

LOCAL NURSING ASSOCIATIONS IN AN AGE OF NURSING
REFORM, 1860-1900

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ABSTRACT

This thesis examines the establishment and work of local nursing associations in provincial England between 1860 and 1900. It challenges the conventional idea that nursing reform was a hospital based phenomenon. Reform was supported by urban elites, people with strong religious convictions and medical practitioners. In addition, associations helped to facilitate the entry of women into management in both voluntary and paid positions. This research indicates that nursing reform took place alongside other initiatives that aimed to train working-class women to be useful and obedient servants in private homes. Associations aimed, in part, to reform the lives of the working classes through the training of district nurses who were expected to give instruction regarding health, as well as caring for the sick. The establishment and subsequent form of associations was dependent upon local conditions and circumstances. An analysis of the success and failure of local associations in reforming hospital nursing, caring for the sick poor and competing in the medical market for private patients is undertaken. The influence of class relations, religion, gender, place and individual agency in the formation of associations, the employment of nurses and the practice of nursing are discussed.

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1. INTRODUCTION: HISTORIOGRAPHY, SOURCES AND METHODS

On 9 December 1868, a ‘large and influential’ meeting, including many ladies, was held at the Plough and Harrow hotel in Edgbaston, Birmingham to consider a proposal to establish a nurse’s training institution to provide trained nurses for hospitals and private families.¹ One of the ladies present was Rebecca, an unmarried member of the Kenrick family who were industrialists and Unitarians. Rebecca, born in 1799, spent her life helping the family when needed and participating in philanthropic work.² For her, the establishment of such an institution for Birmingham was ‘a thing I much rejoice in’ and in January 1869, when she was taken ill, the attendance of Jane Watton, a nurse from the new institution, was ‘a great comfort to us all’.³ Clearly, the advantages of employing trained nurses had come to the attention of the urban elite.

Over 130 years later, when I undertook two studies on the history of hospital nursing in Birmingham,⁴ I came across this very organisation known as the ‘Birmingham and Midland Counties Training Institution for Nurses’ and it appeared that no one had ever examined its work. This institution was the first initiative introduced in the city for the training of nurses. Once trained, these women were employed in the homes of both the rich and poor within the city and beyond. On further investigation, I found that few

¹ ‘Proposed training institution for nurses’ *Birmingham Daily Post*, 10 December 1868; London Metropolitan Archives ‘Birmingham Training Institution for Nurses’ printed document, December 1868 (H01/ST/NC/18/009/041)

² L. Davidoff and C. Hall *Family fortunes: men and women of the English middle class, 1780-1850*, 2nd Edition, (London, 2002), p. 435.

³ Birmingham Archives and Heritage (hereafter BAH): ‘Diaries of Rebecca Kenrick, 1839-1889’, Volume 2, 10 December 1868 & 28 January 1869 (MS 2024/1/2)

⁴ S. Wildman ‘The development of nursing at the General Hospital, Birmingham, 1779-1919’ *International History of Nursing Journal*, 4, 3, 1999, pp. 20-28; S. Wildman ‘The development of nurse training in the Birmingham teaching hospitals, 1869-1957’ *International History of Nursing Journal*, 7, 3, 2003, pp. 56-65.

people connected with the history of nursing were aware of the existence of similar institutions nor was the presence or contribution of these organisations, in the development of nursing, addressed within the literature. Further searching revealed that upward of 150 associations were established, during the nineteenth century. Although the first was in Liverpool in 1829, all others date from the 1860s onward, and records of a number of these associations, from the middle of the century, survive in local and county archives.

The aim of this study is to add significantly to current understanding of the history of nursing in England, specifically with nursing reform during the middle decades of the nineteenth century. Following a thorough examination and analysis of the records of a number of local nursing associations and institutions, the study demonstrates that a important movement towards reform of nursing took place in English provincial towns and cities during the 1860s and early 1870s. This was independent from the hospital, where changes were also taking place. This reform was an extension of local philanthropic effort aimed at providing nurses, for both the rich and the sick poor, in their own homes and in most cases was in advance of hospitals in the locality. This is contrary to the traditional view that the impulse for reform came from London, was initiated by Florence Nightingale in particular, and was situated in the hospital.

Historiography

The origin and history of modern nursing is a subject that has occupied the energy of a number of professional nurses and historians since the end of the nineteenth century. This section surveys the ways in which the history of nursing has been represented and the apparent neglect of local initiatives in the narratives of the history of nursing. The choice of associations for study, the nature and availability of sources, and the methods of analysis undertaken are also addressed. For much of the period up until the 1980s, a Whig progressive account of the history of nursing dominated the writings of many nurses based on the concepts of modernisation and professionalisation. This version of history utilised an approach that emphasised the importance of training, science, order, morality and of female calling on one side and a rejection of nursing's 'dark' past, typified by the supposedly drunken, ill disciplined and incompetent nurses of the pre-Nightingale era, on the other.⁵ The emphasis of much writing in the past has focused on significant individuals and their contribution to the improvement and modernisation of nursing. The numerous biographies about Florence Nightingale are only the most common example, but other individuals such as Dorothy Pattison (Sister Dora) have achieved similar celebratory status.⁶ Sarah Tooley, in one of the first history of nursing texts, gave significant biographical detail and career histories of matrons associated with the London training schools and this trend has continued until recent times.⁷ For Salvage, this resulted in the history of nursing being

⁵ C. E. Rosenberg, 'Review article: recent developments in the history of nursing' *Sociology of Health and Illness*, 4, 1 (1982), p. 86.

⁶ M. Lonsdale, *Sister Dora: a biography* (London, 1881); J. Manton, *Sister Dora: the life of Dorothy Pattison* (London, 1971).

⁷ S. Tooley, *The history of nursing in the British empire* (London, 1906); See also P. Arden, *When matron ruled* (London, 2002). A more analytical study of the contribution of individuals is S. McGann, *The battle of the nurses* (London, 1992).

presented as a pageant of great and saintly ladies, and as progress from gloomy Dickensian beginnings to our current state of supposed enlightenment.⁸

In this celebratory discourse, reform took place in the hospital, originated in London and was then rolled out to the rest of country, the empire and the rest of the world.⁹ Many nurses were taught that reform could be dated to 1860, when the training of probationers first took place at St Thomas's Hospital in London, under the auspices of the Nightingale Fund, later known as the Nightingale School. Trained nurses from here were, it is said, sent to other hospitals to reform nursing.¹⁰ Thus, London was identified as the centre of reform, and the hospital as the location in which this reform took place.

The development of nursing in nineteenth-century Britain reveals a more complex story than is conveyed by this simple narrative. Rather than the history of nursing being a linear progression towards the creation of a uniform system of nursing in hospitals and within the home, there was a plethora of organisations and individuals involved in the provision of nursing care for the population.¹¹ This included private nurses, monthly nurses, local handy women and private 'for profit' organisations who took direct payment from their patients, as well as individual philanthropists and local and national religious, and charitable organisations that promoted improvements in patient care, nursing and nurse training. The latter included the voluntary hospitals. As a result, nursing varied

⁸ J. Salvage *The politics of nursing*, (Oxford, 1985), p. 32

⁹ The first history that produced such a grand narrative was Tooley's *The history of nursing in the British empire*. Other typical British examples of this approach are L. R. Seymer *A general history of nursing*, (London, 1932); and A. E. Pavey *The story of the growth of nursing*, 4th Edition. (London, 1953). Histories conforming to this pattern continue to be published and twenty first-century examples are Ardern, *When matron ruled* (London, 2002) and C. B. Carruthers and L. A. Carruthers *A history of Britain's hospitals and the background to the medical, nursing and allied professions* (Lewes, 2005)

¹⁰ L. R. Seymer, *A general history of nursing* (London, 1932), pp. 121-25.

¹¹ R. Dingwall, A. M. Rafferty and C. Webster *An introduction to the social history of nursing* (London, 1988), p. 18.

between different institutions and in different geographical locations. However, by the end of the century, the hospital became synonymous with concept of the trained and skilled nurse.

Why did the hospital become the arena in which the history of nursing was seen to have been played out and where modern nursing, as recognized in the twentieth century, originated? The ‘distorting prism of hindsight’¹² has put the hospital at the centre of the history of both medicine and nursing. The voluntary hospital became the focus for the training of nurses under the strong leadership of middle-class lady superintendents from 1856 when the religious order of St John the Evangelist (usually referred to as St John’s House) took over the nursing and domestic arrangements of King’s College Hospital.¹³ This coupled with the Nightingale initiatives resulted in the hospital being viewed as the origin for the experimentation, modernisation and professionalisation of nursing.¹⁴ Prior to this time, the reform of nursing was initiated to provide skilled nurses, chiefly, in the homes of the middle and upper classes.¹⁵ For generations of nurses, from the late nineteenth century onward, the hospital was the first place in which they gained knowledge and learned the practical craft of their trade. With the development of hospital leagues or nurses’ associations, based upon the training school founded in the late nineteenth and early twentieth centuries, most interest from nurses themselves seems to have been focussed on training schools and hospitals. Just as important, many of the most

¹² J. Harris, *Private lives, public spirit: Britain 1870-1914* (London, 1993), p. 2.

¹³ The religious sisterhoods have been identified as the ‘leaders of nursing reform’ by C. Helmstadter and J. Godden, *Nursing before Nightingale, 1815-1899* (Farnham, 2011), p. xiv.

¹⁴ A. Summers, ‘The costs and benefits of caring: nursing charities, c1830-1860, in J. Barry and C. Jones (eds.), *Medicine and charity before the welfare state* (London, 1991), p. 145.

¹⁵ E. Jordan, *The women’s movement and women’s employment in nineteenth century Britain* (London, 1999), pp. 127 -133.

influential women engaged in the protracted debates about nursing registration from the 1880s onward and the campaign to establish the College of Nursing in 1916 had been employed as lady superintendents or matrons in the major voluntary hospitals, particularly in London.¹⁶ Thus, the most vociferous and powerful interests in nursing were based in the hospital. In the twentieth century, it became the dominant place in which patient care was delivered and it was therefore understandable to associate the hospital exclusively with the development of nursing and nursing reform.

Part of the reason for the focus on the hospital has been the strength of the Florence Nightingale narrative in the history of nursing. For many people, nurses especially, the history of nursing is dominated by this iconic figure and the story of her work in the Crimean War and the subsequent founding of the school of nursing at St Thomas's Hospital. Her presence and personality has dominated accounts of the history of nursing, partly due to the fact of her impressive record in all aspects of health reform, but also from her legendary status, achieved during the Crimean conflict, as recorded even in verse:

Lo! In that house of misery
A lady with a lamp I see
Pass through the glimmering gloom,
and flit from room to room

A Lady with a lamp shall stand
In the great history of the land,
A noble type of good,
Heroic womanhood.¹⁷

¹⁶ S. McGann *The battle of the nurses* (London, 1992), pp. 1-6; S. McGann, A. Crowther and R. Dougall *A history of the Royal College of Nursing, 1916-90: a voice for nurses* (London, 2009), p. 11.

¹⁷ These are two of the verses from *Santa Filomena* by Henry Wadsworth Longfellow published in the first edition of the *Atlantic*, a monthly magazine, in November 1857, some 21 months after the end of the Crimean War.

Nightingale's heroism is said to have rescued nursing from its poor reputation of the past and 'she was a perfect vehicle whereby nursing could lever itself into an acceptable occupational status and integrate itself into society as a respectable work role.'¹⁸

However, there has been much controversy regarding her place in reform even at the time of Queen Victoria's Diamond Jubilee Celebration in 1897. A history written by a nurse, Miss Breay, places Nightingale as the founder of a modern system of hospital nursing, whilst an anonymous article in the *British Medical Journal* accredits the St John's House sisterhood with its establishment.¹⁹ In the twentieth century, uncritical hagiography was challenged by accounts that questioned Nightingale's achievements, motives and character, beginning with Lytton Strachey in 1918.²⁰ Later, F. B. Smith's influential, but hostile account,²¹ described as 'character assassination masquerading as a serious history' based on misogyny and 'snide debunking',²² is said to have adversely influenced the views of many historians of nursing.²³ This produced much subsequent debate about her role, resulting in a spirited defense of Nightingale's record by Lynn McDonald.²⁴ The controversy concerning Nightingale's character is not central to this study; but how the dominance of her place in history has focused attention on the hospital and London as the

¹⁸ E. Whittaker and V. Olesen, 'The faces of Florence Nightingale: functions of the heroine legend in an occupational sub-culture' *Human Organization*, 23 (1964), pp. 125-6.

¹⁹ M. Breay 'Nursing in the Victorian era', *Nursing Record and Hospital World*, 19 June 1897, p. 496; 'The nursing of the sick under Queen Victoria' *British Medical Journal*, 19 June 1897, p. 1646. A full discussion of the differences between the two authors can be found in K. Williams, 'From Sarah Gamp to Florence Nightingale: a critical study of hospital nursing systems from 1840 to 1897', in C. Davies (ed.), *Rewriting nursing history* (London, 1980), pp. 41-75.

²⁰ L. Strachey, *Eminent Victorians* (London, 1918), pp. 119-170.

²¹ F. B. Smith, *Florence Nightingale: reputation and power* (London, 1982).

²² M. Bostridge, *Florence Nightingale: the woman and her legend* (London, 2008), p. 542.

²³ L. McDonald, *Florence Nightingale: The Nightingale School*, Collected Works of Florence Nightingale, Volume 12 (Waterloo, 2009), pp. 31-36; L. McDonald, *Florence Nightingale: extending nursing*, Collected Works of Florence Nightingale, Volume 13 (Waterloo, 2009), pp. 9-11.

²⁴ L. McDonald, *Florence Nightingale: an introduction to her life and family*, Collected Works of Florence Nightingale, Volume 1 (Waterloo, 2001), pp. 843-847; L. McDonald 'Mythologizing and de-mythologizing', in S. Nelson and A. M. Rafferty (eds.), *Notes on Nightingale: the influence and legacy of a nursing icon* (Ithaca, 2010), pp. 91-114.

cradle of modern nursing is significant in the way that almost all other initiatives have been subsumed under this one pervasive narrative. In addition to being associated with the hospital as a result of her war service and work with the Nightingale Fund, she advocated that nurse training could only be undertaken in the hospital when advising all those who sought her opinion.²⁵ The literature concerning the foundation of district nursing also illustrates the dominance of London as the perceived centre of nursing reform. Although the development of district nursing is attributed to developments in Liverpool in the early 1860s, histories of the practice tend to concentrate on the London-based National and Metropolitan Nursing Association founded in 1874 and the Queen Victoria Jubilee Nursing Institute of 1887, whilst earlier provincial initiatives have been neglected.

Criticisms and concerns regarding traditional narratives of the reform of nursing started to be voiced in the late twentieth-century. According to Anne Marie Rafferty, nursing history, until the 1960s, was dominated by writers who used history to justify professionalization.²⁶ This can be seen in textbooks about nursing practice aimed at students, as well as those specifically written about the history of nursing.²⁷ Many of the early history texts were written by nurse reformers and their supporters, particularly those who promoted the idea of reform and registration.²⁸ For instance influential authors such

²⁵ This is discussed in chapters 4 and 6.

²⁶ A. M. Rafferty, 'Historical Research', in D. F. S. Cormack (ed), *The research process in nursing* (Oxford, 2000), p. 207.

²⁷ Examples of nursing texts include: D. H. Scott and M. Hainsworth, *Modern Professional Nursing*, 3 vols. (London, no date but c.1940s), Volume 2, pp. 182-5; W. T. G. Pugh, *Practical nursing* (Edinburgh, 1958), pp. 1-3; E. R. D. Bendall and E. Raybould, *Basic nursing* (London, 1970), pp. 8-13. History texts include: G. Bowman, *The lamp and the book: the story of the RCN: 1916-1966*, (London, 1967), pp. 5-10;

²⁸ A. M. Rafferty, 'Historical Perspectives', in K. Robinson and B. Vaughan (eds.), *Knowledge for nursing practice* (Oxford, 1992), p. 27.

as Lavinia Dock, from the USA, worked closely with Ethel Bedford-Fenwick, the chief protagonist for nurse registration in Britain, in order to promote internationalism through the International Congress of Nursing, women's rights and nursing reform.²⁹ Dock, in collaboration with Adelaide Nutting, wrote a history of nursing in four volumes between 1907 and 1912 which influenced the subsequent historical writing about the history of nursing on both sides of the Atlantic.³⁰ The British texts that followed were said to have been used to socialize new entrants into the profession and to help distinguish the trained nurse from the women who had claimed the title before the nursing reforms of the mid-nineteenth century.³¹ In the USA, Janet Wilson James referred to conventional accounts of nursing history as 'reflections of the profession's view of itself' and a more recent view is that these have been 'dominated by nursing politics'.³² Salvage saw traditional accounts of history as having

served a more political purpose by being used as a form of social control, reinforcing certain strands and beliefs in a tradition which has done little to protect or enhance the interests of the rank and file nurse.³³

In traditional texts, in both countries, the style of writing was congratulatory and based upon the concept of progress, a feature of most historical accounts of professional development as seen in other occupational groups such as medicine.³⁴ These were often

²⁹ Ibid, p. 28.

³⁰ L. Dock and M. A. Nutting, *A History of Nursing* (4 volumes, New York, 1907-1912). A shorter history was published later – L. Dock and I. M. Stewart, *A short history of nursing: from the earliest times to the present day* (New York, 1920).

³¹ S. Nelson, 'The fork in the road: nursing history versus the history of nursing' *Nursing History Review*, 10 (2002), p. 177.

³² J. Wilson James, 'Writing and re-writing nursing history', *Bulletin of the History of Medicine*, 58 (1984), p. 571; Helmstadter and Godden, *Nursing before Nightingale*, p. xi.

³³ Salvage, *The politics of nursing*, p. 33.

³⁴ R. Porter and A. Wear 'Introduction' in R. Porter and A. Wear (eds) *Problems and methods in the history of medicine* (Beckenham, 1987), pp. 1-2; L. Granshaw, 'Introduction'. In L. Granshaw, and R. Porter, R, (eds.) *The Hospital in History*. (London, 1989) p.1; C. E. Rosenberg *Explaining epidemics and other studies in the history of medicine* (Cambridge, 1992), p. 1; J. Reinarz 'Medicine and society in the

simplified versions of history that did not recognise the complexity of events, economic realities, social conditions and the role of religious and social movements within the nineteenth century. Insufficient regard was often given to the wider context within which nursing operated. For instance, the dramatic rise of wealth in Britain gave more people the ability to purchase better health care and stimulated a demand for skilled medical practitioners and private nurses.³⁵ Furthermore, the rapid increase in the population of nineteenth-century British cities and towns and the subsequent poverty associated with the industrial revolution and urbanisation were instrumental in the development of both hospital and community services for the sick poor, through voluntary philanthropy and the government's Poor Law services. The prevailing attitudes towards poverty, class structure and the relationship between the classes also affected the way in which services were developed and operated. In addition, the pivotal role of religion, particularly evangelicalism, within everyday life of the middle classes influenced the nature of philanthropic effort and in this case, the nature of nursing services offered to the poor. Finally, studies of nursing failed to acknowledge the changing role of women in society and the influence of gender on the development of professional nursing.

The first break with the traditional narratives of nursing history came in 1960 with the publication of Brian Abel-Smith's *A History of the Nursing Profession*, a political and organisational history of nursing, based on a thorough use of primary sources, which firmly situated its development in the middle of the nineteenth century. However, this

midlands, 1750-1950: Introduction' in J. Reinartz (ed.) *Medicine and society in the midlands, 1750-1950* (Birmingham, 2007), p. 1.

³⁵ A. Digby, *Making a medical living: doctors and patients in the English market for medicine, 1720-1911* (Cambridge, 1994), p. 43.

account, like many others emphasised the London hospitals. In the latter part of the twentieth century, accounts which sought to reevaluate the history of nursing in nineteenth-century Britain were published. These were preceded by a volume which challenged the traditional valorising history of the past by a group of nurses, sociologists and historians that sought to demonstrate that:

a plurality of issues that embrace social history, health professionalism, feminist questions and the history of welfare, are shown to be relevant to a richer and more challenging history of nursing.³⁶

The intention of publishing *Rewriting Nursing History* was that the history of nursing would become aligned with current historical concerns and scholarship rather than a justification for professionalisation. In a succession of papers, over a period of almost thirty years, historians from the United Kingdom, the United States and Australia have attempted to write a more acceptable history of nursing, incorporating concepts such as class, religion, gender, race and ethnicity.³⁷ From the 1980s, more students undertook historical research into nursing at post graduate level and this resulted in ‘the emergence of a more academically rigorous approach’.³⁸ As a result, an increased number of revisionist accounts have been published. These include Monica Baly’s reappraisal of the

³⁶ C. Davies (ed), *Rewriting nursing history* (London, 1980), summary of content on the back cover.

³⁷ C. Davies, ‘Introduction: The contemporary challenge in nursing history’, in: C. Davies (ed.), *Rewriting nursing history* (London, 1980), pp. 11-17; J. Wilson James, ‘Writing and re-writing nursing history’, *Bulletin of the History of Medicine*, 58 (1984), pp. 568-581; C. Maggs, ‘Nursing history: contemporary practice and contemporary concerns’, in C. Maggs (ed.), *Nursing history: the state of the art* (Beckenham, 1987), pp. 1-8; A. M. Rafferty, ‘Historical perspectives’, in K. Robinson and B. Vaughan, *Knowledge for nursing practice* (Oxford, 1992), pp. 25-41; S. Nelson, ‘Reading nursing history’, *Nursing Inquiry*, 4 (1997), pp. 229-236; P. D’Antonio, ‘Revisiting and rethinking the rewriting of history’, *Bulletin of the History of Medicine*, 73, 2 (1999), pp. 268-290; S. Nelson, ‘The fork in the road: nursing history versus the history of nursing?’, *Nursing History Review*, 10 (2002), pp. 175-188; B. Mortimer, ‘Introduction: the history of nursing: yesterday, today and tomorrow’, in B. Mortimer and S. McGann, (eds.), *New directions in the history of nursing: international perspectives* (London, 2005), pp. 1-16; C. Davies, ‘Rewriting nursing history – again?’, *Nursing History Review*, 15 (2007), pp. 11-27; H. Sweet, ‘Establishing connections, restoring relationships: exploring the historiography of nursing in Britain’, *Gender & History*, 19, 3 (2007), pp. 565-580.

³⁸ S. Hawkins, *Nursing and women’s labour in the nineteenth century: the quest for independence* (London, 2010), p. 7.

success of the Nightingale School, Christopher Maggs' examination of the origins of general nursing and Anne Marie Rafferty's evaluation of training and educational policy-making in the United Kingdom from the 1860s to the foundation of the National Health Service in 1948.³⁹ In addition, Siobhan Nelson reasserted the role of religious communities in the history of nursing and nursing reform.⁴⁰ Anne Summers examined the relationship of the pre-reform nurses in London, and their association with Sarah Gamp, the fictional nurse in Charles Dickens' novel, *Martin Chuzzlewit* (1843-4) She suggested that domiciliary nurses may have been independent practitioners in competition with general medical practitioners for private clients.⁴¹ This particular point has some support in Barbara Mortimer's examination of domiciliary nurses in mid-nineteenth-century Edinburgh. She reveals that nurses were not independent practitioners but some of them were respectable women who could lead independent lives by working closely with doctors in order to care for wealthy clients and were different to the 'Gamp' stereotype.⁴² It has been proposed that there was more in common between those nurses practising before the mid-century reforms and the new order of nurses than most writers of celebratory histories were likely to admit.⁴³ Recently the notion of the old style nurse being a victim of deliberate attempts to blacken their reputation as depicted in some

³⁹ M. E. Baly, *Florence Nightingale and the nursing legacy*, second edition (London, 1997); C. Maggs, *The origins of general nursing* (London, 1983); A. M. Rafferty, *The politics of nursing knowledge* (London, 1996).

⁴⁰ S. Nelson, *Say Little, Do Much: Nursing, Nuns, and Hospitals in the Nineteenth Century* (Philadelphia, 2001).

⁴¹ A. Summers, 'The mysterious demise of Sarah Gamp: the domiciliary nurse and her detractors, c1830-1860', *Victorian Studies*, 32,3 (1989), pp. 365-386;

⁴² B. Mortimer 'Independent women: domiciliary nurses in mid-nineteenth-century Edinburgh', in A. M. Rafferty, J. Robinson and R. Elkan (eds.), *Nursing history and the politics of welfare* (London, 1997), p. 146.

⁴³ Rosenberg, 'Review article: recent developments in the history of nursing', p. 90.

revisionist accounts has been challenged.⁴⁴ The debate about nurses and nursing reform has continued into the twenty-first century and revisionist accounts of the late twentieth century are now themselves under scrutiny.⁴⁵

However, the debate has not extended to a consideration of place as a useful concept when examining the reform and practice of nursing. The most frequent use of place has been the examination of nursing within different settings. There are a large number of studies that have shown the development of nursing practice within institutions and other locations. Not least are those that describe the history of nursing in particular hospitals or the district nursing service within people's homes.⁴⁶ Some of these have sought to explain how local factors and conditions have influenced the development of nursing and the nature of nursing work. However, these studies do not consider place in the same way that scholars in other disciplines have addressed the concept. According to Elliott, *et al.*, nursing has been viewed as a 'universal category of identity', in which a standardised system of training and work linked to the hospital has produced a standardised nurse in the eyes of the public, irrespective of the type of people who practised nursing or the setting in which nursing took place.⁴⁷ However, the place where nursing is located is said

⁴⁴ Helmstadter and Godden, *Nursing before Nightingale*, pp. xii – xiii.

⁴⁵ See, for instance, Helmstadter and Godden, *Nursing before Nightingale*, pp. xi – xiv; and McDonald, *Florence Nightingale: The Nightingale School*, pp. 31-36.

⁴⁶ For example Z. Cope, *A hundred years of nursing at St Mary's Hospital Paddington* (London, 1955); W. Brockbank, *The history of nursing at the MRI, 1725-1929* (Manchester, 1970); G. Yeo, *Nursing at Barts* (London, 1995); M. E. Baly and M. Skeet, *A history of nursing at the Middlesex Hospital, 1745-1990* (London, 2000); M Stocks, *One hundred years of district nursing* (London, 1960); M. E. Baly, *A history of the Queen's Nursing Institute: 100 years 1887-1987* (London, 1987); and H. M. Sweet and R. Dougall, *Community Nursing and Primary Healthcare in Twentieth-Century Britain* (London, 2008).

⁴⁷ J. Elliott, C. Toman and M. Stuart, 'Introduction', in J. Elliott, M. Stuart and C. Toman (eds.), *Place and practice in Canadian nursing history* (Vancouver, 2008), p. 1.

to have ‘served to reshape nurses’ roles as well as their personal and social lives’.⁴⁸ Thus, the examination of place is an important element when striving to understand the nature and organisation of nursing in the past. Similar points have been made by those who have studied place in relation to science which at one time was thought to be universal and beyond the influence of local conditions or factors.⁴⁹ The work of David Livingstone in particular has emphasised the importance of place when considering science and other human endeavours:

To understand the *history* of medicine, or religion, or law, then we must necessarily grasp the *geography* of medical, religious, and legal discourses. It is critically important to those sites that have generated learning and then wielded it in different ways. At every scale, knowledge, space, and power are tightly interwoven.⁵⁰

A ‘spatial turn’ first occurred in the history of science in the 1990s and it is being actively debated in the relationship between health and place within the history of medicine.⁵¹

Place as an important factor has also been examined in relation to the therapeutic spaces in which nurses worked. For instance, studies of the historical geography of asylums and workhouses have been developed.⁵² Place and space are concepts that have been examined within studies of contemporary nursing practice by geographers and nurses, but

⁴⁸ Ibid, p. 3.

⁴⁹ S. Shapin, ‘Placing the view from nowhere: historical and sociological problems in the location of science.’ *Transactions of the Institute of British Geographers*, 23 (1998), p. 5.

⁵⁰ D Livingstone, *Putting Science in its place: geographies of scientific knowledge* (Chicago, 2003), p. 11.

⁵¹ E. Dyck and C. Fletcher, ‘Introduction: healthscapes: health and place among and between disciplines’ in E. Dyck and C. Fletcher, (eds.), *Locating health: historical and anthropological investigations of health and place* (London, 2011), pp. 1-10.

⁵² C. Philo, ‘Enough to drive one mad’: the organization of space in nineteenth-century lunatic asylums’, in J. Wolch and M. Dear (eds.), *The power of geography: how territory shapes social lives* (Boston, 1989) p. 270;

C. Philo, *A Geographical History of Institutional Provision for the Insane from Medieval Times to the 1860s in England and Wales: The Space Reserved for Insanity* (Lampeter, 2004); F. Driver, ‘The historical geography of the workhouse system in England and Wales, 1834-1883’ *Journal of Historical Geography*, 15, 3 (1989), pp. 269-286.

have yet to influence more widely the mainstream of nursing history.⁵³ The small amount of work on the historical geography of nursing has focused on the places where nurses and patients interact: the ward, the home and the bedside.⁵⁴ Macro studies of the history of nursing, although anchored in specific places, tend to concentrate upon changes in care, management or education through time and have not dwelt on the influence of the place in which practice actually occurred. The emphasis on time has been said to have masked the role in which the study of place could play in understanding knowledge production and social relations.⁵⁵ The location of practice has tended to be seen as neutral and ‘a bare stage on which the historical drama was enacted’.⁵⁶ However, place is not just a location on the surface of the earth, but it is a setting for social relations and places are socially constructed through the meanings that people in particular locations give to them. This is important when considering the past and historians need to be aware that events and practices are ‘always clearly rooted in a particular time and place’.⁵⁷ In the case of hospitals, Reinartz has demonstrated that it is difficult to make national or regional comparisons in regard to their work without understanding local conditions.⁵⁸ The same applies to nursing institutions.

⁵³ G. J. Andrews, ‘Locating a geography of nursing: space, place and the process of geographical thought’, *Nursing Philosophy* 4, 3 (2003), pp. 231-248.

⁵⁴ See, for instance, E. Peter, ‘The history of nursing in the home: revealing the significance of place in the expression of moral agency’, *Nursing Inquiry*, 9, 2 (2002), pp. 65-72; and G. J. Andrews, ‘Nightingale’s geography’, *Nursing Inquiry*, 10, 4 (2003), pp. 270-274.

⁵⁵ E. Soja, *Postmodern Geographies: the reassertion of space in critical social theory* (Oxford, 1989), p. 1.

⁵⁶ S. Gunn, ‘The spatial turn: changing histories of space and place’, in S. Gunn and R. J. Morris (eds.), *Identities in space: contested terrains in the western city since 1850* (Aldershot, 2001), p. 3.

⁵⁷ J. Reinartz, ‘Putting medicine in its place: the importance of historical geography to the history of health care’, in E. Dyck and C. Fletcher (eds.), *Locating health: historical and anthropological investigations of health and place* (London, 2011), p. 30.

⁵⁸ *Ibid*, pp. 39-40.

The development of professional nursing was rapid within the nineteenth century, but more complex than traditional histories would have us believe. In addition, most scholars have focused upon changes in the London hospitals. As a result, the history of nursing is often associated with the voluntary general hospital and other branches of nursing seem to have received little attention until the latter decades of the twentieth century⁵⁹. Apart from the pioneering work of Christopher Maggs, there has been little analysis of developments in the nursing profession within provincial England.⁶⁰ According to Celia Davies, local nursing associations have not received much attention from historians of nursing.⁶¹ Histories, such as those by Stocks and Baly, have done little to address the development of district nursing outside Liverpool and London in the period prior to the establishment of the Queen's Nursing Institute in 1887.⁶² These were histories commissioned by the Institute and have therefore concentrated on district nursing after 1887. William Rathbone, widely viewed as the founder of district nursing, confined his discussion of its history almost entirely to developments in these two cities.⁶³ Most recent research on the history of district nursing concentrates on the period from the 1880s onward, although Helen Sweet and Rhona Dougall identify that early initiatives spread from Liverpool after 1864.⁶⁴ Historian of philanthropy Prochaska writes that:

⁵⁹ M. Carpenter, 'Asylum nursing before 1914: a chapter in the history of labour', in C. Davies (ed.) *Rewriting nursing history* (London, 1980), p. 124.

⁶⁰ Maggs, *The origins of general nursing*.

⁶¹ C. Davies, 'A constant casualty: nurse education in Britain and the USA to 1939', in C. Davies (ed.) *Rewriting nursing history* (London, 1980), p. 120.

⁶² M. Stocks, *One hundred years of district nursing*; M. E. Baly, *A history of the Queen's Nursing Institute*.

⁶³ W. Rathbone, *Sketch of the history and progress of district nursing: from its commencement in the year 1859 to the present date, including the foundation by the "Queen Victoria Jubilee Institute" for nursing the poor in their own homes* (London, 1890).

⁶⁴ H. M. Sweet and R. Dougall, *Community and primary healthcare in twentieth-century Britain* (Abingdon, 2008), p. 20. Other work includes: E. N. Fox, 'District nursing and the work of district nursing associations in England and Wales, 1900-1948' (Unpublished PhD thesis, University of London, 1993); C. Howse, *Rural district nursing in Gloucestershire, 1880-1925* (Cheltenham, 2008).

most of the historical writing about philanthropy has focused on prominent institutions, celebrated personalities and policies radiating from the centre. It has rarely done justice to the innumerable local institutions...⁶⁵

This is a point that has been made by Marland in relation to the history of medical institutions.⁶⁶ The history of local philanthropic associations which promoted nursing has received little attention, apart from the situation in Liverpool.⁶⁷ In Bristol and Manchester where associations were founded in the early 1860s, there is no recognition in the respective city-wide studies of philanthropy undertaken by Gorsky and Shapely, of the existence of nursing institutions until the latter part of the nineteenth century, some twenty to thirty years after their foundation.⁶⁸ This is in spite of the existence of, albeit limited, archival material and newspaper reports. In most locations there has been little, if any, analysis of the work of nursing organisations, particularly those that came into being during the middle decades of the nineteenth century. Denny's thesis regarding the development of district nursing in nineteenth-century England is an exception and as part of her study she examined practice in a number of localities including Stratford-upon-Avon and Derbyshire, which are included in this study.⁶⁹ However, in another study that has been undertaken, Damant fails to connect the Institute of Trained Nurses for the Town and County of Leicester (founded in 1866) to local urban philanthropic initiatives,

⁶⁵ F. Prochaska, *The voluntary impulse: philanthropy in modern Britain* (London, 1988), p. 25.

⁶⁶ H. Marland, *Medicine and society in Wakefield and Huddersfield 1780-1870* (Cambridge, 1987), p. 96.

⁶⁷ M. Simey, *Charity rediscovered: a study of philanthropic effort in nineteenth-century Liverpool* (Liverpool, 1992); G. Hardy, *William Rathbone and the early history of district nursing* (Ormskirk, 1981).

⁶⁸ M. Gorsky, *Patterns of philanthropy: charity and society in nineteenth-century Bristol* (Woodbridge, 1999); P. Shapely, *Voluntary charities in nineteenth-century Manchester: organisational structure, social status and leadership* (Unpublished PhD thesis, Manchester Metropolitan University, 1994).

⁶⁹ E. Denny, *The emergence of the occupation of district nursing in nineteenth-century England* (Unpublished PhD thesis, University of Nottingham, 1999), p. 51.

middle-class elites or to advice from the Nightingale Fund.⁷⁰ In reality, there was definite communication between the founders of the Leicester institution and the Nightingale Fund, and as well as this, the institution paid St John's House to train probationers up until at least 1868.⁷¹ Additionally, Damant incorrectly assigns the foundation of the institution in Lincoln to 1856 and describes its founder, Mrs Bromhead, as a person who accompanied Florence Nightingale to the Crimea.⁷² If district nursing connected to local associations has had poor coverage, the history of private nursing has had much worse. Barbara Mortimer's work on nursing in mid-century Edinburgh is probably the only research on private nursing undertaken in recent years.⁷³ This is surprising as private nurses made up the majority of those practising throughout the nineteenth century.⁷⁴ To date, the most comprehensive account is over one hundred years old and, as one would expect, concentrates on the situation in London with no mention of the English provinces.⁷⁵ Overall, it appears that local associations have not been served well by historians to date.

During the course of the nineteenth century, the reform of nursing took place as England was evolving into a more homogeneous and centralized society. Culturally, the increased availability of newspapers and journals were said to have 'narrowed distances between classes and cities, and between town and country, almost vigorously as had the new

⁷⁰ M. Damant, *District Nursing: professional skills and knowledge in domestic settings – linking national and local networks of expertise 1866-1974* (Unpublished PhD thesis, University of Leicester, 2005).

⁷¹ London Metropolitan Archives, Saint Thomas' Hospital, Letter to Mrs Wardroper from W H Walker, Hon. Sec. Institute of Trained Nurses for the Town and County of Leicester, 12 September 1866, (H01/ST/NC/18/007/017); Saint John's House, St John's House Financial Journal, (H01/ST/SJ/D/04/002).

⁷² Damant, *District Nursing*, pp. 25 and 32.

⁷³ B. E. Mortimer, *The nurse in Edinburgh c1760-1860: the impact of commerce and professionalisation* (Unpublished PhD thesis, University of Edinburgh, 2002).

⁷⁴ Dingwall, *et al.*, *An introduction to the social history of nursing*, p. 79.

⁷⁵ Tooley, *The history of nursing in the British Empire*, pp. 261-280.

railways'.⁷⁶ Newly founded national institutions, voluntary associations and professional bodies all contributed to the idea of a more united nation. Moreover, government became more involved in regulating and directing activity in areas such as public health, welfare provision and education and thereby created systems and institutions that influenced every part of the country.⁷⁷ As a result, it is understandable that some later commentators saw nursing reform as part of a national movement co-ordinated from London.⁷⁸

In reality, reform took place in individual towns, hospitals or institutions and to an agenda set by local people. Following the 1919 Nurses Registration Act and the creation of the National Health Service in 1948, in which the vast majority of nurses are employed, it is unsurprising that nurses should look back on the history of nursing as progress from uncoordinated chaos to an inevitably enlightened national system that has enabled nursing to develop into a profession. A parallel can be seen in the history of welfare reform in which a recognisably 'Whiggish' narrative which viewed the nineteenth-century poor laws as the beginnings of the welfare state has been challenged and replaced by accounts which reveal a much more complex history of social welfare.⁷⁹ In respect to nursing, this view of central coordination is flawed in two ways. First, there was little national coordination of nursing prior to the 1919 Nurses' Registration Act and, secondly, it underestimates the strength of provincial and local feelings and autonomy during the mid-nineteenth century. Localism remained strong in the provinces as:

the widely varying occupational and manufacturing specialisms of the new industrial centres; the flourishing municipal culture and civic pride of many

⁷⁶ A. Sanders, 'High Victorian Literature, 1830-1880', in P. Rogers (ed.), *The Oxford illustrated history of English literature* (Oxford, 1987), p. 327.

⁷⁷ H. Perkin, *The origins of modern English society, 1780-1880* (London, 1969), p. 123.

⁷⁸ For instance A. E. Pavey, *The story of the growth of nursing*, Fourth Edition (London, 1953), pp. 303-4.

⁷⁹ B. Harris, *The origins of the British welfare state: social welfare in England and Wales, 1800-1945* (Basingstoke, 2004), pp. 2-3.

provincial cities; and the rise of new, locally based, middle-class elites who challenged the aristocracy for predominance: all combined to produce in the mid-nineteenth century a society that in certain respects was *less* metropolitan than it had been a hundred years before.⁸⁰

Central government exerted much less control over the lives of its citizens than today, for instance, the administration and finance of social welfare provision in the form of the Poor Law was in the hands of local ratepayers. Good government was seen to be both limited and decentralised with local voluntary activity regarded as the best way to advance the welfare of the people.⁸¹ Thus, it was often a matter of civic pride for towns and cities to have their own philanthropic organisations and to organise these in ways which suited local conditions and which would act as ‘laboratories of social reform’, to use Harris’ expression.⁸² Local nursing associations, whilst conforming to a similar pattern of organisation and management differed from one place to another. Their existence has been ignored in most accounts of the history of nursing or dealt with briefly because they seem to be anomalies that do not fit into the overall progressive account of how nursing has developed. Is it possible that associations could have been an alternative to the development of systems of nursing and training in the hospitals? A similar question has been posed about the nursing sisterhoods.⁸³ However, neither the sisterhoods nor local associations exerted any significant influence beyond the end of the nineteenth century. Some local associations went out of business, others split in two with private and district nursing becoming separate organisations, whilst some became purely private nursing organisations. History is often written with hindsight and, as these organisations seem to have made little impact on the national scene, it is hardly surprising that their

⁸⁰ Harris, *Private lives, public spirit*, pp. 17-18.

⁸¹ A. Kidd, *State, society and the poor in nineteenth-century England* (Basingstoke, 1999), pp. 1-2.

⁸² Harris, *Private lives, public spirit*, p. 18.

⁸³ Helmstadter and Godden, *Nursing before Nightingale*, pp. 195-6.

existence and work has largely been ignored or forgotten. This is compounded by the fact that the records related to these organisations are either incomplete or have not survived. Unlike the records for the Queen's Nursing Institute which exist in one central archive, records for these nursing organisations are scattered across the country in local and county archives. Up until recently with the creation of on-line databases of archives there was probably no easy way of discovering whether these organisations existed or whether records survived.

A time frame for nursing reform was proposed by Martha Vicinus, who divided the history of modern nursing into an initial period from the late 1850s until the late 1880s, which she described as the 'pioneer age', and a 'mothering age' continued until the passage of the Nurses' Registration Act in 1919.⁸⁴ The 'pioneer age' was typified by the struggle to establish modern or reformed nursing based upon recruitment and training of a different kind of woman within the hospitals. It is within this period that local associations were most innovative and active in the sphere of nursing reform. However, contemporary commentators, such as Sir Henry Burdett,⁸⁵ and later historians, for instance Christopher Maggs, firmly put the reform of nursing in the 1880s rather than in this earlier period.⁸⁶ Maggs is precise in his choice of time for the emergence of modern

⁸⁴ M. Vicinus, *Independent women: work and community for single women 1850-1920* (London, 1985), pp. 87-88.

⁸⁵ C. Maggs, *The origins of general nursing* (London, 1983), pp. 5-6. Burdett had experience as a hospital secretary in Birmingham and London but, by the late nineteenth century, he was seen as an expert in hospital administration, finance and nursing, through a range of publications including the journal *The Hospital*. See, C. J. Maggs *A century of change: the story of the Royal National Pension Fund for Nurses*, (London, 1987).

⁸⁶ C. Maggs, 'A general history of nursing, 1800-1900', in W. F. Bynum and R. Porter (eds.), *Companion encyclopaedia of the history of medicine, Volume 2* (London, 1993), pp. 1309-1329.

nursing: 1880.⁸⁷ Anne Summers has proposed that reform of nursing arose from the desire to generate missions to the poor, based upon Christian faith and charity, and that this was the driving force behind the reform of nursing from the 1830s onwards.⁸⁸ Writings in the late nineteenth and early twentieth century point to reformed nursing emanating from the 1840s with the establishment of the Institute of Nursing Sisters by Mrs Fry.⁸⁹ For Summers, there are ‘no strict beginnings and endings in history’⁹⁰ and, as such, Maggs’ precise dating of reform seems too prescriptive when considering the beginnings of modern nursing. Helmstadter and Godden propose that the first initiatives in the reform of nursing in the London teaching hospitals took place early in the century in order to introduce a new ward system of nursing in response to the changing nature and demands of clinical medicine. This was superseded by the central system introduced by nursing sisterhoods from the 1850s onward which in turn was replaced by the Nightingale system by the end of the century.⁹¹ Even though the reform of nursing was complex and not as clear cut in its timing as past accounts suggest, the 1860s were a period in which the ‘reform of nursing swept the country’.⁹² It is the intention of this study to analyse the contribution of philanthropic associations or institutions, established during the middle of the century, in the early development of nursing in particular localities.

⁸⁷ Maggs, ‘A general history of nursing’, p. 1309.

⁸⁸ A. Summers, ‘The costs and benefits of caring: nursing charities, c1830-1860, in J. Barry and C. Jones (eds.), *Medicine and charity before the welfare state* (London, 1991), p. 144.

⁸⁹ M. Brea, ‘Nursing in the Victorian era’, *Nursing Record and Hospital World*, 19 June 1897, p. 493; ‘The nursing of the sick under Queen Victoria’, *British Medical Journal*, 19 June 1897, p. 1644; A Hughes, ‘The origin, growth, and present status of district nursing in England’, *The American Journal of Nursing*, 2, 5 (1902), p. 337.

⁹⁰ A. Summers, *Female lives, moral states* (Newbury, 2000), p. 7.

⁹¹ Helmstadter and Godden, *Nursing before Nightingale*, pp. 191-96.

⁹² R. White, *Social change and the development of the nursing profession: a study of the poor law nursing service 1848-1948* (London, 1978), p. 50.

Locating Associations

At the outset of this study, an effort to locate associations or institutions that were founded in the 1860s and 1870s was undertaken. Traces of eighteen individual associations were found through a variety of strategies. Some had been found within archives, when previous work on the history of nursing within hospitals was undertaken, whilst others were located in texts on the history of hospitals. A systematic search of the *British Medical Journal* and the *Lancet* during these two decades brought some more to light. A number of associations were located through an online search of the National Archives' A2A database of records held in local repositories in England and Wales. If records belonging to associations could not be located online, individual record offices were contacted by email or letter to ascertain the existence and extent of holdings.

Appendix 1 gives the identity of associations, the date of establishment and some idea about the type of records available. In a number of instances, no records have survived, in the case of Bath, Buckingham, Bristol and Leicester only one annual report exists and those of the Kent and Canterbury Institution have only survived from 1887. As a result, nine institutions or associations were selected for study (see Figure 1.1). Those institutions that were selected had records that offered good coverage of their work, had the most complete run of records or gave insight into the issues concerning the establishment or management of an institution. These nine towns and cities cover the different types of communities that existed in the mid-nineteenth century. The Liverpool Training School and Home for Nurses has been celebrated as the first location in which modern district nursing was established. As this greatly influenced the nature of other associations, it was included in the study. Liverpool was a great port and seen as the

second city of the Empire in terms of the value of trade it handled.⁹³ Manchester and Birmingham represent the rapidly expanding industrial and commercial centres associated with the industrial revolution.

Figure 1.1 Associations included in the study

| Founded | Association or Institution | Comments / Change of Name |
|----------------|---|---|
| 1862 | Liverpool Training School and Home for Nurses | |
| 1864 | Manchester Nurse Training Institute | Manchester and Salford Sick Poor and Private Nursing Institution (1882) |
| 1865 | Derby and Derbyshire Nursing and Sanitary Association | Royal Derby and Derbyshire Nursing and Sanitary Association (1892) |
| 1865 | Nursing Association for the Diocese of Lichfield | Closed 1872 |
| 1866 | Lincoln Institution for Nurses | |
| 1867 | Cheltenham Nursing Institution | Closed 1872 |
| 1869 | Birmingham and Midland Counties Training Institution for Nurses | |
| 1871 | Salisbury Diocesan Institution for Trained Nurses | |
| 1872 | Nursing Institute, Stratford upon Avon | Nursing Home for Convalescent Women and Sick Children (1873) |

⁹³ R. Lee 'Domestic service and female domestic servants: a port-city comparison of Bremen and Liverpool, 1850-1914' *The History of the Family*, 10, 2005, p. 436.

Along with Liverpool, they are typical of a different type of urban area not seen before the nineteenth century in England, in that they were dominated by a merchant and industrial elite and local nonconformist religious groups wielded considerable power in relation to their size within the population. Derby was smaller, but was a significant industrial and commercial centre for the county. In contrast to the industrial areas, the associations based in the cathedral cities of Lincoln and Salisbury represent older urban centres dominated by the presence of the church which had influence within large rural hinterlands. The Lichfield diocesan association, whilst serving large rural areas, also included the industrial areas of the Black Country and the Potteries. The associations in Cheltenham and Stratford-upon-Avon were essentially single-parish organisations. Cheltenham was both a spa town and a retirement destination for many officials who worked across the empire. Stratford, apart from its connection with Shakespeare, was a small Warwickshire market town. Thus, associations in various types and sizes of towns and cities, where possible, have been included in the study. Whilst, as outlined above, these reflect the types of urban settlements that were involved in promoting an association, it is not possible to claim that they are truly representative of English towns and cities of the time as they were chosen mainly as a result of the survival of sufficient documentary evidence that analyses the foundation and work of these nursing associations.

The geographical concentration of associations in this study, limited to the midlands and the northwest, with the exception of Salisbury, has been offset by the inclusion of information about other associations, particularly Bath and Bristol in the southwest, but

also Cambridge and Leicester, when this proved relevant to the analysis. This is not as wide a geographical spread as employed by Maggs in his study of hospital nursing in London and in the north and the south of England, but still adequately provides opportunities to draw conclusions about the contribution of local associations in the reform of nursing in England during the mid-nineteenth century.⁹⁴ This study utilises a much wider sample than most which have been conducted in the history of nursing in recent years. Most studies investigate a single town, organisation or hospital in detail and relate the findings to similar studies elsewhere or to the general literature on the topic.⁹⁵ This has been part of a trend in historical studies, following the advent of post modernism, whereby there has been movement away from grand narratives towards small-scale or micro-studies, leaving ‘scholars to identify commonalities in studies of different places’.⁹⁶ For Roy Porter

Micro-studies are all very well [...] but without an adequate sense of scale and perspective, the real interplay of forces – intellectual, social, and political – cannot be grasped; history becomes impoverished and our grasp of the present is thereby impaired by default.⁹⁷

The main reason behind the use of multiple sites in this study is the paucity of surviving records of the associations under study. However, a comparative approach which examines a number of towns provides additional valuable information that single site studies cannot reveal.⁹⁸ To be able to gain an understanding of the role of nursing associations that moves beyond a particular setting is advantageous in furthering knowledge about nursing reform in England and determining whether there were

⁹⁴ Maggs, *The origins of general nursing*, pp. 33-4

⁹⁵ The studies by Damant, Howse and Hawkins referred to in this chapter are examples.

⁹⁶ J. Reinartz, ‘Putting medicine in its place’, p. 29.

⁹⁷ R. Porter cited in D. N. Livingstone, *The geographical tradition* (Oxford, 1992), p. vii.

⁹⁸ J. Pickstone, ‘Medicine in industrial Britain: the use of local studies’ *Social History of Medicine*, 2 (1989), p. 198.

commonalities in the purpose and work of associations in different places. Conversely, this analysis also will reveal whether local factors or conditions affected particular locales, resulting in unique patterns of provision.

Records and Methods

Each of the associations in this study generated a significant amount of records during their existence. However, much less has survived into the twenty-first century.⁹⁹ Like all voluntary societies, they generated minutes of management or executive committee meetings and any other subcommittees that were used to manage their day-to-day organisation, especially house committees. Complete management committee minutes exist for the associations in Cheltenham and Salisbury, but, in contrast, there are none for Stratford-upon-Avon. The others have one or two sets of minutes which cover part of the time concerned, particularly the latter part of the century. Thus, details of the week-to-week management of the business of associations and the response to particular events or situations have mainly been lost.

In addition, all associations produced and distributed annual reports to their subscribers and supporters. These contained a list of the patrons, officers and committee members; a summary of the previous year's activity and significant events or issues; a list of the subscribers and donors to the association, including the amounts contributed by each individual; a detailed description of the income and expenditure in the form of a balance sheet and sometimes a list of the types of cases attended and the numbers of nurses employed are also occasionally available. These are the records most likely to have

⁹⁹ See the list of archives and primary sources at the end of this thesis for the full list.

survived and, in five of the associations, a full set of reports exist up to 1900. None survive for the Salisbury association as it was the custom to cut out lists of nurses and the accounts and paste these into the minute book. This has resulted in a complete lack of surviving data concerning the subscribers and donors. Data in annual reports tends to be reliable as the accounts were always audited before publication and lists of subscribers and donors underwent scrupulous checks to ensure people were recognised for their contributions.¹⁰⁰

Information from annual reports have been used, first of all, to determine the identities of the officers and committee members of associations, especially in order to determine which individuals or groups were crucial to their foundation and management. Secondly, an analysis of the lists of subscribers and donors has been undertaken to ascertain the contribution of women, in particular, in supporting these organisations. This data is also compared with the support local voluntary hospitals received. Finally, the accounts have been utilised in an analysis of the relative success of individual associations in meeting their aims to promote private and district nursing. In order to discover the status of those members of the local community involved in an association, both the census and local commercial directories have been consulted to determine professional or occupational standing of individuals or male relatives, in the case of some women.

Most associations would have kept some form of register of the nurses employed, giving details of age, place of training and a short work record. However, apart from the comprehensive registers available for Liverpool, two registers in the surviving reports of

¹⁰⁰ Marland, *Medicine and society*, p. 114.

the Lichfield association and an incomplete register, covering two years, discovered in the back of a minute book belonging to the Salisbury association there are no systematic records in existence for the employees for most associations.¹⁰¹ It is known that associations instructed nurses to write up patients' case notes and they also expected report forms from the householder and attending doctor concerning the work and conduct of the private nurses.¹⁰² District nurses were expected to maintain registers or casebooks of their patients to be overseen by the supervising lady superintendent.¹⁰³ Apart from one casebook,¹⁰⁴ none of these documents appears to have survived and a valuable source of information concerning nursing practice has been lost. A small number of the nurses' cases are described in annual reports. These should be treated with caution, as they were written with a particular goal and readership in mind and were a means of retaining and recruiting subscribers and donors. Often only exceptional cases of nursing care were reported and the few illustrative accounts that are included were probably used to elicit sympathy for the plight of the sick poor and maximise financial support for the work of the respective association.

Correspondence to and from associations is a useful source of information, but few official letters have survived. However, correspondence between individual committee

¹⁰¹ Liverpool Record Office, Registers of Nurses (614 INF/26/1/1-5), Staffordshire Archives Lichfield, (Hereafter, SAL), Nursing Association for the Diocese of Lichfield *Annual Report*, 1866 (D30/11/118); and *Annual Report*, 1869, (B/A/19/2/106); Wiltshire and Swindon Record Office, Salisbury Diocesan Institution for Trained Nurses Minute Book, July 1876 – Nov 1878 (J8/109/2).

¹⁰² Manchester Local Studies Library and Archives, Manchester Nurse Training Institution *Annual Report* 1866, p. 32 (362.1 M85); SAL, Nursing Association for the Diocese of Lichfield, *Annual Report* 1869, p. 7 (B/A/19/2/106).

¹⁰³ W. Rathbone, *Organization of nursing: an account of the Liverpool Nurses' Training School* (Liverpool, 1865), pp. 88-90. The author of this book is given as a 'member of the committee', but it has since been recognized as Rathbone.

¹⁰⁴ Lincolnshire Archives, Lincoln Institution for Nurses, *Nurses' Memoranda: Cecilia Quinney's Case Book*, 1872. (Dixon 22/11/20). The archives record her name as Quincey, but an examination of census returns reveals her name to be Quinney. See Appendix 7 for a brief biography.

members of associations and Florence Nightingale, or the secretary of the Nightingale Fund, Henry Bonham Carter, or Mrs Wardroper, the matron of St Thomas's Hospital, exist in a number of archives including the British Library, Liverpool Record Office and the London Metropolitan Archives. In addition, communication between these three individuals regarding the circumstances of particular associations has also been preserved. Those letters held by the British Library are in a large number of bound volumes and there is no detailed or complete list for all of the correspondents. This makes it difficult to locate letters that may be relevant to this study.¹⁰⁵ Letters from Nightingale to Dr William Ogle of Derby have been deposited in the archives of the Royal College of Physicians. All letters offer some insight into issues confronted by associations and can fill some of the gaps in the official records. Much of the correspondence with Nightingale seeks advice about the establishment of an association or the provision of training for nurses and rarely goes beyond the initial stages of setting up an association.

Newspapers and periodicals are an important further source of information in this study. The annual general meetings of associations were often reported in detail in the local press. They provide additional information that does not appear in other sources, such as annual reports, and include speeches by officers but also interesting anecdotal information regarding the work of associations, including the quality of care experienced by individuals and families. In addition, some individual reports about the work of an association have been published.¹⁰⁶ There is a small amount of correspondence on the subject of the associations in newspapers and periodicals. Copies of these publications

¹⁰⁵ McDonald, *Florence Nightingale: an introduction to her life and family*, p. 863.

¹⁰⁶ See, for instance, 'Our lesser charities, No.8. The Nurse Training Institution' *Manchester Guardian*, 13 January 1870.

were consulted at local libraries and archives, the British library Newspaper Library or online databases.

Personal documents belonging to both the nurses and superintendents are almost non-existent. As working-class women, the ordinary nurses, just like domestic servants, 'did not leave a large body of personal papers which could serve to elucidate the conditions of their work, their aspirations, and their relationships with their employers'.¹⁰⁷ In the first place, some of the early nurses were probably barely literate, but when the quality of recruits improved later in the century no personal documents seemed to have been generated or retained for posterity. This is a problem in that virtually all we know about nurses has been documented by their superiors in the official records of associations to the possible detriment of the nurses. This is a situation that is not only confined to working-class women. Those from the middle classes in general, and specifically those in positions of authority in nursing, did not, in the main, leave personal papers or, if they did, they have not survived.¹⁰⁸ More evidence exists for the middle classes than the working-class women in this period. A biography of Emily Minet, of the Stratford-upon-Avon institution, was written following her death.¹⁰⁹ Mary Merryweather wrote about her time as a 'moral missionary' in a silk factory in Halstead, Essex before she undertook a career in the management of nursing, but she left no account of her experience in the Liverpool Training School and Home for Nurses.¹¹⁰ There is a small amount of

¹⁰⁷ T. M. McBride, *The domestic revolution: the modernisation of household service in England and France 1820-1920* (London, 1976), p. 10.

¹⁰⁸ P. Branca, *Silent Sisterhood: middle class women in the Victorian home* (London, 1975), p. 11; McGann *The battle of the nurses*, p. 7.

¹⁰⁹ C. G. Gepp, *A short memoir of Emily Minet* (London, 1894).

¹¹⁰ M. Merryweather, *Experiences of factory life* (London, 1862). See Appendix 8 for a biography.

biographical information about some superintendents in the records and there are one or two newspaper obituaries.

Two strategies have been developed in order to learn more about the women who were employed by the associations. The first was to write a number of partial biographies based on the entries about individuals from surviving records of associations and hospitals, letters, newspaper reports and the decennial censuses for the United Kingdom. Appendices 2 and 3 demonstrate the process in which individual lives were investigated and in which career histories were constructed. Initially, a small sample of wills were obtained, but it was decided not to proceed with this analysis because of the cost, but also because the information was quite limited in relation to the women's working lives. These biographies have been used to generate illustrative accounts of the lives and careers of both nurses and superintendents (see Appendix 7 and Appendix 8).

The second strategy involved the use of a prosopographical approach to generate data about the two groups of women employed by the associations. Prosopography, or collective biography, is a method by which biographical details of individuals are used in order to build up a picture of the 'common background characteristics' of a group under study.¹¹¹ This is an approach which has been utilised in both ancient and modern historical studies. In modern history, it is concerned with social trends and social mobility within society or particular groups. Fragments of data about individuals are aggregated

¹¹¹ L. Stone, *The past and present revisited* (London, 1987), p. 45.

together in order to reveal factors about the group under study.¹¹² In this case, data from records belonging to the local associations and hospitals have supplemented the information that is available in the decennial censuses undertaken between 1841 and 1901. Results from this study are used to compare this group of nurses to studies conducted elsewhere in terms of social class, employment or activity before undertaking nursing and subsequent careers or life history.¹¹³

Access to nineteenth-century census returns for the United Kingdom was facilitated by using an online commercial database.¹¹⁴ Although the census has been taken every ten years since 1801, the 1841 census was the first to include individual names that could be matched to occupation, but this gave incomplete information regarding age and place of birth. In contrast, the censuses from 1851 onwards recorded full information regarding name, gender, age, occupation, marital status and place of birth.¹¹⁵ Thus, the censuses between 1841 and 1901 were searched to obtain personal information relating to individual nurses and were combined with documentary sources to build up a picture of the nurses' lives before their careers commenced, a career profile as a nurse and their lives following the end of their time of employment as a nurse with the associations in this study. This information has been utilised for some women in the form of partial biographies, but is presented for the group as a whole in tabular form.

¹¹² K. S. B. Keats-Rohan (ed.), 'Introduction' in *Prosopography approaches and applications: a handbook* (Oxford, 2007), pp. 10-13.

¹¹³ For example, S. Hawkins, *Nursing and women's labour in the nineteenth century: the quest for independence* (London, 2010).

¹¹⁴ The commercial site – ancestry.co.uk - was used to access the censuses for 1841 to 1901.

¹¹⁵ E. Higgs, *A clearer sense of the census* (London, 1996), pp. 97-99.

Content of the thesis

Chapter one of this study discusses the historiography of both hospital and domiciliary nursing. The latter included both private nurses for those that could pay and also nurses provided free of charge or gratuitously for the poor. District nursing, a system of delivering care to poor patients in a particular geographical area of a town, was a form of domiciliary nursing adopted by most associations. Until recent times, the historiography of nursing has been influenced by progressive accounts of professional development. This chapter will consider the neglect of local associations in historical studies and integrates the concept of place, something which has not been addressed sufficiently in considerations of nursing history. The availability of sources, choice of locations for study and the methods undertaken will also be discussed.

Chapter two considers the context of the development of nursing in the nineteenth century and evaluates this in relation to changes in society, public health, medical treatment and care, religion, philanthropy and the role of women. The idea that nursing reform was first introduced as a means to improve nursing for the middle classes and was then extended to the nursing of the poor is discussed. This chapter also demonstrates that nursing associations aimed, in part, to reform the lives of the working classes both through the training of working-class women to be obedient and useful servants in the homes of the rich and also the use of district nurses to give instruction regarding sanitary principles, diet and health to the poor whom they visited and whose homes they entered. The emergence of local associations in the 1860s and the role of the Liverpool Home and

Training School, established in 1862 as the model that influenced other towns and cities are described.

In chapter three, the establishment and management of local nursing associations is analysed. It demonstrates that nursing reform was part of mainstream, philanthropic effort in provincial towns and cities and was supported by local elites, often people with deep religious conviction, and also leading medical practitioners in most localities included in this study. These associations conformed to the pattern of management and organisation as seen in other subscriber democracies of the nineteenth century. Associations were also very important in facilitating the entry of women into management in both voluntary and paid positions and data is presented to show the importance of the contribution of women to these institutions. This analysis uses subscriber lists, contained within the annual reports, and presents data to reveal the relative involvement of men and women in the associations and compares this to the local voluntary hospitals. Two case studies demonstrating the importance of place as an important factor in the establishment and the subsequent organisational form of an association are used. The first examines religious ‘party’ conflict within the Church of England in the Lichfield diocese, and in particular how the strength of evangelical conviction in Derby led to the establishment of two separate associations. The second case study traces developments in Lincoln and examines the way in which conflict within the County Hospital resulted in the creation of an institution controlled and managed by women.

Based on documentary evidence and census returns, chapter four reconstructs the characteristics of the nursing workforce by the use of prosopography or group biography. This has enabled a picture of the social class, work experience prior to appointment and subsequent career pathways of the women employed by institutions to be constructed in order, in part, to compare the nurses and the lady superintendents. In addition, the geographical origin of the nurses is identified. Results from this study are compared to those undertaken elsewhere, particularly in hospitals both in London and the provinces, as well as the Queen Victoria's Jubilee Nursing Institution. Rather than moving towards recruiting women from higher social classes, these associations continued to obtain the bulk of their recruits from the working classes, in contrast to the situation elsewhere. An account of the similarities between nurses and domestic servants is presented. The recruitment and training of nurses and the management of the nursing workforce is also addressed. The issues and challenges involved in using the census and in record linkage are discussed.

Chapter five considers the nature of nursing care and practice offered by the associations and implemented by the nurses. This is an area that has not been fully investigated and evaluated by historians of nursing.¹¹⁶ Two different types of nursing are identified and described: sanitary nursing and nursing as a handicraft. The type of cases that were nursed and the way in which care was organised is illustrated. An examination of the nature of nursing within different therapeutic spaces also demonstrates the importance of place or location when considering nursing practice and the role and function of nurses,

¹¹⁶ C. J. Maggs 'A history of nursing: a history of caring?' *Journal of Advanced Nursing*, 23 (1996), pp. 632-633

in that there were differences in practice and the expected role of the nurse in the homes of the rich as opposed to those of the poor. In addition, the importance of the sickroom in Victorian life is emphasised by the central place it is afforded in the care and management of patients as recorded in both nursing texts and home manuals.

In chapter six, an evaluation of the success and failure of these nursing associations in reforming nursing, caring for the sick poor and competing in the medical market for private patients is undertaken. Reasons as to why two of the associations, one in the Lichfield diocese and the other in Cheltenham, went out of business are discussed and related to the challenges faced by all associations. This latter point is illustrated through a discussion of the income and expenditure of associations. A detailed examination of the attempts of some associations to take over the management of nursing within local hospitals and their ultimate failure in this endeavour is undertaken. The issues associated with funding and organising effective district nursing services in the respective towns and the issue of caring for the rural poor in Wiltshire are examined. Finally, a postscript is added to account for the subsequent development or decline of the associations in the twentieth century.

In the final chapter, the findings of this study are related to the existing literature on the history of nursing. Overall, it challenges the traditional idea that nursing reform was largely a hospital-based phenomenon dictated by the diffusion of ideas from London. It shows that a significant attempt to reform nursing did occur in the 1860s and 1870s outside of the hospitals, and driven by local philanthropic effort. It demonstrates that

nursing associations were dependent upon local conditions and circumstances and that place was an important determining factor in their establishment, subsequent form and ultimate success or failure. A discussion of the influence of class relations, gender, place and individual agency in the formation of associations, the employment of nurses and the practice of nursing is undertaken.

Summary

This chapter has reviewed the historiography of nursing. Different historiographies have been identified, the once dominant form of nursing history depicts the development of this work as professional progress and this is a narrative that is still being promoted in the twenty-first century by some amateur historians. This version was challenged by revisionist accounts starting in the 1980s which attempted to put the history of nursing into context by considering factors such as social structure, class, poverty, religion, gender and ethnicity and thereby debunk some of the widely-held beliefs about the nature and course of British nursing. The assumptions underpinning some of these studies, in turn, are now themselves being scrutinised in the latest scholarship.

Criticism of history from post-modernist and cultural studies perspectives has challenged the certainties of the past and the discipline of history as an activity by questioning the validity of grand narratives and theories and in promoting theoretical pluralism. As a result, much historical work since has focused upon small scale and local studies. The idea of place as an important factor in the history of science and medicine is now accepted, but the concept has yet to penetrate the main stream of the history of nursing.

The purpose of this study is to consider nursing in those places that have largely been ignored in the chronology of nursing reform to date: the towns and cities of provincial England. Data from nine principal towns and cities and limited data from a small number of others have been utilised to determine why nursing reform occurred in these places, how alliances of different social, religious, political and professional groups came together in the process of nursing reform, how nursing was influenced by the locales in which it was practised and the relative success of the associations in nursing reform. This is undertaken through the analysis of a number of underused, if not neglected sources.

2: SOCIETY AND NURSING REFORM

By the middle of the nineteenth century, Britain's cities and economy had undergone unprecedented changes not witnessed anywhere else in the world. These posed a challenge for the governance of society, public health and social relations between the classes. On the other hand, it was also a time of great opportunity in which the increasing availability of wealth stimulated demands for better goods and services, including medical and nursing care. This chapter gives an overview of those changes and links the role of the middle classes, public health, medicine, religion and philanthropy to the development of nursing as an occupation in England.

Changes in Society

Fundamental changes within society related to economic growth, industrialisation and urbanisation occurred in the late eighteenth and early nineteenth centuries, but not evenly across the country. Recent scholarship has placed the roots of the industrial revolution in the late seventeenth and the early eighteenth centuries and suggests that changes in agriculture preceded changes in the structure and size of the population.¹ In 1750, the population of England and Wales was around six million; by 1801, it stood at nearly nine million and, by 1901, at 32.5 million (see Table 2.1). This increase occurred in all towns and cities but was particularly marked in the new industrial centres (see Appendix 4).

¹ B. Harris, *The origins of the British welfare state: social welfare in England and Wales, 1800-1945*, (Basingstoke, 2004), pp. 29-30; P. Hudson, *The industrial revolution* (London, 1992); M. Berg, *The age of manufacturers, 1700-1820: industry, innovation and work in Britain*, second edition (London, 1994), pp.13-33

Table 2.1 Population growth, England & Wales, 1801-1901²

| Year | Total | % Increase |
|-------------|--------------|-------------------|
| 1801 | 8,893,000 | |
| 1811 | 10,164,000 | 14.3 |
| 1821 | 12,000,000 | 18.1 |
| 1831 | 13,897,000 | 15.8 |
| 1841 | 15,194,000 | 9.3 |
| 1851 | 17,928,000 | 18.0 |
| 1861 | 20,066,000 | 11.9 |
| 1871 | 22,712,000 | 13.2 |
| 1881 | 25,974,000 | 14.4 |
| 1891 | 29,003,000 | 11.7 |
| 1901 | 32,528,000 | 12.2 |

Appendix 4 shows that there is a difference between those centres associated with the industrial revolution and the more traditional urban centres in the counties. Thus, there was rapid population increase in Liverpool, Manchester, Salford, Birmingham and Derby in the first half of the century, whilst population growth in Stratford-on-Avon and Salisbury was equivalent to or below the national rate. In contrast, Lincoln had sustained population growth from the mid-century onward, when industrialisation came late to the city.³ Cheltenham was unique in that it was mainly a place for recreation and retirement and underwent rapid growth in the early part of the century, but declined later.

Industrialisation, urbanisation and a demographic explosion brought about the threat of disruption to normal life and government in many urban areas. As a result of the increased demand for labour in the industrial towns (including London), urbanisation went ahead at a fearsome pace with fifty percent of the population being urban by 1851 and eighty percent by 1901. Population densities in some parts of some cities reached, for

² J. Black and D. M. MacRaid, *Nineteenth-century Britain* (Basingstoke, 2003), p. 56.

³ K. Hill, 'The middle classes in Victorian Lincoln', in A. Walker (ed.), *Aspects of Lincoln: discovering local history* (Barnsley, 2001), pp. 90-92.

instance, 138,000 per square mile in Liverpool, 100,000 in Manchester and 50,000 in London in the 1840s.⁴ This resulted in a degraded environment consisting of overcrowding, inadequate housing, accumulations of animal, industrial and human wastes, increased pollution and insufficient supplies of clean drinking water. This, together with increasing deprivation in the lowest echelons of society, led to disease and death.⁵ This had an effect on the national average life expectation at birth, which had risen slowly in the eighteenth-century to about 41 years in 1811, but failed to register any great improvement until the 1870s.⁶ This was due mainly to the deteriorating health conditions in Britain's industrial towns and cities where life expectancy was significantly below the national average. In Liverpool and Manchester, this never rose above the age of 40 for the entire nineteenth century.⁷ The direct effect of this fell hardest on the working classes. This was to pose particular problems for the ruling classes and the issue of the poor was to dominate the debate about social and public health reform in the first half of the nineteenth-century. In the early and mid-nineteenth century, little faith was placed in government and a laissez-faire attitude prevailed within society, where a belief in minimal state intervention in the lives of the people was necessary in order to support the market economy.⁸ The emphasis was put on individuals to provide for their own and their family's needs. However, the breakdown in normal social relations between classes,

⁴ S. Mosley, 'Fresh air and foul: the role of the open fireplace in ventilating the British home, 1837-1910', *Planning perspectives*, 18 (2003), p. 5.

⁵ S. Szreter, 'Rapid economic growth and "the four Ds" of disruption, deprivation, disease and death: public health lessons from nineteenth-century Britain for twenty-first-century China', *Tropical Medicine and International Health*, 4, 2 (1999), pp. 147-48.

⁶ S. Szreter, 'Industrialization and Health', *British Medical Bulletin*, 69 (2004), pp. 79-80.

⁷ S. Szreter and G. Mooney, 'Urbanization, mortality, and the standard of living debate: new estimates of the expectation of life at birth in nineteenth-century British cities', *Economic History Review*, 51, 1 (1998), p. 88.

⁸ D. Porter, *Health, civilization and the state: a history of public health from ancient to modern times* (London, 1999), p. 112.

unemployment, a lack of education and health problems, such as outbreaks of epidemics, frightened many in the upper and middle classes. Since the time of the French Revolution, and certainly during the 1840s, the fear of a revolution was a reality for many in the United Kingdom. To a certain extent this was superseded by a fear of infectious diseases. Cholera epidemics occurred in 1831-2, 1848-9, 1853-4 and 1866,⁹ whilst typhus was an endemic disease which often reached epidemic proportions in towns during the early nineteenth century.¹⁰ In order to ameliorate the problems associated with poverty and the health needs of the poor in particular, many philanthropic societies and charities had been set up from the eighteenth century onwards. Voluntary hospitals, in particular, were established during this period and, later, many more societies and associations were set up to provide for the material comforts of the poor, including health care.

The Poor Law Amendment Act of 1834 created a sphere of operation for both the state and philanthropy. The Act was designed to free labour and to encourage people to move to take up employment. It intended to abolish the right to outdoor relief for the able-bodied and union workhouses were to be created, where all those unable to support themselves were to be housed. The Act introduced the concept of less eligibility, making the level of support available under the minimum that could be made by working for a living. The idea was that those able-bodied people who would not work for a living were undeserving of assistance and that they should suffer the harshness of the workhouse system. Thus, the pauper was to be deprived of his liberty and his family split up. This was intended to deter pauperism and encourage people to seek work and support

⁹ F. B. Smith, *The people's health, 1830-1910* (New York, 1979), p. 230.

¹⁰ B. Harris, *The origins of the British welfare state: social welfare in England and Wales, 1800-1945* (Basingstoke, 2004), p. 106.

themselves. In contrast, the impotent poor: the elderly, orphaned children and the sick deserved support. Ultimately, the poor law system was to take responsibility for the helpless and the undeserving poor who needed relief, whereas, charitable efforts through philanthropic societies and associations were directed towards the labouring poor, in order to prevent them from sliding into pauperism, particularly as a result of ill health or lack of education. Thus, a mixed economy of social welfare had developed.

Dissemination of ideas

Thomas Carlyle, in his essay 'Signs of the Times' (1829), described the nineteenth century as the 'mechanical age', referring specifically to the power and force of industrialisation.¹¹ For later commentators, the impact of the railways and their ability to alter perceptions about distance and time made the century the 'age of steam'. To Mrs Gamp, the nurse created by Charles Dickens in 1843, steam power represented a world of 'hammering and roaring and hissing',¹² but the railways were eventually to contribute to the replacement of the old guard of nurses, whom she was seen to represent. The development of the rail network, in which every major town with the exception of Luton, Hereford and Weymouth had been connected to the national network by 1854, facilitated a revolution in the transportation of people, goods and information.¹³ The railways would be crucial to enable future nursing organisations to recruit suitable women and to be able to dispatch nurses to private clients quickly over long distances in Britain, and sometimes abroad. Matthew connects the development of the railways alongside that of the

¹¹ A. Sanders, 'High Victorian Literature, 1830-1880', in P. Rogers, (ed.), *The Oxford Illustrated History of English Literature* (Oxford, 1987), p. 334.

¹² D. Turnock, *An historical geography of railways in Great Britain and Ireland* (Aldershot, 1998), p. 41.

¹³ C. Wolmar, *Fire and steam: how the railways transformed Britain* (London, 2007), p. 113.

telegraph, the universal postal service and the increased availability of printed newspapers and journals, made cheaper by the abolition of stamp duty (1853) and paper duty (1861), with the increased availability of national and international news, as well as an ‘increasing velocity of ideas’.¹⁴ Subjects of every kind were reported upon and discussed which filled the pages of an emerging national and provincial press. By the middle of the century professional, secular and religious publications were widely available to men and, increasingly, to women who had a wide variety of interests, including philanthropy and reform. Urban places were the focus of the flow of information as they were the sites of economic and cultural innovation. Newspapers and other print journals brought news from other centres.¹⁵ Innovations in business, religious, social and philanthropic action in one town were read, evaluated and acted upon in others.

The middle-classes and philanthropy

The concept of class as an overarching narrative in British history has been challenged in light of postmodernist critiques.¹⁶ However, the emergence of the middle rank of people, the reasons for which have been subject to much debate, did occur in the late eighteenth and early nineteenth centuries.¹⁷ The term ‘middle class’ has been used to describe a large group of people from the lowest clerk to the factory-owning magnate and included professional men, such as doctors. The emphasis in this study is on the upper middle

¹⁴ C. Matthew, *The nineteenth century: the British Isles: 1815-1901* (Oxford, 2000), pp. 1, 85-88.

¹⁵ R. J. Morris, ‘Civil society and the nature of urbanism: Britain 1750-1850’, *Urban History*, 25, 3 (1998), pp. 289-301.

¹⁶ A. Kidd and D. Nicholls, ‘Introduction: history, culture and the middle classes’, in A. Kidd and D. Nicholls (eds.), *Gender, civic culture and consumerism: middle class identity in Britain, 1800-1940* (Manchester, 1999), pp. 1-11.

¹⁷ S. Gunn, *The public culture of the Victorian middle class: ritual and authority and the English industrial city, 1840-1914* (Manchester, 2000), p. 15.

class, who formed the elite in towns, as it was this group that was involved in nursing reform. They were separated by education, wealth and status from the petit-bourgeoisie, the shop owners and clerks, known as the lower middle class.¹⁸ During the eighteenth and early nineteenth centuries, English middle-class men were denied public power, although they were influential in business and the professions. A large proportion of these men in localities, such as the industrial towns and cities, were religious non-conformists or dissenters. The political and social arena was controlled by the upper classes and most opportunities for political power only open to adherents of the Church of England. Increasingly, professionals, merchants, manufacturers and farmers, who were marginal to the ‘world of rank’, established their own associations and networks to challenge the existing status quo.¹⁹ This gave elites influence and power in local affairs and over a large number of lives in towns, which was outside of the normal political system.²⁰ After the Reform Act of 1832, middle-class men entered the world of politics at national and local levels. Initially, there was intense rivalry between denominational and political groups, but after 1850, rivalry between elites began to wane.²¹

Crucial to the development of philanthropic societies and also the entry of middle-class women into public life was the concept of the public and private sphere, concepts associated with the work of Jürgen Habermas.²² Habermas equates the creation of a public

¹⁸ J. Black and D. M. MacRaild, *Nineteenth-century Britain* (Basingstoke, 2003), pp. 106 and 109.

¹⁹ L. Davidoff and C. Hall, *Family fortunes: men and women of the English middle class, 1780-1850*, Second Edition (London, 2002), p. 73.

²⁰ J. Gerrard, *Leadership and power in Victorian industrial towns, 1830-80* (Manchester, 1983), pp. 46-47.

²¹ Gunn, *The public culture of the Victorian middle class*, p. 22.

²² The theories of Jürgen Habermas have influenced much of the academic discussion concerning the public sphere. First published in German in 1962, his work was only translated into English in 1989. For a summary regarding its relevance to health care, see S. Sturdy, ‘Introduction: medicine, health and the

sphere with the rise of capitalism. This created both a private sphere, based on the household as the centre of private business and home life, and a public sphere where like-minded men could meet to discuss and debate issues that affected their own common interests.²³ The latter was separate from the state and rational discussion and reason was the basis of this public debate.²⁴ Further developments resulted in the separation of the home and workplace around the turn of the nineteenth century, with a corresponding movement of the wealthier citizens in many towns to residences in the suburbs. This resulted in the poor and their wealthier fellow citizens becoming residentially separated and more socially distant.²⁵

The formation of voluntary societies has been seen as crucial in the development of the middle classes, in that they were able to form associations, to meet the needs of their own class, but also to intervene in national issues and in the lives of the working classes. These were established to achieve their aims without government aid or sanction. They gave those who were excluded from politics a say in local and national life.²⁶ Voluntary societies first arose in the eighteenth century. Numerous cultural, political and philanthropic societies were created and, in particular, many concerned with medical care and relief of suffering were established. The voluntary hospitals were amongst the first of these institutions, more than two dozen were established throughout the country by the

public sphere', in S. Sturdy (ed.), *Medicine, health and the public sphere in Britain, 1600-2000* (London, 2002), pp. 1-24.

²³ Ibid., pp. 1-2.

²⁴ S. Gunn, 'The public sphere, modernity and consumption: new perspectives on the history of the English middle class', in A. Kidd and D. Nicholls (eds), *Gender, civic culture and consumerism: middle class identity in Britain, 1800-1940*, (Manchester, 1999), p. 14.

²⁵ A. Summers, 'A home from home- women's philanthropic work in the nineteenth century', in S. Burman (ed.), *Fit work for women* (London, 1979), pp. 35-37.

²⁶ R. J. Morris, 'Voluntary societies and British urban elites, 1750-1850: an analysis', *The Historical Journal*, 26, 1 (1983), p. 96.

end of the eighteenth century. Voluntary societies conformed to a common model. People with a shared interest were usually invited to a meeting to establish the society. Once an agreement was reached, a committee and officers were elected and an appeal for donations and subscriptions was distributed widely, often through the local press. These were democratic associations, which were controlled by annual general meetings of all subscribers where committees and officers were elected. They kept in contact with members and the public 'through annual general meetings, printed annual reports, audited accounts and published subscription lists'.²⁷ Newspapers printed full accounts of both annual meetings and the ongoing work of an association. They have been described as 'subscriber democracies'.²⁸ From the 1830s onward, the middle classes were pictured as agents of improvement in all aspects of urban life including reform of the environment, municipal government, cultural development and voluntary initiatives to reform the condition of the poor. In the 1850s and 1860s, this was led by a network of ministers of religion, medical men and philanthropists.²⁹ Middle-class men and, increasingly, women were encouraged to contribute to, and participate in charitable activities

from the pulpit and the platform, the reports, and pamphlets of the charitable societies, the numerous family and women's magazines, and from millions of penny tracts pumped out by the religious publishing houses.³⁰

By the middle of the nineteenth century, middle-class men were heavily involved in the management of medical charities, such as hospitals. Like other causes, nursing reform in

²⁷ R. J. Morris, 'Civil society and the nature of urbanism: Britain, 1750-1850', *Urban History*, 25, 3 (1998), p. 298.

²⁸ R. J. Morris, 'Voluntary societies', p. 101.

²⁹ S. Gunn, 'Class, identity, and the urban: the middle class in England, c1790-1950', *Urban History*, 31 (2004), pp. 39-40.

³⁰ F. K. Prochaska, *Women and philanthropy in nineteenth-century England* (Oxford, 1980), p. 39.

the English provinces was advanced through the formation of local associations from the 1860s onward.

Whilst middle-class men could move freely between the private and public spheres, the position of their spouses and female relatives was different. Men operated in the public, economic and amoral world of the market, whilst their wives were expected to be confined to the home, where they might promote and protect the moral and spiritual health of the family.³¹ The family was of central importance to the middle classes, irrespective of religious denomination. A middle-class domestic ideology, typified by separate spheres for the sexes and the subordination of women to men, was in place by mid-century.³² As a result, it was expected that the role of women would be confined to the private sphere in child rearing and the management of the home, including supervision of the domestic servants. They had a pastoral role of maintaining the religious tone of the home, not just with the immediate family but also with the servants.³³ For some middle-class women, the domestic work in the home remained the focus of their attention, especially when the household income was insufficient to employ servants.³⁴

On the other hand, elite women with adequate domestic support were not necessarily constrained by the demands of home life or the ideology of separate spheres, as

³¹ Davidoff and Hall, *Family fortunes*, p. 74. B. E. Mortimer, *The nurse in Edinburgh c1760-1860: the impact of commerce and professionalisation* (Unpublished PhD thesis, University of Edinburgh, 2002), p. 12.

³² J. Purvis, *A history of women's education in England* (Milton Keynes, 1991), pp. 2-3.

³³ A Summers, 'Ministering angels – Victorian ladies and nursing reform', *History Today*, 39, 2 (1989), p. 32.

³⁴ P. Branca, *Silent Sisterhood: middle class women in the Victorian home* (London, 1975), p. 54; K. Gleadle, *British women in the nineteenth century* (Palgrave, 2001), p. 52.

philanthropic work gave them an accepted reason to be active outside of the family home. Public charity has been seen as a borderland between the public and private spheres which allowed women to colonise and extend their activity. This was unpaid and voluntary and it drew on those qualities women already employed in the home.³⁵ They were used to ensuring that servants were ‘obedient, disciplined, clean and broken into the daily methods and routines’ of the middle-class household.³⁶ As much charitable work addressed working-class conditions and behaviour, middle-class women were presumed to be able to cross class boundaries and impose these standards outside of their own homes.³⁷ This was known as a ‘woman’s mission’. Women were initially involved in activities such as Sunday school teaching and home visiting, but this expanded into visiting prisons, hospitals, workhouses and other institutions, as well as educating working-class women and girls.³⁸ By mid-century, women were regularly involved in the administration of philanthropic associations. Their attempts to regulate, manage and control the working classes were seen as an extension of the domestic management role of bourgeois women.³⁹ Involvement in nursing reform was a continuation of this role, as nurses were mainly recruited from the working-classes, and were seen to need careful supervision in both their work and behaviour. In addition, this gave ladies the opportunity to be involved in the care of the sick by ensuring the introduction of sanitary principles

³⁵ E. Jordan, *The women’s movement and women’s employment in nineteenth century Britain* (London, 1999), p. 99.

³⁶ Summers, ‘A home from home’, p. 39.

³⁷ C. Davies, ‘The health visitor as mother’s friend: a woman’s place in public health, 1900-14’, *Social History of Medicine*, 1 (1988), p. 41.

³⁸ Jordan, *The women’s movement and women’s employment*, pp. 100-102.

³⁹ E. Langland, *Nobody’s angels: middle-class women and domestic ideology in Victorian culture* (Ithaca, 1995), p. 56.

and a moral influence into the lives and homes of the poor.⁴⁰ Giving care to the sick poor also fulfilled two objectives: the first was to prevent the patient and his family from drifting into pauperism and, secondly, it created opportunities to demonstrate Christian care for fellow human beings.⁴¹

Nursing reform gave middle-class women an unprecedented opportunity to be involved in voluntary or paid work. Most elite women involved in nursing outside of the hospital undertook their work in a voluntary capacity. Pioneering women, such as Nightingale, took up unpaid positions. Similarly, the superintendents and sisters belonging to the nursing orders, such as St John's House, were ladies of independent means who did not receive a salary. Paid employment posed a problem for upper- and middle-class women.

This was explained by Sarah Ellis in 1869:

As society is at present constituted a lady may do about anything from motives of charity or religious zeal ... but so soon as a woman begins to receive money, however great her need, ... , the heroine is transformed into a tradeswoman.⁴²

However, during the same period that Ellis was commenting on the loss of 'caste' by genteel women who took up employment, there was an urgent need for some to find ways of supporting themselves. There was much discussion and debate concerning the rise in the numbers of 'redundant' or superfluous middle-class women who had little or no opportunity for marriage. However, many of these women had both the education and

⁴⁰ Similar points have been made in relation to women's involvement in hospitals, see H. Marland, *Medicine and society in Wakefield and Huddersfield 1780-1870* (Cambridge, 1987), pp. 160-64.

⁴¹ A. Summers, 'The costs and benefits of caring: nursing charities, c1830-c1860', in J. Barry and C. Jones (eds.), *Medicine and charity before the welfare state* (London, 1991), p. 135.

⁴² Sarah Ellis, *Education of the heart: women's best works* (London, 1869), cited by Mortimer, *The nurse in Edinburgh*, p. 13.

confidence to take advantage of the social changes that occurred at mid-century.⁴³

Women like Nightingale and the ladies who joined the sisterhoods demonstrated that they were able to successfully hold down responsible positions in public institutions, such as hospitals. In the 1860s, small numbers of unmarried or widowed middle-class women entered nursing as paid lady superintendents, seemingly ‘without loss of social status or personal dignity’, as they earned higher salaries than the nurses and maintained their respectability through having extensive authority.⁴⁴

These women employed a system of work based on a domestic service paradigm or domestic service model in nursing in order to reform and control working-class women in their work in hospitals or as district nurses. This mirrored the ways in which domestic servants were managed. This is unsurprising as domestic service was widely regarded by the upper and middle classes as the ideal occupation for working-class women as it ensured they would develop appropriate habits, behaviour and religious observance under the supervision of their social betters.⁴⁵

Working-class women as nurses

If nineteenth-century society posed problems for the emergence of middle-class women into the public sphere, to work, no such issues existed for those from the working classes. They always had to earn a living and work was a necessity for single, widowed and some married women. The type of employment for this class of women was consistent from the

⁴³ M. Vicinus, *Independent women: work and community for single women, 1850-1920* (London, 1985), pp. 2-5.

⁴⁴ M. H. Preston, *Charitable words: women, philanthropy, and the language of charity in nineteenth-century Dublin* (Westport, 2004), p. 160.

⁴⁵ G. Holloway, *Women and work in Britain since 1840* (London, 2005), p. 20.

early modern period into and including the nineteenth century, in that the main occupations available were low status and were made up mainly of opportunities in domestic service, laundry work and textiles and clothing.⁴⁶ Domestic service was prominent in that it accounted for the largest group of women workers. In 1851, there were approximately one million female domestic servants, just under 10% of the total female population, and, in 1891, it stood at 1.75 million, 11.8% of the female population.⁴⁷ Throughout the late nineteenth century, domestic servants accounted for more than one third of all employed women.⁴⁸ In contrast, nurses and midwives made up just 0.5% of all women over 20 in 1851 and 0.6% in 1891.⁴⁹ Nurses were seen as specialised servants by many, but few were employed permanently in private homes or in public institutions such as hospitals. Larger numbers of private nurses existed in the community offering services directly to the public as sick-nurses, ladies nurses and monthly nurses. The latter were employed to care for women and babies following birth. The quality of female servants and nurses in both domestic settings and in public institutions, such as hospitals, became a concern.

Nursing in the mid-nineteenth-century was said to be of a poor quality and hospital nurses were described by one anonymous correspondent as 'brutalised by coarse habits, a low condition of feeling, and very often by the abuse of stimulants'.⁵⁰ Reports about nurses in the London teaching hospitals in the early part of the century indicated that

⁴⁶ J. Bennett, 'History that stands still: women's work in the European past, review essay', *Feminist Studies*, 14, 2 (1988) p. 279.

⁴⁷ E. Roberts, *Women's work 1840-1940* (Basingstoke, 1988), p. 31.

⁴⁸ M. Ebury and B. Preston, *Domestic service in late Victorian and Edwardian England, 1871-1914* (Reading, 1976), p. 2.

⁴⁹ Jordan, *The women's movement and women's employment*, p. 123.

⁵⁰ 'Hospital and workhouse nurses', *The Lady's Newspaper*, 4 December 1858, p. 335.

many were lacking in sobriety, punctuality and correct moral behaviour.⁵¹ Many accounts of nursing cite Charles Dickens's Mrs Gamp as an example of what nursing was like prior to the introduction of reforms. This is often expressed in a negative way, focussing on women portrayed by Gamp and her friend Betsy Prig, the hospital nurse from St Bartholomew's, as uncaring, uneducated and rough. For instance, the night nurses' duties in the Lincoln County Hospital in 1864 were:

performed with the most scrupulous observance of the rules laid down by that eminent authority, Mrs Gamp – that is to say, they sleep as much as they can, and leave the sick as long as is possible to the care of their useful sister, Nature.⁵²

This and other examples employed by those interested in reform were of course, in part, ideological and used to justify the case for reform either before or after its implementation. There were examples of good nurses within the hospitals. Many of these were skilled, respectable and properly behaved, as acknowledged by Nightingale during her time at Scutari.⁵³ However, although the best nurses in the Crimea came from the working classes, some needed constant supervision with regard to their behavior and drinking habits. By the late 1850s, a system whereby working women were closely supervised by middle-class superiors in a variety of institutions seemed to be the solution to the nursing problem. The increased demand by the middle classes for reliable, skilled, sober and deferential private nurses along with changes associated with sanitary reform and medical care necessitated a new type of nurse.

⁵¹ C. Helmstadter, 'Old nurses and new: nursing in the London teaching hospitals before and after the mid-nineteenth-century reforms', *Nursing History Review*, 1 (1993), 43-70.

⁵² T. Sympson, *A short account of the old and new Lincoln County Hospital* (Lincoln, 1878), p. 18.

⁵³ C. Helmstadter, 'Shifting boundaries: religion, medicine, nursing and domestic service in mid-nineteenth-century Britain', *Nursing Inquiry*, 16, 2 (2009), p. 142.

Public health and sanitary reform

Interest in the effects of the environment on health surfaced with the deteriorating of many industrial centres in the eighteenth-century.⁵⁴ Work by provincial doctors, such as John Haygarth in Chester, pointed to the link between ill health and poverty as a result of overcrowding, lack of cleanliness and poor diet. Fever resulted from noxious air from respiration and putrefaction infecting members of households.⁵⁵ Others interested in the health of prisons, hospitals, ships and army barracks warned against the foul air of confined spaces causing suffocation and disease.⁵⁶ Throughout the first half of the nineteenth-century, sanitarians warned about the ill effects of oxygen depletion and the build up of carbon acid gas or carbon dioxide, but a greater danger was in the ‘re-breathed’ air of rooms. Adherents of miasmatic theory held that disease was caused by invisible atmospheric substances arising from decaying human and animal wastes, but also from the poisonous products of human physiological activity such as breathing, which resulted in diseases, for example tuberculosis, bronchitis, fever, anaemia, headaches, depression and, in due course, death.⁵⁷ As both the accumulation of filth and overcrowding were implicated in the cause of disease,⁵⁸ cleanliness and ventilation became prominent in campaigns for improvements in health.

⁵⁴ An early version of some of the material presented in this and the next section was published in S. Wildman, ‘Nurses for all classes: home nursing in England, 1860-1900’ in S. Hähner-Rombach (ed.), *Medizin, Gesellschaft und Geschichte – Beiheft 32* (Stuttgart, 2009), pp. 47-62.

⁵⁵ W. F. Bynum, ‘Hospital, disease and community: the London Fever Hospital, 1801-1850’, in C. E. Rosenberg (ed.), *Healing and disease: essays for George Rosen* (New York, 1979), pp. 97-115.

⁵⁶ See, for instance, R. Porter, ‘Howard’s beginning: prisons, disease, hygiene’, in R. Creese, W. F. Bynum and J. Bearn (eds), *The health of prisoners* (Amsterdam, 1995), pp. 5-26.

⁵⁷ Mosley, ‘Fresh air and foul’, pp. 5-7.

⁵⁸ F. Driver, ‘Moral geographies: social science and the urban environment in mid-nineteenth century England’, *Transactions of the Institute of British Geographers, new series*, 13, 3 (1988), pp. 275-287.

In addition, a discourse emerged that linked poverty and immorality with disease. The moral health of the population was seen to be threatened by the collapse of the family, ignorance, drunkenness, sexual impropriety, prostitution, criminality and political sedition. Immoral conduct was seen to be a direct result of the filth and squalor of the urban working-class environment.⁵⁹ As a result, a regime of greater surveillance and regulation of the poor emerged within local and central government and also in philanthropic circles. This resulted in an assault on the culture of the poor including efforts to both control and educate them into habits of cleanliness and morality⁶⁰. In order to ameliorate the problems associated with poverty and in particular the health needs of the poor, many philanthropic societies and charities were founded from the late eighteenth century onwards.

Edwin Chadwick the secretary to the Poor Law Board investigated the conditions of the working classes between 1834 and 1842 and argued that there was a correlation between poverty and the environment since the relevant diseases of poverty - fevers, cholera and tuberculosis - were caused by environmental factors. *The Report on the Sanitary Conditions of the Labouring Poor of Great Britain in 1842*, written by Chadwick, advocated that the solution to the health problems of the poor was not medicine or food or better living conditions, but social action aimed at cleanliness through the reform of the urban environment to include clean water and the removal of dangerous wastes.

Sanitary science and reform galvanised the middle classes who joined organisations like the Health of Towns Association (1844) and the Manchester and Salford Sanitary

⁵⁹ T. L. Nichols, *Human physiology: the basis of sanitary and social science* (London, 1872), pp. 32-33.

⁶⁰ F. Mort, *Dangerous sexualities: medico-moral politics in England since 1830*, Second Edition (London, 2000), pp. 11-32.

Association (1852) and, later, the National Association for the Promotion of Social Science (1857) in order to work for the improvement of health, especially within the urban environment. By the 1850s, there was widespread consensus regarding the nature of public health within the United Kingdom, that the quality of air and water were particularly important and that environmental reform and the control of the lives of the poor was required in order to improve living conditions. Sanitary science and sanitary reform emerged as something that united both lay and professional medical opinion, in terms of emphasising the importance of ventilation and cleanliness in maintaining health and in the care of the sick.⁶¹

Medical Treatment and Care

Medical science and care had undergone change and between the beginning of the nineteenth century and the 1860s the use of aggressively lowering, depleting therapies declined. Heroic practices, for example purging using mercury, calming patients by large volume blood letting and inducing sleep by using opiates, all attesting to the physicians power to alter the patient's physiology at will, gave way to the use of stimulants, palliation and care.⁶² Under the influence of initiatives in Paris, pathology and concerted efforts to monitor the patient's physiology had revolutionised diagnostic medicine.⁶³ However, many doctors admitted that clinical medicine at this time was not all that effective, in that

⁶¹ V. Skretkowicz, (ed.) *Florence Nightingale's notes on nursing* (London, 1992), p. 15; J. H. Warner *The therapeutic perspective: medical practice, knowledge and identity in America, 1820-1885* (Cambridge, Massachusetts, 1986), p. 102; W. F. Bynum, *Science and the practice of medicine in the nineteenth century*. (Cambridge, 1994), pp. 66-87.

⁶² Warner, *The therapeutic perspective*, p. 5.

⁶³ R. Porter, *The greatest benefit to mankind: a medical history of humanity from antiquity to the present* (London, 1999), pp. 314-320 and 341-347.

The present state of Medical Science is in one respect most unsatisfactory. While our knowledge of the facts of disease, as well as the facts of healthy physiological life has made great progress of late years, Therapeutics, or the science of healing, has not. ... We know tolerably well *what* it is we have to deal with, but we not so well ... (know) *how* to deal with it.⁶⁴

In his textbook, *A Treatise on the theory and practice of medicine*, published in 1876, John Syer Bristowe, a physician at St Thomas's Hospital and Medical Officer of Health for Camberwell concurred with this stance, in that cure in most cases of disease was impossible. Medicine was able to kill or expel some parasites; by surgical operations get rid of foreign bodies, remove diseased parts and drain cavities; by the use of a few medicines alleviate or cure some diseases - for instance quinine for the ague, mercury for syphilis, iron for anaemia - and by diet correct some problems such as scurvy, but for most infectious diseases, cancer and degenerative diseases there were no cures. He outlined three principles associated with medical treatment: hygienic or sanitary principles, including ventilation, drainage and cleanliness; prophylaxis or prevention of disease by the adoption of certain measures to prevent outbreaks for instance the use of clean drinking water; and, finally, remedial measures to support people during illness.⁶⁵

Bristowe, like Nightingale, believed that medical and nursing care was there to support the patient's natural reparative processes, in medicine's case by supporting the patient's strength, relieving symptoms and preventing complications. The first element of care was to protect the patient from injurious influences, such as the formation of bedsores. The second aimed at maintaining the patient's strength by the timely administration of food in

⁶⁴ *The Practitioner*, 1, 1868, p. 1, cited in A. Digby *The evolution of British general practice, 1850-1948* (Oxford, 1999), p. 193.

⁶⁵ J. S. Bristowe, *A Treatise on the theory and practice of medicine* (London, 1876), pp. 118-125.

order to counteract wasting and rapid emaciation associated with disease. Next was the administration of tonics to maintain a healthy alimentary tract. The fourth aim was to rid the body of poisonous elements using methods including the use of sweating in renal disease to enable the body to excrete urea. Finally, the doctor would treat the symptoms of disease by relieving pain, giving sleep, soothing irritability or anxiety of the mind. In other words, the doctor made the patient's life more tolerable by using the limited amount of drugs available or other means, such as the mechanical drainage of effusions.⁶⁶ These interventions were labour intensive and required regular and skilled intervention to support the sick person.

Having few effective cures, Victorian doctors attempted to actively control the patient and his illness through monitoring any deviations from normality and also through the management of the environment.⁶⁷ Patient monitoring required measurements of temperature and pulse, but also assessment and observations of the nature and amount of secretions and excretions. Environmental management focused upon adequate ventilation, a constant temperature and absolute cleanliness of the sick room or hospital ward. To be able to prescribe and introduce new supportive measures for patients and to monitor them effectively, the doctor increasingly needed a competent and skilled assistant. This was especially important for those doctors consulting the patient at home,

⁶⁶ Ibid.

⁶⁷ Warner, *The therapeutic perspective*, p. 102

as they probably only saw their client, at most, once a day. Thus, a knowledgeable, reliable and observant nurse became essential for the successful treatment of patients.⁶⁸

As nursing became integral to the delivery of medical treatment in both the hospital and the home, doctors became more interested and involved in nursing reform. Initiatives from doctors in the reform of nursing occurred before 1850 in the London hospitals, but later in the provincial institutions.⁶⁹ Some doctors saw themselves as equally threatened as patients by the effects of poor nursing.⁷⁰ This was probably because poor care could reflect badly on the doctor and affect his reputation, and potential to gain new clients, within a community. In contrast, competent and socially acceptable nurses who delivered a good standard of care would enhance the standing of the doctor, but also free him from constant attendance on the sick patient. This had two consequences, first it meant he could maximise the time available and therefore undertake more work, but, second, it altered his role and position in local society. He was able to concentrate upon diagnosis and the prescription of treatment regimes for the sick, leaving the mundane tasks of monitoring and caring for the patient, including dealing with the waste associated with bodily functions, to the nurse. This removed the doctor from those activities associated with the domestic sphere, women and servants and may have contributed to some doctors achieving an elevated social position.

⁶⁸ A. T. Thomson, *The domestic management of the sick-room, necessary, in aid of medical treatment, for the cure of diseases* (London, 1841), p. 123; A. Munro, *The science and art of nursing the sick* (Glasgow, 1873), pp. 100-110.

⁶⁹ C. Helmstadter and J. Godden, *Nursing before Nightingale, 1815-1899* (Farnham, 2011), pp. 47-66; S. Wildman, 'Changes in hospital nursing in the west midlands, 1841-1901', in J. Reinartz (ed.), *Medicine and society in the midlands, 1750-1950* (Birmingham, 2007), pp. 109-110.

⁷⁰ J. C. Lory Marsh, *Lectures on nursing: short notes addressed to nurses on what to do and what to avoid in the management of the sick and the sick-room* (London, 1865), Lecture 1, p. 6.

Rafferty has argued that doctors at mid-century were competing in a crowded market place with both regular and irregular practitioners. Nurses who practised independently, as typified by Mrs Gamp, and who could be viewed as ‘veritable general practitioners’, were rivals for clients. Doctors eventually, through legislation which stipulated appropriate medical qualifications were able to see off the ‘quack’ and, through their support for the institutionalisation of nursing following reform, which demanded absolute obedience to the doctor, destroyed the independent practice and local power of these nurses.⁷¹ This is a point that resonates with the work of Summers.⁷² However, as discussed in the previous chapter, there is no evidence in Mortimer’s work to indicate that private nurses were independent practitioners. In addition, doctors were demanding action before nursing reform became a national concern.⁷³ Whatever the doctors’ motives, it was clear that the requirements of sanitary reform and improved medical knowledge, diagnosis and supportive therapies demanded a different kind of nurse.

Religion, missions to the poor and the reform of nursing

Coinciding with the revolution in the economic and social conditions of the people was a widespread religious revival which originated in the Methodist Church in the eighteenth century and in the conservative ‘low church’ within the Church of England in the nineteenth century. This revival resulted in widespread evangelical activity, particularly

⁷¹ A. M. Rafferty, ‘Nursing, Medicine, quackery, and health care reform, 1844-1994’, *Nursing Research*, 45, 3 (1996), pp. 190-91.

⁷² A. Summers, ‘The mysterious demise of Sarah Gamp: the domiciliary nurse and her detractors, c1830-1860’, *Victorian Studies*, 32, 3 (1989), pp. 375-78.

⁷³ Thomson, *The domestic management of the sick-room*, p. 123. Helmstadter and Godden, *Nursing before Nightingale*, p. xii.

aimed at the English working classes. Evangelicals linked philanthropy and religion in an attempt to share the Christian experience with others. They accepted the existing order of society and also accepted the inevitability of poverty,⁷⁴ but many were alarmed by the apparent breakdown in the moral conduct of the urban poor. Evangelical fervour within the Church of England was challenged by a ‘high church’ Anglican revival in the 1830s and 1840s initiated by the Oxford Movement as advanced by the Tractarians Keble, Pusey and Newman.⁷⁵ Both of these movements facilitated the entry of middle-class women into the public sphere and, for some, participation in the reform of nursing.

Evangelicalism was a religious movement characterised by simplicity of worship, the authority of the scriptures, personal contact with Christ and God, social action through philanthropy, missionary activity to reclaim souls and a religion of the home in which family prayers and observation of the Sabbath were important.⁷⁶ Both Anglican and Nonconformist evangelicals participated in social action and were at the forefront of efforts to improve the conditions of their fellow men. Within the Church of England, the first impact of evangelical action came from the ‘Clapham Sect’ whose philanthropic work had resulted in legislation concerning working conditions in mines and factories, principally for women and children, and the abolition of slavery.⁷⁷

Evangelicals tended to believe in the status quo in which people’s position in life was fixed and inequality was part of the natural order. According to Archbishop Sumner,

⁷⁴ D. Owen, *English philanthropy 1660-1960* (Cambridge, Mass., 1965), p. 95.

⁷⁵ J. Dagers, ‘The Victorian Female Civilising Mission and Women’s Aspirations towards Priesthood in the Church of England’, *Women’s History Review*, 10, 4 (2001), pp. 651-670.

⁷⁶ N. Scotland, *Evangelical Anglicans in a Revolutionary Age, 1789-1901* (Carlisle, 2004), p. 22.

⁷⁷ *Ibid.*, p. 8.

inequality challenged human ingenuity and discouraged idleness.⁷⁸ Christian conversion was seen as the most reliable means of securing improvement in the social, as well as spiritual condition of the poor. The work of Thomas Chalmers of Glasgow who, between 1819 and 1823, developed a system of regular contact with his parishioners through home visitation and poor relief, was held up as an exemplar for evangelical endeavour both in Scotland and England.⁷⁹ Although this experiment failed, the idea spread to other parts of the country.⁸⁰ Thus, home or district visiting became one of the main ways in which the word of God and the relief of poverty were taken to the homes of the working classes. Within the Church of England, the parish became the main focus of activity with volunteers, many of whom were middle-class women, supporting the work of the parish clergy. Ladies were seen as ideal workers to contact, befriend and teach the poor and, therefore, act as a bridge between the rich and poor.⁸¹ In the large urban centres, visiting societies which aimed to serve a town or city, such as the London City Mission and the Manchester City Mission founded in the 1830s, attempted to set up city-wide systems of visiting.⁸² These were founded as nondenominational organisations which employed paid visitors to evangelise, but not proselytise.⁸³ Other religious groups, such as the Unitarians, were also active in large urban areas. At the beginning of the century, they viewed the poor as victims of a corrupt and untrustworthy state that sanctioned the

⁷⁸ B. Dickey, 'Going About and Doing Good: Evangelicals and Poverty', in J. Wolfe (ed.), *Evangelical Faith and Public Zeal: Evangelicals in Britain, 1780-1980* (London, 1995), pp. 38-58.

⁷⁹ *Ibid*, p. 45.

⁸⁰ D. E. H. Mole, 'Challenge to the church: Birmingham 1815-65', in H. J. Dyos and M. Wolff (eds.), *The Victorian city: images and reality*, Volume 2 (London, 1973), pp. 815-836.

⁸¹ Summers, 'Ministering Angels', pp. 31-37.

⁸² See, for instance, D. M. Lewis, *Lighten their darkness: evangelical mission to working-class London, 1828-1860* (New York, 1986); H. D. Rack, 'Domestic visitation: a chapter in early nineteenth-century evangelism', *Journal of Ecclesiastical History*, 24, 4 (1973), pp. 357-376; M. Hewitt, 'The travails of domestic visiting: Manchester, 1830-70', *Historical Research*, 71, 175 (1998), pp. 196-227.

⁸³ M. Hewitt, 'The travails of domestic visiting', p. 205.

established church to impose its own rules and values on them.⁸⁴ As a result, they founded their own domestic missions for the poor in places like Manchester (1833), Liverpool (1836), Bristol (1839), and Birmingham (1840).⁸⁵

By the middle of the century, district visiting societies were widespread and a system by which ministers of religion, district visitors, scripture readers, paid agents or Bible women visited the poor was common place. Visitors were assigned to specific streets and households. The intention was to visit occupants on a regular basis to disseminate a religious message but also to prevent distress, promote family life and increase social harmony. Many visiting societies also distributed material comforts, such as coal, food, recipes, clothing and blankets. In order to prevent dependence, many collected money from the poor to pay for rent, furniture or even Bibles. Some visitors gave advice on health, cookery and child care and referred the sick to doctors or dispensaries for treatment.⁸⁶ The relative success of religious visiting societies acted as examples to secular societies, such as provident societies and sanitary associations, which aimed to promote appropriate habits and domestic practices within working-class households rather than advance an overtly religious message.⁸⁷

These organisations, whether religious or secular, were rarely able to meet the aims they had set themselves, mainly because of limited resources, but also because they were

⁸⁴ G. M. Ditchfield, 'English rational dissent and philanthropy, c1760-c1810', in H. Cunningham and J. Innes (eds), *Charity, philanthropy and reform from the 1690s to 1850* (Basingstoke, 1998), p. 195.

⁸⁵ D. Turley, 'The Anglo-American Unitarian connection and Urban Poverty', in Cunningham and Innes, (eds), *Charity, philanthropy and reform from the 1690s to 1850*, p. 229.

⁸⁶ F. Prochaska, *The Voluntary Impulse: Philanthropy in Modern Britain* (London, 1988), pp. 44-48.

⁸⁷ Hewitt, 'The Travails of Domestic Visiting', p. 207.

unable to recruit sufficient middle-class volunteers to advance the work. Many areas within the urban setting were left unvisited and there is some doubt about their overall effectiveness on the social fabric of society.⁸⁸ However, by the 1860s, there had been almost forty years of experience of work with the working classes in their own homes. This was to influence the form and work of district nursing organisations first formed in the 1860s. According to Hewitt, experiments in district nursing in the 1860s and 1870s ‘redirected and reinvigorated the mechanisms of private philanthropy towards casework and domiciliary activism’.⁸⁹ In some instances, nursing associations grew directly out of district visiting schemes.⁹⁰ The most well known was the London Bible and Domestic Female Mission, known as the Ranyard Mission after its founder Mrs Ellen Ranyard.⁹¹

In 1857, Mrs Ranyard created a unique district visiting scheme based on the paid employment of working-class Bible women. These women were given a three-month course in scripture, the poor law and hygiene, were appointed to postal districts, sold Bibles in instalments and gave advice on domestic matters. To Ranyard, they were the ‘missing link’ between the poor and their social superiors and these women were more likely to gain access and deliver a religious message to the poor than the middle classes. However, they were supervised by female, middle-class volunteers, known as superintendents. They met weekly with the Bible women, read their reports, paid their salaries and ran the local mothers’ meetings. They also ensured that indiscriminate relief

⁸⁸ Ibid., p. 224.

⁸⁹ Ibid., p. 226.

⁹⁰ For example, the origins of the ‘Society for Providing Nurses for the Sick Poor’, founded in Belfast in 1872, was attributed to the evangelical ‘Belfast Female Mission’. Source: J. N. I. Dickson, ‘Evangelical religion and Victorian women: the Belfast Female Mission, 1859-1903’, *Journal of Ecclesiastical History*, 54, 4 (2004), pp. 700-25.

⁹¹ Prochaska, *The Voluntary Impulse*, p. 45.

was not given and that the Bible women encouraged self help amongst the working classes.⁹² By 1868, Mrs Ranyard, who was aware of the limitations in terms of the support offered to the sick, established a corps of Bible nurses, who received an additional three months training in a hospital to equip them to care for the sick. An Anglican experiment, inspired by the Ranyard Mission, was established by Mrs Jane Talbot in 1860. She employed six parochial mission women to support the work of clergy within poor parishes. In 1862, the Church Congress affirmed that such women should be drawn from the ranks of the poor, a subordinate worker within the parish structure, to develop self-help amongst the poor there.⁹³ The contribution of the Ranyard Mission and others to the development of district nursing is similar to that of the other district visiting societies, but equally lay in the use of paid working-class women, supervision from middle-class ladies and the creation of districts in which the service was delivered.⁹⁴

Evangelicals were influenced in their work by the order of deaconesses founded by Pastor Theodore Fliedner at Kaiserswerth, an enclave in the German Duchy of Jülich-Berg, in 1837. A stream of visitors from England, including Elizabeth Fry and Florence Nightingale, travelled to this northern German town to examine the system employed. In 1861, the Reverend W. Pennefather and his wife established an order, eventually known as the Mildmay Deaconess Institute, modelled on similar lines to that of Kaiserswerth. The Institute eventually had its own hospital, orphanage, dispensary and old people's home. In 1858, Elizabeth Fearde visited Kaiserswerth and, on return to England, founded

⁹² F. Prochaska, 'Body and soul: Bible nurses and the poor in Victorian London', *Historical Research*, 60 (1987), pp. 336-348.

⁹³ B. Heeney, *The Women's Movement in the Church of England, 1850-1930* (Oxford, 1988), p. 52.

⁹⁴ E. Denny, 'The Second Missing Link: Bible Nurses in 19th Century London', *Journal of Advanced Nursing*, 26 (1997), pp. 1175-82.

the North London Deaconesses Institute, which provided the nursing at the Great Northern Hospital and undertook house visiting to the poor.⁹⁵ These initiatives were relatively late to influence the development of nursing, but provided examples of how women could be trained to serve the church. However, the visit of Elizabeth Fry to Kaiserswerth in 1840 and the subsequent establishment of the 'Protestant Sisters of Charity', later to be known as the 'Institution of Nursing Sisters' in London, was a significant milestone in nursing. It provided a blueprint for those that followed, as it was organized on the basis of the formal selection of literate nurses, through interviews and references; a training of three months in hospitals inspected by the committee; the separation of nursing and domestic duties; the use of a residential home for the nurses; the provision of a uniform; and the improvement in pay, including a superannuation fund.⁹⁶ The nurses were employed to work in the homes of the middle and upper classes, as well as in those of the sick poor but, apart from the founding principles of recruitment, selection and training, it had little impact on nursing, particularly in the hospital, at a national level. It was not until 1854 that it had a small, but efficient, district nursing service and, in the main, it acted as a private agency of nurses for the wealthy.⁹⁷

In contrast to the 'Institution of Nursing Sisters', the re-introduction of religious orders within the Church of England had far reaching consequences for nursing. These came about as a result of the Oxford Movement, which attempted to return the Anglican Church to its spiritual roots and Catholic history of the medieval period. This activity

⁹⁵ S. Gill, *Women and the Church of England: From the Eighteenth Century to the Present* (London, 1994), p. 165.

⁹⁶ R. G. Huntsman, M. Bruin and D. Holttum, 'Twixt candle and lamp: The contribution of Elizabeth Fry and the Institution of Nursing Sisters to nursing reform', *Medical History*, 46 (2002), pp. 351-380.

⁹⁷ *Ibid.*, p. 377.

arose at the same time as a Romantic movement, typified by the fiction of Sir Walter Scott, and a gothic revival, both of which looked back at a golden age.⁹⁸ Leading members of the movement, such as Pusey, advocated the formation of sisterhoods in order to channel ‘feminine religious zeal’ and to give worthwhile employment to middle-class women.⁹⁹ The first sisterhood, formed in 1845, was known as the Park Village Community and the second, created by Priscilla Sellon with the help of Pusey in 1848, worked amongst the poor in Devonport, Plymouth.

The impact of the sisterhoods has been understated in the past. Their contribution was seen as pioneering, but their ways of working were replaced by the Nightingale initiatives.¹⁰⁰ Whilst acknowledging the work of religious nurses, Brian Abel-Smith provides little analysis of their impact and concentrates upon the work of Florence Nightingale, ‘the most influential of the reformers’.¹⁰¹ Recent historiography has addressed the role of the sisterhoods in the formation of a core of professional nurses prior to the 1860s.¹⁰² Helmstadter and Godden claim that the central system employed by the sisterhoods, consisting of professional autonomy and clinically-based education, was an effective alternative to the Nightingale reforms which were adopted at most hospitals by 1900.¹⁰³

⁹⁸ A. M. Allchin, *The Silent Rebellion: Anglican Religious Communities, 1845-1900* (London, 1958), pp. 36-39.

⁹⁹ Gill, *Women and the Church of England*, p. 148.

¹⁰⁰ A. Pavey, *The Story of the Growth of Nursing*, Fourth Edition (London, 1953), p. 269; S. A. Tooley, *The History of Nursing in the British Empire* (London, 1906), p. 90.

¹⁰¹ B. Abel-Smith, *A History of the Nursing Profession* (London, 1960), p. 19.

¹⁰² J. Moore, *A Zeal for Responsibility: The Struggle for Professional Nursing in Victorian England, 1868-1883* (Athens, Georgia, 1988); S. Mumm, *Stolen Daughters, Virgin Mothers: Anglican Sisterhoods in Victorian Britain* (London, 1999); S. Nelson, *Say Little, Do Much: Nursing, Nuns, and Hospitals in the Nineteenth Century* (Philadelphia, 2001).

¹⁰³ Helmstadter and Godden, *Nursing before Nightingale*, pp. 195-96.

The two most prominent religious organizations that influenced nursing in the hospitals were the, broad-church, St John's House Sisterhood, founded in 1848, which took over the entire nursing of Kings College Hospital in 1856 and Charing Cross Hospital in 1866 and, secondly, the high-church, All Saints Sisterhood, which was contracted to undertake the nursing at University College Hospital in 1862.¹⁰⁴ In a similar way to the Institute of Nursing Sisters, St John's House also provided private nurses, as well as nurses for the sick poor. Between the 1840s and the 1870s, these two organizations offered high standards of post surgical care, invalid cookery, cleanliness and a superior form of night nursing to the wealthy in their own homes. These skills were transferred to the hospital for the benefit of the sick poor and, eventually, through the training of nurses from a variety of local organisations to the urban poor.¹⁰⁵

The sisterhoods changed hospital nursing in two ways.¹⁰⁶ First, they introduced training and clinical education for nurses. This elevated the social and moral character of the nurses, as well as improving their technical abilities. Second, the hospital itself was reformed. The staff was divided between the sisters who were ladies of independent means and the working-class nurses who were salaried. The sisters managed the hospital and appointed the nurses and servants. Nursing work was separated from domestic tasks and heavy cleaning was given to charwomen or scrubbers. Time schedules were introduced for all staff and the nurses were made resident, living in dormitories, and later

¹⁰⁴ C. Helmstadter, 'The First Training Institution for Nurses: St John's House and 19th Century Nursing Reform, Part II: The Impact of St John's House on 19th Century Nursing Reform', *History of Nursing Journal*, V, (1994/5), pp. 3-18.

¹⁰⁵ Nelson, *Say Little*, p. 74; A Summers, 'The costs and benefits of caring: nursing charities, c1830-c1860', in J. Barry and C. Jones (eds.), *Medicine and charity before the welfare state* (London, 1991), p. 144.

¹⁰⁶ A. Summers, 'Hidden from History? The Home Care of the Sick in the Nineteenth Century', *History of Nursing Journal*, 4 (1993/4), pp. 227-43.

nursing homes, where they were provided with regular meals and comfortable accommodation. As a result, nurses' lives became regulated and supervised, and conditions and standards of care in the hospitals generally improved. Nursing under the sisterhoods functioned as an independent body contracted to the hospital.

The cost of nursing under the sisterhoods was more expensive compared to that offered elsewhere and this eventually led to disputes between the sisters and hospital authorities. For Nightingale, the system in operation at King's College Hospital, whereby nursing was provided by a religious order and the hospital had a lay administration produced improved standards of care for the patients and a better class of nurse than was available under any other system.¹⁰⁷ However, the sisterhoods made little impact on the hospital system as a whole, for many hospitals were controlled by Protestant governors who were hostile to the idea of religious orders. There was widespread suspicion of the Tractarians or Anglo-Catholics within society as a whole since the Pope had re-established the Roman Catholic hierarchy in England in 1850 in what was dubbed the 'Papal Aggression'. This made the position of the sisterhoods worse as opposition was widespread and riots against practices, such as ritualism, did occasionally occur. Florence Nightingale was repeatedly attacked in the columns of *The Record*, the organ of the evangelicals, during the early part of the Crimean War for carrying out what many suspected was a 'Romish plot' to restore the convent system in England.¹⁰⁸ Although this did not last, hostility and suspicion of religious orders persisted. By the 1880s, most sisterhoods had withdrawn from public hospitals, in some cases acrimoniously, and their

¹⁰⁷ F. Nightingale, *Notes on Hospitals*, Third Edition (London, 1863), pp. 181-187.

¹⁰⁸ J. C. Whisenant, *A fragile unity: anti-ritualism and the division of Anglican Evangelicalism in the nineteenth century* (Milton Keynes, 2003), p. 33.

influence as such had waned. However, the sisterhoods offered an opportunity for respectable women to enter the public domain.¹⁰⁹ Also, several nursing associations from across the country sent women to the London sisterhoods for training before they took up appointments as nurses.

Nightingale's contribution to nursing reform

Following Florence Nightingale's return from the Crimea, a large sum of money was donated by a grateful nation and empire. After some deliberation, Nightingale and the committee, set up to administer the Nightingale Fund, decided to introduce a scheme for nurse training. The intention was to introduce reforms at St Thomas's Hospital similar to those ushered in elsewhere in London by the sisterhoods. However, nursing was not contracted out to the Fund, as had happened in the case of the sisterhoods. Instead, changes based on training were drafted on to the old system with the matron and many of the ward sisters still in place and in charge. In this case, the revised system concentrated on developing the moral character of the nurses. Nightingale's contribution was important in that she advocated a role for educated women in nursing reform. As early as 1858, she put forward the proposal that nurses needed to be supervised by a female head and continued to give the same advice to all who sought her opinion.¹¹⁰ A succession of other papers published between the 1860s and the 1890s advocated the appointment of a

¹⁰⁹ Nelson, *Say Little*, pp. 74-75.

¹¹⁰ F. Nightingale, 'Subsidiary notes as to the introduction of female nursing into military hospitals' (1858) reprinted in L. R. Seymer, *Selected writings of Florence Nightingale* (New York, 1954), pp. 1-122; F. Nightingale, 'Suggestions on a system of nursing for hospitals in India' (1865), reprinted in L. R. Seymer (ed.), *Selected writings of Florence Nightingale* (New York, 1954), pp. 228-70; F. Nightingale, 'Letter to E J Edwards, dated April 13th 1865', reprinted in E. J. Edwards *Nursing association for the diocese of Lichfield* (London, 1865), p. 1; F. Nightingale, 'Suggestions on the subject of providing, training and organizing nurses for the sick poor in workhouse infirmaries' (1867), reprinted in L. R. Seymer (ed.), *Selected writings of Florence Nightingale* (New York, 1954), pp. 271-309.

trained female head who would be in sole charge of the female staff and who would supervise the nursing of the sick.¹¹¹ In 1875, Nightingale put forward the idea that women appointed as matrons should be trained and have had experience as ward sisters and assistant matrons before taking on such positions.¹¹² She also believed that the success of a training school depended upon:

The authority and discipline over all the women of a trained lady-superintendent who is also matron of the hospital, and who is herself the best nurse in the hospital, the example and leader of her nurses in all that she wishes her nurses to be...¹¹³

The position of the matron or lady superintendent was to become crucial in the reform and modernisation of nursing. A major achievement of the Nightingale reforms was to enhance the managerial role of the matron, setting up a female chain of command in the hospital. The importance of reformed nursing was acknowledged by Bristowe and Holmes in their report on hospitals for the Privy Council.¹¹⁴ They advocated that nurses should be educated and that those who had received training at St Thomas's Hospital and whom they encountered in other hospitals were 'in all aspects far above the average of ordinary hospital nurses'.¹¹⁵

¹¹¹ H. Bonham-Carter, *Suggestions for improving the management of the nursing department in large hospitals* (London, 1867); E. Garrett, 'Hospital Nursing', *Transactions of the National Association for the Promotion of Social Science* (1866), pp. 472-478; London Metropolitan Archives: A. Pringle, 'Nurses and Doctors', reprinted article from the *Edinburgh Medical Journal* (1880), (H1/ST/NC16/10).

¹¹² F. Nightingale, 'Suggestions for improving the nursing of hospitals and on the method of training nurses for the sick poor', in National Association for Providing Trained Nurses for the Sick Poor *Report of the Subcommittee of Reference and Enquiry*, (London, 1875), Appendix VII, pp. 90-102.

¹¹³ F. Nightingale, 'Training of nurses', in R. Quain, *Dictionary of Medicine* (London, 1883) pp. 1038-43.

¹¹⁴ J. S. Bristowe and T. Holmes, 'The hospitals of the United Kingdom' in *6th Annual Report of the Medical Officer of the Privy Council* (London, 1863), