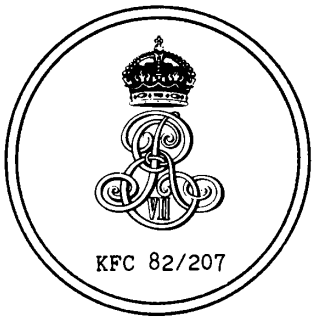

NEW PERSPECTIVES IN NURSING HISTORY

A forum at the King's Fund Centre on Friday 10 September 1982

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HOW THE NIGHTINGALE FUND INFLUENCED NURSING EDUCATION

Monica Baly, Part-time Lecturer and Author, Bath

Archive material concerning the Fund

The records about the Fund are immense, it is in two main collections but there is subsidiary material all over the place. Some of it is contradictory, and you can prove almost anything with a quote from Florence Nightingale. Nevertheless, in spite of the fact that nothing seems to have been thrown away, including that marked 'Burn at once', there are gaps in our knowledge that make interpretation difficult. You must remember that we have been fed for years with biographies that relied heavily on Sir Edward Cook, and this includes Woodham-Smith, but although Sir Edward was thorough and accurate as far as he went, some of the material was not then available and the interpretation tends to be over-kind because so many of the characters concerned in the story were still around in 1913.

However, more important, from the nursing point of view, nursing was but a small part of Miss Nightingale's work and it tends to be overcondensed by the general historians. The nursing aspect has been, it seems to me, very largely concocted from official reports and the mass of publicity material put out by the Nightingale Fund Council and sickled o'er with the pale cast of sentimental thought.

I hope to show you that what people said happened, and what people like to think happened, can be rather different from what did happen.

What was the Fund?

While Miss Nightingale was still in the Crimea the ladies of England started collecting for a presentation to her, in gratitude for her services to the sick and the wounded. On the investigation of Mrs Sidney Herbert, the Fund was enlarged into a National Appeal to

provide Miss Nightingale with money

> "to establish an institution for the training, sustenance and protection of nurses and hospital attendants".

This Fund is interesting inasmuch as it is the first National Fund to which all classes were asked to give and, indeed, did give: but not, I may say, without a certain amount of religious bickering that was so characteristic of the period. Contrary to what nurse historians have liked to tell us (by the middle of the 19th century) nursing in the hospitals and indeed on the district, was by no means universally bad. There were in fact 22 Sisterhoods of various denominations, mostly Church of England, nursing in the London Hospitals, some of their nurses had a year's training.

Miss Nightingale herself, out in Scutari, with one immediate objective - to revolutionise the Army Medical Service and if necessary the Army itself - was not amused. She was afraid the Fund would be used to divert her from her main task and when she was asked about her plans for the use of the Fund, she wrote to Mrs Bracebridge,

> "If I had a plan it would be to take the poorest and least organised hospital in London and put myself there and see what I could do, not touching the Fund perhaps for years, till experience had shown how the Fund might best be available. This is not to detract from the Fund to the work, it will be invaluable as the occasion arises".

This of course was not what the grateful public intended and the delay in announcing a 'plan' was an embarassment to the distinguished Trustees of the Fund, including Sidney Herbert, whose political future was a little uncertain. In 1856 Miss Nightingale returned and by 1857 she had had her famous collapse and was now an invalid, mainly confined to her

bed and to the mountains of work in connection with the Barrack Commission, the Army Sanitary Reform and the Sanitary Commission for India. Therefore, on two counts, health and the amount of other work, she could now be excused (and one suspects she thankfully excused herself) from ever being the superintendent of any nursing institution. Accordingly a Deed of Delegation was drawn up and a Council of her own choosing set up - including old friends like Monkton-Milnes, Mr Bracebridge and, I may say, five distinguished physicians, which is not bad for one whose avowed aim was to wrest power from the dotors.

While Miss Nightingale havered, the Council cast around for a hospital or institution on which to latch themselves. Sidney Herbert favoured King's College, where patients were already nursed by the St John's nurses under Mary Jones, Miss Nightingale's 'Dearest Friend' as superintendent. There is also correspondence about the Royal Free, where again there was nursing by an outside organisation which gave training. There was always some reason why not, usually some sectarian row.

Then, a strange thing happened; Miss Nightingale had published her Notes on Hospitals, which advocated the building of hospitals on healthy sites outside the cities, and this coincided with a bid by the South Eastern Railway to extend its line from London Bridge through the back yard of St Thomas' Hospital. St Thomas', in the slums of Southwark, was already in a terribly dilapidated state: as long ago as 1830 the physicians were saying that rebuilding was urgent. Now, if the Railway could be made to pay enough compensation, it could be rebuilt on a new site in a more favourable area and away from Guy's which had in fact taken the best teaching material and the medical students. Now, for some reason I have not discovered except he seems to have been a Chadwickian sanitarian, Mr Whitfield, the Resident Medical Officer at St Thomas', was anxious that the hospital be built in the suburbs - preferably Lewisham. He accordingly wrote to Miss Nightingale for support. She, with ideas about Blackheath, entered into what can only be described as a Machiavellian intrigue,

releasing Whitfield's purloined statistics about catchment areas for Southwark to the press. The doctors at St Thomas', led by Flint South, were furious and counter attacked in the Lancet. But in the course of this row there is a significant letter from Whitfield about the possibility of St Thomas'

"accomodating the Fund and its requirements"

The fact that the Fund was insisting on being responsible for the selection and control of the 'probationers', as they were to be called, meant that it was by no means every hospital's choice and it certainly looks as if there was a quid pro quo between Mr Whitfield and Miss Nightingale. The Trustees, convinced by Miss Nightingale that this was the best offer, signed a contract with St Thomas'. The mind boggles at the decision. St Thomas' was certainly the poorest and least organised hospital, it was about to be pulled down, its future site was not decided and it hardly seemed the most suitable place for a model training school. One can only conclude that the Trustees were working on the principle of 'jam tomorrow' and that they, the Fund, would be able to dictate what happened in the new hospital, wherever that might be.

The arrangement was for the probationers to have separate board and lodging, to be supplied with a certain amount of outdoor clothing by the Fund and to serve as 'assistant nurses in certain wards'. At the close of the year's training, the probationers would be expected to enter into service as nurses in such hospitals for the poor sick as the Fund might offer - for this valuable training was not to be wasted on private nursing.

The accepted candidates under the scheme had their names entered in a Register in which was recorded their conduct and experience, which was seen by the Committee of the Fund each month. At the end of the year the successful survivors were 'certificated' and sent off to a post that had been well vetted by the Fund.

Probationers could only withdraw for a reason approved by the Fund but they could be discharged at any time by the matron for misconduct or if she thought they were inefficient. The Fund paid St Thomas' a certain sum for the board of each probationer. £50.00 a year to Mr Whitfield to give 'instruction', £100.00 a year extra to Mrs Wardroper, the matron of St Thomas' 'to oversee the moral conduct' and to be Head of the Nightingale Training School and, interestingly, £10.00 a year extra to the Sisters at St Thomas' who helped with the training. The probationers were paid £10.00 a year and given small gratuities if they completed their contract - with a good report.

The Fund's capital of £47,000 was invested in Consols at 3 per cent which gave an income of £1,400. In the first years £1,000 was used to defray the cost of the School at St Thomas' and, later, at Highgate, while the remainder was set aside for a Midwifery School which the Fund started at King's College Hospital the following year. As you probably know, for various reasons this experiment only lasted 5 years and the money was then diverted to increasing the number of probationers at St Thomas' helping with District Nursing and starting 'Schools' elsewhere.

Now there are several things to notice about this contract and, in spite of her preoccupation with other things, Miss Nightingale's hand is behind it. It is a contract for the 'servant class': the probationers served an apprenticeship, they were given their keep (including tea and sugar) and outdoor clothing and they were found a situation - provided they had a 'good character' and they were answerable to the Fund for another 3 years. It was the kind of contract Miss Nightingale had with her parlour maid. It was not an attempt to get educated ladies: Miss Nightingale, in her writings, had made it clear that she thought paid nurses best and those already nursing could apply.

The second thing to notice is the power given to the Matron, an article of faith Miss Nightingale never retracted but lived to regret. Mr Bracebridge, one of the Trustees, wrote,

> "I object to these regulations. It was always intended at first, and since, to establish a profession and give incentive to those in it to rise by grades.....A nurse, after getting her certificate ought to be free to take any post".

