernst (ed.).

³⁵ This concept is discussed in depth in Walby, S., J. Greenwell, et al., 1994, Medicine and Nursing: 52.

subtly different understanding of that body's role and the mode of intervention based on historical precedent as well as of their own professional autonomy. Central to this is the gendered professional ideal that implies individuality, objectivity, and mastery of knowledge, particular science-based skills and techniques based on formalised training which placed the doctor in a privileged, detached and controlling position over the patient, whilst the nurse was held in a supportive and multifarious role, attending to the *perceived* lower status physical and emotional needs. Rafferty³⁶ describes nursing as: 'caught in a contradiction in so far as it provides the necessary support for medicine to maintain its dominance, thereby perpetuating the subordination of nursing to medicine'. Nevertheless it should be noted that since the 1980's nursing might be seen to have been moving towards the medical autonomous model, whilst medicine was becoming more accountable to the patient as consumer, and to medical audit.

If we apply these concepts to the district nurse's developing role, she may be seen as occupying what has been stereotypically represented as a vocational, maternal or semi-domestic dominantly female role, as a generalist, located outside the hospital institution, concerned more with the 'caring' than the 'curing' of her patient (and until the NHS Act (1948), largely supported through the voluntary sector rather than by local authorities). White³⁷ sees this as critical to the isolation of particular sectors of the nursing profession at least until the Rushcliffe pay agreements of the 1940s. In contrast, the arrival of qualified district nurses and midwives reduced the GP's workload (particularly from the mid 1920's) with less time needing to be spent by the GP at the bedside thereby creating a move towards the surgery list and prescription pad and a professional disposition that was becoming more 'clinical' and less holistic or 'domestic'³⁸.

From a national viewpoint, the second world war marked an important watershed in the professionalisation process, with a substantial increase in the number of nurses employed at Ministry of Health headquarters including the creation of a Nursing Division and appointments of nursing officers for general public health as well as for hospital nursing. It was felt this gave nursing, 'a voice in formulating policy affecting it, and not as one which as hitherto, has had its problems presented chiefly by the Medical Profession.'³⁹ At grass-roots level there was also a move from within the QNI to have a greater say in the running of the profession through the formation of the Queen's Nurses' League in 1942 and its subsequent

³⁶ Rafferty, A. M., 1996, The Politics of Nursing Knowledge: 186-7.

³⁷ White, R., 1978, Social Change and the Development of the Nursing Profession: A Study of the Poor Law Nursing Service 1848-1948.

³⁸ QNI Archives, C., 1907, 1910, 1932, SQNI/ Box 79/H8/2: correspondence re. a case of friction between doctor and nurse, 1907, and cuttings, 1910, 1932. Correspondence between GPs debating the reasons for reluctance on behalf of some GPs to take advantage of district nurses in reducing workloads.

³⁹ Maguire, 1945, 'Report of an Address', QNM, XXXIV(1 (January)): 2-5.

regional and national meetings and conferences.⁴⁰ The NHS Act marked a move away from voluntaristic control and employment and to uniformity of pay under the Rushcliffe and Taylor salary scales and compulsory inclusion of all nurses employed by local authorities in the Local Government Superannuation scheme.⁴¹ Nevertheless, as was shown in chapter 6, these advances were of little value with regard to the critical issues of professional organisation: training and self-regulation of district nurses, which received low priority from government. The result of this was that grass-roots employment and supervision of district nurses fell largely to the office of the MOH. Kratz claims the Working Party that was set up in 1953 to look at the training of district nurses was 'at the behest of local authorities and their medical officers of health'⁴² and that this influenced the findings that 'only little additional preparation was required' for SRNs and none for SENs- a fact supported by testimony from several interviewees cited earlier (chapter 6), who were employed and expected to learn 'on the job'. A comment in the Royal Society of Health Journal expressed the economics of the situation: 'It remains to be seen how many authorities will consider it desirable or will be able to insist that their district nurses have some special training, especially in view of the fact that a district nurse with special training at present earns £10 per annum more than a nurse who does not have such training.'⁴³ Inter-professionally, even following NHS re-organisation in 1974, some district nurse sectors came under hospital nurse-management, whilst others were under the community-based control of HV directors of nursing - either scenario continuing effectively to bar district nurses from *direct* participation in their own management, policy-making and implementation. This was eventually addressed in 1979 with the Nurses, Midwives and Health Visitors Act, which was responsible for reconstituting the Panel of Assessors for District Nursing Training.

A further concern was the introduction of home helps, auxiliary nurses and SENs to community nursing, (see below) and the title 'home nurse' to encompass all grades of nurse working in the community and which was also used to describe care provided by voluntary organisations such as local branches of the British Red Cross and St. John's Ambulance. Concern was expressed, 'for proper distinction between the amateur with an elementary knowledge of basic principles, that enables her to look after a sick relative or neighbour, and the experienced, fully trained, professional district nurse.'⁴⁴ This emphasises the importance

⁴⁰ See, for example issues raised in 1942, 'Queen's Nurses' League Conference', ONM, XXXI(11 (November)): 83-95, relating to relationships with other professional organisations, salaries, interprofessional issues, post-war refresher courses and the need for State recognition of Queen's training.

⁴¹ 1945, 'The Ministry of Health Superannuation of Nurses and Midwives', QNM, XXXIV(S (May)): 43-44.

⁴² Kratz, C. R., 1982, 'District Nursing', Nursing, Midwifery and Health Visiting, P. Allan, and M. Jolley: 80-91, referring to Ministry of Health and S. F. Armer, (Chair) et al, 1955, Report of the Working Party on the Training of District Nurses.

⁴³ 1957, 'Training of District Nurses', Royal Society of Health Journal(11 (November)): 728-729.

⁴⁴ 1958, 'Editorial', DN, 1(8(November)): 175.

of 'professional' (as opposed to amateur) status, and the editorial continues: 'A general practitioner would not expect to be called 'home doctor' because he visits patients in their homes. [...] To refer to a district nurse as a 'home nurse' is just as illogical.'

Generalists or specialists?

Writing a series of articles to *The Times* in 1926 Dr. Shadwell, an MOH and member of the QNI executive council commented:

Of all the multitudinous forms of social service carried on today none is more real and practical, yet more unobtrusive, than what is called district nursing. Little is heard of it, and many readers probably have only a vague notion, if any, of what it is ... The sick nurse is the doctor's assistant and ally, universally recognised to-day as indispensable, and the district nurse in particular is the assistant and ally of the general practitioner, who practises among the sick poor. She shares his work, the importance of which is becoming better understood and appreciated than it used to be ... The public have a curiously exaggerated idea of the extent and value of specialism ... But the modern general practitioner is an all-round specialist, if one may use the expression, and his assistant ... the district nurse must be one, for in her sphere there is no specialism; she must take the cases as they come, medical or surgical, acute or chronic ... It is as necessary for the nurse as the doctor, and in some respects less easy. He comes and goes and wields an authority, which she does not command, by virtue of his position. Her relation is more intimate and homely ... But that gives her a unique influence equally free from patronage and officialism, both of which are generally suspect and often resented.⁴⁵

This concept presented in this quotation that, 'the modern general practitioner is an all-round specialist' seems to be a contradiction in terms and yet district nurses and hospital nurses alike recognised that a generally (but hospital only) trained nurse, 'should undergo special training in district nursing by specialists in this branch of her work before she commences work on the district.'⁴⁶ Clearly certain aspects of the work differentiated between the specialised techniques and demands (seen as 'specialist') and the broad mixture of patients and their illnesses to be nursed (viewed as 'generalist').⁴⁷ In particular this article specified the need for more initiative than in hospital nursing, the ability to improvise in less than ideal surroundings and the weight of increased responsibility as amongst the *specialist* facets of

⁴⁵ Shadwell, D. A., 1926, 'District Nursing', *The Times* (September 27-29).

⁴⁶ Rave, R. W., 1949, 'Annual Meeting Address to the Queen's Institute of District Nursing', *QNM*, XXXVIII(10(October)): 129-133, speaking on the necessity for special training in district nursing.

⁴⁷ Royal College of Nursing, 198, *Specialties in Nursing: Report of the Working Party Investigating the Development of Specialties within the Nursing Profession*, differentiated between a specialist (as in expert practitioner with additional qualifications) and someone working in a specialised field or specialty.

district nursing. Other articles emphasised the educative, public health role of preventative medicine or early symptomatology of disease or terminal care management at home in a similar light as all being specialist aspects of district nursing practice.

