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Understanding Politics:
an historical perspective

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UNDERSTANDING POLITICS: AN HISTORICAL PERSPECTIVE

INTRODUCTION

Three papers were read to the King's Fund History of Nursing conference on 29 July 1983. The great interest demonstrated by the audience at this conference persuaded the King's Fund Centre to reproduce the papers so that those who attended might have an opportunity to study them more closely and so that they might be read by others who were not there.

The papers included, in programme order,

Rosemary White	Altruisim is not enough: barriers in the development of nursing as a profession
Sarah Robinson	From independent practitioner to team member: some aspects of the history of the midwifery profession
Christopher Maggs	The hospital, the firm and the nurse

Although dealing with widely different aspects of history, these papers shared much in common.

All three papers find that the division of labour in hospitals and the health care system had profound effects on nurses and midwives. Maggs detects this in relation to the hospital as a social unit, Robinson discusses it in relation to doctors and midwives as well as between midwives and White deals with it between nurses.

There are also differences in how the authors have viewed their subjects. White looks at nursing as a pluralist society held back from full development by the policy makers who seek to impose a common policy on what they have traditionally regarded as a unitary structure. Maggs treats his nurses as a social activity located and linked with wider forces within a local society. Robinson tends to see midwives as a unitary group influenced by remote policy makers, planners and terratorially hungry doctors. Perhaps these differences serve to demonstrate another similarity: that of the inability of nurses and midwives to control their own occupational development.

Robinson's account of the struggles for registration of midwives is an interesting contrast to the better known accounts of the moves to register nurses. Both endeavours were directed towards the protection of the public. There is now a need for someone to study if the registration of nurses and midwives did achieve that objective.

Maggs described the early hostility to the employment of the 'new nurses' on grounds of cost but, later, how the use of these staff was exploited to gain commercial advantage for their hospital authorities. In contrast to this, White makes the point that nurses' altruisim was exploited by the Ministry of Health to stunt their training and provide semi-skilled labour for the hospitals. Each of these authors illustrate how the pragmatic values of officialdom were adopted by nurse leaders and turned into moral ideals for the better control of their nurses.

The sources used by the three authors also compare interestingly. Maggs used local sources of information and seeks, very cautiously, to generalise his findings. Robinson and White used national sources for their more general interpretations. Maggs and Robinson have supplemented their sources by the use of personal histories.

In view of the title of the conference, it is perhaps not surprising that all three papers demonstrate how politics and policy constrain and influence the structure and function of nursing and midwifery. Whilst Maggs refrains from relating his findings to the present, both Robinson and White use history as a tool for identifying current issues and as a background against which to interpret or illuminate the present. This difference is probably because Robinson and White deal with midwifery and nursing whilst Maggs deals with nurses.

At first hearing there are more differences than similarities in these papers. On closer study, the similarities begin to appear. This chance to have a second look at the papers will add to the interest and learning experiences of those who attended the conference. One hopes that the conference helped to sharpen the awareness of those present to the value of historical studies and, particularly in developing a better understanding of today's politics.

Rosemary White

ALTRUISM IS NOT ENOUGH: BARRIERS IN THE DEVELOPMENT OF NURSING AS A PROFESSION

In recent months the nursing profession has been exhorted to get political. The Nursing Standard (14.4.83) used the headline, 'the political power nurses might wield' and, again, on 19.5.83 headlined the message, 'members urged to get political'. Similar messages have been sent their readers by the two weekly nursing journals and, indeed, the RCN Conference, 1983, was given over to the theme of political engagement by nurses.

The message is therefore clear: nurses should lobby their Members of Parliament, write to newspapers, provoke debate on the BBC and form political networks.

What is not clear is what are nurses to lobby for? What are nurses to get political about? Are we to demand those things that the College tells us to? or the unions? Are we to insist that nurses should be paid better? given a better training? have their qualifications paid for? have better working conditions? that only trained nurses should nurse the sick? that we need more SENs, more students, more auxilliaries? that the Salaries Review Board should deal with only the trained nurses? or all nurses? Or, shall we persist in saying that we want all these things but that the patient must come first?

There have been several studies of the strategies used by nurses to achieve professional status. These have assumed a common goal for all nurses, that of professional status. They have, however, varied in their definition of the term 'profession'. Some have looked at control of labour, some have preferred to look at a theoretical base of knowledge and some have examined the autonomy of the nurse or organisational concerns.

Sociologists have not been entirely successful in establishing criteria for professionalisation and many now believe that the old trait approach is sterile. I should like to examine the question in more detail in order to discuss the political barriers that nurses experienced in the past, specifically between the start of the NHS in 1948 and the establishment of the Salmon grades in the middle of the 1960s. I shall end this paper by looking at the position as it is today.

The Past

Before the nationalisation of the hospitals in 1948, nurses were employed by individual hospitals. These were the old voluntary hospitals, the old municipal hospitals and the remnants of the Poor Law hospitals. The second and third types were run by the local authorities under the Public Health Acts and the Poor Law Acts respectively. Different committees therefore were responsible for each of them.

Under the voluntary hospitals, which took patients as an act of charity, the nurses were the symbols of this charity and worked under the Lady Bountiful ethos.

Under the municipal hospitals, the nurses were paid by the rates and had a different status. They tended to be seen as employees of the local authorities or, if you like, as servants of the ratepayers in the same way as civil servants used to sign themselves 'your obedient servant' when writing to members of the public.

Under the Poor Law authorities, the nurses were seen as agents of the despised workhouse authorities or as agents of social control.

The NHS put all nurses into the common employment of the health authorities which necessitated a new occupational status. This status was not clearly defined and had, with the help of passing time, to be worked out. Certainly the occupational status of the nurses was not in the same class as that of the doctors who were clearly understood to be professionals and whose status was underlined by the State. Neither was it in the same class as the administrators who achieved theirs through monopolising information and, therefore, power.

In 1954 the Matrons, through the Royal College of Nursing and the Standing Nursing Advisory Committee, rejected proposals for setting up a Group Matron post. In doing this they rejected their route to power and thence forward, until the institution of the Salmon posts, came under the authority of the Group Secretaries. That route to professionalisation, for the nurse managers anyway, was therefore closed to them during a crucial period in our history.

Whilst the Horder Reports (1942-49) described nursing as a profession, there was little substance, except natural occupational pride, to this claim. Professional status was accorded to nurses of the great teaching hospitals who shared the charisma enjoyed by their institutions. This over-flowed to the nurses of both the non-teaching voluntary and municipal hospitals. But nationalisation interupted the charisma of the non-teaching hospitals and broke this ascription of professional status for the RHB establishments. In 1974, when the teaching hospitals were regionalised, even those nurses lost their ascribed status and the search for a new occupational status continued. (White, 1982)

Sociological criteria for professionalisation have changed over the years. Interpretations of professionalism in 1948 rested largely on organisation, service and altruism. Tawney (1921) considered that professionals were 'a body of men who carry on their work in accordance with rules designed to enforce certain standards both for the protection of its members and for the better service of the public.....[its] essence is that though men enterit for the sake of a livlihood, the measure of their success is the service which they perform, not the gain which they amass'. Carr-Saunders and Wilson (1933) wrote that 'the attitude of the professional man to his client or his employers is painstaking and is characterised by an admirable sense of responsibility; it is one of pride in service given rather than of interest in opportunity for personal profit'. Cole (1955) offered three characteristics,

technical efficiency and examination, a code of ethics which included service, and a closed structure.

Later sociologists began to concentrate more on the application of an intellectual technique, higher education and specialisation. Merton et al(1957) and Millerson (1964) both specified theoretical knowledge and higher education whilst retaining the characteristics of altruism and service. In the next decade, less emphasis was placed on altruism and this often became displaced by consideration of power, organisation and life-style deriving from specialisation and professional monopoly. (Jackson 1970, Johnson 1972).

In the 1950s, therefore, there was still the emphasis on service and altruism but the educational theme was becoming more apparent.

Whilst nursing still lacked most of the current traits of a profession such as a theoretical knowledge base, control and individual responsibility of practitioners, it clung to the older understandings of professionalism and continued to emphasise altruism and the service ethic.

You will see, later in this paper, how this tactic played into the hands of the Ministry of Health and how the nursing institutions were forced into certain inconsistencies in their policies and strategies.

Before we examine these issues, I must first point out that the post war period was one in which the division of labour became most marked. Jobs were broken down into components and workers were required to perform these simple tasks in a repetitive way rather than to work at the whole process. These simplified tasks required the minimum of training or skill and the worker's level of responsibility was commensurately reduced.

A few workers supervised and took responsibility for the whole process and qualified for their higher status by taking further training or education.

In time, task workers became known as the generalists, the unskilled or semi-skilled people. The contrasting category became known as the specialists and often qualified as the new technical experts or semi-professionals.

The Ministry of Health considered nurses to be only one step removed from the hospital domestics and advised the new HMCs accordingly in their Notes of Guidance (1948). In future years this concept of the nurse as a generalist was further manifested.

The ministry reduced the training for SEANs in 1949, they reduced the training for district nurses in 1956, the Jameson Report (1956), confirmed the health visitor as a general family visitor, the training of nurse tutors was abreviated in 1954 and all the combined courses for multiple training effected a shortened period of preparation for nurses. Furthermore, whilst the RCN and GNC fought for the return of a minimum education level for recruits, the Ministry resisted this until 1962, when it allowed only two 'O' levels as the entry requirement.

In contrast to the Ministry's actions to generalise nurses, the College had a policy to prepare specialists after their basic training and to site post-registration training in centres of further education. The College, influenced by the Horder Reports, believed that there should be both generalists and specialists. In this policy, the College sought to develop specialists - or professionalists - by further education. Thus whilst many nurses clung to the idea that altruism was the fundamental criterion for professionalism, the thinking of the College moved forward and kept pace, in this respect, with current theory: it sought for an educational basis for professionalism.

At the same time, the College was fighting to establish itself as the legitimate representative body of nurses. Before it could confirm its place it had to be accepted by the policy makers, the Ministry of Health, and it had to fight off the trade unions.

Nettl (1965), considered that any organisation seeking to be recognised as the official representative body has to demonstrate certain characteristics. These include the adoption of government terminology and methods (specifically in consultation and negotiation with the appropriate government department) and the demonstration of concern for 'the common good'. Grove (1962), Also believed this and thought it was the civil service administrators who defined what was the common good.

During the 1950s and 1960s the common good was very much conceived as being the staffing of the NHS hospital beds and community nursing services by 'pairs of hands'. The need for more nurses therefore emphasised the Ministry's concern to generalise nurses.

The College was forced to go along with this definition of the common good if it wished to be accepted as the legitimate representative body. Furthermore, in fighting off the unions, it had to increase the size of its membership and it was therefore active in its recruitment, at first only of nurses on the general register but, after 1960, of nurses on any register maintained by a statutory body, including the enrolled nurses.

We must turn now to look at the nurses themselves. I have indicated earlier that the charisma of nursing derived from the great teaching hospitals and overflowed to nurses in the other hospitals. Soon after 1948 the nurses sensed that this charisma was diminished and that their status was deteriorating as the health service became increasingly bureaucratised. This at first led to their felt need for a ritualisation of their professional ethos, that of disinterested altruism. But in the age of the Affluent Society, when they began to be aware of their relative deprivation of status in the hospital bureaucracy, they started to look for greater material rewards. Their search for status turned towards this direction rather than an improved educational status for three reasons.

In the first place, the open entry to nursing had introduced too many candidates without formal educational standards who were rising through the ranks by means of natural ability and a paucity of competition. These nurses interpreted the call for a minimum education standard as a threat to themselves and resisted it by emphasising the practical roots of nursing.

In the second place, the government had persistently refused to allow the reintroduction of the minimum education standard. Therefore, failing that, the nurses turned to other goals.

As far as most nurses were concerned, therefore, their search for status was directed towards better salaries and a better position in the social stratification within hospitals.

As far as the RCN was concerned, their search was for greater power in policy making.

The aggregation of these two points of view was 'status' even though there was ambiguity in the respective definitions of the term.

There were, therefore, three layers of objectives: the College's official objectives of professionalisation, a middle layer of common good goals and a third layer seeking for improved employment conditions and rewards for its members.

In this delicate balance of sometimes conflicting objectives, the College had to maintain or encourage membership by negotiating for better salaries. Even in this it had to keep a balance between the unions' aggressive claims for the junior ranks (who were more often their members), the interests of the more senior nurses (who were more often College members) and the appearance of concern for the common good.

It had to pursue its declared policy of seeking for the Horder model which included more enrolled nurses, better trained SRNs and advanced training for some nurses. In this it risked upsetting the junior nurses who resented the enrolled nurses, the older nurses who resented a policy of promotion by additional training rather than by experience alone, and the matrons who gave lip service to Horder but who preferred not to train pupil nurses and who were primarily concerned to staff their wards.

Lastly, it continued to strive for further education for nurses, which few of its members wanted and which most actively did not want. Furthermore, in seeking to encourage advanced training for specialists, it appeared to be depressing the status of the general nurses.

The College's concern to retain or revive the professional status of nursing by encouraging specialisation ran counter to the trend generated by the government. Its concern with the altruistic ideals of nurses, which was the equivalent of the common good, ran counter to its search for professionalism.

The College was forced to mute its official objectives for the sake of maintaining the goodwill of the Ministry and its generalist members. But in the course of time, more nurses qualified as specialists. The health visitors were most influential in this trend as many of their courses were situated in centres of further education, often in universities. Their academic success in these centres helped to open up other further education courses and enabled more nurses to gain educationally legitimate qualifications. The specialist sections of the College increased in numbers and became more vocal.

Gradually, the College Council developed the practice of referring issues to the specialist sections for consideration and these sections quickly became more influential in the formulation of College policy.