From the first the Trustees were a trifle ambivalent about their aims. Mr Bracebridge's other quibble was,

> "I object that she (Mrs Wardroper) or her successor may contract acts of tyranny if she can expel without leave of a sub-committee. This evil will act against good women taking service and it would be a pleasanter thing for her to refer to a tribunal of Appeal".

Actually, Mr Bracebridge spoke truer than he knew. These two points were objected to and the first had to be overlooked when the bid was made to get better educated recruits.

Miss Nightingale having recommended better food and shorter or more flexible hours for the probationers and having drawn up her famous character sheet under 14 different heads, to be filled in monthly by Mrs Wardroper, withdrew to immerse herself in metaphysical thought, the Indian Sanitary Reform and the Herbert Memorial Hospital; her young cousin, Henry Bonham Carter, a barrister, was left to cope with the day to day running of the Fund. Of all the strange and eccentric characters in this story, Henry stands out as being quite imperturbable and while the libellous and scandalous stories flashed around him he was always discreet. Mrs Wardroper wrote to him continually but he never interfered; meanwhile, she, having been given such powers, used

them. There is a letter which quotes her as saying to a sister,

"I can dismiss Miss Champman and every woman
in this place without referring to anyone".

"This is true"

wrote Miss Nightingale to Henry,

"but what a way to use authority".

Of the first fifteen, what Woodham-Smith and others call 'carefully selected probationers', two were dismissed for disobedience, one for insobriety, one for ill health, one died of typhus, one disappeared at the end of the year and only three were nursing at the end of the contract. (80% wastage on the 4 year contract). The first year might be forgiven, or even the next, but for every year of the first 20 it looks much the same and certainly for the first ten of the first 100 (which takes us to 1867) 28 were dismissed, six resigned (mainly because of ill health) four died in their training year and a further 11 married and four resigned before their contracts were up. This means there was a 50% wastage, but the situation is probably worse. With my utmost detective work, ransacking the reports and the gratuity lists, I can only be sure of 27 still working at the end of their contracts.

The sickness rate was apalling. In 1862 - the year St Thomas' moved to its temporary home in Surrey Gardens - there were four cases of typhus and one of scarlet fever among the 20 probationers and the rest all seemed to suffer from debility and sore throats. This, in spite of the fact that many were dismissed, as 'too delicate for hospital work', within the first few weeks. There seemed no acceptance that the hospital itself was to blame. Elizabeth Pratt had both diptheria and scarlet fever, was very ill and then was dismissed for poor health! Her conduct report said,

"would have made a good nurse".

The Trustees, when they wrote privately to one another, admitted that the circumstances were hardly favourable to launching a publicity campaign which they felt the scheme needed. However, an impressive address by Sir Joshua Jebb brought some dividends and Mr Rathbone, the Liverpool Philanthropist and friend of Miss Nightingale, sent the two Miss Merryweathers as observers (they did not sign the contract) and Agnes Jones, the niece of the Governor General of India came to train. At the same time, Mr Rathbone asked Miss Nightingale if she could supply a group of nurses and a Lady Superintendent to staff the scheme he hoped to put into operation at the Brownlow Hill Work House Infirmary. Miss Nightingale agreed, though when one looks at what was happening at St Thomas', one wonders how she dared. The only possible Superintendent was Agnes Jones, in whom Miss Nightingale had little faith and who, as far as I can make out, had some psychological problems and what seems to be hysterical deafness. Nevertheless, the group eventually left and did in fact make some impact, though not without dissension. Then, as you know, Agnes died of typhus and Miss Nightingale, rationalising the situation, more or less canonised Agnes and wrote eulogies about her sacrifice in the press. It made the School better known, and this and other publicity brought a sprinkling of better candidates.

Meanwhile St Thomas' was rebuilt, not in the healthy suburbs, but on the banks of the foggy and then, dirty Thames. The doctors had won and this is another reason why the Entente Cordiale between the Fund and St Thomas' was rather less cordial than the sentimental historians make out. Mr Whitfield, having lost this battle, also lost interest in the training school.

If we look at what the Fund had achieved in fact, as opposed to what its publicity said, by 1871 it was not much. The Liverpool experiment had been closed; a group had been sent to Australia under Miss Osburn who did start a training school but, of the five sisters who went with her, three were dismissed and one married

within three years: Miss Osburn remained but, in disgrace with the Fund. The Fund had trained a Superintendent for the War Office for the Hospital at Netley and a few Nightingale nurses had gone with her: of the remainder, one or two had matrons' posts in small hospitals, a small 'school' was started at Highgate in 1869, two were sisters at St Thomas' and the rest were scattered as nurses over the country

For a variety of reasons, by 1870, Miss Nightingale herself began to take more interest and to scrutinise the reports, to have the probationers for 'tea and talk'. She was horrified at what she found and what the probationers themselves thought of their training. It is at this stage that we get the famous remarks written across the Register and the Report Book. More often than not, Miss Nightingale disagreed with Mrs Wardroper's assessment and the fact that the 'goods' and 'moderates' in the various columns were indiscriminate. It was now borne in on her, which should have been obvious before, that not enough thought had been given to who should train the probationers. It is curious, is it not, that after all the ink that had flowed from the 'Reformers' saying how bad hospital nursing was, that these sisters should be thought fit to train the new style nurses and should be paid to do it?

The second problem arose out of the probationers being assistant nurses - the Fund was paying for them to be the labour force on the ward - as their diaries now revealed. Now Miss Nightingale's red pencil began to underline entries like 'washed the utensils' and to comment '<u>This is not training, this is hospital work</u>'.

The third problem arose from the power given to Mrs Wardroper. It looks, in retrospect, as if Miss Nightingale had not given enough thought to whether Mrs Wardroper would be equal to the task. Of course the publicity spoke of a 'well tried matron' but there were pages and pages of letters complaining of Mrs Wardroper acting like an 'Insane King - governing by Divine Right'. Mrs Wardroper herself is a bit of an enigma; several people hint that some tragedy had

unhinged her - she certainly seemed muddled, excitable, given to gossip and at times tearful. She had a vacillating relationship with Mr Whitfield but she was always loyal to Miss Nightingale. One cannot but be appalled at the to-ing and fro-ing between the hospital and South Street and the revelations of the detective work and the intrigue. It all betokens a very unhealthy situation.

Apart from Mrs Wardroper there was the question of Mr Whitfield who, it was now revealed, 'had been in the habits of intoxication for years' and whose behaviour with the probationers was on 'the verge of (and beyond) impropriety'! The last straw was a very rude letter from Mr Whitfield about papering the matron's room 'with wallpaper of arsenical green' which I can only conclude must have been written during his 'habits of intoxication'. The Fund now dispensed with Mr Whitfield's services. Miss Nightingale cut him out of her will.

The missed opportunity

We now come to what may be regarded as the missed opportunity. In spite of the new hospital, Miss Nightingale was writing,

> "The probationers come out of St Thomas' worse women than they went in"

and, "We made St Thomas' - they are now unmaking us".

On Miss Nightingale's advice the Fund took Counsel's advice about the possibility of spending capital, or even exhausting the whole sum, providing the objectives of the Fund were met. We do not know what they had in mind, the minutes are silent.

I think the trouble was that it would have been difficult to break the contract with St Thomas' and really the Fund were hoist with their own petard. For years they had trumpeted the essential of the 'reformed system' as practiced in the training school at St Thomas' - they could hardly now beat the retreat. What they did

was to give thought to how the public image could be saved and yet the system made to work. The steps they took are important because they influenced nursing for the next 100 years.

Firstly they brought in Elizabeth Torrance from the School at Highgate to take charge of the class instruction and the moral welfare of the probationers. For want of a better title she was called 'Home Sister' but the intention was that she should be in charge of the moral and educational needs of the probationers; the idea being sold to Mrs Wardroper was that Miss Torrance was only there as an assistant and she, Mrs Wardroper, was Head of the Training School, (which was rather hard on Miss Torrance) a nice example of a job description not matching the stated requirements. Miss Torrance, blocked by Mrs Wardroper, left and married Dr Dowse of Highgate and another candidate had to be found, but it was a strange and not entirely satisfactory compromise.