Burnham describes medical specialisation as having grown, 'out of the proliferation of knowledge and technology that called for physicians to limit their focus so as to have a deep competence in a restricted field'⁴⁸ that is, expertise. Similarly, in making the case for recognised and standardised training, a special group set up by the RCN Executive Committee noted that health visitors and midwives were both required to undertake 'specialist training' before being allowed to practice. In their view it was equally necessary for district nurses to fulfil a similar post-registration requirement because of their particular responsibilities in supporting whole 'families in the crisis of illness' or in the special demands of clinic or school nursing, and taking into account the growing 'complexity and volume of work undertaken'.⁴⁹ In addition they felt the increasing trend towards 'a community health team, able to provide comprehensive family care' and the desired 'close co-ordination of the hospital and community services' could be better achieved if community nurses were 'adequately prepared'. Explaining what this implied for the proposed training curriculum, the report itemised aspects such as: awareness of the district nurse's distinctive educative role, understanding the social services available for patient and family and awareness of particular socio-economic and emotional implications of illness at home, together with instruction in presymptomatic diagnostic procedures, adaptation of hospital techniques for community practice and 'to prepare the student for her role as a member of the family health care team within general practice'.⁵⁰ However, like the GP it is significant that generalisation was often considered inferior to specialisation by their respective hierarchies and that training was confined to hospital practice with the community aspects not reaching the compulsory teaching curriculum in either profession until mid-twentieth century

The post-war period may therefore be seen as one marking considerable changes particularly in inter-professional relationships: Firstly the doctor was being forced to become a team player - the primary healthcare team perhaps providing a prime example, - losing autonomy and becoming increasingly answerable to a more critical and litigation-minded public, handing over management to practice managers, and much of the previous role including some prescribing to practice and district nurses. In addition an increasing trend towards alternatives to biomedicine had found a market-led response by the GP in particular to

⁴⁸ Burnham, H. C., 1998, 'How the idea of profession changed the writing of medical history', *Medical History*(Supplement No. 18): 170-171.

⁴⁹ RCN Executive Committee 1969, 'Occasional Papers: The Future of District Nursing', *Nursing Times* (March 20): 45-48.

⁵⁰ *Ibid.*

embrace homeopathy, acupuncture, osteopathy etc. Similarly, district nursing from the 1970s was embracing specialist areas of nursing such as terminal care, stoma care, diabetic or respiratory care, either combined with 'general' district nursing or working alongside specialist nurses working in the community. The integration of these specialisms within the general field of district nursing was met with varying degrees of success – some nurses seeing this development as a direct threat, encroaching on their professional territory or diminishing their status.^{s1} Similarly, the widespread introduction of practice nurses in the 1970s was felt to be removing some of the more interesting aspects of district nursing work such as running clinics, doing minor surgery with GPs and giving vaccinations or doing dressings on the more ambulant patients able to attend the surgery. At this stage practice nurses were often SRNs with no special training and employed directly by the GPs, so presented somewhat of a threat to the district nurse in several ways - coming between district nurse and GP, undermining her status and taking away her more ambulant, 'easier' cases.

However, in general the nurse had become a more interdependent practitioner at the patient level with negotiation between nurse and doctor being a more common feature replacing the earlier relationship based on subservience, i.e. respected more within the therapeutic encounter as a 'reflective user of experience and expertise'.^{s2} Perhaps the final word on this should belong to the oral history interviewees. I was bemused by the responses of district nurses and GPs to questions about interprofessional relationships, which appeared to be almost invariably 'we always got on very well' and never indicated any tensions or conflict. Having worked in this field myself I knew perfectly well this was not always the case and was minded of the 'silences' that alerted Gittins to unspoken problems in some of her oral histories.^{s3} Closer enquiry revealed that where there were personality clashes or professional disagreements, the solution on the part of the nurse was often to take evasive action and avoid that particular doctor if at all possible.^{s4} This, together with other studies, would suggest that, whilst the team approach brought members of the primary health care team together to work from the same physical environment and gave them opportunities for better interaction, in

^{s1} Haste, F. H., and Macdonald, L.D., 1992, 'The role of the specialist in community nursing: perceptions of specialist and district nurses', *International Journal of Nursing Studies*, 29(1): 37-47.

² Davies, C., 1995, *Gender and the Professional Predicament in Nursing*: 149-50 & Table S.1.

^{s3} Gittins, D., 1998, *Madness in its place: Narratives of Severalls Hospital, 1913-1997*. Gittins, D., 1998, Silences. The Case of a Psychiatric Hospital, *Narrative and Genre*. M. Chamberlain, and P. Thompson: 46-62.

^{s4} This is described in Stein, L., 1967, 'The doctor-nurse game', *Archives of General Psychiatry*, 16: 698-703, Stein, L., 1978, The doctor-nurse game, *Readings in the Sociology of Nursing*. R. Dingwall and J. McIntosh, particularly in negotiating differences of opinion and professional judgement and Jaeger by Allen, D., 1998, 'Doctor-Nurse Relationships: Accomplishing the Skill Mix in Health Care', *TU Sociology of the Caring Professions*. P. Abbott, and Liz Meerabeau, looking at the negotiation of professional boundaries.

reality they continued to work alongside one-another, rather than together as an integrated team."

Attempting to ascertain exactly what the district nurse perceived necessary to make her a 'professional', led to some quite different observations -in particular the relationship with the patient was seen as a professional one if there was a degree of business-like detachment or what might appear to be impassiveness on the part of the nurse -for example:

ES: I mean, there has been patients, you know, that's complained about me as well.

HS: Yes?

ES: Well, there was one particular one, and ••• Ted and Mary, and, of course, Mary had multiple sclerosis, she was ex-nurse ••• the man she was living with, this ... with Ted.

Well, he's had every nurse in St. Helen's crying. Everybody's come out of that house and said, "I'm not going back again". And he used to then ... sometimes he would phone up and he would say, "I am not having Sister Skepper in this house again". And I would walk in the next morning, and would just say, "Good morning, Ted. Did you have a good night?" But, you see, always went in exactly the same every day, because I'm not a moody person don't take umbrage. You tell me, "Get lost!", well, you know, I'll just go back in the next day ••• And really do think that you've got to keep that being professional with patients, because ... have got to tell you off if need be. You know, if you're not pulling the weight, really, so I ... and when I went in, I always introduced myself as "Sister Skepper", you know, so did ••• although I was very kind to patients, I was still, you know •••⁵⁶

Being professional was a term applied, not only to particular skills and practice, but also to 'professional behaviour', which incorporated the code of nursing ethics (mentioned above in outlining the list of professional values and judgements). However, what was considered 'unprofessional behaviour' ranged from criticising the doctor in front of the patient, to rather less obvious failings such as spending too long talking to the patient or relatives i.e. not keeping a 'professional distance'.

By the mid-1970s nursing was beginning to move towards the longer, university-based, training bearing more similarity to the medical model with post-registrational specialisation (including district nursing and community specialisms), becoming the trend. The professional skills were therefore becoming more easily defined and identified with technical expertise and associated with formally acquired knowledge. Gender balance was also changing during that

"Battle, S., J. Moran-Ellis, et al., 1985, *The District Nurse's Changing Role*: 11
⁵⁶ *DIN* 21, 15/05/00, Oral History: Mrs. E.S.: trained SRN 1954-57 St. Helen's and later worked on the district learning 'on the job' until later local authority training in 1973. NB Names changed to protect identity.

decade - more men in the mainstream nursing profession significantly reaching the higher levels more quickly than women (averaging 8 against 18 yrs. from qualification to nurse manager⁷) and considerably more women in the medical profession although noticeably absent at the upper levels. As might be expected, district nursing attracted less men than hospital acute nursing, although numbers had risen considerably in the thirty years of accepting men into this field. This may be partly explained by the fact that for promotion to senior jobs, midwifery was a pre-requisite, and until the mid-1970s this was an area closed to men.

Conclusion:

The professional image of nursing as judged against the opening key characteristics, appears no longer in doubt by 1979 yet still appears to have presented a somewhat contradictory picture. District nurses had become by then, like their hospital counterparts, more closely associated with the medical model and the team aspect of health care, losing much of their communitarian image. With changes in hospital policy - particularly relating to reductions in inpatient length of stays⁹ the job was becoming more demanding in knowledge of medical and surgical advances as a 'nursing science'. Corresponding changes in the terminology associated with current nursing procedures such as 'reflective practice', 'nurse prescribing' and 'patient care plans' were soon to mirror this. The question to be asked in the final chapter is: how far could this paradigm shift in nursing values allow the district nurse's professional role to be extended towards the 'curing', specialist-focused 'medical sciences' and away from the gendered social limitations of the more holistic and generalistic 'nursing art' of 'caring'?

1919-1979 was a period during which district nursing saw a pendulum swing back and forth between managerialism and professionalism, with the professional model emphasising the educational and theoretical foundation of nursing combined with self-regulation, whilst the managerial model pulled in another (although not totally opposite) direction. This managerial model followed the hierarchical system of levels or grades of specialist-trained, basic-trained and untrained nurses whilst allowing for some degree of non-nurse management to oversee practice and/or patient care. Throughout this time period, can be seen a continual struggle to achieve parity of status with other nurses in the community and with medical colleagues largely through striving to establish an 'autonomous knowledge base'.⁶⁰ Whilst it would be

⁵¹ Walby, S., J. Greenwell, et al., 1994, Medicine and Nursing: Professions in a changing Health Service: 68.

⁵² Antrobus, M. F., 1985, District Nursing: the nurse, the patients and the work.

⁵⁹ DoH, 1993, Social Services Inspectorate/ Regional Health Authority Community Care Monitoring: National Summary; Timmins, A., 1996, 'Dilemmas of Discharge: the case of district nursing'.

⁶⁰ Abbott, P., and Wallace, Claire, 1998, 'Health Visiting, Social Work, Nursing and Midwifery: a History', The Sociology of the Caring Professions. P. Abbott, and Liz Meerabeau, : 20-53, explore this idea in greater depth with particular reference to the Briggs Report in 1972 supporting the professional

over-simplistic to suggest an 'either/or' scenario, as the emphasis clearly drifted between the two models rather than totally embracing one or the other, this does provide a useful approach for understanding the changing situation in which district nurses had to live and work. The issue of reconciling professionalism and caring skills and the frustrations of nurses who say that the system does not allow them to nurse'⁶¹ is highlighted by the dilemma of extended, technicalised roles that continue to the present often to be resented as perceived money-saving para-medical skills and 'dumping' of responsibility by time-pressed doctors without adequate training or financial recompense. It created a dilemma for nurses in the community as in hospital, attracted by previously 'forbidden fruit' in the form of technical skills that reduce patients' and nurses' waiting times for harassed GPs to perform tasks clearly within the nurse's capabilities. At the same time, accepting these extra duties added significantly to workloads and feelings of being taken advantage of by medical colleagues and management.

model whilst the Griffiths Report (1983) supported a more managerial system returning to the professional stance with Project 2000.

⁶¹ Davies, C., 1995, Gender and the Professional Predicament in Nursing: 147.

Chapter 10: Conclusion

Broad Sweep of Change

In 1979, the year of the Nurses, Midwives and Health Visitors Act which provided for a District Nursing Joint Committee under the direction of the UK.CC, the QNI established a lectureship in Community Nursing based at Chelsea College, London, and the following year the new curriculum on district nursing training was published, coming into force in 1981. These three steps may be seen to represent major developments in the professionalisation of district nursing within the wider nursing profession. In discussing the extension of the clinical role of the district nurse ten years after the 1979 Act, a steering group of the newly established District Nursing Association (UK)¹ was set up to report on the current position of district nursing. Its conclusion stated: 'The district nurse is concerned with working alongside doctors, other nurses, health visitors and social workers and in sharing with other members of the primary health care team'² and the importance of 'professional judgement' in deciding on the degree of extension to the clinical role to be accepted, was also stressed. In 1987 the Social Services Inspectorate of the Department of Health carried out an inquiry into the transfer of some tasks previously performed by district nurses as a result of the move from 'home help' provision to that of 'home care'. This resulted in the removal from the district nursing caseload of many of the chronic sick and elderly whose care was deemed not to be 'nursing care' but 'social and personal care', so that the 'basic' caring tasks were often being done by 'carers' rather than trained nurses. The two concerns are not unrelated -both reflect changes in the role and job-description of the district nurse, extending towards more •medical' tasks at one end of the continuum, whilst curtailing other tasks such as bed-bathing, getting patients up and putting them to bed. The technical tasks undertaken by a district nurse in 1979 would have doubtless shocked a nurse in 1919 who was trained to 'clean the sick room', 'overlook the patient's diet' empty ashes from the grate and attend to the ventilation and sanitation of the house.³ Similarly, a nurse in 1979 would probably never have nursed a case of tuberculosis or pneumonia without the safety blanket of antibiotics and anti-inflammatory drugs.

By the beginning of the 1980s, the role and image of the district nurse had clearly evolved to become quite a different one from that of 1919. The earlier, somewhat professionally isolated figure confined to a relatively small district area and travelling on foot, bicycle or pony-and-trap, had become a much more mobile member of the wider community health care team, yet

¹Now the Community and District Nursing Association (CDNA)-an independent trade union specialising in community nursing.

²SAIQNI Box 112 P7/69: Mackenzie, Ann (on behalf of steering group District Nursing Association (UK)), 1989 'Key Issues in District Nursing: Paper I The District Nurse within the community context': IS-16.

³'Some Queen's Superintendents', 1924, Handbook for Queen's Nurses.

her professional and public persona still appeared contradictory. She/he spent less time by the patient's bedside performing these traditionally recognised nursing tasks and was therefore less intimately familiar with patient and family as care became shared amongst the team thereby reducing continuity of care. Public respect for district nurses' professional standing had in many ways increased, and the concept of the 'proper' nurse as synonymous with the hospital nurse had been superseded so that her professional image was no longer in doubt. In many ways a new role was opening up as coordinator of services involved in providing community health care, which placed her at the centre of this team along with the GP.⁴ However, as she became more closely associated with the GP practice or Health Centre, and the team approach to health care, patients and their relatives were said to have become more critical and less appreciative or co-operative, recognising the district nurse less as part of their immediate community. She was no longer recognised as *the* district nurse but as *one of* the district nurses, working from an office alongside other grades of district nurse • a team player of a team within a larger team.

This illustrates the dynamic nature of district nursing which has been shown throughout this thesis to have responded and evolved its role according to a number of variables. Perhaps the most obvious of these is found in the changing health needs within the community, and changes in medical practice, which have created increasing or decreasing demands on their workload. For example, district nurses required specialist training in nursing patients with tuberculosis and other infectious diseases, but this changed dramatically with the introduction of antibiotics and sulphonamides, whilst the introduction of vaccination campaigns against diphtheria in 1940, poliomyelitis in 1956 and measles in 1968, virtually eliminated this aspect of district nursing within a decade.⁵ Surgery performed in the home by the GP assisted by the district nurse, which was common practice in the inter-war period, became a rarity by the 1960s as did home confinement by nurse-midwives. On the other hand the policy and practice of hospitals and related government policy resulted, for example, in the earlier discharges of acutely ill patients from hospitals begun in the 1960s⁶ and in making the job more demanding in knowledge requirement of medical and surgical advances and corresponding changes in nursing procedures. In addition, increased pressure on outpatient and casualty departments had the dual effect of improving hospital liaison whilst increasing numbers of referrals to GP and district nurses by the 1970s.⁸ Likewise, the 'Care in the Community' movement, and resultant transfer of large numbers of psychiatric patients from institutional into community

• Battle, S., J. Moran-Ellis, et al., 1985, The District Nurse's Changing Role: 7-9.

s Carre, J., 1974, 'Health Care in the Community', Nursing Mirror (May 24).

6 1963 'Community Care: The Ten Year Plan', DN. 6(May): 31.

7 For example early discharge of patients following open-heart surgery or day-surgery may require quite complex dressings, or therapies, also patients (for example post-surgery or terminally ill) are sometimes nursed at home despite requiring intravenous or naso-gastric feeding/therapy when they would previously have required hospital admission.

• Carre, J., 1974, 'Health Care in the Community', Nursing Mirror (May 24).

care, had the effect of increasing the workload and creating a need for specialist community psychiatric nurses, whilst district midwifery in all but the most remote areas, was separated from district nursing from the early 1970s. All of these would have been totally alien to the experience of a district nurse in 1919.

By the late 1970s and 1980s developments in community health policy were also beginning to force a number of fundamental changes in role, workload and working day/ routine, constantly redefining the nurse's job description and changing the relationship with other health care professionals. He/ she could no longer remain so autonomous especially with specialist nurses such as community psychiatric nurses, stoma-care nurses, and Macmillan or Marie Curie nurses, increasingly present, whilst daily liaison with practice nurses and GPs was becoming essential. This view was expressed by a nurse working in South Wales, with considerable strength of feeling demonstrated by her choice of words when referring to the social services and care workers:

there were big changes then when you had a Macmillan service came in to it - you had the practical work teachers would go through there, I think the Marie Curie nurses, specialist nurses fragmented everything then and then the nurses, the field nurses were wondering well what is our role, you know, where do we stand here, what do we do? Then of course a further insult was the Social Services come along, and the care workers. So again you know what was our role and I think this is what they are looking at the moment, what is the actual role?'

The three-tier recommendation of the QNI committee set up to look at post-registration training¹⁰ in the 1960's which was intended to anticipate and minimise this autonomy dilemma by providing career opportunities for both specialists and generalists in this field was largely ignored although many of the findings were quoted in support of the move towards GP attachment and provided the foundation for a national post-registration training. A nurse who trained as a district nurse in the 1970s described her view of later developments in training and team structures and changes in the district nurse's role up to the present time:

I think what happened over my time in a way has ... what pleased me enormously from when I did my very short course, then it moved to a much more kind of acknowledgement of the complexity of working in the community within District Nursing and courses became much - became longer and the curriculum became much broader and the qualification I think became mandatory • it did it became mandatory to practice and I think that for me was really where District Nursing reached a peak - It never quite got where Health Visiting was because of statute but it achieved for me then

⁹ *DIN* tI, 01110/96, Oral History: Mrs. B. R. (see above).

¹⁰ Hockey, L., *Feeling the Pulse and Care in the Balance* (Queen's Institute of District Nursing 1966 and 1968).

more recognition or it's worth. I think (...) that almost it seems that we are going a little bit backwards. I think that the U.K.C.C. thank goodness do acknowledge that there needs to be a specialist qualification to practice in the community now but I think what - because I think there was a lot of concern at the time whether they would actually come out and say 'yes you do something more than the R.G.N. to function in the community', but I think what saddens me a bit is again I think it is the economics of this is driving grade mix and skill mix and maybe there will be fewer qualified - *qualified* Community Health Care practitioners and more a range of - if I can put it - 'unqualified' people delivering care. (...) and the service being much more focused and Primary Health Care team lead, with the demise of nursing management in community what's happened is that the responsibilities that senior nurses had - a lot of those are now being devolved to those clinicians with the specialist practice so the very people with the expertise in District Nursing for example are being locked now in budgets, and having less time to deliver the clinical expertise and much more of managers or teams of other people, and facilitators of others and I think that's what concerns me in terms of the nature of the service that is being delivered to patients, clients and carers.¹¹

Importance of local history and oral histories

In the use of oral histories, personal testimonies and written autobiography, this thesis has gone some way in challenging the state of affairs reported by Summers who described a paucity of sources relating to nursing in the domestic environment.¹² Although her concern was focused on the nineteenth century community nurse, her comments about the obscurity of these practitioners were equally relevant to the district nurse of the twentieth century, with the main attention having hitherto been given to the method of district nursing's organisation as a 'top-down' approach, rather than the more holistic view attempted here. Wherever possible the aim has been to recount the actual experiences and work undertaken by district nurses.

An important aspect explored in some detail, greatly assisted by oral histories, has been that of the district nurse's relationships with her professional colleagues, management and employers - from GPs, midwives and health visitors to fellow district nurses. Each one had his or her own agenda and professional boundaries to protect. Likewise, state enrolled nurses and auxiliaries working in the community under the supervision of the district nurses, were encroaching on another set of professional boundaries whilst presenting a different kind of challenge. The 'Ladies Committee' of the nursing association and QNI visitors and superintendents to the local authority MOH have been shown to have presented further potential obstacles in this struggle to find and maintain professional foot-holds. Policy issues

¹¹ *DINIO*, 27/09/96, Oral History: Mrs. E. R. (see above).

¹² Summers, A., 1989, 'The Mysterious Demise of Sarah Gamp: The domiciliary nurse and her detractors -1830-60', *Journal of Victorian Studies* (32 (3)): 365-386.

such as training, recruitment and retention of trained nurses and dramatic changes in workload caused by the war or by economic depression, all had a major impact on the work and role of the district nurse, and the local and regional studies have been central in exposing these.

Changing resources have been shown throughout this thesis to have had an equally important effect: in particular we have looked at the introduction of motorised transport during this period, which facilitated a gradual widening of the nurse's district area, but also enabled nurses to carry more equipment. Similarly the introduction of the telephone improved communication with colleagues as well as patient accessibility and the developments in pre-sterilised dressings, instruments and disposable equipment increased efficiency but reduced the need for patient-contact time. Neither of these was introduced uniformly across England and Wales, and the environments in which they worked have also been shown through the case studies in Part 3 and from the oral histories, as having been far from identical. The greatest differences in practice, role, and working experience, appeared to be between urban and rural settings, but cultural, demographic and regional influences also created significant differences such as relationships with patients and with employing district nursing associations, types of cases nursed, and facilities available. Whilst this was the most elusive point to establish, interviewees made it clear that although their basic practice would be the same, and daily routines essentially followed the same schedule, the patient and the place always made the experience unique.

Ambiguities and contradictions in the process of professionalisation and team building

The period 1919-1979, saw the waxing and waning of the QNI from the height of its powers as a voluntaristic association responsible for overseeing training, examination and subsequent regulation of a large percentage of the district nurses working in England and Wales. By the 1960s it had redirected its remit towards research and development, relinquishing the post-registration training initially by placing greater emphasis on refresher courses and management training through the William Rathbone Staff College. Since that closed in 1975 it has fulfilled its obligations through an awards programme which provides both funding and professional support for nurses administering community nursing projects, whilst running a series of seminars and conferences relevant to community nursing policy and practice and continuing to provide welfare support for elderly and infirm district nurses. For the district nurses themselves, the NHS Act meant a move to employment that was no longer subject to the uncertainties of charitable collections or voluntary subscriptions, or in the case of QNs to the bureaucratic and authoritarian control of the QNI and district associations. However the gradual loss of QNs' homes and training centres was regretted by many who had enjoyed the experience of living and working in them and the loss of influence of the QNI also marked a

reduction in professional status (and pride in the title 'Queen's Nurse'), as well as the loss of an important support network.

These sixty years also mark a period of change in composition of district nursing as a workforce from one which has been shown to have a rapid turnover of unmarried women in many posts, and with older nurses preferring rural nursing and younger ones concentrated in the urban areas, to a more stable and mixed workforce including men and married women staying in post for rather longer periods. The introduction of men into district nursing was clearly accepted by some colleagues better than others but the fact that they were perceived as a threat by some may be indicative of the uncertainty and lack of professional security just below the surface at a time of considerable change and challenge from within the field of community healthcare. Nurses' autonomy also underwent considerable changes during this time. Perhaps most obvious was the change from practice under a lay committee with infrequent supervision by QNI inspectors (in the case of rural QNs) or tight supervision by QNI superintendents (in the case of urban QNs). This transferred to local government control and reduced levels of supervision, to team practice and GP attachments with resultant increased accountability and more direct line-management. There was also a considerable change in the nurse-patient relationship over this period which indirectly affected nurses' perceived autonomy: in 1919 the main aim was to provide nursing care for 'the sick poor' with assessment of ability to pay often being at the nurse's discretion but being answerable to the GP for treatment and care provided; during the 1920's and 1930's this remit widened through provident and other subscription schemes to include any patients who were willing to contribute, whilst from 1948 the district nurse cared for any and everyone under the provisions of the NHS but with the nursing care becoming solely the province of the nurse and progressively less intervention coming from the GP. By 1979 few district nurses except in very rural areas combined nursing with midwifery, school nursing or health visiting, so that the nurse's work in urban areas was no longer so dissimilar to that of the rural district nurse – in fact many no longer lived within the districts in which they practiced by the end of the 1970s. This had a dual impact on the role and image of the rural district nurse: areas instantly doubled in size as district nursing for one area was taken from the midwife by the district nurse, whilst simultaneously, loss of midwifery dramatically reduced the broad community focus of her daily work to a more specialist one. It has not been part of the remit of this thesis to look at the midwifery role of district nurse-midwives in any depth, but this particular transitional period deserves further study.

Changes in hospital nursing practice also made their impression -with shorter in-patient stays, some hospital nurses complained of lack of continuity and experience reducing the degree of job-satisfaction, whilst district work was becoming proportionately more fulfilling.

Oral history interviewees always commented on this aspect of community work as high amongst their reasons for leaving hospital, together with the freedom of general nursing that gave the opportunity to care for patients of all age groups and the variety of medical and surgical conditions encountered as well as the pleasure (and challenge) of nursing patients in their own homes.

The balance of specialism within generalism has proved a difficult one to address. With medicine still holding many of the aces, the room for negotiation over extended roles was (and arguably still is) limited. This was demonstrated by the power held by the GPs firstly in avoiding the 'team' approach, and later in pushing it forward when it appeared more advantageous. Nevertheless, doctors' control over patterns of work and division of responsibilities in the community remained less straightforward than in the hospital.¹³ As Dr Hockey commented:

I've campaigned for a specialism in generalism - I don't want to mimic doctors either - but I think the General Practitioner training, the vocational training scheme for G.P.'s is very valuable, and a GP is considered as a specialist in his own right because he is a general practitioner, but a general nurse is always considered to be of less value than a specialist nurse, and I would like to feel that we could educate, and could really have the most important specialism of a generalism. (•••) I think we're educating in the wrong way. You know educating actually means 'leading forth into' it doesn't mean giving people information but you know to be a graduate in nursing now doesn't mean that you give patients a bath. I mean that's beneath your dignity now! - that's what worries me. I think they're losing something regarding their sanctity of life - I mean at the risk of becoming a little bit sentimental about the whole thing, I think they should be activities regarded to be important and have a scientific value and I think you can -for example to help a patient to eliminate in public is a very responsible job and if you really analyse what it means in terms of everything you can use psychological skills, physical skills in terms of posture, knowledge in physiology, excretory system of the body, the emotional things I've already mentioned, patient privacy, confidentiality - all those things you can utilise. All of which are academic subjects in their own right and you can bring them to bear on a very simple -what they considered simple, activity. But because it is elimination it's considered to be something that you don't do if you're an academic. (•••) I think it started to deteriorate a little bit in my view when the Doctors' Charter was introduced - when Doctors got money for employing their own nurses and nurses became employees of doctors - when doctors were able to use nurses as they wished because they employed them. And I remember I think a little paper in the Journal of

¹³ Allen, D., 1998, 'Doctor-Nurse Relationships: Accomplishing the Skill Mix in Health Care', *The Sociology of the Caring Professions*. P. Abbott, and Liz Meerabeau, (eds.): 226-228.