In this way, the College developed a pluralist structure with the generalists attending branch meetings and the specialists attending their section meetings.

The Present

After the implementation of the Salmon Report (1966) there was a proliferation of nurse managers. These nurses developed their own values which contrasted with those of both the generalists and the specialists. The nurse managers' peer group includes the bureaucrats of the health service: the administrators and the treasurers. In seeking to achieve authority in team management they have had to adopt the values of their administrative colleagues, those of in-put control, budgetary management and cover. This is not to say that they have lost their nursing values but as Froebe and Bain (1976) have pointed out, in a continuum between clinical skills and management skills, the further up the hierarchy a nurse gets, the further away from clinical values does she move.

The generalists do not want to raise the educational standard of entry, do not want to phase out the enrolled nurse grade, do not accept that anything other than experience should be a qualification for promotion. Graduate nurses for them, are only theorists and have little relevance to nursing. They seek to include untrained nursing staff in the College membership and in the prospective Salaries Review Board; they want solidarity, affiliation with the TUC, the abolition of Rule 12 * and are more inclined to be activists.

The professionalists are elitists and are slowly distancing themselves from the generalists. They prefer most post-basic nurse training to be given in centres of further education and they stress the need for educational qualifications for promotion. They reject affiliation with the TUC, wish to preserve Rule 12 and propose that only registered nurses should be included in the Review Board's considerations. Material rewards are important to them as a means of achieving a certain life-style commensurate with that of other professionals but are secondary to professional status and authority derived from a legitimate educational standing.

The managers find themselves more at home with the generalists who are more easily controlled, less likely to challenge accepted nursing dogma and who are therefore less of a threat to the status quo. The nurse managers understandably argue that the generalists are the basic component of the labour force and that only a very few specialists are required as leaders or advisors.

The managers are achieving professional status today through their exercise of power and control but will only be successful if they can develop management skills and expertise, including bureaucratic values.

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* Rule 12 of the RCN which prohibits members from taking stike action.

The specialists are slowly achieving professional status through their improving education and the development of a knowledge base.

It is unlikely that the generalists will ever achieve professional status since their qualifications lack any educational status, their numbers are too great and they refute the value of anything other than practical skills. Indeed, it is open to question whether they want professional status.

It is of some interest to note that Prandy (1965) found a similar typology in his study of engineers and scientists. He removed the managers from the others and found that the rest divided between what he called the professionalists and the unionists. He drew a continuum between these and described their dominant attributes as status consciousness on the part of the professionalists and class consciousness on the part of the unionists.

The professionalists were concerned with further education, strengthening their profession and improving their efficiency. They were less politically minded and accepted the ideology of stratification.

The unionists were more concerned with collective bargaining, material conditions and were less highly qualified. They were instrumentalists, more politically minded and accepted the ideology of conflict between groups.

Prandy found that unionism was greater in nationalised industries, central and local government. The more bureaucratic and centralised the organisation, the more was the unionistic tendency.

Prandy also found that the professionalists aspired towards greater self-control in their work whilst the unionists were amongst those with less control of their work and subject to more supervision.

There are many similarities between his analysis and mine.

The Future

We must turn now to apply these findings to our position in nursing today.

Our current concerns centre largely around the proposals put forward by the UKCC, the National Boards and the RCN.

The UKCC has proposed that the enrolled nurse grade should be phased out. The College has put forward its proposal for A Structure for Nursing (1981).

As you know, there is considerable resistance from some quarters to the loss of the SEN and many people believe that this practical grade is vital to the maintenance of the service. I have not analysed the directions from which this resistance stems. Naturally, it will come from the SENs who

have, or think they have, a career at stake. I should imagine that some resistance is also being shown by the generalists who interpret this proposal as a further attack on them and an attempt to boost the elitist professionalists. I guess, also, that the managers are worried because, unless they can understand the future more clearly, they see themselves losing an important section of their labour force.

If we look at the College's proposals for a new clinical structure, we see that they have based them on a single portal, a single training. This means that they, too, see the phasing out of the SEN. After basic training, the nurse must take a further development course before she can be appointed to a staff nurse post. From then on, each promotional step relies on further training and some sort of assessment or examination.

There will be those, the future professionalists, who will pass through all gateways and get to the top. There will be those who pass through some gateways and decide to stay put. There will be those who stop at the staff nurse level. It is these last grades of nurses who now represent the basic, trained grade, and will be the first grade of the future.

Since each level up the hierarchy is entered through a further training and assessment, what need is there for a grade of training below that of the first grade?

Although the UKCC has not come clean on its model, it looks as if they see the future in much the same way as does the RCN. (UKCC, Working Groups 2 and 3, Consultative Papers, 1982).

We see, therefore, that we shall be getting the sort of structure which the Wood Working Party (1947) first proposed for us. Nobody read Appendix VIII and so nobody understood his model. (White 1982)

We also see that we are getting the model put forward by the Horder Committee (1942-49). Because people had misinterpreted the Wood Report they failed to see that the two models were very similar.

We also see that we shall be getting the model drawn out by the Goddard Job Analysis of the Work of Nurses in Hospital Wards (1953). Again, this report was not read properly and was misinterpreted. It was, I must say, also mis-reported by the two nursing journals.

All these reports were similar and entirely reconcilable with each other. The profession failed to understand the concept behind any of them, failed to understand the essence of these reports and we have had to wait until now to get ourselves sorted out. History does have lessons for us today.

In conclusion, let me return to the title of my paper. **Altruism is not enough.** I hope that I have shown that whilst altruism is an ideology which binds all of us in a common occupational culture, there are, besides altruism, different needs with which different interest groups identify.

There are the material needs and the needs for structural status felt by the generalists.

There are the educational needs and the search for professional authority by the professionalists.

And there are the control or power needs felt by the managers.

Besides these, there are the needs of the RCN for dominance over the unions and authority in policy decisions negotiated with the DHSS.

The DHSS continues with its needs to staff the hospitals and community services as cheaply as possible. It also has to preserve the balance between the power groups in the service and their demands, whilst appearing to support the employing authorities who, after all, are their agents.

The employing authorities, the regional and district health authorities, are concerned to provide a service within their budgetary resources which are now strictly finite. They will cut corners as much as they can and will rob Peter to pay the more powerful Paul. It may not be entirely fair to generalise but, on the whole, their concern is for cover rather than quality and pressures force them to offer a breadth of service rather than one of depth.

Nursing, as an occupation, can no longer be treated as a unitary social system. It must be understood and treated as a pluralist society. A common policy for all nurses is no longer helpful. If nursing is to develop and function properly, the needs of all its groups must be satisfied.

Until now, nurses have had no reference framework by which to assess reports and the proposals emanating from them. One section of nursing wants all nurse education to be sited in the Schools of Nursing. Another section wants, at least, most post-registration courses to be centred in universities or colleges of further education.

One group wants the minimum education requirements to be two 'O' levels or less. Another group insists on university entrance standards.

None of these people is less than sincere; all firmly believe that their opinion is right. How are we to decide between them? We have lacked any criteria for doing so.

Because of this, nurses' intrusions into the realms of politics have been tentative, aggressive or emotional. We have failed to make any coherent mark. If we go along with the College policy we often appear to have succumbed to the voice of authority, even if we do get a pat on the back for supporting the dominant ethic of harmony.

If we voice a different opinion, we are accused of rocking the boat, of 'not understanding all the issues' or of being unrealistic or impractical, or, the current cry, 'of living in an ivory tower'.

All these responses have been emotional rather than reasoned. Each response corresponds to the objectives of one or another interest group but, because we have not recognised nursing as a pluralist society, these interest groups and their different value patterns, goals and strategies have not been acknowledged.

I am proposing that my typology will help towards achieving a more useful reference framework. It will help to give better understanding of the different meanings and values placed by the different groups to such terms as 'status', 'profession' and 'rewards', used by nurses.

The greatest barrier to the professionalisation of nursing in my opinion, is the attempt to achieve this for all nurses. Many do not want it if it is to be bought by educational means.

An increasing number, but still a minority, prefer the educational route. The service needs all kinds of nurses but cannot afford to professionalise all of them. In any case, it would not be what is needed. To use Horder's terms, we need both the 'other ranks' and the 'officers'. To use my terms, we need the generalists as well as the professionalists.

But, as history has clearly shown us, we need to distinguish between the aspirations of the groups and we need different policies to satisfy and develop their contrasting needs. Furthermore, we need to understand the different values of the groups so that we may understand how they come to assess priorities and interpret events.

If we continue to see altruism and service needs as the dominant value of all nurses we shall fail to develop the specialists that we desperately need and we shall drive them into the periphery. If we fail to satisfy the generalists with material rewards, we shall not have the body of the nursing teams which the specialists will lead. If we continue to accept the civil servants' definition of the common good and persist in ritualising altruism, we shall help the government and the employing authorities to reduce all nursing to a state of total generalism or proletarianism.

We must understand that the nurse managers have their own needs and values. They are the advisers to the employing authorities and the agents of the DHSS. They have to implement the authorities' policies and should not always be seen as the mirror image of nurses. Indeed, if they try to reflect the needs of nurses, we should now ask which nurses? the managers? the generalists? the specialists?

Whilst altruism is an ideology shared by all nurses we must understand that it is not a route to professionalism.

To sum up

The barriers to professionalism include the persisting attempt to deal with nursing as a unitary social system instead of recognising it as a pluralist structure. Other interest groups including the civil servants, the administrators and many doctors, prefer to emphasise the generalist nature of nursing. Within nursing, there is a majority of nurses who are generalists and who seek to achieve their material objectives whilst the RCN, acting as a referee between the varying objectives of the interest groups included in its membership and always mindful of its needs to retain its legitimacy as the representative body, has to walk a tightrope. Whilst it pursues its long-term goal of professionalism, it has to depress this from time to time, as it also pursues the short-term goals of the generalists and managers. At the same time it has to be seen to be mindful of the common good and to emphasise the needs of the health service.

If the College claims to represent nurses, we must ask which group is dominant? We must analyse their statements and policy documents to determine if they are seeking to impose a policy of consensus and harmony or if they are trying to reconcile the interests of all groups. In doing this, are they suppressing the needs of one group too severely?

It will not be possible, always, for the College to satisfy all groups. When this situation arises, it will be necessary for us to be alert to their use of the fall-back strategy when they revert to the use of the common good, altruism, service needs. This position may satisfy the managers, the DHSS and, often, the generalists, but it will do nothing to improve the lot of the professionalists.

Perhaps, if we really succeed politically, we may even manage to persuade the civil servants to change their definition of the common good.

Rosmary White
July 1983

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FROM INDEPENDENT PRACTITIONER TO TEAM MEMBER: SOME ASPECTS OF THE HISTORY OF THE MIDWIFERY PROFESSION

Introduction

During this century, the role fulfilled by the majority of midwives has changed from that of an independent practitioner providing continuity of care throughout pregnancy, labour and the puerperium, to that of a member of a maternity care team in which each midwife is likely to be involved in only a part of the care provided for childbearing women. In this paper, some of the developments in maternity care which have led to this change are described. *

My interest in the history of the midwifery profession arose from a research project which I have been undertaking, with colleagues at Chelsea College, on the present role and education of the midwife. The project was commissioned and funded by the Department of Health and Social Security. It was commissioned partly in response to the view that the curriculum for midwifery training needed to be revised to take account of the many changes which had taken place in maternity care in recent years, and partly in response to concern about the effects of some of these changes on the role of the midwife. We decided that the analysis of the role and responsibilities of the midwife must logically precede the development of the curriculum and divided the project into two phases; the first analysing the role of the midwife and the second developing the curriculum.

With regard to the role of the midwife, it had been maintained that, in some respects, midwives no longer had the opportunity to fulfil the role for which they are trained (e.g. Royal College of Midwives 1977). A number of factors were regarded as contributing to this situation, including: the move from home to hospital confinement; changes in the organisation of the maternity services; developments in obstetric technology; changing obstetric policies concerning the management of pregnancy and labour, the increasing involvement of other health professionals in maternity care whose roles sometimes conflicted with that of the midwife. In 1979, we undertook a national survey of the midwife's role and responsibilities by the following means: sending questionnaires to a quarter of the midwives in practice; sending questionnaires to a sample of health visitors, medical staff in obstetrics and general practitioners on the obstetric list; and by interviewing 140 midwives. The data obtained documented the areas in which the midwife's role has been eroded, and also revealed a considerable diversity of view between midwives and medical staff as to who was - and also who should be - responsible for certain aspects of maternity care.

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* This paper is based on the historical chapter in 'An Analysis of the Role and Responsibilities of the Midwife' by S Robinson, J Golden and S Bradley, Nursing Education Research Unit, Chelsea College, 1983. I should like to acknowledge the contribution which Josephine Golden and Susan Bradley made to the writing of that chapter, and thus to this paper.

During the pre-pilot phase of the survey, the need for information about the history of the midwifery profession was recognised: firstly, as part of the process of identifying the issues which should be examined in the survey; secondly, in order to have background information against which the data collected on the midwife's present role could be considered. A literature review undertaken in 1978 revealed that at that time there was no indepth history of developments in the profession this century, particularly with regard to the period since the introduction of the National Health Service. We decided, therefore, to compile our own account during the course of the research, and this was done using the following sources: reports of the Central Midwives Board from 1905 to 1979; documents and policy statements produced by the Royal College of Midwives and other professional bodies; reports on the 1958 and 1970 national maternity surveys (Butler and Bonham 1963, Chamberlain et al 1978); various accounts of the history of the midwifery profession (Wood 1963, Gordon 1967, Donnison 1977, Cowell and Wainwright 1981, Bent 1982); Government reports on the maternity services and on the training and practice of midwives; recollections of practising midwives concerning the changes in role which they had experienced in their professional life (these midwives included the project's two research associates and those interviewed in the course of the survey).