The second step was to increase the number of 'Specials', 'Free' or otherwise. The new St Thomas' wanted to take more Fund nurses but the Fund was now committed to sending groups to other hospitals like the Edinburgh Royal. If it was to train more nurses, it needed money, hence the attraction of paying probationers. But there was another reason. If the ward teaching was as bad as Miss Nightingale said, then it needed an infusion of better educated recruits who would be better able to teach and to lead. During the 1870s the Fund was lucky in getting a group of 'Specials' - some of them 'Free Specials' who, though they themselves got little training (as some of them commented with asperity) they did get a lot of tea and talk with Miss Nightingale and individual encouragement. They went out to other hospitals where they were often more innovative than the School at St Thomas' and these few, probably more than anything else, saved the scheme. This phase did not last long and by the end of the century, with other teaching hospitals training their own leaders, St Thomas' tended to become inbred.

The third change was the increase in the number of doctors' lectures. This was partly because the more educated entrants wanted them and because medicine itself was becoming more scientific. But Miss Nightingale saw the danger, if others did not. In a revealing moment, the British Medical Journal said,

> "The doctors give the lectures and they can decide what is taught".

And they did. By 1907 there are examination questions about the heart sounds and the nervous reflexes. The medical model was firmly established.

There was another outcome. The Lady probationers started clammering for a Higher Training. As early as 1874 Florence Lees was writing about the need for a training that would elevate nursing to a scientific profession and some doctors were talking of nursing requiring a 'liberal education at least equal to that required by a doctor'. Not quite what Miss Nightingale had in mind, when she planned to raise the standard of care given to the poor sick in hospitals and infirmaries.

What Miss Nightingale and spokesmen of the Fund said about nursing was admirable. We go on quoting them to this day:

> "Training is to teach the nurse to help the patient to live".
>
> "To scour is a waste of power".
>
> "Nothing should be fetched by the nurses .....everything should be brought by lifts etc".
>
> "Day nurses should have eight hours' sleep and four hours for private occupation".
>
> "Ward Sisters should be trained - they are the key to the whole situation".

Given the life and times of the second half of the nineteenth century it was all very sensible and often quite advanced. But what were those probationers doing? Fortunately, they have left us the diaries that went for inspection and here is a sample of a day in the life of a Special in 1890 - thirty years after the beginning of the scheme.

7.00 p.m.	Went on duty. Helped the night nurses' side; washed two patients.
7.30	Helped on the day nurses' side; washed a convalescent patient.
8.00	Went to prayers.
8.15	Washed a typhoid patient.
8.30	Washed the urine bottles and the locker tops with chlorinated soda.
8.45	Washed and dusted Sister's table and the window ledges. Cleaned and trimmed the lamps. Washed the urine and medicine glasses and small jugs and.....
9.15	Prepared the lunch - bread and milk, served it round.
9.45	Went into the bathroom: washed out bath, basins and traps. Put fresh cloths on the ice bowls, folded and put away the clean mattress. Tidied the pillow basket.
10.15	Went off duty.
11.00	Went to Sister's class.
12.45 p.m.	Went to dinner.
1.30	Came on duty. Made beds with Nurse Chaplin. Washed the wine glasses, dusted and tidied the centre of the ward. Put ready the dressing gowns for the doctor.

1.50 p.m.	Cut up 7lbs of beef for beef tea - made beef tea.
2.20	Attended Dr Ord's round and waited on Sister.
3.15	Went to Steward's office with a telegraphic message.
3.30	Helped Sister to wash an unconscious patient.
4.00	Filled three steam kettles.
4.20	Cut thin bread and butter for fever patients, prepared tea, served tea round, fed a patient.
5.50	Came off duty (tea, 25 minutes).
6.15	Went on duty. Washed specimen glases, washed feeders, washed gas globes, gave patients their supper..
7.15	Made the beds with Nurse Moon.
7.45	Tidied the Centre. Arranged and lighted the lamps. Arranged the ink stands. Took out the flower pots. Turned down the gas.
8.00	Carried round the wines and brandies.
8.15	Collected the wine glasses.
8.30	Came off duty.
8.45	Went to prayers.
9.00	Had supper.
9.20	Went to bed.

She had been on duty 13½ hours with 3½ hours off in which she had been to a lecture.

Only for about 1½ hours had she been doing nursing or giving care. Most of the day - except for the time she helped Sister, she had been unsupervised.

The influence of the Fund on nurse training

What then was the influence of the Fund? In 1860 its main aim was to 'wrest the control of nurses from the doctors and lay administrators' .....and it succeeded. The matron was the Head of Nursing Service and Nurse Training. When there was little classroom work this did not matter too much but it soon produced conflict. In history it is always earlier than you think.

It gave, or tried to give, the poor sick a better service by selecting nurses of better moral character, though not necessarily better education, and giving them a short practical training, then finding them situations in other hospitals and vetting the pay and conditions of service. The Fund was a sort of Whitley Council of its day. The Fund tried to get the best. Although what the Fund did was slight, what people thought it did and could do, was considerable and this coincided with medicine becoming more scientific. Other hospitals (particularly teaching hospitals) copied and, to some extent, it became a self-fulfilling prophesy.

The original idea was blown off course when it was found that there was little ward teaching or supervision but then there developed the Specials or Lady probationers and the separation of classroom teaching and ward practice. The Ladies later pressed for more theory and higher training.

The Fund never came to terms with the fact that two types of entry really needed two trainings. But, with the Registration campaign and the insistence that nursing was as much about character and motivation as about education, this would have been lesé majesté.

In the early days the Fund was ecumenical: it helped with training for the Poor Law Infirmaries, it had a hand in the development of District Nursing and it was, of course, interested in midwifery.

When people like Mrs Bedford-Fenwick started agitating for a three year training, regardless as to whether the end product required that time, the Fund could not cope financially. Sadly, gradually the sphere of influence retracted; the last to go was the School at what is now St Charles, in 1904. The Fund, not without misgivings, now concentrated on St Thomas' where, presumably, it merely saved the Board of Governors some money.

The fact is that the system that was set up as a 'humble experiment' in 1860 to meet the needs of the time and was adjusted to overcome the intrigues of the 1870s and the aspirations of the Ladies in the 1880s, was regarded as the Tablets handed down from Sinia, because it was associated with the name of Miss Nightingale.

The routine described in that diary, was bearable as a test, if done for one year: it was a nonsense when done for three years. The check on experience in those 14 columns becomes task orientation when translated into three years of ticks for the GNC. The discipline of the Nurses' Home, to convince the public and safeguard women in the slums of Southwark, becomes discipline for its own sake. The emphasis on the medical model may have had some justification when most illness was episodic, acute and often curable but the idea of training, which was a pale shadow of that given to doctors, was clung to long after the nursing needs of the country had changed.

For the next 60 years or so the inheritors of this scheme have torn themselves apart as to whether nursing is a profession, a calling or a 'manual craft'; whether there should be more than one standard of entry and whether all should be trained in the same mould and whether this training should be given on the job, in the classroom or

part in an institution of higher education.

We cannot decide. Perhaps we should not blame the Nightingale Fund that it did not leave a blue print for nursing for the next hundred years.

EDUCATION AND THE NURSING SYSTEM

Rosemary White, Senior Research Fellow, University of Manchester

This paper derives from a study I have recently completed of The Effects of the NHS on the Nursing Profession, 1948-61.

For the sake of brevity I have had to omit many details of the arguments and substantiating evidence which are available in my full research report.

As a result of my studies I must explain that I am more than ever convinced that nursing structure and nurse education (as well as salary structure) cannot be considered separately but have to be taken together - hence the title of my paper.

In talking about nursing, we have traditionally accepted that it is a single or unitary system. We talk about the profession of nursing, not the professions of nursing.

Since 1943 we have had the Roll of Nurses which has given us a second grade of trained nurse, but we still consider nursing as a unitary system with a common ideology, that of caring for people, the service ethic, altruism.

It has also been the practice to assume that all nurses have a common goal, the professionalisation of nursing. By this we mean that nurses want to have greater control of their work practices, organisation, recruitment, training and discipline.

I should like to discuss with you today, a different view-point. I propose to offer a new perspective for nursing and its structure and to suggest that nursing, rather than being a single or unitary system is what Edward Shils (1975) described as a mass society, composed of several different primary groups or sub-systems.

Shils was talking about the structure of modern societies, and the beliefs, values and symbols which govern them. He believed that each society has a centre around which is a net-work of sub-systems.

Although all the sub-systems share certain values with the centre, they also develop their own value sets and goals. The common values or ideologies hold the society together and the varying values and goals of the sub-systems keep them apart. This tension serves to give the system its dynamism and helps to generate change.

In his theory of mass society, Shils described the relationship of the mass to the centre as being integrated through the exercise and acceptance of authority in the major sub-systems of the society. Integration, he said, occurs horizontally and vertically: by the unity of the elites of the various sections of life and in a hierarchy of power and authority and a status order. Education and communication have brought about a shared culture; language is the link between the members and the sub-systems.

Shils believed that competition and conflict in this consensual society, is vigourous: there is great awareness of antagonism, inequalities and diversity. What is specific to the mass society are the consensually legitimate institutions within which this conflict takes place and which limit this conflict. The consensus derives from an attachment to the centre, the central institutional system and the value order of the society. Hence, despite all the internal conflicts, there is a strong sense of attachment to the society, as a whole. He believed that ideology upholds consensus and that consensual belief structures are pluralistic. At the same time he also described a form of dis-sensual consensus which affects the balance of a society and helps to bring about change. This dis-sensual consensus took the form of an attachment to a common value which had a different meaning for the various groups. There was an ambiguity in the understanding or meaning of the value.

Let us now look at nursing and see how it fits into this model of mass society with its pluralistic structure.

Before the last war, nursing was a fragmented system with three streams of nurses: the voluntary hospital, municipal hospital and poor law institution nurses.

The voluntary hospitals accepted only acute cases and their nurses, therefore, had no experience of chronic or long-stay nursing.

By and large, the municipal hospitals received the cases which the voluntary hospitals refused to accept. These included the chronic cases for which there was little hope of recovery or cure. The municipal hospital nurse, therefore, lacked experience in acute nursing, specifically surgical nursing.

The poor law nurses worked in institutions which cared for the aged and infirm. The people who nursed in these institutions were mostly untrained and there were very few qualified nurses, even for supervision of the other staff.

After 1943, the assistant nurses who were the mainstay in these institutions were allowed to be enrolled in the new Roll of Nurses, by virtue of their experience. Pupil nurses were accepted in training only on chronic wards. This meant that they, too, only had experience of nursing the long-stay sick.

Since the 1939-45 war, there have been a number of reports on nursing all of which have enquired into recruitment and training.

The Athlone Interim Report (1939) proposed that assistant nurses should be placed on a new Roll of Nurses to be set up by the GNC. According to this report, the enrolled nurse should work under the substantive grade, the registered nurse.

During the years 1942-49, the RCN Reconstruction Committee, the Horder Committee, issued four reports, the principal recommendation of this committee was that the enrolled nurse should be the main grade of nurse and that the registered nurse should be the officer grade. This meant that the number of registered nurses should be substantially fewer and the numbers of enrolled nurses should be much greater. The Horder Committee proposed that registered nurses should be trained to a much higher level than hitherto so as to leave more room below for the enrolled nurse to function. The Horder Committee used the term 'advanced education' for the registered nurse and proposed degree courses at under - and post-graduate levels.

When the Wood Working Party reported in 1947, they based their recommendations on their understanding that nurses from the three streams had very narrow training, in either acute or chronic work; they believed that a general trained nurse should have had experience in all forms of general nursing and that her training should offer a common base for all forms of specialist training.

Their recommendation for a two year broad, general training was made in this light. They made that recommendation in the main body of their report without very much amplification of their arguments but, in Appendix VIII, they added an extremely important rider, which was missed by most people who commented on the Wood Report. They said 'this training is not intended to prepare nurses for functions over and above those usually carried out by a staff nurse in hospital or a first public health post.....consequently, we do not consider it unreasonable to assume that before a nurse proceeds to a post carrying new functions.... she should receive some training beyond that provided in the basic course'.

In other words, the Wood Report proposed a broadly trained general nurse and a second level of nurse who had received some specialist training. The Working Party specifically included the ward sister as a specialist and considered that most special trainings could be taken at a university level. They emphasised the need for promotion based on further training rather than further experience.

Both the Horder and the Wood Reports were, therefore, preaching the same message: there were to be generalists and specialists in the nursing structure. Unfortunately, the common ground in these reports was not perceived. The RCN adopted the Horder model as their policy and went for the so called officer and other ranks. This meant that they had to reject what they believed was the Wood Report's model, that of the two years broad training. As I have said, they had not noticed the critical rider in Wood's Appendix VIII. The pursuit of the Horder model required a reversal in the proportionate numbers of enrolled and registered nurses.

The Ministry of Health also failed to understand the Wood Report. It did however accept that it would be economically and logistically impracticable to have all patients nursed by only SRNs. Given that the nurses had rejected the Wood model, the Ministry implicitly accepted the Horder proposals that more SENs should be trained to staff the wards, under the supervision of SRNs.

The Ministry, however, did not accept that SRNs needed to have additional specialist qualifications. In this, they made a significant departure from the Horder model. There is ample evidence in government papers to demonstrate that the civil servants considered nurses as only one step removed from the domestics in hospital. There was a clear feeling of contempt for nurses whom they considered to be 'flickers of dusters' in the wards. They therefore adopted a policy of deterring nurses from taking additional qualifications. They did this by refusing to give them paid leave for courses, by paying them student nurse salaries during further training and by not supporting the establishment of post-registration courses. They did however, have to encourage some further training in areas of shortage such as in midwifery, health visiting and tuberculosis nursing. In the main they did this by setting up integrated training which allowed the duration of the courses to be reduced.

The Ministry's activities therefore tended to confirm nurses as generalists and to proletarianise nursing.

In direct contrast to this, the policy of the RCN was towards making some nurses into specialists and towards professionalising nursing.

During the years after 1948, the function of hospitals changed and they became centres for diagnosis and medical intervention. Medical technology developed rapidly and generated highly technical and increasingly complex routines. Furthermore, the bureaucracy of the NHS brought about a vertical hierarchy of management with a proliferation of specialists. This was an era of increasing division of labour which implied the break up of occupations: specialists became not only the supervisors and leaders but also developed very often into the new professions. The generalists remained as the proletarians and subordinates.

Events after 1948 therefore tended to support the College's policy of specialistation. Specialist nurses were needed in administration, teaching and the clinical areas.

Not all nurses wanted to take post-registration training, however, and many preferred to continue as generalists.

It may not be too much of a generalisation to say that these were the anti-educationists in nursing, the folk who insisted that nursing had to remain based on purely practical skills. By definition, the specialists were those who were looking for greater depth of understanding and a knowledge base.

Nursing, therefore, from being a fragmented system became a pluralist one with an assortment of sub-groups, each with its own value system and goals, although all were united in nursing's common ideology of altruism.

Furthermore, since the goals of the sub-groups varied, so did their strategies. The specialist looked for greater professionalism via the RCN: the generalist looked more for economic status and material rewards via unionist activities.

In 1948, there were few specialists but their numbers proliferated through the years, as did the areas of specialisation. Naturally, they remained fewer in number than the generalists but they became better organised and, by virtue of their educational advantages were more vocal.

The RCN had entered the period after 1948 as an elitist organisation but as more specialist sections developed, it too, became a pluralist system. The specialists found that their sections were able to represent their interests whilst the generalists tended to look to the branch organisation of the College (unless they were members of unions).

In the meanwhile, hopes of recruiting more SENs to work as the 'other ranks' in the Horder model were continuously dashed. There was, until 1962, an open entry system to nursing, with no educational requirements. After 1962, the two 'O' levels standard was so low that it was difficult to establish any real demarcation between pupil and student nurses. Although many training hospitals demanded a much higher entrance qualification, the SRN training had to be geared to the GNC minimum level for recruits. The SRN training therefore was suitably depressed and both the Prices and Incomes Board Report number 60(1968) and the DHSS Job Evaluation Report (1977) failed to identify any difference between the work of the SEN and that of the SRN.

Therefore, the policy of making the SEN the main working level in nursing failed. But, all the while, nursing was achieving the same effect by a different means. By the process of division of labour, nursing had produced the generalist (or proletarian) nurse and the specialist (or professional) nurse. In nursing, pluralism had happened.

However, this development and its implications has not until now been recognised. We have continued to hear said of nurses "If only they would make up their minds about what they want" or, "Nurses have to unite and speak with one voice". As a pluralist system, of course, this is not possible. Under Shils' model of a mass society, we may be a single society but we have a number of sub-systems and, although we may be united by the common ideology and language, each sub-system has its own particular values, goals and strategies.

Apart from the division of generalists and specialists, the specialists themselves have different goals and value sets. The nurse managers are primarily concerned to preserve cover for their wards. The nurse teachers are at loggerheads with the service nurses, the curative nurses with the preventative nurses. The generalists continue to proclaim the practical nature of nursing and the specialists call for the development of a knowledge base.

The point that I have to make is that we need no longer be concerned with whether we have a single professional register or half a dozen of them. We are already presented with a new and natural division in nursing. The important thing to recognise is that whereas in the past, the breaks came between SRN and SEN and SEN and Auxiliary, the break now comes after state registration. In other words, the registered nurse remains a generalist and will have to take further training before she qualifies as a specialist. I would venture to suggest that this specialised training must have academic acceptability.

One further point needs to be made. Whereas in the past, in a system that has been recognised as a unitary one, we have had a common policy imposed on all nurses. As a pluralist system with a number of sub-groups, a common policy will no longer be functional. Indeed, we are rapidly reaching a stage where a common policy will be dysfunctional.

Pluralist systems, as Shils and many other writers have found, have consensus and dissensus built in. That is to say, conflict is an inherent part of pluralism. So long as conflict is appropriately managed, it remains dynamic and productive. If conflict is mis-managed, pluralism becomes coercive (of the less well organised groups), the society loses its equalibrium and the system loses its coherence.

We must learn from history and not make that mistake.

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SHARING THE DELIBERATIONS - SUMMING UP THE MORNING PAPERS

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When we first talked about this forum it seemed to some of us that it was going to attract two kinds of people, those who were interested in history for its own sake and those who were interested in using history as a tool in their teaching of nurse learners: in perhaps broadening them, sharpening their critical faculties, encouraging them to raise questions and, I think, in the programme today there has been something for both groups. In summarising these papers I want to focus especially on the second group.

What have these papers offered to those people who want to learn from history and impart the idea of learning critically from history to their students? For this, of course, we have to be able to comment critically, we have to be able to back away from the idea that historical texts are tablets of stone. I think both papers in their different ways have given us an opportunity to do this.

If I start with Monical Baly's paper, I think it is very tempting, listening to Monica, to go away remembering her exuberance, her joy in actually doing history, what she has actually dug out of the records and, if I am not careful, I go away remembering Mr Whitfield and his drinking habits. But if I take myself in hand there is a very serious side to a lot of the things that Monica has explored in those voluminous records at the Nightingale Fund. I think one has to say what painstaking work it really is to use source materials like that. If I could just pull out two or three points, because I think what she has done and what often happens when we take a set of sources which really haven't been explored before, is that she has raised new questions and she has offered new answers to old questions and, as she said herself, what has come out of what she has done is to put the private face, as it were, against the public face of what we thought we knew about Nightingale and about the School at St Thomas'.

What struck me first of all is that she is insisting that what we know as the Nightingale system wasn't something cut and dried; it wasn't something that was ready to be imposed in the first convenient setting that came along. As she insists, Florence Nightingale wasn't even that clear that she wanted to have a training school at all and, furthermore, she and others learnt as they went along. I think she makes it very clear for us, that it was a situation that, after the first few years, had got really badly out of hand and had to be recouped in some way and so came the important shift, which she dates as around 1871, in principles and practices, greater involvement of Miss Nightingale, the arrival of the home sister, the Ladies coming on the scene. So, one of the things that we have to consider for ourselves, is 'is there any such thing as the Nightingale System which one finds in most of the text books?' I think that is an important point to debate and to assess.

What Monica's papers mean, I think, is that we can't/shouldn't lay either all the praise or all the blame at Florence Nightingale's feet. I think she is doing what is a very important task in history, which is grounding the data, as historians put it, in its time and in its place. She has made me think again about some of the things that I have said about Florence Nightingale. I have argued that she made a compromise, that she went in with her eyes open, she knew what kind of compromise she was making. Well, perhaps she didn't, perhaps she learnt over a good few years what kind of compromise it had to be. The big contrast comes with Lucie Seymer's account of the Nightingale School which, perhaps, Monica didn't wish to mention. But I think if we are in situations where we are teaching people, a little bit of a comparison between those two people wouldn't go amiss. So there is this whole question of the Nightingale System and whether we should sensibly talk about it any more?

Next, Monica raises the question of the class of the nurse. Everyone uses that quotation of Florence Nightingale's saying she wanted the daughters of small farmers, artisans, trades people; that she didn't want ladies. We will leave aside the arrival of the Ladies for rather later. I was struck by Monica arguing that the kind of contract was rather like that of one with a servant. Now I'm not so sure that that was actually the case. What came to my mind was more the older style apprentice, the boy who signed his indentures with a master, went to live with the family, had to obey the rules of that family whilst he was learning his trade and who must have been responsible for his moral behaviour as well as imparting a skill. There is an interesting loop here with some of the work that I have done on American nursing. I have in mind a quotation, a very puzzled quotation from an American in the 1790s. She says,

> "It would seem that the nurse in the Nightingale School never graduated in the sense of being placed on her own responsibility. She always remained under the supervising control and authority of the training committee. This idea of pledging oneself in this way is unthinkable to us."

Of course, it is quite unthinkable to us today and, if one tries to bring it forward a little, I think particularly of the period when the NHS was coming into being and the debates in the early days of the Whitley Council about how you looked at pay and whether people lived in and whether you quoted net salaries or whether you didn't and I think there might be something here to talk about in terms of the kind of commitment which was made in the Nightingale School and when that shifted and, indeed whether it did, to a notion of a contract. You only have to read the daily papers over the last week to see that the whole notion that the nurse has a contract or, maybe, a commitment is something that is being debated in Brighton just at the moment.

So, I think what Monica is saying here is the beginning of that debate about what the nurse's contract is really about. And, again, one of the things in history which is so important for us to do, is to understand the models of behaviour and the ideas of rights and obligations which are around in a particular period. If we can get those right then the contrasts raise very relevant questions for us today. Perhaps one of the most striking things that she told us about, is the drop outs, the failures, the sick, the marriages, the deaths and so on. The level of ill health in the hospitals really shouldn't surprise us and as Abel-Smith and many other people have pointed out, it is not until after the 1900s that the chance of survival as a patient in hospital were better than survival at home, though patients who had any choice stayed out. Or perhaps those would-be nurses who had any choice didn't go in for that reason! It does point out of course the need for us to know more about the kind of women who took up this work and that debate that went on with Margaret Verslusen (in the audience) was pulling this out. What other options did women have and why did they come into nursing? It is much harder to do that kind of history than to look at the records of an institution which are there, lurking about. We have to use much more imagination, more subtlety to try and find the records of nurses but I think this is one of the tasks some of us will have to try to move on to and use our ingenuity to try and piece together. Records of nurse leaders perhaps, or ordinary nurses. So, in a way, I have moved on to mentioning what isn't in Monica's account and, perhaps, the last thing I want to say about it is something else that isn't there.

If there was a point in which I was disappointed in Monica's account it was on the question of finance. The Fund she said, presumably saved the governors some money. This, I suspect, was one of the things that it would be really useful to unpack and to see whether it really did save the governors money, and how. We always assume that it did, this was part of the deal, the cheap labour of nurses. What I would like to see someone do is to take the internal mechanics of the

funding which Monica might be able to tell us, is possible, or isn't, and to compare that with the funding of medical education of the same time. What resources were really there, how much better off and in what way and why and with what results. I think the material is around for a comparison of that sort.

Monica then led us very nicely into the second paper by Rosemary White, because she did talk about the legacies of that training school. It wasn't a blueprint for the future but in its vacillation about what the basic grade of nurse was and is, in the lack of facilities for any post basic training, the lack of thinking about that, there is, I think, a direct link with Rosemary's paper.