General Practice called 'Is a practice nurse really a good idea?' ... separation occurred In that the well qualified district nurse was out on her rounds doing bed-baths for old women and the less well trained practice nurse was doing what was considered to be the prestigious aspect of practice and she was close to the doctor physically so he would confide in her and get her to help him with technical tasks and all the rest of It - and she became more prestigious than a better qualified district nurse.¹⁴

GP attachment and the 'team' approach had obvious advantages in terms of improved communications inter-professionally, but this and similar comments made by other district nurses interviewed in the primary series, suggest that some of these were offset by the introduction of the practice nurse as Dr. H. indicated in this quote.

There were also practical and ethical concerns expressed about intra-professional difficulties relating to continuity of care and the interests of the patient including patient advocacy. A study that looked at the intra-professional teamworking concluded that: 'there are multiple ethical problems to address in teamworking, and that mechanisms for discerning moral issues, patterns of communication, self-scrutiny and conflict resolution are substantially under-developed at the present time'.¹⁵ This study suggested one alternative might be to assign responsibility for overall nursing management to one member of the care team as care manager to ensure that 'the patient has a spokesperson who is well placed to steer a course through them.' The loss of the QNI county superintendent of district nurses from 1948, effectively removed some of the peer review and internal controls, which had been one of the strengths of that system in regulating and maintaining a high standard of care. Subsequently the move from geographical 'community' based district nursing where the nurse was 'our' nurse, to the GP attachment, where he or she became 'one of the' district nurses, may have increased some aspects of efficiency of care-provision, but may have inadvertently reduced the more holistic characteristics of care provided.

The future of district nursing and continuing 'invisibilities'

There are a number of areas either not covered or only touched upon by this study, yet deserving of further consideration. Firstly, the legislation of the later period from 1960 was considerable. This has been referred to only briefly as this was not intended to be a political history of community health legislation. The 1960s onwards represents the beginning of intensive re-assessment of community healthcare with numerous official studies, inquiries and reports resulting in a stream of legislation. Equally it has not been possible to look in detail at later development since 1979 and the effects of changes in policy towards community

¹⁴ *DIN 01*, 13/08/96, Oral History: Dr. L. H. (see above).

¹⁵ Griffiths, J. M., Luker, K. A., 1994, 'Intraprofessional teamwork in District Nursing: In whose Interest?' *Journal of Advanced Nursing*, 20(6 (Dec.)): 1038-1045.

healthcare, nor the effects of a dramatic surgical and technological ascendancy on changing patient demands. The rising expertise of specialist community nurses, and the introduction of the practice nurse and nurse practitioners into community health have also received only brief attention. The development of materials technologies, CSSD and a huge expansion in the medicines being used to treat patients in the community also deserves further attention – whilst the effect this had on the role and daily work of the district nurse has been addressed, there is a wealth of information to be drawn from each of these that is clearly worthy of further research. Likewise, it would be interesting to draw some comparisons with overseas developments in district nursing -for example, was there a one-way or two-way sphere of influence and how were similar problems dealt with elsewhere? Work done in the USA suggests there were many similarities, with the biggest of these being the problem of caring for the elderly and chronic sick, with the lack of adequate finance creating a stumbling block that repeatedly brought down an otherwise effective home nursing service on each attempt to re-establish it.¹⁶ Similarly, work undertaken in South Africa demonstrates a racially and culturally defined system of community care provision in which the nurse might find herself in the position of culture-broker, whilst her district area would be considerably greater and medical contact much more physically remote than her British counterpart.¹⁷

Finally, the overriding feature of this research has been the individuality of these nurses, which often comes through vibrantly in inspectors' reports, oral histories, photographs, films and autobiographies. Many show a strong degree of independence and adaptability in tackling harsh and often unpleasant working conditions -from the descriptions of QNI Chief Superintendent Amy Hughes to the lowliest of village nurse-midwives -which enabled them to draw upon an innate resourcefulness and initiative to handle the most difficult of situations. Their mobility of practice throughout the inter-war period was one of the surprises of this thesis, upsetting the stereotypical image of district nurses staying in one place throughout their working lives. They were largely women from working-class backgrounds¹⁸ (although this was certainly not invariably the case), which makes their determined bid for professional status and autonomy particularly remarkable, set alongside a much more powerful, largely male, established professional group.

Bearing in mind the emphasis on the professionalisation of this subgroup of nursing throughout this thesis it is significant that at the time of writing this thesis, a steering group of

¹⁶ Buhler-Wilkerson, K., 2001, *No Place Like Home: a history of nursing and home care in the United States*.

¹⁷ Digby, A., and Sweet, H., 2001, 'Nurses as culture brokers in twentieth-century South Africa', in: *Plural Medicine. Tradition and Modernity, 1800-2000*, W. Ernst (ed.); Marks, S., 1994, *Divided Sisterhood.*; Searle, C., 1965, *The History of the Development of Nursing in South Africa, 1652-1960*.

¹⁸ This was claimed by Hockey, L., 1968, *Care in the Balance*, and chapter 2 confirmed this to have been case with most of the oral history interviewees in the primary series.

the RCN has been preparing a definition of nursing led by Professor Dame June Clark, intended to cover the whole range of nursing and to be used, 'to influence policy, to determine skill mix, to inform resource management, in job-description, in legislation, and in many other ways'.¹⁹ Part of the underlying rationale to this has been concern, 'to be able to distinguish between professional nursing and the nursing undertaken by other people', and therefore to establish a particular knowledge base for nursing. The need to be recognised as a profession remains as strong as ever, with professional tensions or conflicts of interest never far below the surface as the main motivation. However, the latest report from the QNI and English National Board for Nursing is ominously entitled: 'District Nursing: The Invisible Workforce'. It reveals continued concerns about the role of the district nurse, workload and caseload management, education and 'a workforce which clearly feels under-resourced, overburdened and lacking in support. Serious variation in service provision across the country, confusion about the district nurse's role and the impact that the lack of visibility has had on patient care, are strong messages, which cannot be ignored. District nurses see themselves as members of an unseen and unvalued workforce who provide the bulk of care outside hospital settings.'²⁰ It has been the intention of this thesis to address this 'invisibility' and thereby to provide a better understanding of the historical background to some of these issues.

¹⁹ see www.rcn.org.uk/professional/defining_nursing.html: The current draft definition states that nursing is: 'the use of clinical judgement and the provision of care to enable people to promote, improve, maintain, or recover health, or when death is inevitable, to die peacefully'.

²⁰ Low, H., and Hesketh, Jo, 2002, District Nursing: The invisible workforce.

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Primary Series Oral Histories

DNOI-40 and COI-07 (for detailed listings see Appendix A).

Personal Communication:

Mrs. S. Hargreaves (2002).

Mr. J.M.D. Hoyle (2002).

Mr. G. Lloyd (2002).

Mr. S. Midgley (2002).

Mrs Margaret Newsnham (2002).

Miss M.I. Sankey MBE (2002).

Appendix

Appendix A: Oral history: List of primary and secondary oral histories, letter of introduction sent to oral history respondents and basic (working) questionnaire.

Removed for reasons of confidentiality

Oral History: draft letter to respondents.

Introductory notes to the Project:

I would like to begin by thanking you for agreeing to be part of this study which forms part of a research project into community care history being jointly undertaken by the Schools of Humanities and Health Care Studies at Oxford Brookes University. This interview will also be incorporated into the oral history project currently being undertaken by the Royal College of Nursing History of Nursing Society and the tape-recordings of all the interviews will eventually be held in the RC.N. archives. Apart from a formal acknowledgement, your name and identity will in no way be linked to data or information when we eventually publish our project and all confidences will be respected.

Our aim is to re-evaluate the strategic roles of health professionals in community care from mid-19th Century to the present day. This will enable us to explore a number of issues of professional collaboration and conflict from the historical context which we hope will fill a major gap in the history of health care. Simultaneously this should contribute significantly to current debates on trends, dilemmas of management, administration and the re-evaluation of policy in community health provision.

The following is an outline of the questions I should like to cover in our interview, however I should make it clear that this is intended as an informal interview and if you feel there are areas this does not cover, or there are questions with which you are not comfortable, please feel free to change by rejecting or expanding questions accordingly. Similarly if you have any questions about the project or the reasons behind the questions, please feel free to ask.

The interview is constructed so that we can first consider your family background and childhood, then how and why you chose your career, followed by your training and post-training experience and conditions of employment. Finally it would be helpful to ask you a number of questions relating to the role of district nurses in society, how you have felt about being a district nurse and the changes you have seen within the profession and in society's changing attitudes to the profession. Obviously this covers a lot of ground, so if you feel we should break at some point, please say so.

Basic Interview for use in History of District Nursing

Section 1 *Aim: To establish Social, Family & Educational Background of interviewee*

- 1) Could you tell me when & where you were born?
- 2) Where did you live as a child?
- 3) Where did you go to school?
- 4) (i) What sort of school did you attend?
(ii) What were the teachers like? - were they strict?
(iii) Did you enjoy school?
(iv) Do you have any special memories of your school days?
(v) How well did you get on at school?
(vi) What subjects were best and worst?
(vii) Did your school results effect your career choice?
- S) (i) Did you have any hobbies?
(ii) What sorts of things did you particularly like and dislike?
(iii) Did you belong to any youth organisations eg. St. John's/ Red Cross
- 6) What were your parents occupations? (*prompt: attitudes/ relationships towards subject*)
- 7) What were your parents backgrounds? -
 - (i) where were they born,
 - (ii) did they move from there place of birth,
 - (iii) how did they meet,
 - (iv) is there anything of particular relevance to your career choice that was affected by your parents or friends/ neighbours eg. attitudes to education and employment, illness, their occupations?
- 8) How large was your family (*prompt: no.of siblings, ages, sexes etc*)
- 9) Did you travel?
- tO) Did you move house often? - if so, how often, why and where did you move to?
- 11) Can you discuss your childhood? -
 - (i) do you have any particularly good and bad memories
 - (ii) how would you describe your lifestyle and home background as a child?
 - (iii) was it mostly rural or urban?
 - (iv) were illnesses particularly common events in your childhood?
 - (v) what was the attitude of your family towards illness?
 - (vi) how did the the war effect your childhood (*prompt eg. evacuation, loss of loved ones, experience of injuries etc*)

12) Do you have any childhood memories of the district nurse? (in your locality or elsewhere)

Section 2 *Aim: To establish background to career choice and training*

13) What made you choose nursing as a career? When did you make that choice?

14) Were there any other careers that you might have chosen as alternatives or by preference?

15) What did your family and friends think of your choice of career?

16) Did any other members of your family have nursing or medical backgrounds?

17) Was there anything about your family background or childhood that you feel contributed towards your career choice? (*prompt: influence of parents, teachers, siblings, friends, role-models, life-experiences, career expectations etc*)

18) Where and when (duration & years) *did* you train? -

a) general nursing training (qualification gained?)

b) district nursing training (qualification gained?)

c) other qualifications?

Section 3 *Aim: To establish details of training*

19) What were your first impressions of your training? (*prompt: first arrival, matron, tutors, ward-sisters, doctors, how (if) different from prior expectations*)

20) Describe to me how your training was organised:

(i) How were wards allocated?

(ii) How was teaching arranged in relation to ward work, lectures etc.?

(iii) At what stage did you do district nurse/ midwifery training?

(iv) How were districts allocated?

(v) Who instructed you and how was this done?

(vi) How were you examined - was this any different from hospital to district assessments?

(vii) Where did you live

(viii) What were the accommodation conditions like?

(ix) What were your conditions of service e.g. holidays, sickness, uniforms, hours, 'on-call' arrangements, salary, hours?

(x) Did you enjoy the training?

(xi) Who was your supervisor and what was she/ he like? (*develop this if possible*)

Section 4 *Aim: To establish details of qualification(s) & post-training experience*

21) After completing training where was your first appointment?

22) What were your conditions of service and how were these explained to you?

23) If you moved from this to other appointments, describe subsequent appointments as 19) & 20) above, and duration of each.

24) If you moved from this to other appointments explain why, - if not, what made you remain?

25) Were your place of training and subsequent place(s) of practice in any way influenced by your personal or family background (*Prompt: this may include racial &/or social influencing/actors which may be explored where relevant/suitable, also was nursing seen as a form of social mobility*)

26) Were you encouraged to become a Queen's nurse or to do any further training or post-graduate courses?

Section 5 Aim: To ascertain conditions of employment, description of job & professional development

27) Can you describe a typical day's work when you started as a district nurse? (*prompt: treatments, nursing procedures, drugs-giving routines, types of cases, locality, conditions of work & how affected by social & environmental conditions etc*)

28) What changes (if any) were there to this routine over time?

29) Why do you feel these changes came about?

30) How did you feel about those changes at the time?

31) How do you feel about those changes now, in retrospect?

32) Was your job affected by:

- (i) Changes in drugs?
- (ii) Changes in other therapies?
- (iii) Changes in technologies?

33) How, (if at all) were you affected by national issues? (*prompt: war, shortages, changes in the law - including NHS Act, and methods of public/private transportation*)

34) Were you affected by professional issues? (*prompt: changes in professional rulings, changes in employer/employment/registration, wages, unions*)

35) Were you a member of the RCN, RCM or other unions or professional organisations? (*prompt: dates of joining? why? amount of involvement? committee work & officers worked with, branch involvement etc*)

36) Were you able to enjoy any 'off-duty' pursuits - if so, what?

37) How would you describe your relationship with fellow professionals:

- (i) colleagues working with you on the district eg. nurses, midwives & health visitors
- (ii) medical colleagues
- (iii) hospital colleagues

38) Was this relationship any different if the colleague was male or female?

39) Were there any problems or difficulties in working with other health-care professionals?

40) Did that situation change over the course of time? (*prompt:- what reforms and adaptations were there within the job, and were they welcomed?*)

Section 6 Aim: to establish role of district nurses in society

41) How did people regard the district nurse in your area (both in terms of social status and relationships) -:

- (i) as a child?
- (ii) when you began as a *DIN*?
- (iii) when you finished as a *DIN*

42) Do you feel these have changed in any way? In what ways? - how & why?

43) How do you see the role of the district nurse in the present day health service?

44) Have you worked abroad or in the armed services at any time? (*prompt: details? why? where? awareness of nursing/ district nursing developments in ot/1er countries? comparisons?*)

45) Do you have any regrets about any changes you have described, or criticism or approval of working conditions, relationships, attitudes etc. not already mentioned?

46) What do you consider to have been particularly good or bad about the career path you chose?

47) Are you, or have you been married? (*if "No" go to 41, if "Yes" go to 42*)

48) Was marriage obstructed in any way by your career choice? (*Go to 44*)

49) Could you tell me any details about your marriage and family? (*Prompt: when, how long, husband's occupation, children - sex and age, how family life and nursing fitted- in with each other, family's view of nursing*)

50) If you have children, what career choice have they made/ are they making? (*Expand if relevant*)

51) Were you working as a nurse during World War 2? - if so can you describe what you did?

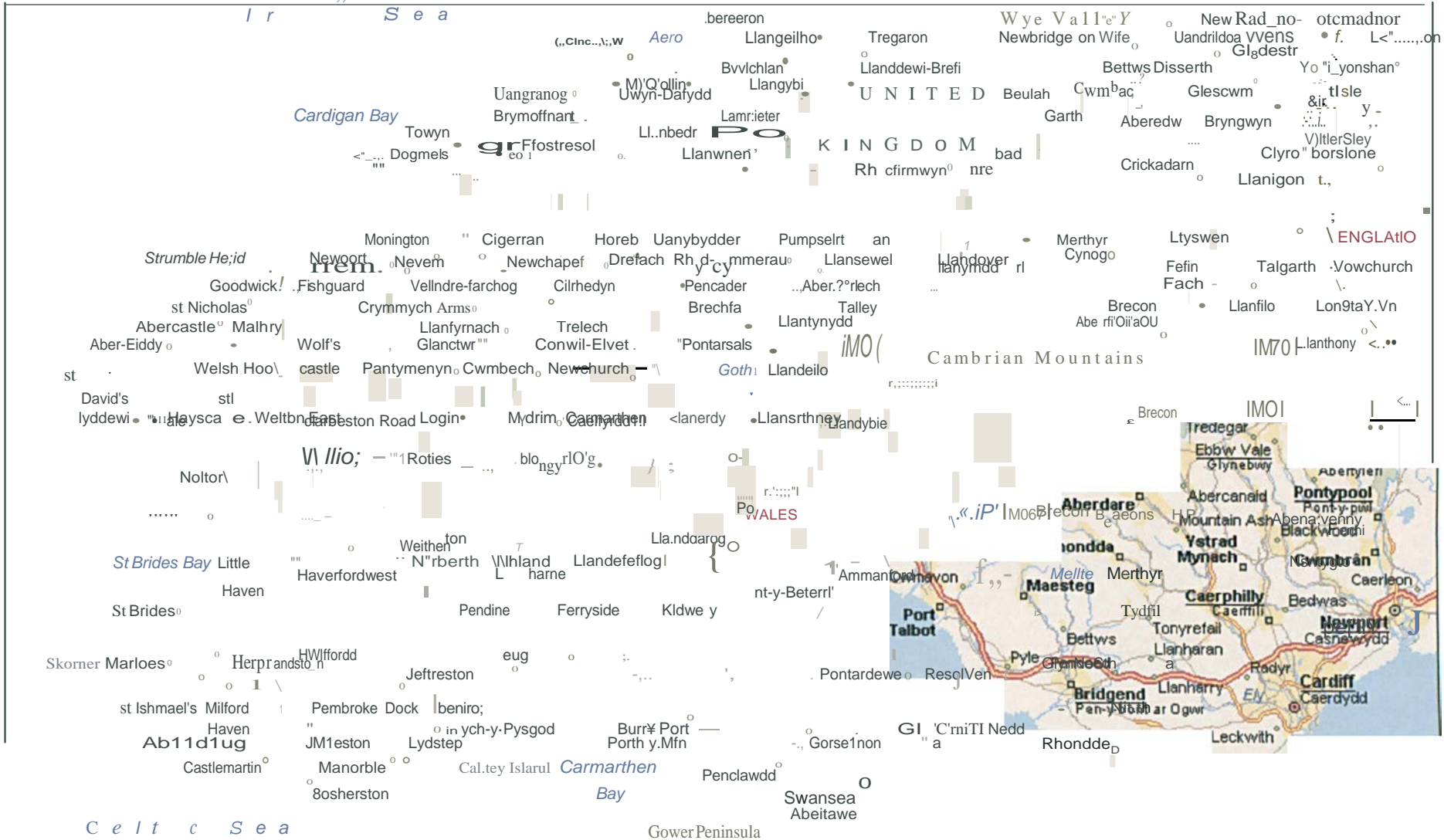
52) Can you tell me any memorable stories or events that happened to you whilst you were a district nurse?

Appendix B: Regional Maps:

- (i) South Wales
- (ii) Dorset
- (iii) Lancashire

South Wales

Microsoft AutoRoute 200 I



Porthcawl^o

Llantwit
Major^o

Sully^o Idenarth

Rhose

Barry^o

Dorset

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Lancashire

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Appendix C: Tables for Bacup and Stackstead compiled
from Nurses' Record Books (RCN Archives C444)

Appendix C Table 1 Stackstead numbers of cases and visits nursed (1915-40) 5 yearly

Year and Month	Cases at beginning of month	New cases accepted during month	Total cases nursed in month	Total visits in month
1915	1		8	22
Jan. 1915				235
February	19		8	27
March	18		8	27
April	18		5	23
May	15		7	22
June	15		8	23
July	13		7	20
August	13		5	19
September	14		7	21
October	17		8	25
November	16		4	20
December	14		3	17
Total	187		78	265
average				22.08
1920	12		5	17
Jan. 1920				212
February	12		3	15
March	8		4	12
April	9		2	11
May	8		3	11
June	11		3	1
July				
August				
September				
October				
November				
December	9		5	14
Total	68		25	94
average				13.42857143
1925	8		6	14
Jan. 1925				148
February			1	12
March	7		11	18
April	11		3	14

May	7		13	175
June	9	5	14	172
July	8	3	11	
August	11	1	12	185
September	10	5	15	225
October	8	4	13	16
November	11	7	18	191
December	13	5	18	192
Total	110	62	172	1644
average			14.33	182.61
1930				
Jan. 1930	11	12	23	183
February	13	9	22	212
March	1	18	30	325
April	12	14	2	233
May	13	9	2	158
June	8	11	20	231
July	10	14	24	264
August	13	8	21	210
September	13	8	22	271
October	11	12	23	270
November	11	13	25	27
December	15	8	23	298
Total	141	130	281	293
average			23.42	244.75
1935				
Jan. 1935	15	14	25	343
February	18	13	31	313
March	21	13	3	300
April	14	21	35	35
May	22	31	43	392
June	29	18	41	451
July	22	7	25	331
August	14	13	21	312
September	21	10	31	324
October	15	14	25	361
November	18	13	31	355
December	20	16	30	365
total	229	183	402	4206
average			33.5	350.5
1940				
Jan. 1940	15	3	18	266

February	15	7	22	301
March	19	6	25	304
April	11	6	17	278
May	15	5	20	31
June	12	2	14	29
July	18	8	26	339
August	14	11	25	293
September	14	16	30	356
October	18	8	26	325
November	15	10	25	423
December	11	12	29	344
Total	183	94	27	3833
average			23.0	319.42

Appendix C Table 1 Bacup numbers of cases and visits nursed (1915-40) 5 yearly

Year and Month	Cases at beginning of month	New cases accepted	Total cases nursed during month	Total visits in month
1915				
Jan. 1915	15	9	24	451
February	15	9	24	402
March	17	6	23	300
April	H	H		(1)
May	13	8	21	255
June	14	7	21	27
July	13	10	23	141
August	H	I	23	246
September	14	11	23	297
October	H	8	26	267
November	H	t	21	292
December	18	10	22	297
Total			282	3522
1920				
Jan. 1920	22	7	25	282
February	23	8	31	28
March	25	7	32	34(1)
April	23	0	29	302
May	19	7	26	204
June	11	5	H	323
July	H	4	20	
August	18	8	27	22
September	21	3	25	218
October	22	8	31	183
November	U	11	29	171
December	14	t	20	241
Total	23	81	JV	248
Average			26.1	207.0
1925				
Jan. 1925	14	H	30	231
February	14	S	23	15(1)
March	14	13	21	243
April	16	i	23	164
May	11	14	25	189
June	12	13	25	228

July	13	10	23	19S
August	13	8	21	225
September	11	14	25	222
October	14	5	1S	212
November	12	10	22	21S
December	11	?	18	18S
total	155	120	281	2482
average			23.42	206.83
1930				
Jan. 1930	13	11	24	301
February	11	11	20	213
March	13	18	31	318
April	11	11	21	263
May	13	13	22	271
June	10	11	21	220
July	10	14	24	260
August	14	11	21	213
September	10	14	24	204
October	11	11	23	270
November	11	11	23	270
December	11	11	23	289
total	144	131	271	3093
average			22.92	257.7
1935				
Jan. 1935	11	14	30	339
February	17	14	31	295
March	21	15	35	298
April	20	15	35	350
May	19	11	33	370
June	11	11	31	375
July	12	11	23	321
August	11	15	21	334
September	11	11	28	331
October	11	11	31	356
November	15	15	31	336
December	15	21	33	378
Total	171	181	364	4086
average			30.33	340.
1940				
Jan. 1940	19	18	37	412
February	21	13	41	342
March	21	13	40	361

April	21	14	40	296
May	22	13	35	
June	23	12	35	190
July	24	15	35	334
August	23	10	33	303
September	20	14	34	286
October	24	10	34	293
November	25	16	41	353
December	21	1	38	375
Total	270	161	442	3821
average			36.92	318.92

Appendix D: Data compiled from QNI Reports giving numbers of district nursing associations and staffing ratios (from Wellcome CMAC, SA/QNI The Queen's Institute)

Appendix D Table 1: Staffing and Workload figures (1915)

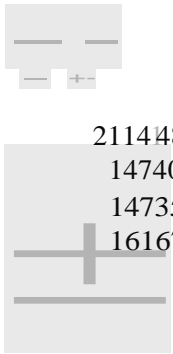
	No O/Ns excl Superintendents	No Cases	Cases per nurse pa	No Visits pa	Visits per nurse pa
2		191		963407	1704
7		702		10020064	2866
5		1609		12217287	3457
4				667726	1932
				1049394	
3		38		12712223	4074
1		1		1312431	2431
		120		1203284	3284
		220		1106826	3413
24		2304		9659002	2458
				6522662	2266
1				2252857	2857
7		1		24125295	3614
4		366		929342	2336
3				12010805	3602
3		304		10110864	3621
5		J38		147129710	15942
1		-#6		2764546	4546
2		400		20512324	6162
1		292		2923584	3584
3		23		108503	2501
		1513		257111408	5704
1		163		1633530	3530
1		144		1442277	277
3		346		1159624	3208
2		213		1074121	2061
8		1226		16633291	4161
5		733		14724043	4809
9				9209	1023
1				1184596	4596
50		4760		9598073	1961
10		1402		14029057	2906
		53		774103	2052
21				11676955	13665
7		1279		18333472	41a2
11		J1708		15550601	4600
				13244	13244
7		13987		5136365	466
2		0		1307468	3734
5		207		414692	938
2		208		1047750	3875
6		190		3221989	13665
4		838		2102194	1549
7		896		12817582	2512
		921		18422612	4522
6		613		10215137	12523

8		1324	166.31561	3945
2		249	1257484	3742
L		1012	202 20142	4028
17		2591	15273685	4334
6		252	15927741	4524
4		491	12 15671	3918
			183 24985	4997
		51		
		1		4337
5		1	303.17567	3513
9		16	17939035	
2		167	94 4379	2189
10		1452	14532439	3244
11		114	114 1628	11628
		1042	208 18350	13670
		103	52 3903	1952
L		126	1263087	13087
1		128	1381490	1490
8		1257	157 26070	3259
3		481	1609164	3055
Q			197 26030	5206
7		478	68 16560	2366
9		1M2	18231023	3447
3		356	119 14018	14573
4		11032	25 35876	109s9
11		2789	254 50258	4559
L		1 146	57324569	12285
L			21322223	2469
3			94 9288	3096
.			1528463	4232
2	559		28010361	5181
4	786		197 13833	3458
5	3237		147 175003	3409
5	424		8 13034	2607
.		4	25940743	6791
.			13034976	14997
f.		4 8	21 7324	3662
58		16759	117 143654	2477
4		36	94 11111	2929
!Q		54	20 37188	3719
10		1966	19752000	5200
12		784	6529175	2431
25		13230	1279048	3162
17		1318	7851520	3031
14		1283	92126893	1921
5		1097	21 30252	16050
27		14932	18 152886	15662
14		1365	9824867	1776
90		9933	110289794	13220
23		5139	22397182	4225



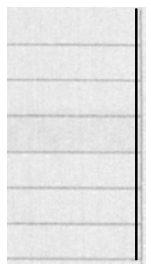
g_ 16 20 1 12 11 16 71 Total 1915 Average 1915

1286 2169 2838 2114 1763 1615 2580 901



10737774 13663122 14277354 211448119 14740781 14735698 16167541 1391242065 12993 125

3148 3945 3868 48119 3398 3245 4221 3409

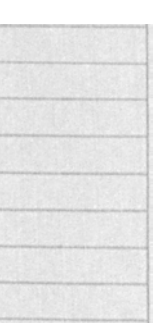
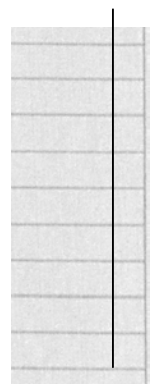
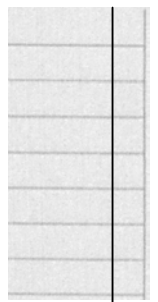


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Appendix D Table 2: Staffing and Workload figures (1920)

No D/Ns excl Su	Superintendents	No Cases pa	Cases per nurse pa	No Visits pa	Visits per nurse pa
2		532	266	9924	4962
4		491	123	15671	3918
14		99	227	46705	3336
				210500	
9		2033	226	138699	4300
5		11513	303	117567	3513
5		1193	199	2085	4417
9		1611	179	139035	4337
1		114	114	1628	1628
7		850	114	20366	12909
10		1993	199	31379	3138
90		10442	114	221198	2458
7		204	199	21236	3034
5				16000	13200
19		1556	240	60292	13173
12				42418	3535
5		1540	308	12034	4207
6		1328	221	14544	2424
6		953	159	27741	424
2		194	97	5402	701
2			112	6069	3035
2		228	114	3945	1973
5		750	150	4472	2894
			191	2272	
10		1187	119		(227
17		1839	108	61427	3613
5		921	184	12	4522
4		402	108	13936	484
4			66	7726	1932
1		24	120	3284	3284
2		150	75	3761	181
2		703	352	12268	6134
3		291	97	7224	2408
3		852	284	7183	2408
2		202	101	7	2699
106		4285	40	150224	474
1		114	114	3072	3072
2		140	120	17529	3765
1					
7		774	1	16017	12288
3		2-73	4	55	1852
4		937	234	24	620
3		311	104	9394	3131
5		1097	219	30252	6050

11		408	15393	
g		65	129175	2431
7		27	131687	4533
	405	J7	60897	1149
18	ir12	0	22213	1234
1		1	13244	3244
		258	6678	12226
IS		956	191	6984
2		664	332	5554
1		354	364	3280
1		163	163	3530
5		468	94	30233
f		1091	182	128348
3		281	94	9288
sf!		6123	106	247551
e-	jo8	104		17750
4	5	141		10976
1		276		4546
				4546
		409	82	12719
				2544
1	is?	57	12100	2100
14		380	+95	fs1a1
5		207		4692
S		3101	141	190443
2		309	103	8177
2				2726
6		627		21724
27		3938	r	97887
2			74	10896
1		1292	292	3584
§ 0		4760	95	98073
7			103	19780
27				f,4451
L				,4751
2		208	i104	2933
2		@	158	4396
2		331	166	7782
		37	1154	1102882
		1977	1140	122658
16		2134	133	1514118
20		1486	74	494112
		J119		114018
LL		850	194	27277
io		1529	76	38422
/.		103		8



	1087	6		13903	1952
				13395	4174
9	_____	1143	1127 --	124120	12680
8	_____	738	,123 _____	f1 666	2778
2	_____	_____	_____	(
6	_____	_____	1155 _____	5016	12508
		71	_____ 1129	23123	3854

	19822		1 173274
	17557	130	174669
7	88	126	21043
5	893	179	23198
9	11248	139	28630
Q	1293	129	30093
	659	94	27186
	6		11076
	421	1140	16916
114	1365	98	24867
12	177	9	2554
12	260	130	7468
111		G11	44733
	1121		
7			
23	1380	138	131398
Gt	135		67662
IS	1262		18288
	710	ag	18589
124	2563	J101	59768
!Total 1920			18352
Average			168
			416204
			13116

23		27	23912	11040
132	1067	81	231398	1753
1	60	60		
2	170	M	2186	1093
	-t 46	-j 149	6961	2320
5	253	51		
L			11265	3755
	155		10154	5077
1	80	180	11899	11899
\$	1g55	191	32497	16499
			2522	2522
			12438	2073
			17289	2470
7	1664	95		
5	1218	244		
4	287	72	10981	2745
3	1325	108	8873	12958
8	537	67	22055	12757
4	1405	01	110968	2742
6	1544	1257	31575	5263
176	2	75	148964	1960
2	1505	253	8904	4452
2	1193	97	5631	2616
5	09 4	182	12719	12544
25	4185	161	104851	14194
L	3c	1151	19989	14995
1	p6	276	4546	4546
2	1/2	150	6550	3275
27	4	121	190972	3369
				1899
E7	10198 - ilo5		187646	1934
50		129	128349	12567
/		1	3776	11888
			5805	2903
	489	163	11590	13863
3	31	104	1676	12559
2		410	13099	1550
17	12249	132	57035	3355
21	124		44793	2133
12	1398	rm 7	13317	3779
8			45342	
	i17			2313
17	6S-	1104	27519	3440
	95			
7	970	139	14309	3473
6	1952"	159	24103	4017
			11450	2663
4	574	144	4457	2229
9	229	103	24033	2670
55	15957	8	50137	2730
5	622	124	20908	4182
7	1881	126	26501	13786
	1270	145		
11	1271	141	129029	2639
9			32466	3507

1	1239	13a	31000	3444
:	957	191	22071	4414
	935	187	25276	5055
				3275
[t		132	1700	1700
		67	45582	3799
1	1245	113	141095	3736
g	1420	158		
6	1747	125	22260	3710
25	3532	141	89245	3570
24	4832	201	61956	2582
Total (1925)			16094	336489
Average (1925)			153	3235

Appendix D Table 4: analysis of Tables 1-3 for use in Chapter 4

No. of cases per year 1915	No. of districts 1915	No. of cases per year 1920	No. of districts 1920	No. of cases per year 1925	No. of districts 1925
>50		1>50		4>50	2
50-99		1850-99		2250-99	20
100-149		42100-149		44100-149	44
150-199		20150-199		17150-199	64
200-249		12200-249		9200-249	5
250-299		7250-299		6250-299	4
<300		4<300		7<300	6

No of visits per year 1915	No. of districts 1920	No of visits per year 1920	No. of districts 1920	No of visits per year 1925	No. of districts 1925
>1000		3>1000		2>1000	1
1000-1999		101000-1999		181000-1999	16
2000-2999		212000-2999		252000-2999	35
3000-3999		39 3000-3999		39 3000-3999	29
4000-4999		214000-4999		174000-4999	12
5000-5999		7 5000-5999		35000-5999	6
6000-6999		36000-6999		46000-6999	2
<7000		3<7000		4 <7000	3

Appendix D Table 5: QNI figures for District and County Nursing Associations (1915-47) – Data used in Chapter 4.

District Year	NAs	County NAs	Q/Ns	Village N/Ms	Subtotal	Total	Others (trainees etc.)
1915	627	27	1560	1231	2791	3531	740
1916	620	27	1522	1108	2630	3435	805
1917	622	27	1484	1327	2811	3719	908
1918	640	31	1401	1616	3017	3932	915
1919	680	32	1289	1761	3050	4069	1019
1920	715	36	1294	2255	3549	4377	828
1921	677	37	1324	2432	3756	4647	891
1922	670	41	1387	2490	3877	4706	829
1923	688	42	1474	2529	4003	4843	840
1924	710	43	1525	2565	4090	4950	860
1925	738	42	1586	2630	4216	5120	904
1926	737	42	1685	2738	4423	5278	855
1927	767	42	1785	2666	4451	5260	809
1928	804	42	1879	2758	4637	5399	762
1929	847	43	1984	2762	4746	5646	900
1930	865	43	2047	2871	4918	5733	815
1931	888	44	2179	2947	5126	5942	816
1932	930	44	2322	2909	5231	6010	779
1933	963	43	2439	2961	5400	6161	761
1934	1006	45	2513	2823	5336	6157	821
1935	1083	46	2687	2905	5592	6375	783
1936	1149	46	2864	2857	5721	6509	788
1937	1262	47	3037	2659	5696	6568	872
1938	1316	46	3223	2986	6209	6967	758
1939	1378	47	3337	2936	6273	7204	931
1940	1413	47	3340	2784	6124	7122	998
1941	1428	46	3216	2772	5988	6599	611
1942	1449	47	3123	2702	5825	6298	473
1943	1487	47	3180	2722	5902	6449	547
1944	1532	47	3264	2655	5919	6550	631
1945	1603	49	3315	2572	5887	6726	839
1946	1674	50	3384			7387	
1947	1731	50	3428			7439	