The Campaign for the registration of midwives

During the latter half of the nineteenth century, many attempts were made to secure the state registration of midwives, and to make provision for their training. At this time nearly all midwives practised independently and few, if any, training facilities were available to them, * other than being apprenticed to another midwife. Concern over the lack of training facilities and the inadequate standard of care provided by many untrained midwives, motivated a small group of midwives to form the Matron's Aid Society, or Trained Midwives' Registration Society in 1881. The aims of the Society, which was later renamed the Midwives's Institute, were to raise the efficiency of midwives and to improve their status. The Institute's members set out to achieve these aims by organising lectures and meetings for midwives and by campaigning for Parliamentary legislation for the state registration of midwives. State registration was regarded as the most effective means of regulating midwives' practice, providing them with proper training and enhancing their status.

Between 1890 and 1900, eight Bills to secure the registration of midwives were introduced into Parliament; they were all lost for various reasons, including opposition from some sections of the medical profession and lack of Parliamentary interest. Diverse views regarding the desirability of the registration of midwives were held by various groups within the medical, midwifery and nursing professions; these have been documented by, amongst others, Donnison (1977) and by Cowell and Wainwright (1981). For example, many of the leading figures in the medical profession did support the registration and training of midwives, so that qualified midwives could be available to attend the poor in childbirth. However, their support was

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* The facilities which did exist were a course leading to the award of the London Obstetrical Society's diploma, and training provided by some of the lying-in hospitals.

usually on the understanding that the proposed Central Midwives Board, which was to be responsible for determining the rules to control the practice and examination of midwives, would be under the control of the General Medical Council. However, some sections of the medical profession, particularly the general practitioners, were opposed to any scheme to register midwives as they feared that they would be in competition with the general practitioners for maternity patients, and thus deprived them of a source of income. The proposals for registration were in fact opposed by some midwives, amongst them the Manchester Midwives' Society, who maintained that the midwives' status and training would not be improved by a system which was controlled by the medical profession. Members of the Midwives' Institute also were not entirely satisfied with some of the proposals, but they supported the various Bills on the grounds that the over-riding concern was to secure legislation which would protect women from being attended in childbirth by unqualified practitioners calling themselves midwives.

The ninth Bill for the registration of midwives was introduced in 1902, and differed from the others in a number of respects. In particular, the Central Midwives Board was to be directly responsible to the Privy Council and not to the General Medical Council. According to Donnison (1977), these changes were due in part to the influence of certain Home Office officials who regarded it as undesirable for the midwifery profession to be entirely controlled by the medical profession. Although this ninth Bill was supported by a number of leading members of the medical profession, it was opposed by the General Medical Council and by the British Medical Association, primarily on the grounds of insufficient medical control of the registration and examination machinery. But by this time the case for the registration of midwives enjoyed widespread public and parliamentary support, mainly because of growing concern over the high levels of maternal and infant mortality, and the Bill was consequently passed, becoming the 1st Midwives' Act of 1902.

Developments in the profession in the early years of the twentieth century

The Act stipulated that until the end of March 1905, midwives were entitled to register with the Board if they held a certificate approved by the Board, or if they could provide evidence that they 'bore a good character'. After 1905, women were only entitled to call themselves midwives if they were already registered with the Board, or if they passed the Board's examination, having taken a course of approved training. Thus for the first time the title 'midwife' was protected. The Midwives' Act was primarily for the protection of the public against unqualified practitioners, and in contrast to most legislation concerned with the recognition of professions, it was not designed to protect legitimate qualified practitioners from competition from those who were unqualified. As Bent (1982) has commented, this was reflected in the fact that there was no requirement under the Act for the Central Midwives Board to include a midwife in its membership. Despite the lack of provision for direct representation of the midwifery profession, three of the original members were in fact midwives. *

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* The three midwives were Rosalind Paget, who represented the Queen Victoria's Jubilee Institute, Dorothea Oldham, who represented the Royal British Nurses' Association, and Jane Wilson, who was appointed by the Privy Council.

From 1920 onwards, it was mandatory to have midwife members on the Board, but they were always statutorily precluded from being in a majority of the membership.

In the early years after the Act, nearly all women were delivered at home by a midwife, or by a midwife and a general pratitioner. The majority of midwives continued to work as independent practitioners, earning their living from the fees paid to them by the women whom they attended. They were mainly local residents and were well acquainted with the social background and family history of the women in their area. A small proportion of the domiciliary midwives was employed by nursing organisations which provided midwifery services, particularly in sparsely populated rural areas, where independent midwives found it difficult to make an adequate living, and a small proportion worked in hospital. The midwives' work at this time was primarily concerned with the care of the mother and baby during labour and in the immediate postnatal period. The view that antenatal care might contribute to the welfare of the mother and baby was only beginning to gain in recognition. Also, in order to make an adequate living, many of the independent midwives had to take on such a large number of cases that they had little or no time to visit women during the antenatal period.

In the years which followed the Midwives' Act, the State became increasingly involved in the provision of maternity care, and this had a number of effects on the training and practice of midwives. The State's involvement was primarily in response to public and professional concern over Britain's levels of infant and maternal mortality, which were regarded as unacceptably high in comparison to those in other European countries. The Ministry of Health undertook numerous investigations into the question, particularly of maternal mortality and put forward varying plans as to how the maternity services should best be organised (e.g. Campbell 1924, 1927). In particular, the provision of antenatal care was identified as the major factor in reducing the mortality figures, and the establishment of antenatal clinics in exisiting maternity centres was encouraged by the Government. The clinics were under the overall direction of the local Medical Officer of Health. Also the growth of salaried and subsidised midwifery services was encouraged by the Government who gave grants to Local Authorities to enable them to provide these services.

It was estimated that during the 1920s, between 50% and 60% of women were attended in childbirth solely by a midwife and thus the provision of sufficient numbers of well-trained midwives was regarded as of paramount importance in the attempt to reduce maternal mortality. One of the Ministry of Health's reports dealt specifically with the question of the training of midwives (Campbell 1923). It was recommended that the period of training should be extended so that midwives could be adequately trained for their demanding and increasing responsibilities. This proposal was in accord with the views held by the Central Midwives Board and the Midwives Institute, and in 1926 the training was extended to one year for non-nurses and to six months for those who had nursing qualifications and who by this time were undertaking midwifery training in increasing numbers.

One of the main recommendations of the maternal mortality reports of the 1920's was that midwives should be more involved in the care of women during the antenatal period. Midwives were encouraged to visit their patients more frequently during pregnancy, and to refer them to the local authority antenatal clinics if they identified any complicating factors necessitating medical advice. Views expressed by the Midwives' Institute in the 1920s show that they were anxious for midwives to become more involved in the expanding field of antenatal care. The Institute did, however, express reservation that the Ministry of Health reports were very medically orientated and did not make the midwife's role in maternity care clear enough, or fully acknowledge the contribution which she could make (Lewis 1980).

It was recommended that the antenatal clinics should be linked up with small maternity homes or hospitals, and that beds should be available for women requiring antenatal observation, for those with abnormal and complicated conditions and for those whose home circumstances were unsatisfactory (Campbell 1924 and 1927). By 1927, 15% of live births took place in an institution. It was said that midwives were sometimes reluctant to refer their patients to the antenatal clinic, as they would lose their fee if institutional confinement was recommended, and in one of the Maternal Mortality reports, it was suggested that provision should be made for midwives to be compensated in this event (Campbell 1927).

Despite the efforts made to reduce maternal mortality, the level did not drop during the 1920s, and from 1928 onwards it began to rise to more than 3,000 deaths per annum. Of particular concern to those who were investigating this problem, were the difficulties experienced by independent midwives in making a satisfactory living. Although an increasing proportion of midwives were employed by nursing associations and by Local Authorities, the majority continued to practise independently. Competition for patients was often severe and few midwives earned sufficient income to provide for their retirement. It was maintained that unless the employment conditions of midwives were improved, well-educated women would not be attracted into the profession and the quality of care would not improve (Campbell 1927). It was decided that the training, supply and subsequent employment of midwives needed to be reconsidered, and consequently a Departmental Committee was set up in 1928 with the following terms of reference:

> "To consider the working of the Midwives' Acts 1902 to 1926, with particular reference to the training of midwives..... and the conditions under which midwives are employed."

The Committee had twelve members, one of whom, Alice Gregory, was a midwife. The Committee, whose report appeared in 1929, was of the opinion that the training and employment of midwives could only be considered in the context of two much wider questions:

> "what form of midwifery service should be aimed at in this country?" and,
>
> "what place therein should the midwife be given?"
>
> (Ministry of Health 1929).

They recommended that an ideal system of maternity care should include the services of the general practitioner, the midwife and the obstetric specialist if required and that these services should be provided through insurance schemes and administered by the Local Authorities. The Committee maintained that the first basic requirement of such a system was the service of a qualified midwife throughout pregnancy, confinement and the puerperium but was also of the opinion that medical supervision during pregnancy and the puerperium was desirable. This, of course, had not been the case in previous years for the many women whose care had been provided entirely by midwives. The Committee made many recommendations to improve the working conditions of midwives, including substantially increased fees for independent midwives and the introduction of pension and sickness schemes. It was also urged that Local Authorities, in areas where independent practice was not economically feasible, should provide a subsidised or salaried midwifery service. However, the economic crisis of the following years prevented the Committee's recommendations from being implemented.

During the 1920s and 1930s, general practitioners and obstetricians put forward proposals as to how they wished to see the maternity services of the country organised. Some of the various schemes proposed are described in Lewis' recent account of the development of policies concerning child and maternal welfare in the period from 1900 to 1939 (Lewis 1980). For example, the scheme proposed by the British Medical Association in 1929 emphasied that the 'general practitioner should always be the bedrock on which the medical services of the country, including midwifery, must be built up' (quoted in Lewis 1980). In this scheme, it was suggested that only 3% of women needed hospital deliveries, thus minimising the need for maternity beds. Under the BMA Scheme, the role of the midwife would have been diminished in that it was proposed that the general practitioner should give all the antenatal care, and also make the decision as to whether the case would be handled by the midwife. Obstetricians, on the other hand, proposed maternity schemes which were based on large 60-70 bedded hospitals. By the late 1920s, consultant obstetricians were in fact represented in some strength on the Ministry of Health Committees investigating maternal mortality. These obstetricians emphasised the clinical aspects of care during childbirth and advocated hospital delivery for an increased proportion of women, on the grounds that it afforded the mother and infant greater safety.

The introduction of a salaried domiciliary midwifery service

In the early 1930s, several factors contributed to making it even more difficult for independent domiciliary midwives to make a living. The birth rate was falling and the institutional confinement rate was rapidly increasing - to 15% by 1927 and to 24% by 1932 (figures quoted in Walker 1953). Two factors were mainly responsible for this increase: firstly, the 1929 Local Government Act placed hundreds of Poor Law Hospitals under municipal control; secondly, some of the leading obstetricians were encouraging more women to be delivered in hospital. In an increasing number of areas, subsidised or salaried domiciliary midwifery services were provided by nursing associations or

Local Authorities, and in these areas independent midwives found it difficult to establish or maintain a practice. It was estimated that by 1936, less than half (about 7,000) of the 15,000 midwives in practice worked independently.

The development of a nationwide salaried domiciliary service came increasingly to be regarded as a necessity, in order to improve the working conditions of midwives, and to raise the status of the profession. This, in turn, it was argued, would help to attract well-educated entrants to the profession and enable it to make the maximum contribution to the effort to reduce the maternal mortality rate, which still remained constant at 3,000 deaths per annum.

The details of a scheme for a salaried service were outlined in a report by the Joint Council on Midwifery, a body initiated by the National Birthday Trust Fund, in association with the Midwives' Institute (Joint Council of Midwifery 1935). The Institute was in favour of a salaried service, but anxious that the rights of midwives to practice independently should be preserved. The Government of the time also favoured the creation of a national salaried midwifery service, and this was brought into being by the Midwives' Act of 1936.

The Act placed upon every Local Supervising Authority the duty of providing an adequate domiciliary service, either directly or by voluntary organisations, to ensure that all women having a home confinement could have the services of a qualified midwife. The Act made provision for the majority of midwives to become whole-time salaried employees, and also required compensation to be paid to those who wished to retire, and to those who were compelled by the Local Authority to retire on the grounds that they were no longer competent to practise. Once an area was adequately covered by midwives, it became illegal for unqualified women to attend women in childbirth.

Developments in the midwifery profession between 1936 and 1948

Under the provisions of the 1936 Act, a salaried midwifery service was gradually established all over the country. In her account of the development of the midwifery services, Audrey Wood, a former General Secretary of the Royal College of Midwives, described the great improvements which occurred in the midwives' working conditions with the move from independent practice to salaried employment and with the provision of uniforms, equipment, holiday and pension schemes, etc. (Wood 1963). One of the effects of the 1936 Act was to facilitate the domiciliary midwife's role in antenatal care, because as employees of the Local Authority, it was much easier for them to undertake a major part of the work of municipal antenatal clinics (Wood 1963). Data from a survey carried out in 1946 showed that the number of women attending these clinics had increased to 54% by 1946 (Oakley 1982). There was increasing public demand for the use of pain relief in childbirth and midwives were anxious to be allowed to administer analgesia in the home (Lewis 1980). After much discussion they were allowed to administer certain types of analgesia to woemen delivered at home.

The number of women delivered in hospital continued to rise, reaching 36% of live births in 1937 (Walker 1953). At the same time the number of midwives working in hospital as opposed to domiciliary practice increased, reaching about one fifth of those in practice by 1942. This increase in institutional confinement was due partly to the effects of the war - pregnant women were evacuated from areas likely to be bombed and arrangements were made for them to be delivered in hospitals and maternity homes. The trend towards hospital confinement continued after the cessation of the war, and by 1947 the proportion of births in England and Wales which took place in an institution had risen to 52.8% (Ministry of Health 1959).