So, lets take a deep breath and move on to the second paper of the morning. Now that was a very different presentation altogether. The task of history sometimes, I think, is to take a set of resources, as Monica did, amd to ask what we can learn from them but, equally as important, is the task of the historian, sometimes, to step back and take a broader canvass and to try to develop a coherent thread of interpretation across a wide span of years and of events. You can sometimes do that, and it is useful to do that, as a prelude to depth study, indicating to yourself before you get bogged down in the depth, what it is that you really want to look at and look for. You can equally do it, in fact some historians cop-out and don't do it, at the end of an historic study and Rosemary White, I think, is a case of the latter.

I could wish that she had told us some more about the very considerable amount of work that I know that she has done over the last couple of years with 20th century records. She has examined the minutes of committees and sub-committees and GNC and RCN. She has looked at government documents, although, of course, she will have been hampered as we all are, by the forty year rule and had access only to published papers and circulars, and not to those internal memos and minutes with those marvelous marginal annotations on certain peoples' copies which

can tell you so much. So, that she won't have had. What her paper does do is to draw attention to those questions of weighing evidence and arriving at a line of interpretation and, as we saw, a number of people quite firmly disputed the line of interpretation she was taking. I think the key, when one is trying to do this, is the concepts that you use in trying to contain and, hopefully, to clarify the massive data which surrounds us. Concepts, if I paraphrase one distinguished sociologist, are after all, the charts which help us navigate in an ocean of facts. I think what Rosemary did was to abandon the idea that the nursing profession is a useful concept, and I have a lot of sympathy with her since I, too, have struggled vainly with this notion: something called the nursing profession, trying to find it and trying to find how it acted. I'm sure it confuses more than it clarifies. I'm sure we need to look at divisions, what she likes to call sub-systems, within nursing and we need to do that even though at the moment we are operating in a world where we are all supposed to be pulling together and to get the UKCC working and whatever. We are analysing nursing and we don't have to pull together, we have to look very clearly at a lot of the divisions and try to understand them. I think, if I had my time over again, I would focus on the divisions in nursing and stop getting so het up over this thing called 'the profession'. I'm not sure I would focus on exactly the same divisions as Rosemary has, although I will say a word about those in a moment. I think I would crucially try to focus on the divisions between hospital and community. It seems to me that this is of paramount importance at the moment, especially as we are trying in some of the new districts to create organisation structures which blur those divisions between hospital and community and break down the loyalties and the identities which have developed; but there has been a tremendous bias in historial work in nursing towards examining the hospital nurse and confining our enquiries to inside the hospital wards. I have a colleague at Warwick called Marjory Lodge who is working on early 20th century health care arrangements for children under five. When she knew I was coming to the conference she said "Just remember that I want to

know something, will you, about district nursing?" I said, "I bet nobody will mention district nursing." Marjory's problem is that Coventry was an area which was late in providing maternity and child welfare services. There were no municipal clinics; there weren't even voluntary clinics until about 1915 and she has a hunch that the district nurses were doing the job that health visitors were doing elsewhere. She has also come across some 1920s newspaper clippings that suggest that the district nurses were not just doing nursing care, they were giving advice on care of the elderly and on various other topics. So, what was the District Nursing Association? What was it doing? Intriguingly, she has also found out one or two things about fund raising in the district nursing service. She came in one day to inform me that she had found an announcement that 'eggs this week would be taken to a certain address in Coventry' which was the district nursing service, and the following week there was a report of how many eggs had been taken to the district nursing service. It was thought to be something to do with fund raising. But, if someone could enlighten me as to how eggs and fund raising go together I would like to know. I would also like to know about district nursing much, much later on - in the 1950s - when the nurses' home, and the Queens Institute, started to break down and district nurses worked as married women, of course, from their own homes and there were tremendous problems as to how their calls would actually be brought to them and how the administration of the service would work. The fire brigade was involved, in some places, in just taking the calls for the nurses. I think this is something we don't know very much about.

Again, it's difficult, but not impossible, to begin to piece together the history of district nursing. We need some ingenuity, again, in tracing the sources; we need hard work in poring through the professional journals. We need a bit of persistence and persona, I think, because part of the thing to do is to go and talk to colleagues, and talk to retired nurses in this field. Whoever does this job needs a very good understanding of the workings of

local government as a prerequisite of this study and, perhaps, needs to know about that now extinct breed of Medical Officer of Health and his relations to the GP. It's a tough assignment, but I think it's worthwhile, especially because district nursing needs rescuing, needs re-evaluating at this precise point in time, in my view.

So, other divisions than the ones that Rosemary looked at. Another one, I think, which is dear to my heart, is the division between psychiatric nursing and general nursing and that one, because of men and women in nursing. Now, many people are commenting on the men in top posts, after Salmon. I have done a little sum which tells me that the men in district nursing officer posts, after 1982, are proportionately even more than they were in the Salmon days, but I think this badly needs setting into the bigger context of the history of the exclusion of men from top positions, in prestigeous teaching hospitals, in the RCN, in the GNC. I am not justifying or excusing anything by saying this but I am saying we do need to look at the sexual division of labour inside nursing and how it has developed and set that, of course, in a much bigger sexual division of labour in which the doctors are overwhelmingly men, the nurses are overwhelmingly women and the unpaid health workers in the home are overwhelmingly women. I think this kind of work could eliminate these kinds of problems but, its about time I came back to Rosemary's paper which I will do in my last couple of minutes.

The divisions that Rosemary elects to trace are the ones between the registered nurse and the enrolled nurse and between basic training and post-basic. These things are quite as important as the ones I have outlined. The debate is a complicated one, a crucial one and I am looking forward to Rosemary's fuller work to help elucidate it. There is no doubt in my mind that RCN leaders who were at first hostile in the 1930s, had come round to accepting the second grade by the 1940s - I think we are as one on that.

I am also pretty convinced that the outcome in the 1950s-60s was neither planned nor particularly welcomed by anyone: the second grade just didn't grow, student numbers did grow but wastage remained high. I think that what I would want to emphasise, more than Rosemary does, is the role of the Ministry. The Ministry of Health as holder of the purse strings, as ultimately responsible for the new health service. They had two problems:

1. There weren't enough nurses

2. Nursing cost too much

Those two things are somewhat contradictory. I think they fed into each other and in the end they meant a tremendous pressure on the GNC to keep the numbers up - students being cheaper than trained nurses. Keep the numbers up and NOT to impose an entrance test. So, I am hoping that Rosemary's fuller account will include the machinations of the Ministry and the interests, as they look from that point of view, because there is a big issue here that I think was coming out of some of the questions from the audience as well as coming out of the accounts. History does evaluate, in both of the papers, but especially in Rosemary's. I think there are a number of comments:

Did nurses see? Did they not see?
Did they judge well? Did they judge badly?
Could they have acted differently?

The important thing here, I think, is to balance this out. We do, I think, in historical accounts, need to make these judgements but we also need to see them in their context:

What were they up against at the time?
What kind of constraints were faced?

I would like to pull out a little quotation from the Athlone Report back in 1939 to point out to you what I think nurses were up against:

> "It is abundantly clear that some means must be found to replace the existing haphazard system of recruitment. What is required is a regularised and ordered system of recruitment, in which the national needs receive equal consideration with the needs of the individual training hospital."

Athlone's consideration came to an end because of the war but that, it seemed to me, was saying 'GNC beware - nursing is too important to be left to the nurses.' I think that in our debate of what nurses did do and didn't do, we must bear this in mind.

Finally, I think we also have to note whether or not nursing is a mass society, as Rosemary says. Nursing is certainly a massive occupation. The vast majority of NHS employees are the nurses, the biggest slice of the budget goes to nursing; there are complicated divisions between grades, types of work, settings of work. The problems of those who try to lead this unweildy nursing profession are unique because of this massive character. The task is daunting, it is different from medicine, from para-medical specialities, and one of the tasks on us as researchers and teachers in this field, is to play a role in acknowledging this, in creating an awareness of the complexity of the problems that the leaders in such a massive occupation as nursing are trying to grapple with. History is perhaps one way of generating this awareness, generating discussion of the issues and, perhaps, now and then, trying to clarify it.