At the same time that the 1936 Midwives' Bill was under consideration, the Central Midwives Board undertook a substantial revision of the content of midwifery training in order that it might reflect the many developments which had occurred in midwifery practice. The length of the training was doubled to one year for the qualified nurse and to two years for those without nursing qualifications. The training was divided into two periods: the first was spent entirely in hospital and the second was spent only or mainly in the community. The two-period training was introduced partly in an attempt to deal with the still-existing problem of nurses taking midwifery training but not intending to practise. It was hoped that the first period would be sufficient for those who wanted a midwifery qualification for career purposes, whilst only those who wanted to practise as midwives would proceed with the second period.

During these years, the maternity mortality rate began to fall rapidly; figures for England and Wales show a rate of 3.56 per 1,000 for the years 1931-1935 and 0.95 per 1,000 for the years 1946-1950 (Ministry of Health 1959). A number of factors were cited as being responsible for this decline; they included the introduction of sulphonamides and penicillin, healthier mothers, fewer grand multiparae, the increased skills of midwifery and obstetric personnel and the increase in the proportion of women who were delivered in a maternity hospital (Royal College of Obstericians and Gynaecologists 1944, Ministry of Health et al 1949).

Much debate and discussion took place during the late 1930s and early 1940s on the form that the maternity services should take in the proposed National Health Service. The College of Midwives was concerned that the Government's 1944 White Paper on the proposed National Health Service contained "no clear-cut account of the midwives' part in the service" (Cowell and Wainwright 1981). In the College's view the "aim of the new health service should be to keep the midwifery service by midwives as an important and independent public service". Midwives were concerned in particular that their role in antenatal care and delivery might be supplanted by that of the general practitioners as, under the provisions of the new service, women would be able to book the services of a doctor without payment of a fee. The general practitioners themselves maintained that all general practitioners should be entitled to provide maternity services under the National Health Service, although by the end of the war only one in three were actually involved in maternity work. This demand was agreed by the Government, despite

opposition from some health officials and obstetricians who wanted general practitioners to be selected for maternity work on the basis of postgraduate qualifications and experience (Honigsbaum 1979).

The views of the Royal College of Obstetricians and Gynaecologists as to how the maternity services should be organised are to be found in a document they published in 1944, entitled 'Report of a National Maternity Service'. In this document it was said that the country should be divided into areas, and the maternity services in each should be focused on a large hospital and be under the overall leadership of a consultant obstetrician who should be given professorial status. They also recommended provision of facilities to enable 70% of confinements to take place in an institution. Whilst recognising the excellent results achieved by midwives, the College sought to restrict the extent of the midwife's responsibility, for example it was stated that:

> "Midwives should not be regarded as competent to undertake unaided the antenatal care of the expectant mother, but should always work in collaboration with the general practitioner or the obstetrician."
>
> "Midwives and health visitors would be taught the management of breastfeeding from the paediatrician, who would direct its detail in the maternity ward."

The 1949 Report on Midwives

Before going on to look at some of the effects which the introduction of the National Health Service had on the role of the midwife, consideration is given to a major report which was published in 1949. This was the Report of the Working Party on Midwives, set up to inquire into the shortage of midwives which prevailed during the 1940s. The Working Party was chaired by Mary Stocks; the other members were two midwives (Miss Ferlie and Miss Shand), Richard Titmuss who worked at the Cabinet Offices, and Albertine Winner of the Ministry of Health. In the course of its inquiry the Working Party addressed itself to some of the problems which, to some extent, remain with the midwifery profession today - in particular:

1. the division of responsibility between midwives and medical staff for maternity care

2. the relationship between the midwifery profession and the nursing profession

Instead of just taking evidence from relevant organisations, the Working Party also conducted their inquiry by means of a large-scale survey of the midwifery profession, using questionnaires and interviews, as this would provide them with "considerable knowledge of what midwives are thinking, what they criticise, what they praise and what their suggestions are for the future." As a survey researcher myself, I was very interested to learn that the Working Party had been warned that midwives were too over-worked to fill in more forms and that the questionnaires were too complicated for midwives to cope with. Despite this, response rates of 84% and 76% were achieved.

The Working Party stated its view of the role of the midwife in the maternity services as follows: "The midwife should be the practitioner of normal midwifery, the expert in normal child-bearing in all its varied aspects. The doctor is her partner in the detection and treatment of abnormalities." They said that the midwife, unlike the doctor, had time to spend with her patients, and in the course of her work she acquired great skill and experience in the management of normal pregnancy. She was the person who focused primarily on the normality of childbirth "as a physiological process, not on its potential abnormality as an illness." The Working Party said that in their view the campaign to reduce maternal mortality had overshadowed the essential contribution which midwives made to the care of child-bearing women. Therefore, the report argued, "it is time the pendulum swung back to a greater emphasis on the normality of childbirth, a swing which should bring the midwife back into her rightful place." They stressed the need for doctors and midwives to recognise their partnership: "the doctor must accept the midwife as his fellow practitioner and not attempt to relegate her to the status of his hand-maiden, and the midwife must be willing to summon the doctor whenever his skill was required."

The Working Party expressed concern that the central role of the midwife in the maternity services, which they envisaged, might be jeopardised by aspects of the recently introduced National Health Service. They thought that women might feel it was necessary to have a doctor present at confinement and that this would "react unfavourably on the popularity of the midwifery profession....." The other aspect of the Act which caused concern was that the entitlement of general practitioners to provide and to be paid for maternity services might result in their tending to take over antenatal care and relegating the midwife's status to that of maternity nurse.

The Working Party considered whether it was necessary or desirable for all midwives to be SRN trained and came to the conclusion that it was not. They said that the main focus of the nurse's work was on illness and caring for the sick whereas the midwife cared for mothers and children during an important but normal episode in their lives. Yet, under the current system most midwives were spending three of their four years' training in caring for the sick. The Working Party recommended that there should be a common basic training of 18 months or two years for all nurses and midwives, to be followed by a specialised training in midwifery or a selected branch of nursing. Very similar recommendations were in fact made by the Briggs Committee 23 years later. The Wood Report on nursing, which had appeared two years earlier in 1947, recommended that the General Nursing Councils for England and Wales and Scotland should be amalgamated with the respective Central Midwives Boards to form a single General Council for nurses and midwives of Great Britain. This proposal was, however, rejected by the Midwives Working Party on the grounds that midwifery was a separate and distinct profession from nursing. Although they regarded a common basic training for nurses and midwives as desirable, they maintained that separate statutory bodies were necessary if midwifery was not to lose its identity.

The years following the introduction of the National Health Service

Under the provisions of the 1946 National Health Service Act, maternity care was provided by all three branches of the new service: the hospital services, the domiciliary services and the general practitioner services. At the inception of the National Health Service the Minister of Health recommended that there should be provision for 50% of births to take place in an institution; by 1957 the rate had in fact risen to 64% (Ministry of Health 1959). The number of consultant obstetricians and gynaecologists working in the hospitals increased and, at the same time, the number of general practitioners who undertook maternity work increased considerably. The majority of women booked a general practitioner for confinement if they were to be delivered at home and an increasing proportion of women received antenatal care from their general practitioner rather than from the staff of the local authority clinics (Ministry of Health 1959).

Throughout the 1950s the midwife continued to be the most senior person present at approximately three quarters of all deliveries (Central Midwives Board Annual Report 1952, Butler and Bonham 1963). The nature of the midwives' clinical responsibilities for antenatal care and care during labour did not change greatly during this period. However, they spent less time on carrying out detailed nursing procedures for 'lying-in' mothers as there was an increasing emphasis on early ambulation and on encouraging women to do as much as possible for themselves and their babies. There was also an increasing emphasis, during the 1950s, on health education during pregnancy and on the psychological aspects of childbearing.

The increased involvement of general practitioners in maternity care resulted in a number of changes in the role of the domiciliary midwife. The fact that women could book a general practitioner for confinement, without payment of a fee, led to a tendency for women to go to their general practitioner rather than to the domiciliary midwife for confirmation of pregnancy (Bent 1982). This meant that, for the majority of women, the first point of contact with the maternity services was a doctor and not a midwife, as it had been previously. Domiciliary midwives continued to provide antenatal care in women's own homes and at local authority clinics, but they also became involved in attending antenatal clinics held by an increasing proportion of general practitioners. The majority of women who were delivered at home booked a general practitioner for attendance at confinement, if necessary. Figures from the Central Midwives Board show that in 1955, for example, general practitioners were present at delivery in only 26% of the domiciliary cases for which a doctor was booked (Central Midwives Board Annual Report 1957). This meant that the domiciliary midwives continued to take responsibility for the actual delivery of most of the women who had a home confinement. These women were cared for postnatally by the domiciliary midwife, who thus continued to provide continuity of care throughout pregnancy, labour and the puerperium. However, the proportion of women delivered at home continued to decline and by 1957 represented only 36% of all deliveries (Ministry of Health 1959).

Despite the midwives' initial misgivings about the effects on their role of the increasing involvement of general practitioners in maternity care, reports of the period suggest that on the whole midwives and general practitioners worked together well and much more closely than hitherto (Ministry of Health 1959, Wood 1963).

During the 1950s, the continued rise in the institutional confinement rate meant that the hospital midwives were responsible for the care of an increasing number of women. In the hospital antenatal clinics, they worked alongside their obstetric colleagues in providing antenatal care, but in many hospitals they also held their own midwives' clinics at which women were examined and advised by a midwife and were only examined by a doctor if the midwife detected a complication which she thought necessitated medical advice. In most maternity hospitals, each ward had several labour and delivery rooms as well as its own postnatal beds. At this time most women stayed in hospital for at least 10 days after delivery, and were likely to receive at least some of their postnatal care from the midwife who delivered them. Thus, during the 1950s, hospital midwives, like their counterparts in the community, were able to provide some measure of continuity of care.

The 1950s saw the development of two trends in the organisation of maternity care which were to become increasingly widespread during the 1960s and 1970s and which had a considerable effect on the role of hospital and community midwives. Firstly, some hospitals started to delegate part of the antenatal care of women booked for hospital confinement to community staff. Secondly, some hospitals adopted a policy of discharging women to the care of the community midwife a few days after delivery in hospital. Both of these developments arose partly in response to the increasing proportion of hospital confinements and the resulting pressure on hospital resources. Throughout this period there was said to be a shortage of midwives in practice, particularly in the hospital service (see for example Central Midwives Board Annual Reports 1957, 1959 and 1960, Ministry of Health 1959).

The role of the midwife in the 1960s and 1970s

Throughout the 1960s and 1970s, the midwife continued to be the most senior person present at between 70% and 80% of all deliveries (Chamberlain et al 1978, Cartwright 1979). These two decades were, however, a period of many changes for the midwifery profession. Midwives learned many new skills as obstetric technology developed. They also played an increasing role in health education and in providing women with emotional support throughout pregnancy, labour and the puerperium. The midwifery

course was restructured and changed from two parts to a single period course; this was subsequently extended in length. * Management structures in hospital and in community midwifery services were changed and the services were integrated under the 1974 re-organisation of the health service.

During the 1960s and 1970s there were also many changes in the organisation of maternity care and in policies concerning the management of childbirth. These, in turn, led to changes in the pattern of work of both hospital and community midwives. In particular, the individual midwife became much less likely than in previous years to be providing continuity of care throughout pregnancy, labour and the puerperium. Instead, she became increasingly likely to be working on one or two aspects of maternity care, as a member of a team of health professionals led by the consultant obstetrician. These developments occurred partly as a result of recommendations made in two major reports: the report of the Maternity Services Committee on the organisation of the maternity services which was published in 1959 (the Cranbrook Report), and the report on domiciliary midwifery and maternity bed needs which was published in 1970 (the Peel Report). The recommendations in these two reports which particularly affected the midwife are briefly outlined in the following section of this paper, as are some of the other factors which resulted in the change in the midwife's pattern of work.

a) The Cranbrook Committee's Recommendations

The Cranbrook Committee was set up in 1957 to examine the problem of lack of co-ordination and co-operation in the maternity services under the tripartite system of the health service. The Committee had 12 members, two of whom were midwives. They concluded that to reorganise the maternity services, in isolation from the rest of the health services, would create more problems than it would solve. Instead, they recommended a number of changes which they hoped would lead to improved co-operation, such as local liaison maternity committees and co-operation cards.

The Committee endorsed the trend towards institutional confinement, and recommended that provision should be made over the country as a whole for 70% of births to take place in hospital. They also recommended that general practitioner maternity beds should be situated within or very close to consultant units and that a consultant should have overall responsibility for general practitioner maternity beds. The Committee also endorsed the

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* The extended training, 18 months for nurses and three years for non-nurses, was introduced in 1981 and not in 1979 as originally planned.

trend in the increase in the number of women receiving antenatal care at their general practitioner's surgery and the decrease in the numbers attending local authority clinics for this care. The Committee recommended that the general practitioner obstetrician should replace the local authority medical officer in the field of community antenatal care. They also recommended that approximately 20% of hospital maternity beds should be reserved for women requiring hospital care during the antenatal period. With regard to postnatal care, the Committee recommended that the minimum stay in hospital should continue to be ten days after delivery.

The Committee stated that its recommendations for an increase in hospital confinements and an increase in the number of beds which should be reserved for antenatal patients could either be met by increasing the number of maternity beds or by reducing the length of postnatal stay in hospital. The majority of those who gave evidence to the Committee, including the Royal College of Midwives, were opposed to women being discharged from hospital prior to the tenth day, on the grounds that this would disrupt the continuity of care provided by the midwife during the postnatal period. The Committee accepted this view and stated that their recommendations should be met by an increase in the actual number of beds available.

The Committee made a number of recommendations concerning the respective responsibilities of the domiciliary midwife and the general practitioner. They said that the woman's doctor, rather than the midwife, should be responsible for ensuring the co-ordination necessary for adequate care to be provided, that both the doctor and the midwife should be present at antenatal examinations and that both the doctor and the midwife should be present at delivery, if possible. It can be argued that these recommendations would lessen the degree of responsibility which midwives had, and thus were at odds with another view expressed by the Committee, namely, that "a midwife should be given every opportunity to participate in the maternity care of her patients to the fullest extent to which her skill and experience entitle her. Nothing should be done to lessen the importance of the midwife."

The Committee expressed its concern over the shortage of practising midwives, particularly in the hospital service, and drew attention to the still intractable problem of the large number of nurses who undertook midwifery training but who did not subsequently practise as midwives.

b) Developments in the maternity service and in the role of the midwife in the 1960s

In the years which followed the publication of the Cranbrook Report, the proportion of births which took place in an institution continued to rise, reaching 80.6% in England and Wales by 1968 (Department of Health and Social Security 1970). During the same period many hospitals adopted a policy of providing much more of the antenatal care for women booked for hospital confinement than they had during the 1950s, when much of the antenatal care of many of these women had been provided by community staff: midwives, general practitioners and local medical

officers of health. This policy was in part a response to the findings of the 1958 perinatal survey, which had been quite critical of the standard of antenatal care provided by some general practitioners. Data from the two national maternity surveys show that between 1958 and 1970, hospital involvement in antenatal care increased from 49% to 64% of those women receiving care (Butler and Bonham 1963, Chamberlain et al 1978).

The Cranbrook Committee's recommendation that women delivered in hospital should normally stay for ten days proved not to be feasible, given the rapidly rising birth rate of the early 1960s and the increase in the proportion of births which took place in hospital. Consequently, the length of postnatal stay was reduced for an increasing number of women and, by 1968, just over half of the women delivered in an institution were discharged prior to the tenth day (Department of Health and Social Security 1970). This development was not welcomed by the Royal College of Midwives, on the grounds that it disrupted continuity of care during the puerperium and they expressed the view that early discharge schemes should only be regarded as a "temporary emergency measure" (Royal College of Midwives 1964). In addition, the College expressed its concern that there were insufficient midwives in many units to cope adequately with the increasing workload (Royal College of Midwives 1964). The President of the College said that midwives had been criticised for not offering adequate emotional support to mothers during childbirth but that this was often very difficult to do, given the pressure of work (Cowell and Wainwright 1981).

The increase in the proportion of women delivered in hospital meant a decline in the number of deliveries attended by domiciliary midwives. At the same time, however, there was an increase in the amount of postnatal care for which they were responsible, with the adoption of schemes whereby women delivered in hospital were discharged to the care of the domiciliary midwife prior to the tenth day after delivery. The changing pattern of the domiciliary midwives' work during the 1960s was shown in figures published by the Central Midwives Board in their 1971 report. Thus in 1959 there were 4819 domiciliary midwives (whole-time equivalents) and they attended 266,584 deliveries and provided postnatal care for 148,494 women who were delivered in hospital but discharged home prior to the tenth day. By 1968, the number of deliveries attended by a similar number of midwives had fallen to 156,880 whereas the number for women they provided postnatal care, following early discharge from hospital, had risen to 339,187.

With regard to antenatal care, the domiciliary midwives continued to provide care at home for women booked for home confinement. They also participated in antenatal clinics held by general practitioners. At these clinics antenatal care was provided for women booked for home confinement as well as for those women booked for hospital confinement but who received some of their antenatal care from community staff. By the end of the 1960s, the general practitioner had virtually replaced the local medical officer of health in the provision of community antenatal care, as the Cranbrook Committee had recommended. Consequently, the domiciliary midwife's long association with the work of the local authority antenatal clinics came to an end.

Two other new developments in the domiciliary midwife's role began in the mid to late 1960s. Firstly, some of them were attached to general practices and so related to the women on a general practitioner's list rather than to the women in a specific geographic area as they had done previously. Secondly, experimental schemes were introduced whereby some women were delivered in hospital by domiciliary midwives who had provided their antenatal care and who provided their subsequent postnatal care. These schemes, usually referred to as 'domino' schemes (domiciliary in and out), enabled the domiciliary midwives to provide continuity of care and were welcomed by the Royal College of Midwives. They were, however, available to only a very small number of women. The overall trend in the domiciliary midwife's work in the 1960s was a decrease in the number of women she delivered at home and for whom she provided continuity of care and an increase in the number of women for whom she provided partial care.

c) The Peel Committee's recommendations

The increase in the hospital confinement rate and the falling birth rate of the late 1960s led to the view that in some areas it was becoming uneconomic to maintain an efficient domiciliary midwifery service. Consequently, a sub-committee of the Department of Health's Standing Maternity and Midwifery Advisory Committee was established in 1967 to:

> "....consider the future of the domiciliary midwifery service and the question of bed needs for maternity patients and to make recommendations."

The Committee was chaired by Sir John Peel, the then President of the Royal College of Obstetricians and Gynaecologists. It had eight members, two of whom were midwives.

In its report, which appeared in 1970, the Committee made two recommendations with regard to the place of confinement (Department of Health and Social Security 1970). Firstly, there should be sufficient facilities to allow for 100% hospital delivery, on the grounds that hospitals afforded greater safety for mother and baby. Secondly, small isolated obstetric units should be replaced by larger combined consultant and general practitioner units, on the grounds that continuous medical cover and modern equipment could more easily be provided in these larger units. The Committee also recommended that all women, wherever they were to be delivered, should be seen by a consultant obstetrician at least twice during pregnancy.

Throughout the report, it was emphasised that hospital medical staff, general practitioners, hospital midwives and domiciliary midwives should work together as members of the obstetric team. It was recommended that continuity of care would best be achieved by continuity of association of particular groups of midwives with particular general practices based, where possible, in health centres or group practices, although it was noted that

attachment of midwives to practices appeared to be more difficult than for health visitors or district nurses. Having commented on the various problems of co-ordination of the maternity services under the tripartite system of administration, the Committee recommended the unification of the maternity services and the consequent employment of all midwives by a single authority which would be responsible for the provision of all midwifery services.

d) Developments in the maternity services and in the role of the midwife in the 1970s

The 1970s saw an acceleration of many of the trends which had characterised the organisation of maternity care in the 1960s; in particular, the move towards hospital confinement and early discharge home after delivery. The Peel Committee's recommendations concerning the place of birth were largely implemented; thus the hospital confinement rate in England and Wales rose from 84.6% in 1970 to 96% in 1976 (Hospital In-Patient Enquiry Maternity Tables 1980) and many of the small units, most of which were general practitioner hospitals, were closed. With regard to the provision of antenatal care, a growing number of areas adopted the policy of 'sharing care' between the staff of the consultant unit and the general practitioner. This development was partly in response to the growing pressure on the resources of the hospital antenatal clinics which was caused by the increase in the number of women booked for hospital confinement and the policy of centralising antenatal care in hospital. Under this policy of 'shared care', women with low risk pregnancies attended the hospital antenatal clinic to be assessed early in pregnancy by obstetric medical staff and, again, at other specified times during the pregnancy whilst their general practitioner agreed to make provision for the rest of their antenatal care. A number of hospitals were already sharing the care of their booked patients with community staff but, during the 1970s, the policy was adopted in an increasing number of areas and for an increasing proportion of women. This meant that the amount of antenatal care provided by community staff increased. The trend continued whereby women delivered in hospital were discharged to the care of the community midwife, prior to the tenth postnatal day. In 1970, the number of women delivered in hospital but discharged early, to the care of community midwives, represented 51% of total births, but by 1979 this proportion had risen to 90.7% (Central Midwives' Board reports 1979 and 1980).

As the hospital confinement rate rose to virtually 100%, so hospital midwives became involved in the care of almost all childbearing women during labour and delivery. The incidence of obstetric interventions carried out in the course of labour increased at a much faster rate than it had during the 1960s (Butler and Bonham 1963, Chalmers and Richards 1977, Chamberlain et al 1978, Hospital In-Patient Enquiry Maternity Tables 1980). This development

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Domiciliary midwives were referred to as community midwives from the early 1970s onwards.

resulted in an increase in the proportion of labours in which medical staff participated and which were not managed entirely by midwives. In an increasing number of maternity units, policies were developed for the 'active management' of labour, which staff are required to follow, for example: the frequency with which vaginal examinations are carried out, at what point to rupture membranes. Techniques such as continuous fetal monitoring and epidural anaesthesia were used much more frequently during the 1970s and, consequently, midwives have learnt new skills such as applying scalp electrodes, interpreting cardiotocograph traces and topping up epidurals.

Changes also occured in the hospital midwife's role in the provision of antenatal care at hospital clinics. They became involved in the increasing range of tests of fetal health and normality which were used and in providing information and support to women undergoing these tests. It became the practice in many hospitals for all women to be examined by medical staff at every visit to the antenatal clinic and, consequently, some of the midwives' clinics were run down or closed. This meant that midwives became more likely to be working with medical staff in making antenatal assessments and less likely to be making them on their own responsibility. The increasing adoption of the policy of 'shared care' contributed to this development in that women booked for shared care attended hospital clinics primarily for the purpose of being assessed by the obstetrician and not by the midwife.

As already noted, the trend towards early discharge home following hospital delivery continued. Although hospital midwives were therefore not responsible for providing care throughout the postnatal period for all women delivered in hospital, they were responsible for the early postnatal care of most newly-delivered women and for helping them with establishing infant feeding and caring for their babies. During the 1970s, an increasing number of hospitals appointed nursery nurses and nursing auxiliaries to work in the postnatal wards, alongside the midwives.

The hospital midwives' work during the 1970s was also characterised by increasing specialisation. They tended to work in the antenatal clinic, on the labour ward or on the postnatal ward. This was partly due to changes in hospital design. The Ministry of Health's Ten Year Hospital Plan of 1962 led to the replacement of independent maternity hospitals by maternity units in district general hospitals. These new maternity hospitals usually had one central delivery suite, whereas the older hospitals usually had several labour and delivery rooms each attached to different postnatal wards. In these older hospitals, the midwife who delivered a woman was also likely to be involved in her subsequent postnatal care, whereas the new central delivery suites tended to be staffed by one group of midwives who then handed the care of newly-delivered women to the staff of the postnatal wards. Data provided for the Peel Committee indicated that in 1968 approximately one quarter of hospital midwives were working solely on one aspect of maternity care (Department of Health and Social Security 1970). Data from our research showed that in 1979, 64% of consultant unit midwives were working on one aspect of care only (Robinson, Golden and Bradley 1983).

During the 1970s, the proportion of community midwives who were attached to general practice increased rapidly, from less than 10% in 1968 , to 70% in 1979 (Robinson, Golden and Bradley 1983). The move towards 100% hospital confinement meant that the number of home deliveries attended by midwives continued to decline, falling from 107,099 in 1970 to 9,597 in 1979 (Central Midwives Board Annual Reports 1971 and 1980). Some community midwives delivered women in hospital who were booked under the 'domino' scheme but these cases have never constituted more than a very small proportion of the total number of deliveries. The overall trend for community midwives was the same as in the 1960s, namely one of decreasing involvement in the care of women during delivery but an increase in the number of women for whom they cared postnatally following hospital delivery. During this period, the increasing adoption of the policy of shared antenatal care between the consultant unit and the general practitioner, for women with low risk pregnancies, meant that the amount of antenatal care in which community midwives were involved also increased.

Looking at these developments from the perspective of the childbearing women, they mean that, during pregnancy, most women receive care from community midwives when they attend their general practitioner's antenatal clinics or when community midwives visit them at home and they receive care from hospital midwives when they attend the hospital antenatal clinic. They are delivered by the hospital midwives who work on the labour ward, whom they may or may not have met when attending the hospital antenatal clinic. Their early postnatal care is provided by the midwives working in the postnatal wards and the latter part of their postnatal care is provided by the community midwives. At each stage of this process the midwives are likely to be working with other professionals: general practitioners and health visitors in the community, medical staff in obstetrics, nurses and ancillary staff in the hospital.

Conclusion

In the early years of the century, the great majority of midwives worked in the community as independent practitioners; they had overall responsibility for their patients and called in medical staff only in the event of an emergency. Today, the majority of midwives work in hospital, usually in a consultant unit and all, except a very small proportion, are salaried employees. This shift of focus from the community to hospital resulted primarily from the campaigns to reduce first maternal and then perinatal mortality; the main emphases in these campaigns have been on hospital as the safest place for delivery and on the need for various kinds of obstetric surveillance and intervention which require hospital resources. Overall responsibility for the care of nearly all mothers and babies is generally regarded as belonging to medical staff: obstetricians and paediatricians in the hospital and general practitioners in the community. These developments have meant that the role fulfilled by the majority of midwives has changed from that of an independent practitioner providing care throughout pregnancy, labour and the puerperium, to that of a member of a team of health professionals in which each midwife is likely to be involved in only part of the care provided for childbearing women. In addition

to the midwives' traditional role of assessing the course of pregnancy, conducting deliveries and providing care during the postnatal period, the scope of their responsibilities has widened considerably. Thus there has been an increasing emphasis on the role of the midwife in health education and in providing women with emotional support and many midwives have taken on teaching and management responsibilities. Midwives have also learnt many new skills in response to developments in the management of childbirth and in advances in obstetric technology.

However, as noted at the beginning of this paper, the 1970s saw the expression of concern by the Royal College of Midwives and by individual members of the profession, about the role of the midwife. Although the midwife was still entitled by statute to provide care throughout pregnancy, labour and the puerperium and to undertake normal deliveries on her own responsibility, it was maintained that many midwives worked in situations in which they were no longer able to use their skills to the extent to which they were qualified and entitled to do so. The Royal College of Midwives, for example, stated their view in this respect in their evidence to the Royal Commission on the National Health Service: "The midwife is trained and capable of giving prenatal care on her own responsibility, but in practice the medical staff do not fully utilise this valuable resource" and again, "for example, in some hospital prenatal clinics and family group practices, the total prenatal care is given by medical staff" (Royal College of Midwives 1977). In commenting on developments in the 1970s, Barnett (1979) said "many midwifery skills have been ignored or abandoned in the need to give sophisticated care in the electronic age" and commented that, in her view, "although midwives regarded doctors as their partners, the reverse was not always true." Brain (1979) suggested that during the 1970s, the role of the midwife had contracted. In relation to antenatal care, for example, she said, "I believe we are not using her skills today in the community or in hospitals."

Those midwives who are now seeking to restore their role regard the provision of continuity of care as one of the key factors in this process (e.g. Flint 1979, Thomson 1980). But rather than going back to the idea of one midwife providing care for one woman, they are trying to provide this continuity by setting up small teams of midwives, each caring for a small group of women. In addition, some midwives are now seeking to redefine their role within the maternity care team, maintaining that responsibility for the care of women who experience a normal pregnancy and labour should once again rest with the midwife and not the doctor.

Sarah Robinson
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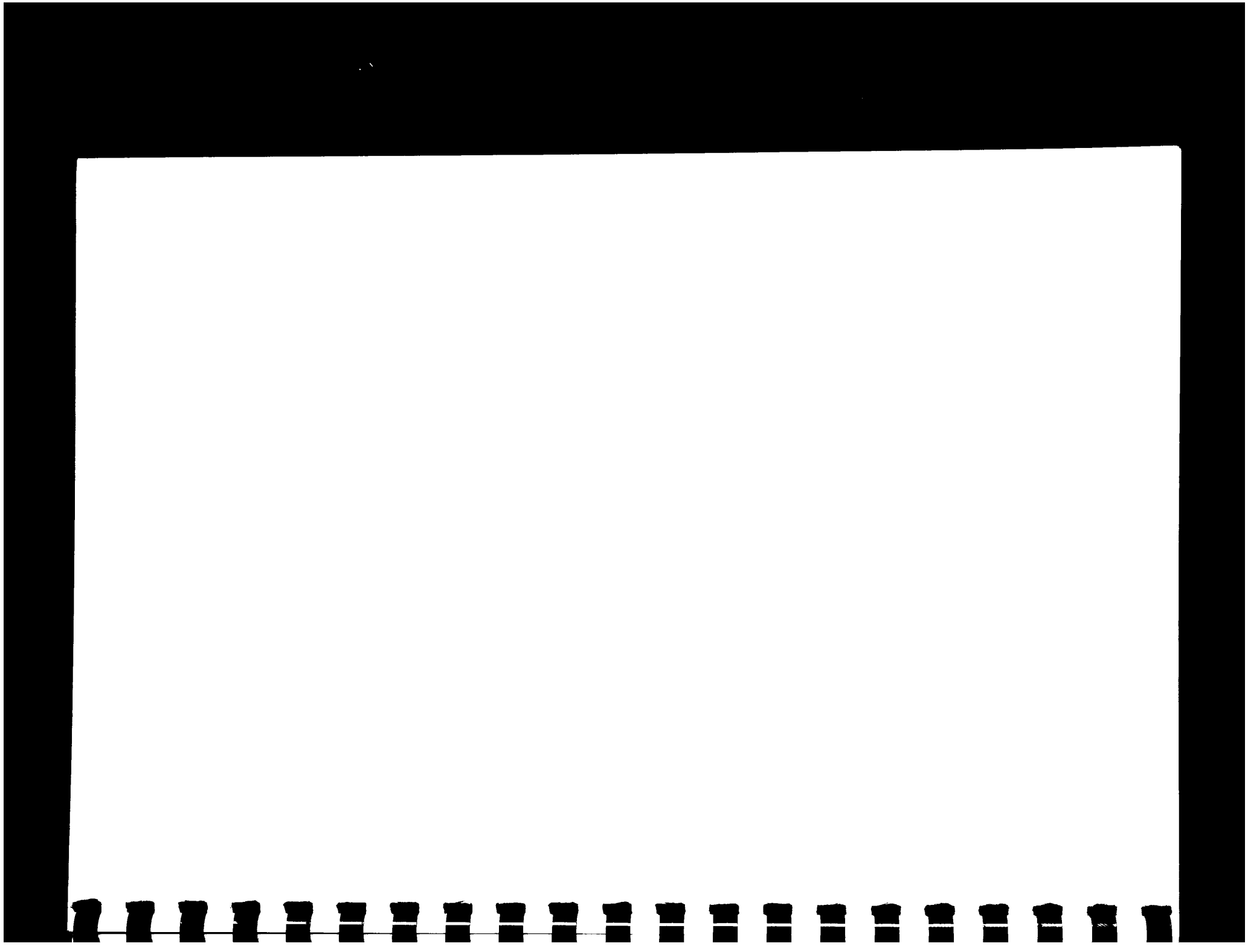

THE HOSPITAL, THE FIRM AND THE NURSE

The understanding of the development of modern nursing suffers if it is discussed in isolation: hospitals, medicine and nursing are all social activities and locations and are not only interrelated but are inextricably linked together by wider forces within society. Given this general outlook, it is intended here to examine nursing change around the notion that the hospital as an institution existed and may still function, not axiomatically as a place of care, cure or even for the advance of medical knowledge, but rather as a means of maximising income and minimising expenditure in the pursuit of what is arbitrarily here called 'profit' and which is defined simply as the viability of the organisation.

In dealing with the idea of the hospital as an element in the production of a metaphor - hospital as firm - it will be suggested that, given the original impetus to organise as a structure, the hospital then continues primarily in order to ensure its own existence. Hence, nursing as a function of the hospital and the changes which took place in that role and function were but elements in the overriding need for viability and 'profit' of the organisation, the hospital. In order that this picture may be presented, the paper looks at the growth of hospitals and the developments within nursing, not separately but as linked events, bound together by the needs of an increasingly complex accounting system which underpinned the physical and ideological structure we call the hospital.[1].

Data produced here in support of the argument are necessarily highly selective; indeed, had they not been so, it might have been the case that the general hypothesis discussed would be untenable. The data are drawn primarily from the voluntary hospitals, that is hospitals set up and maintained through public or personal charity, donations, subscriptions, investment or rents. The other great sector of the hospital world, the Poor Law, is not specifically discussed, except where it is useful to the overall case; this is not, however, because their inclusion would undermine the specific argument, rather the reverse. The Poor Law is omitted because of the complexity of its accounting system and its paucity of readily available data; the voluntary sector provides, thus far, a clearer picture of the hospital as a firm.

The paper takes a broad sweep through at least 150 years of complex history, medical, political, economic and social, and the gaps are obvious. However, the need to identify broad developments determines the way in which the argument is constructed. Also missing is any real discussion of change in medical knowledge or of the growing literature on professionalisation in the period before the First World War, although both inform, covertly, the general tone of the discussion.

Finally, the intracacies of finance management and its historical perspective are not discussed: the paper skirts over the difficulties of the interpretation of data which the researcher is warned of in the useful Historical Association pamphlet, Business History.[2]. The accounts are largely taken at face value here, with the important proviso that they are not trusted to mean exactly what they appear to mean.

It is intended, in a long-term project of which this paper is a part, to draw out from a variety of data on hospitals and nursing the general proposal that the prime function of the hospital was the management of disease and those systems invented for dealing with disease: the hospital did not have as its prime function the treatment of disease or the restoration of health, which ought to include comfortable death. The hospital, then, was not a place or system of treatment but of confinement, even isolation. Like similar structures developed by the eighteenth and nineteenth century reformers (for example, prisons, asylums, graveyards, even schools and factories) physical and ideological separation formed a crucial aspect of the role of the hospital which was mimicked by the heroic phase of medicine - radical surgery and the drive towards intensive chemotherapy.

In order that it could fulfil this management function effectively, the hospital developed internal structures which included time-discipline, cost-effectiveness, book-keeping and a division of labour which owed their origins to changes which had taken place in those other 'firms' such as the factory itself. This paper addresses that development in a very broad perspective using nursing as a way into the ideological system.

The hospital network

It is almost a truism that health is an industry or a sector of an economy; witness the alacrity with which private enterprise and entrepeneurship has expanded what was, in essence, a defunct voluntary hospital system through private health care and insurance. Despite the recognition of the industry -status of health, little has been said of the historical perspective of this development. Indeed, much of the literature on health-as-industry relies on the recent American experience of private care and tends to ignore the existence of such an economy before the twentieth century, especially in Britain. Thus, Hamilton's view, that "the local hospital is the town's biggest employer and operates the largest hotel, laundry, pharmacy and restaurant; [and that] collectively, hospitals make up one of the country's largest industries and are a vital cog in the nation's economic structure" has largely gone unnoticed by medical, nursing or even business historians.[3] With some qualification, the view from the 1960s could as easily be that from the 1860s. In the first part of the paper, we can trace the growth of the hospital network which existed as recently as the 1960s and which was carried through in three major phases of expansion.

The first phase, other than the monastic hospices movement of the Middle Ages, was in the eighteenth century. For example, the London hospitals such as the Westminster, Guy's, St George's, the London and the Middlesex, were all opened between 1720 and 1745. In the provinces, 28 hospitals opened between 1730 and 1800, beginning with Winchester in 1736, Bath General in 1742, Manchester Royal Infirmary in 1752 and Sheffield Royal Infirmary which was opened in 1797.

According to McMenemy,[4] this expansion was the direct result of the perception of a widening gulf between the rich and the poor in a period of relative prosperity associated with mercantile capitalism, wherein the sense of guilt produced by significant wealth and consumpton was translated into humanitarian

concern with the sick through a reawakening of christian charity to others.

There is little doubt about the relative wealth of many of the founders of those early hospitals. To take an extreme case, Thomas Guy was a Lombard Street bookseller who made a fortune 'by the sale of Bibles, Seamen's Tickets and South Sea Bubble Stock'. That fortune, amounting to nearly a quarter of a million eighteenth-century pounds, was endowed for the hospital which bears his name. [5].

Unlike the hospices and earlier hospitals, upon which some of the 'new' institutions were built, these eighteenth-century hospitals were not for the poor: the London, founded in 1740, was set up to help 'in particular, the manufacturers and merchant seamen together with their families', [6]. that is, those whom the Victorians were later to identify as the 'industrious classes'. The divisions within the provision of relief clearly articulated 100 years later in the Poor Law Amendment Act (1834) were thus well established within the health care field in the early eighteenth century.

The principle of providing help to those contributing to the creation of wealth through labour - the basis of the workhouse system of relief - in order that they might continue to create wealth, formed the rationale for founding many eighteenth as well as nineteenth-century hospitals. Indeed, the links between health and the creation of personal, as well as national, wealth through trade and later industry, as well as the close links between eighteenth-century mercantilism and the slave triangle are well illustrated by the opening of the hospitals in the two contemporarily important ports of Bristol (1737) and Liverpool (1749).

The enthusiasm for founding a hospital, especially in the provinces, depended very much on the local community for whom religious and business, as well as family and intellectual ties were often inseparable.[7]. Bristol's hospital in the dock area, for example, was funded in part by a £5,000 bequest by John Elbridge, who was both a Quaker and a collector of Customs Taxes,[8]. and the links between dissenting groups and the development of industrial capitalism through entrepreneurship and the mobilisation of capital etc. are well enough described not to require rehearsal again here. [9].

Despite this phase of growth, however, there were less than 3,000 patients in hospitals by 1800 and the 1851 Census could only list 7,619. [10]. The relative stability of the pre-industrial era gave way to economic, social and political uncertainty, exemplified in the reactions to the two great revolutions in France and in America. Apart from a brief period of excitement generated by revolutionary medicine under the new Empire in France, the hospital network, especially in Britain, fell into disorder and went through a period of decline in size and economy.

The second wave of hospital expansion began in mid-nineteenth century, coinciding with and produced by the return of relative stability of both the economy and the social structure, which now consisted in part of a viable middle class based on a new economic system: industrial capitalism.

In 1861 the total number of hospital beds (for the physically ill) was approximately 65,000 - of which only 15,000 were in the voluntary sector. By 1891 this sector held 29,520 beds and by 1921 56,550. [11] Numerically always less important than the public, Poor Law sector, nevertheless, the rate of growth of the provision of voluntary hospital beds was spectacular and its relative share of the 'market' continued to increase throughout the period up to 1947, stimulated by a third phase of expansion in the interwar years.

Statistics relating to hospitals are, of their nature, crude: for example, bed numbers were frequently falsified up or down by administrators and doctors. Bed numbers were falsified upwards because some of the staff were paid by bed-rates; where 'cure-rates were important, as in fund-raising, numbers were massaged downwards in order to show a higher level of bed-occupancy than was the case. And, of course, such data are crude because there is no obvious or necessary correlation between bed numbers and occupied beds, i.e. patients.

If the numbers of beds as data are suspect, those which describe the growth of hospitals are less so. In 1861 there were 23 teaching hospitals in England and Wales, 25 by 1938; in 1861 there were 130 voluntary hospitals but by 1891 there were 385 and the total was 530 in 1911 and 616 in 1921. [12]

Hospitals were built, opened or expanded (or closed) according to specific historical conditions. One change in provision was produced by the rivalry within the medical profession itself and led to the clear distinction - clear in terms of physical space but not in terms of condition - between medicine and surgery. Hospital provision was also influenced by demographic change, although it is difficult to see any necessary correlation between population growth and national or, even, regional bed provision. London, for example, still had more beds per 1,000 heads of population than any other area throughout the nineteenth and twentieth centuries.