So, we have had two very different papers about very different periods, reflecting different stages in the overall enterprise of doing historical work. Both, for me, sparked off a lot of thought but my comments won't be the same as yours and what I am hoping very much is that after lunch, when you form discussion groups, we can continue with discovering what it is that people want out of history, what kind of historical papers we can most usefully write, what sort of tasks we can address ourselves to. I hope you will continue to discuss these papers, over lunch and into the afternoon session.

NURSING AS HISTORIOGRAPHY

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Years ago in the arrogance of innocence I wrote a paper entitled 'Towards a Social History of Nursing' in which I suggested that a critique of nursing was the proper concern of the social historian and by implication, the socialist historian. Such an approach did not argue only for history from below or of the the rank and file and I went out of my way to suggest that a full critique could only emerge if it included a study of elites, a study of the power relationships within the occupation. We need, that is, to look at the leadership but I would argue that we need to look at them not only in a re-appraisal manner but rather in a fundamentally different way: a theme I shall return to later.

That early paper did argue, however, for a new approach to the study of nursing history, one which bore some relationship to current concerns and debates within history and society. Since that time many others appear to agree with my basic point, although I cannot claim to have inspired anyone of them. They, like me, see a need for a new history and they, like me, are products of the turmoil within the social sciences and history which followed on from, and were created by, the political upheavals of the 1960s.

I have no intention of making another claim for a particular discipline today: indeed, in an interesting aside in a position paper to the Peer Group, Malcolm Newby pointed out that the work of the uninitiated, the unorthodox local study may well help to form the new orthodoxy, the new historiography of nursing. What I do hope to do is to suggest some of the ways in which the teacher and the researcher can situate nursing history as a social event, instead of an anachronistic side-show.

Put at its most simple, historiography is the writing of history: if I therefore explain to you what I mean by historiography, give you a few examples and illustrations, point out some possible projects or concerns, then I will have fulfilled the expected mandate of my title. While I certainly intend to do that, I also want to suggest that historiography means something more than the writing of history: to argue that in writing history we also make it and, that is not only a social action but a political one as well.

Let us stay with the simpler statement for the time being, however. For most of you I suspect that one of the first places you would look for an example of nursing history would be either a study of a particular hospital and its nursing school, (say Brockbank's study of the Manchester Royal Infirmary, or Anning's study of Leeds Infirmary) or it might be a study of the life of some notable like Nightingale, Jones, Fry or Fenwick: or, perhaps, more adventurously, you might choose a study like Abel-Smith. The point I am making is not perjorative; there is no reason why you should not go to one or all of these studies. What I am suggesting is that such studies have, or have acquired, a status beyond their merits or original intentions, a status which has implications for a critique of nursing.

To take one, easy, example, which Celia has dealt with more fully in her articles recently, Abel-Smith's book A History of the Nursing Profession; that work has become, to the point of mis-quoting, THE HISTORY of nursing, something which even Abel-Smith would balk at. The reader could learn from that work how it was that this occupation came to be so divided over status and the means of achieving legal recognition; how the occupation became class-divided, between the voluntary and poor law nurses and between even their patients; how the State was a reluctant party to the debate over regulation and registration, until perhaps the first socialist government after the second world war. But the reader would never guess that Abel-Smith was arguing for one of several interpretations of the events he cites in evidence - the confident statements within the book appear to countenance no argument or discussion, nor are alternative explanations even alluded to, and nowhere is any statement which sets out the author's conceptual framework or problematic.

In the opening pages of his book, Abel-Smith offered two important comments on his own work contained in that book. First, he pointed out that he was concerned with the politics of nursing, and not nurses or nursing; he was concerned with the struggles between competing elites, the role of the state in social administration and welfare and the potential role that pressure groups might play in formulating policy, even if he hardly said so in so many words.

Second, he wrote that illness creates dependency. At first sight a powerful insight into the complexities of relationships which are produced around the notion of health/ill health, especially since the second part of his statement reads that, as a consequence of that dependency, "the sick need not only medical treatment but personal service". The role of the nurse was thus self-evident (1976, p.1).

However, nowhere else in that remarkable book does the author return to this second theme and the first is only presented as a series of chronological events with little 'interpretation' (p.240). Even when the author claims to be providing a 'tentative explanation and modest evaluation' of his highly selective 'facts', the reader is once again presented with description and with unsubstantiated value-judgements. I cite only one, one which really is untenable, and irritates me beyond belief. Talking about the hang-ups, within the occupation, about wastage rates, Abel-Smith writes,

> "Indeed, the use by the profession of the word 'wastage' represents an attitude which is not necessarily far-sighted. Training as a nurse, even if incomplete, has some value as a preparation for motherhood and the profession might be as well advised to draw attention to this aspect of it as to imply that it is a preparation for a life-long career. Nurse training is also a preparation for citizenship received by about one girl in twenty. She can gain from it something analogous to what young men gain from national service: some discipline, some corporate life and some sense of responsibility to the community. It is not necessarily wasteful for so many families to have a mother or aunt equipped with some knowledge of nursing" (p.250).

Such statements are the source of history for the historian when they appear in the rhetorical pronouncements of the reformers of the nineteenth-century; they may be uttered by the apologist of today in recruiting campaigns; they may have elements of verifiable sense in them but they have no place in a history unless they can be substantiated. Where is the evidence that

producing wives/nurses through nursing training acts towards a cohesive social organisation? Where indeed are the male nurses in all this? Are they to be made better fathers and should not national service be dropped in favour of nursing, in order to produce non-aggressive males? It is really too much to palate.

The illness as dependency notion is also not developed, nor is it attributed to anyone else; Shaw wrote that all professions are a conspiracy against a laity - the same sort of idea and at least 50 years before Abel-Smith. Indeed, that notion has a longer but, perhaps, not antiquarian, history. It was not the modern social administrator attempting to influence social policy nor the proto-utopian socialist playwright who invented the idea but, perhaps, their direct predesessors, the emerging middle classes of the eighteenth- and nineteenth-centuries. Defoe, the earliest exponent of individualism in literature used it, as did Richardson. These writers were part of the section of society for whom individualism was paramount and for whom loss of self could be disastrous economically, socially, psychologically and politically. It was this group who most feared illness and having to entrust the care of self to another, as we can all read in Martin Chuzzlewit. This class turned the compassion of humankind into the exploitative 'natural' humanity of women alone and who eventually sought to take even this function away from its own wives, daughters, sisters and mothers and place it in the hands of the new order of paid workers, moulded to their own ends through nursing reforms.

The contribution of Abel-Smith's book should not be forgotten, if only because by looking at the 'events' in a different way he got completely away from the traditional hagiography of previous studies. But its short-comings must not be ignored either, nor, as Celia Davies has already pointed out, its inherent dangers for the reader of history. I cannot help feeling that it is a bad piece of history. If we are to take the printed page at face value and how else are we to follow an author's argument, the evidence for many of Abel-Smith's statements (note, I use the word statements and not arguments) comes from a few well-thumbed sources, including Parliamentary Papers, nursing and medical journals, with the occasional addition of 'personal communication' - for example, the Nurses

Social Union - or almost untraceable typescripts written by burrowers who never surfaced into print.

As a piece of historiography, in the simpler sense in which I have been using the word, I judge it to be bad and offer one last but not necessarily final, proof. Between the date of first publication of that book (1960) and the last two or three years of the 70s interest in nursing history, as seen through published material, was non-existent or virtually so. It was as though, having said that we must not rely on the biographies of the reformers for our understanding, Abel-Smith was saying that all we had to do was look at the interplay between groups of reformers etc., to better know the past and influence the future. One type of total explanation replaced another.

How little had Abel-Smith progressed: in the years before him, when the flood of biographies and institutional celebrations appeared, they too seemed to be the answer to our questions, the gaps in our knowledge of facts. All we needed it seemed, was to know where the Nightingales had gone on their heroic missions (Monica), where the preliminary training schools had been set up, where the best matrons had fought to impose the new nursing order; if we knew that, then we would know all about nursing history. The questions were determined by the studies produced, which in turn determined the type of material produced: yet other local hospital histories or revamped biography.

The sense of finality which such 'histories' generate stifles the imagination far more than they excite the passion. Even allowing that the life of Agnes Jones might have persuaded someone to write the life of some matron or other - or worse, some matron to write her own - the method, the style, the questions never altered. Nor, indeed, did the function change, nor was it articulated or challenged. Nursing history was about filling in the past for the present reader, to inform the present of the means by which the pioneers had brought about the system they had. No wonder, then, that tutors and students were equally bored silly by the story - note the word - the story of nursing as a profession - FN in the Crimea, Fry in Hulks, Acts and Reports ad nauseam, nasty Mrs Bedford Fenwick and, the crowning achievement, state registration. No wonder is it that it no longer appears on many training programmes - except at 'O' level.

There is and must be a role for this sort of material but, if we continue to make it either so dull or so heroic, what function can it serve other than to fill up a compulsory part of a syllabus or timetable or act as a sort of holy grail for a less committed and hardly altruistic group of modern workers.

I want now to suggest one way in which we might turn things on their head, to contemplate nursing history not at the centre of concern but as a factor, a variable. One way, that is, that a new style might be forthcoming.

If any of you have read Brockbank's study of the Manchester Royal Infirmary or Anning's of Leeds Infirmary or any of the countless other similar studies of hospitals and their nurse training schools, you will, I am sure, have been struck by the mass of detail present. There are usually long lists of rules and regulations, detailed accounts of nurses' duties drawn from Minute Books, cases of nurses being disciplined and references to pay and conditions of service and pensions. There is also the usual bit about the state or relationships between succeeding matrons and the doctors and the lay administrators, with the matron looming, metaphorically and actually, large in her battles for control over nurses (not nursing).

How might it be, however, if we did not regard the hospital as an institution revolving around a medical model or metaphor - a place of healing - but around an industrial one? How would we need to adjust our questions about nursing if we regarded the hospital as a firm, a complex somewhat eccentric firm, but a firm nevertheless. With a product-management system, a financial network, owners and shareholders of capital, groups of workers, etc. Certainly such an approach is not new in the social sciences today and many studies of present systems take such an approach. Why, then, should we not address similar questions to the past; one simple and immediate reason for actually doing so is so that the past may engage itself in discourse with the present under a common language.

If we took such an approach, we would engage ourselves in questions which make sense to us; we would understand the competition for labour which underlay so many apparently ad hoc decisions in individual hospitals to reduce the age of entry to training and, incidently, allow us to dismiss sentimentalism like that which pervades Abel-Smith (see his bit about your girls caring for the dying etc).

We would have to confront, head-on, questions about the nature of nursing and nurses' roles; the historian could join in the debate about the nursing process and definitions of health and illness. We could engage in cross-cultural comparisons about ways of care, including the role of the family. We need to understand the dominance of the hospital as an institution and nursing in hospitals as the apex of a heterogenous occupation: why was it that cost-conscious subscribers and rate-payers supported the setting up of so many hospitals rather than using community arenas? It may be that the hospital had some advantages; training etc. but remember that throughout the nineteenth-centurey industrialists in Britain did not develop massive factories for the production of their goods - the large scale factory movement was a sporadic, incomplete and late development. Why was the concentration of the hospital so important? Was it merely in order to maximise the services of medical men? But how could that be cheap, when the administrative ancillary services, which developed to support that system, outreached the costs of medical services?

We need to see nursing in other contexts than hospitals, of course, but not only in the way we tend to do at the moment, when we say 'yes' but what about the village nurse or the charity nurse working? We do not only want to insert such workers into history, although even that would be a step forward; we need to use their absence to challenge existing questions, we need to use them to erect our critique, and we need, as Michael Carpenter has pointed out, to set them and other nurses in the mainstream of debate.

Nursing history as historiography; writing nursing history, or is it? Even if we rewrite nursing history, even if we write in a passionate way but stick to presenting nursing history as only the history of nursing, we shall end up like the hagiographers of the past and the Abel-Smith's of recent years, accused of offering yet another final history, and boring our audiences out of their inquisitiveness and their imagination. The new historiography of nursing will not be about nursing history; the new historiography will situate nursing in its culture and in its context.

The historiography of nursing will be engaged in present debates and not isolated on some antiquarian plain. If nurses are being asked to re-evaluate their altruism, in the light of structural changes and the competition for reducing resources, if nurses are to engage in that struggle, they must take themselves out of the narrow confines of their 'sub-system' and enter the social arena. Nursing history - if we still wish to keep the heading - will contribute to our understanding of genderisation, patriarchy, class struggle, elite relationships, control and mobility of labour, and so on. Nursing history will, like nursing itself, be part of society and its critique.

But to return to my earlier point; there is still a need for what I have in the past called micro-studies of nursing. We need to know about hospitals and their inmates, including nurses; we need to know about the matrons and the sister-tutors, indeed, we know very little about these people at the sharp end of practice. But in doing so we need to put that knowledge in its set of concerns: a study of a group of matrons can only enhance our debate over generalist versus specialist, which Rosemary touched on today. Did local concerns temper the rhetoric of the reformers? Was discipline so important in producing a tractable workforce and why?

So those of you who are engaged in history, as researchers or teachers can continue to use the old history as well as look to the new. But, and this must be two buts really, both of them very big, you must be aware of what it is you are about. I therefore end by making a call to training for the teacher and for the researcher. If we are to fully

understand what I have simply referred to here as contexts and matrices, we need some basic questions to address to our material. Those questions can only come from a knowledge of the processes of social change and are therefore to be found in history itself. The teacher or the researcher of nursing history needs some form of experience in historical method; even down to the basic skills such as correct footnoting - pace Abel-Smith - or of the technique of at least acknowledging that the source or analysis you are offering may have an alternative explanation or that there exists a different body of analysis.

Such skills may be obtained incidentally through the act of reading or even researching, as the Peer Group here is showing. Formal training is already available through OU courses and WEA courses; but I would argue that the occupation has a duty and responsibility to offer that training as well; the RCN, the Unions and the King's Fund must all contribute to that consciousness raising exercise.

Conclusion

To conclude I want to put three short ideas forward; first, those engaged in the work of nursing, at all levels and in all arenas can be encouraged to engage in nursing history, but only if they can see some role for it. It is up to those researchers and teachers already interested in the occupation's past to begin to work towards discovering that role and thus inspiring others to criticise and develop their questions and demands of the past. The ordinary worker is an active agent in the making of their own existence and they therefore make their own history. Whether they are ward sisters, auxillary nurses in community care or matrons; they should be encouraged to see their role as agents.

Second, I am a little surprised and disappointed that only one person wanted to look at the use of oral testimony either as a teaching aid or as a research resource. Rosemary has pointed out how a re-reading

of existing Reports and Commissions can offer alternative interpretations of apparently straightforward events; how much more insight would we have into her topics, and others like it, if we could interogate the protagonists, the people who gave evidence, the members of the committees, the writers of the Reports. The Americans have recognised this important source for nursing history and there is at least one major study completed, using the oral interview combined with traditional sources of nursing leaders in the USA. Oral interviews are not only about talking to ninety year old ex-nurses remembering how it was all different in the past and how easy the present nurses have it; oral testimony provides new insights and asks new questions and the results can offer fundamental criticisms of apparent truths.

Finally, we need to engage in debate. There is no point in individuals doing discrete pieces of work, no matter the nature of their intrinsic work, unless those works are published and subjected to reasoned criticism. At the moment anyone wishing to engage in debate is virtually forced into one of the long-established (or indeed newly established) journals such as BJS or Victorian Studies or into journals which are broadly called Journal of Nursing Research, etc. Those publications are crucial to my point about setting nursing in the major concerns of scholarship, but they have a limited market and limited source of material. For the researcher or teacher in nursing history a new forum is needed, one in which the micro-studies can be tried out, or even where they can help to form a body of information which the contributions to other types of journals can draw upon. There is, I would argue, an awful lot of talk about nursing history but little empirical data produced to justify some of that talking. A new journal, aimed at the occupation and at the educationalists, as well as at the academic market, is long overdue.

Nursing as historiography was the title of my paper and I deliberately said it that way rather than nursing historiography. The writing of nursing history is part of the writing of history itself and contributes to our understanding or questioning of our society. If we merely write about nursing we shall contribute little or nothing to that understanding; if we teach others nothing other than what has so far been written, then the past will not appear to belong to them but to some other group. We owe it to ourselves and to our colleagues to write the new whilst we interogate the old; we owe it to ourselves and to them to question what we feel, perceive and are told.

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