Bed provision and hence hospital growth was still determined, in part, by other than clinical or 'professional' , demographic or pecuniary factors. For example, venereal disease was both a clinical and a moral 'problem', the treatment of which was both class-biased (through lock wards) and long-term. Both issues were potential blocks to the high turn-over of beds and the in-patient treatment of these complex and wide-spread infections remained unusual.

Hospitals were also set up to meet very specific social needs including, for example, the necessity for quarantining sailors in port or even their passengers, or to treat travellers for disease or trauma encountered in transit, and led to the formation of several hospitals in port and dock areas like Bristol or the Seamen's Hospital at Greenwich.

In the provinces, especially the rural areas, hospitals opened either because patients could not or would not travel to the larger voluntary hospitals in the towns or cities. They were also set up at the instigation of local doctors, thus allowing them to control, to some extent, their income from patients requiring in-patient care. [13]

A few institutions were set up to meet or take advantage of change in medical knowledge or, more likely, medical fashion. Included in this group are those like St Mark's Hospital for Stone and the many Mineral Water Hospitals or even more bizarre, the electric or magnetic hospitals of the earlier eighteenth century. Those doctors and some who were not qualified, who chose one of the 'fringe' areas of medicine in which to specialise - for example, homeopathy - were usually forced to set up their own establishments in order to practice. In sum, therefore, hospitals were set up as much for the exploitation of a fashion or skill as for clinical reasons; a few were ways out of the virtual monopoly exercised by the voluntary consultant system and some provided an outlet for alternative, often non-heroic medicine.

Hospital administration and financing

One common thread which connected all these multifarious hospitals throughout the period was the need for them to have some system of internal organisation, one which accrued capital and administered its spending. While the ways in which hospitals were administered varied over time and between types, there are certain similarities which may be described.

Endowed hospitals with large legacies could, if they managed that money 'effectively', reasonably expect to support themselves and even allow for growth in both financial and clinical terms. However, few hospitals were endowed, most being intensively dependent on the subscription of funds in one form or another. While the system varied, we may take that of the Royal South Hants Infirmary at Southampton as a 'typical' small provincial voluntary hospital of the nineteenth century. [14].

Founded in 1838, a subscriber to the RSH paid one guinea annually, later two, and became a governor; payment of £21 or more in a lump sum entitled the donor to become a life governor. Subscribers could recommend one in-patient or three out-patients a year for every guinea subscribed. In 1855 such subscriptions brought in £883-8-6, 36% of total receipts (£2,473). Donations were the next largest source of income, amounting in the year 1855 to £613-14-11 (25% of revenue): unlike subscriptions, however, donations had no obvious immediate advantage for the doner. By 1862, income totalled £3,010-17-10, of which 38% was subscribed income and 22% came from donations.

As well as these monies, income was generated by investment. Popular investment portfolios included railways, consols and dock schemes. Indeed, the investment patterns which have been noted for the economy of mid-century in general may, to a large extent, be seen in all the accounts of this small provincial hospital. Whilst investment in government stock appears throughout the period, it is likely that this was due to codicils within specific bequests rather than investment choice, since their dividends were often below those from other sources.

Much of the income from investment came from stock held in local companies, for example, the South Western Railway, with its terminus in the Southampton Docks or the local Waterworks or the Dock Company itself. As an instance, £1,200 of South Western Railway debentures were held which provided a dividend of £50 in 1856, while £1,253-12-3 worth of consols produced £35-5-3 as dividend the same year. By 1862 the railway stocks had gone, with the last of the Bills being sold for £306-6-0. In the same year, income from the Waterworks and Docks holdings produced only £8 and £10 respectively. The boom in share dealing was temporarily over and, as many of the middle class were coming to realise, the first flush of wealth produced by the age of the railway was fading from the face of the economy.

While total revenue from investment appears, in terms of direct income at least, to be relatively small compared to that generated by subscriptions or donations there is evidence that the two areas of income were more closely connected than simple economic relationships would suggest.

For example, one of the major users of the port facilities at Southampton was the P & O Company, a passenger and cargo service. The need for crew numbers and passengers to use the hospital was inevitable, either as a result of injury or illness during the long sea voyages or sustained whilst in dock. The Company were life governors, and paid £21 each year, through the person of Captain Engledue, who was also a Vice-President of the Infirmary: collections were also organised on board the ships in dock by Captain Engledue. In 1861, the amount raised through collections from P & O ships came to more than £112, a sum sufficient in simple transaction terms to pay almost all the expenses of the infirmary servants, nurses and the porter for that year. In the same year, the Infirmary Committee invested a donation of £400 (which was to form the basis of a building fund) in the Southampton Docks Debentures at 5% interest which, in 1862, produced a dividend of just over £10. The mutuality of investment and self-interest expressed in such transactions was not unusual nor anything other than proper; what is shown here is the very close links which existed between the formation and operation of an institution for the care of the sick and the wider world of money and finance.

This interdependence and support network is also shown in the accounts of 1858, which note the receipt of two £100 Waterwork Bonds from the Trustees of a Fund raised for the relief of sufferers in the fire in a local company store. The fire had been one of the major reasons why the Infirmary had been set up in 1838 but, more interestingly, one of the Trustees of the Fund was also a life governor of the Infirmary, had the same name as the Honorary Physician to the Infirmary and the same family name as one of the Honorary Secretaries. It is fanciful perhaps but intriguing nevertheless to see some connection between the fire, the Infirmary and the need to lay on adequate piped water supplies throughout the expanding town of Southampton.

Many other local firms, including manufacturing and commercial enterprises as well as solicitors and retailers, were individual or company subscribers and/or regular donators. A few, such as the firm of Dixon and Cardus, put up collection boxes on their premises or else encouraged their workmen to pay in regular weekly donations to the Infirmary.

Individual subscribers also increased their standing as patrons of the Infirmary by additional donations or, occasionally, by providing a service, such as a grant of land, at a notional cost to the hospital. Such standing was important, not only in status terms: while tickets could be given by subscribers to those who solicited them, a major group of potential in-patients specifically excluded from the Infirmary were the employees of the local gentry and middle-classes - their servants and apprentices. Such workers could be admitted to the wards following an amendment to the Rules but only if the employer agreed to pay the cost of subsistence while the employee was in the care of the Infirmary. But, even after this change, there was no guarantee that such people would have automatic admission and it was necessary that the informal links between the middle-clases, as employers, and the Infirmary, as subscribers and donors, be strong and public. The Infirmary subscription system, so essential for its financial life, was also a means of health insurance for sections of the local community hidden under the umbrella of domesticity.

This insurance-through-subscription practice grew in importance as the century progressed and as the class composition of the potential users of the Infirmary altered and income from middle class subscribers and donors failed to keep pace with resource needs. When this happened, appeals were made to the respectable working class to follow the example of their betters and contribute on a regular basis for themselves. These workers were, in the main, artisans and lower middle class 'white collar' employees and, like many others around the country, joined as subscribers the Saturday Fund set up specifically for their class. Despite the evident thrift and respectibility such activity demonstrated, the upper section of the late Victorian working class found themselves attacked by their 'betters' on the grounds that the working class was able to exercise power in the health arena out of proportion to the income they generated for the system. [15].

It will have become apparent that the financial position of institutions which relied upon public subscription and donations for the bulk of their income must always be precarious. Fund-raising by bazaars, church appeals, concerts, etc. while one way of introducing new subscribers (needed because of the high 'drop-out' rate) was continually under pressure, not least from fluctuations in living standards and the rate of inflation. The Charity Organisation Society, for example, had attacked indiscriminate charity giving in London not only on moral grounds but also on the grounds that the sources of such charities as existed could not be guaranteed to provide for the ever-increasing needs for distribution to the poor. Charity-giving, it argued, should be put on a firm moral and financial footing and the Society included hospital provision in its attack. It demanded a

House of Lords Committee of investigation into the income and expenditure of the London voluntary hospitals, pointing out that the annual deficit had risen in total from £32,000 in 1877 to £100,000 in 1899, with at least 2,000 beds closed as a direct consequence. [16.]

If income was insecure for the hospitals, then the status and character of the 'collector' and treasurer in the individual hospital could be crucial. A good treasurer could, for example, help advertise 'cure rates' and bed occupancy figures as a way of increasing income; a fraudulent collector could wipe out the entire revenue for the year by running off with the collection. Occasionally, the post as collector could be purchased or was given to a follower by the patronage of one of the Committee members. Such systems meant that the control of the Infirmary could pass, behind the scenes as it were, into the hands of just a few of the potential managers; indeed, it was because of this nepotism that many local groups set up the Visiting Committees to the Infirmaries, along the lines of those organised for the prisons and the workhouses.

Medical responsibility - as long as it was consistent with the ethos of the Infirmary - was left to the doctors except where, once a professional treasurer had been appointed, finance was implied or involved. [17.] In 1858, for example, the number of potential in-patients at the RSH increased beyond the bed-occupancy capabilities: in consequence, the Committee intervened and restricted admissions by ignoring subscribers' tickets, thus creating a waiting list and, incidentally, creating demand for expansion and hence increased revenue and eventual power for the treasurer.

As in-patient costs rose, with changes in treatment, so the administrative and medical staff were likely to come more frequently into conflict of interest. One area of open hostility between the two groups was over the employment of nurses and especially any increase in the nursing establishment.

The apparent institutional isolation of the hospital administrator was dissipated by a network based on social and business ties which allowed this emerging group to develop a common outlook towards hospital finance and administration. This network was aided to a considerable degree by the very methodical investigations which administrators undertook in order to maintain the viability of their individual institution. They conducted surveys, for example, on laundry facilities, the best (i.e. cheapest) method of preparing beef tea, staff ratios and the ticket system, all of which helped them to develop a common awareness of the demands of their role.

One notable administrator was Henry Burdett, initially at Queen's Hospital, Birmingham and later the Seamen's Hospital, Greenwich. By the late 1860s he had devised a system of hospital accounting - the Uniform System - which was adopted not only by those hospitals hoping for a grant in aid from King Edward's Hospital Fund for London, but by many others outside of the metropolis, eager to place their accounts on a regular basis: it is with little hesitation that we could argue that the development of the Uniform System, despite its faults, marked the beginnings of the professional hospital secretariat, finally turning the hospital into an organisation geared to costings rather than to any other prime function.

That newly emerged professional group, however, remained imbued with the problems of old - the difficulties of raising income in line with expenditure as well as creating surpluses; despite the relative sophistication of the new accounting systems, and their publication locally and nationally, such secretaries who were hard-pressed for revenue continued to resort to accounting devises - now known as creative accounting - in order to generate income or disguise expenditure. As Robert Pinker has noted, many administrators "presented their statistics more with the aim of raising additional funds than accounting for those they had already received and spent." [18].

There were many ways in which the accounts might be 'doctored' to increase income. One which Pinker has drawn particular attention to was the 'mystery' of the Capital and Current Accounts. [19]. For example, a new boiler could be included under Extraordinary Expenditure thus reducing the average cost per bed, based on Ordinary Expenditure. [20]. As we have noted, cost per bed and bed-occupancy rates were crucial to the presentation to the public and subscribers that the hospital was efficient and, thus, viable. Again, donations could be presented as special, when they were not, and therefore left out of the Income on Maintenance Account, at a stroke reducing the total current income and thus showing the hospital as continually in crisis - a great stimulus to fund-raising. [21].

The continual problems of hospital administration on a day to day basis, let alone forward planning for more than one or two years, may be seen in the records of many hospitals, including the accounts of the RSH. Without going into great detail of the returns, we can see the overriding impetus for the managers was to balance the accounts each year - income and expenditure in harmony, the mark of good Victorian business practice. Expediency was resorted to, for example, hotel costs to the hospital generally accounted for never less than 53% of total expenditure; in 1858 the total was over £1,345, 56% of expenditure and the rules of the Infirmary that year stated that:

> 'visitors shall bring no provisions (tea and sugar excepted) and shall take none away.'

Without going into detail, we may see that the introduction of night work by nurses, which in the main consisted of cleaning, making bandages, repairing linen and reducing the daytime burden by bedbathing and bedmaking, was an important way in which the numbers of nurses introduced by training could be utilised to the maximum institutional effect.

At the RSH in the eighteen sixties and seventies, the Matron had directly contributed to income generation, as well as saving on expenditure, by the collection and sale of refuse - bones, dripping and wash - since she controlled the kitchens as well as the nurses. By the end of the period, such monies could not be produced by the Matron who was distancing herself from the minutiae of the kitchens; her contribution was now through the work practices of her nurses, which included sewing and mending. Like the middle class female, the economic contribution of the nurses, although hidden from accounting methods, was direct and crucial to the 'domestic' sphere.

The value of directly selling the surplus labour of the new nurses through the setting-up of private nursing establishments within the voluntary hospitals, was not just the all-round training device of the empire-building general nurses but an obvious way of increasing income by a considerable amount, as the £4,000 per annum which Burdett claimed the London made out of its private duty nurses demonstrates. [26.]

As has been noted elsewhere,[27.] the introduction of cost-accounting into health care practices was made easier by the inculcation of a sense of time in which it was 'spent' and hence had a value which was measurable. The discipline code was, therefore, based on the notion of time, even to the extent that skill was measured in terms of length of time spent in specific activities rather than, for example, measures of applied ability in tasks required. This may be most obviously demonstrated in the debate over the length of training required of a good trained nurse and the attempts by some institutions to either lengthen or shorten the number of years but it is also apparent from the arguments about the type of woman who made the best nurses. The preoccupation with moral character and personal discipline which permeates the reform era was as much to do with the introduction of a new work discipline as it was to do with ideas of suitability. As Pollard has noted of early industrialisation, 'a preoccupation with the character and morals of the working-classes', was a vital step in the infusion and internalisation of a new work ethic. [28.] In nursing, reformers and leaders constantly strove to maintain or uplift the moral tone of the nurses; for example, Nightingale saw in the Nurses Home the place in which they could be revitalised after the demoralising exposure to sin/death/disease and dirt: Bedford Fenwick wanted a 'better class' of entrant: Annie Goodrich wanted 'nature's gentlewomen'. Hospitals advertised their moral training and status in their prospectuses whilst religion, as such, was played down at the same time as facilities were made available for prayer and reflection and, hence, penance and punishment. The ultimate demonstration of the moral character of the nurses and her competence to practice was in the way in which she used time; never still but never idly occupied, especially in talking to patients and doctors. The good nurse used her time well and performed her duties on time. She therefore could be counted, literally, and her contribution to the institution accounted.

By the later decades of the nineteenth century, patients were being allowed and even encouraged to bring in 'bacon, butter, bread, cake, apples, slices of meat, etc.' [22]. as well as in some cases, providing bed linen. [23]. It was, therefore, into this context that the new nurses were inserted, seen as additional calls on tight budgets and as potential assets for income generation, by a newly-established hospital secretariat.

The new nurses and the firm

Between 1861 and 1921 the number of nurses working in hospitals rose from approximately 1,000 to 56,000 in England and Wales; of these, after 1881, threequarters were nurses in training and only about 14,000 could lay claim to be trained nurses. [24]. Brian Abel-Smith is undoubtedly correct when he writes that the only real financial obstacle to the introduction of the new nurse was the provision of board and lodgings; [25]. however, this was a considerable burden, especially for the voluntary hospitals, and compromises and accounting devices were needed in order to make this essential contribution to reformed nursing. Many of these compromises reflected, in practice, the general expectations which many administrators had about the new nurses and their role in the hospital as an institution.

One way of funding suitable accommodation for nurses was through special donations, using the name of the donor for the home which also kept the costs outside of the main accounting for the hospital. Alternatively, totally unsuitable accommodation, for example, housing stock accruing through time to the hospital through investment or legacy, was adapted to house the nurses. Or, finally, costs could be minimised by reducing running costs to the bare minimum. While St Thomas' and a few other prestigious hospitals offered their nurses single rooms, many more used shared accommodation for at least the first year of training, if not beyond, and left single rooms as the goal to which the trainee was directed if she succeeded in becoming a trained and good nurse.

Such developments, as much as the need to discipline through a 'moral police force', were responsible for the emergence, transient though it was, of the Home Sister's crucial control role. She it was who saw that the nurses serviced themselves, in cleaning and in dining, (although there was some reaction against this by contemporaries) and who attempted to instil the nursing code of sacrifice, obedience and servility, itself determined by the underlying need to reduce costs to the institution. Any financial burden was ammunition to those, who included the administrators and some of the subscribers, who saw the influx of the new nurses as unnecessarily expensive and hardly cost-effective.

Other ways in which the nurse might contribute to the security of the viability of the hospital, many of them ad hoc decisions rather than planned developments as the standard histories would have us believe, included the introduction of shift-working and the development of nursing tasks around the concept of time - the round - maximising the use of equipment and materials either beyond their intended life or intended use for medical care and private nursing.

Central to this exercise was the ward sister and Michael Carpenter has clearly argued for the centrality of her role in the new order, as did Nightingale herself in her early years of nursing concern. [29] As a result, the accounting process could take place on and off duty and those attributes associated with the old order, bribery, drunkeness and time-wasting (even merely watching), were used as descriptions of nurses failing to meet the exacting profit and loss balance required by the hospitals.

Bribery, corruption and theft of drink were not only attributes assigned to the old order, as moral failings, in order to justify the new disciplines: they were also in themselves threats to the viability of the institutions and, as such, continually attacked by reformers. Indeed, such characteristics were as applicable to the old style doctor or administrator as to the old style nurse and formed the basis of many contemporary fictional attacks on the hospital system including, of course, those by Dickens and Charles Reade. [30] Any money diverted from the hospital purse into the hands of an employee represented a real loss of important income, whether it was a fraudulant collector, a doctor misusing drugs and instruments or the nurse keeping gifts from grateful patients. The records of the RSH show such gifts to the nurses as important sources of money; for example, the cost of insuring the infirmary annually could be met easily from the sums passed to the matron from the nurses.

Conclusion

As this last point illustrates, it is not argued here that the sole motive for, for example, the new code of discipline for the nurses was to earn income for the institution. It was the prime reason but was one which, given the contemporary ideologies, of care and woman especially, was not articulated by its proponents in such an overt way. That is necessarily the role of the historian, to dig beneath contemporary explanations in order to illuminate the social forces at work in producing change or in attempting to maintain a status quo.

For example, the original hostility of the treasurers and the administrators to the new nurses became translated in the later period into positive advantage for the institutions: this may be illustrated by reference to the difficulty of staffing ratios, a problem which many had spent considerable time resolving to the satisfaction of the infirmary. When, as happened, the ratios altered, nurses could be said to have free time, especially in the phase when trainees were so numerous. That free time could, and ought, to be 'sold' and this is precisely what underlay the move to private staff establishments in the voluntary sector.

It was not solely an administrator-inspired redefinition of what constituted the new nursing system: the leaders of the reformed system also were involved, since they were keen to limit entry to the occupation to those they somehow deemed 'fit'. It was almost inevitable that some sort of collusion would emerge between the reformers and the administrators - and incidentally the new nurses themselves - which would lead to a

definition of skill applied to nursing which was socially constructed and which relied not on personal capacity or ability but more on staying a training course which lasted a prefered length of time and involved more emphasis on moral and gender attributes than on ideas of health or care. [31].

That nursing skill was constructed is clearly demonstrated by the long contemporary concern and debate over length of training, moral qualities and, of course, state registration. It may also be seen as a construct after the introduction of registration, when in 1922 an attempt was made by the ex-leading nurse training establishment - St Thomas' - to argue that the nurse was really only a domestic servant. [32]. The case arose because of the introduction of new regulations extending the Insurance Acts to such groups as nurses. St Thomas', like many employers of mainly female labour, felt the burden of the employers' contribution to be too much for its shaky finances to take and attempted, through the courts and Parliament, to argue that, in the end, nurses were still what Sarah Gamp had always been, little more than watchers and cleaners. Concern at the viability of the institution was immediately followed by an attempt to redefine the skill of the nurse as a means of reducing expenditure; significantly, there appears to have been no real hesitation on the part of the hospital at taking such a deskilling position - not surprisingly, the institution had to survive and nothing could be sacred towards that end.

It may be argued, of course, that hospitals existed for doctors to practice their specialism or their skill. Before the eighteenth century and the entry of the medical men, most hospitals had cared for the poorest classes; the entry of the physician and the surgeon into the institutions certainly changed the sort of patient to be found in the hospitals and, in the main, they became places for the mechanical treatment of disease, rather than places of charitable endeavour.

If we ask, however, why it was necessary for dotors to enter hospitals in order to practice their skills more effectively (not efficiently) left with a sense that the metaphor of the firm which we have been talking around has relevance here. The internal structures of the institutions - administration, finance, welfare, capital, investment, salaries, wages, fees and even an address in a central area of a town or city, especially the capital city itself (whether they were at peak or needed reforming), were still better for this emergent capitalist class than the isolation of individual practice, as many of the embryonic GPs knew only too well. The mere fact that there was some organisation which would take 'care' of their patients when they were not there was also a very positive reason why doctors were keen to invade the institutional arena. They were aware that in such settings they could easily divide their time and increase their income by the sub-division of labour; with the employment of deputies, assistants, pupils and, of course, nurses, they could take on many more patients than they might as an individual without the support of the institution. Indeed, one of the first measures adopted by the newly hospital orientated doctors was to recruit apprentices and trainees, thus increasing their range of activities and their income enormously.

A hospital, then, even if it did espouse the aim of caring for the ill in its charter, may also be susceptible to the metaphor of the 'firm'. However, when the doctors made the mistake of leaving the collection of fees, the running of the 'house' and the 'care' of the inmates in the hands of the administrator-class, they lost any real control over the functioning of the institution. It might, indeed, be argued that it was the introduction of the honorary system itself - which gave up the direct relationship between income for the doctor and his skill or ability to get people to buy his labour directly - which opened up the channel by which the administration could ease itself into power in the hospital system.

We could note many simple facets of the introduction into the hospital network of the new nurses which superficially appear neutral but which on closer examination are, like the honorary system, elements in the production of unassailable bureaucracy. Such elements would include for example, the problems of recruitment, in which most recruits to institutions came from fairly local areas, whilst the rhetoric suggested that they came from far afield; it would also include the payment of premiums, provision of uniform clothing and the deductions from salaries contrary to the Truck Acts intent, all of which collectively reduced the burden on the viability of the institution whilst creating long-term contradictions which the institution as an administration was unable or unwilling to face. The instance of the local recruitment pattern suggests that the image of the prestigious and exclusive training hospital was important to the institution for reasons not then immediately obvious; we may suggest, however, that the local recruits could be relied on to make up the deficit in recruitment should it arise and, anyway, such local recruitment was more easily managed and investigated than, for example, the girl from a farm in the north of Scotland. Prestige, therefore, became like 'cure rates' - a commodity.

Locality is and was a crucial factor in the development of the modern hospital and modern nursing and it is a theme on which the paper ends. We have seen how the hospital was inextricably linked to the local economy - and if I had more time I could develop this in terms of nurse recruitment more fully - directly and indirectly. While we cannot at this stage be as certain as Hamilton is for the 1960s, we can see interesting parallels in the nineteenth century. In 1891 the total income of voluntary hospitals exceeded £17,800,000; in 1911 it was more than £31 millions. The voluntary hospitals produced almost all the doctors trained in England and Wales as well as a significant proportion of all trained nurses. 33.

The voluntary hospitals spent £326,000 on provisions; £129,000 on surgery and dispensary items; £172,000 on cleaning and laundries and; £268,000 on wages in 1891 (in 1911 - £435,000; £226,000; £327,000 and: £509,000 respectively), and much, if not the bulk, of that money entered the local economy of the individual hospital. Hamilton has, therefore, a point: hospitals are and were crucial to local and national economies <u>apart from</u>

their roles as medical institutions. Within them, nurses played their not inconsiderable role in that developing area of social economy. The notion of a medical specialism - consisting of consultants, registrars, housemen and nurses (through a ward structure of clinical expertise) - as a 'firm' is not merely a coincidental use of the term, nor merely a metaphor or play on an idea. It is a construction which requires the attention of the historian, especially the historian of nursing, as much as the historian of commerce and business.

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July 1983

NOTES

1. The seminal work on this area is FOUCAULT, M. The Birth of the Clinic: An Archaeology of Medical Perception. 1973.

2. BARKER T. C. et al (Eds). Business History. 1971.

3. HAMILTON J. A. Patterns of Hospital Ownership and Control. 1961. p.9.

4. Cited in F. N. L POYNTER (Ed). The Evolution of Hospitals in Britain. 1964. p.43.

5. STONE J. E. Hospital Organisation and Management. 1952. p.4.

6. POYNTER F. N. L. Hospitals. p.48.

7. WOODWARD J. To do the sick no harm: A study of the British Voluntary Hospital system to 1875. 1978 ed. p.17.

8. WOODWARD J. To do the sick no harm. p.18; ABEL-SMITH B. The Hospitals 1800-1948. 1964. p.5.

9. See, for example, H. PERKIN, The origins of modern English society 1780-1880. 1969. Chapters II onwards.

10. ABEL-SMITH B. The Hospitals. p.1.

11. PINKER R. English hospital statistics 1861-1938. 1966. pp.48-9. For growth in specialist and cottage hospitals, see PINKER, Statistics. p.57, p.61 and also, ABEL-SMITH, Hospitals. p. 102.

12. PINKER R. Statistics.

13. ABEL-SMITH B. Hospitals. pp.21-31.

14. The following data are taken from the unpublished records of the Royal South Hants Infirmary, Southampton.

15. For another example of this, see J HANNAM, Leeds Womens Labour League and Women's Health, Bull. History of Nursing, I, 1983, pp.6-8.

16. STONE J. E. Hospital Organisation and Management. p. 6.

17. ABEL-SMITH B. Hospitals. p.33.

18. PINKER R. Statistics. p.143.

19. ibid.

20. ibid.

21. ibid.

22. ABEL-SMITH B. Hospitals. p.43.

23. PINKER R. Statistics. p.150, citing H. C. Burdett, Hospital Annual 1893. 1893. pp. lxxxii-cxxxiv.

24. MAGGS C. The origins of general nursing. 1982. pp.7-9.

25. ABEL-SMITH B. Hospitals. p.67.

26. MAGGS C. The origins of general nursing. p.73.

27. MAGGS C. Control mechanisms and the new nurses. Nursing Times, September 1981.

28. POLLARD S. The Genesis of Modern Management. 1965. ch.5.

29. CARPENTER M. Asylum Nursing before 1914: A chapter in the history of Labour, in DAVIES C. (Ed). Rewriting Nursing History. 1980.

30. Including Martin Chuzzlewit and Hard Cash.

31. For a recent discussion of skill, which characteristically omits any real analysis of women's work and the skill process, see C. MCCRE, Skill and the English Working Class, 1870-1914. 1980.

32. MAGGS C. Aspects of General Nursing. PhD Thesis, University of Bath, 1980.

33. MAGGS C. The origins of general nursing. ch. 1.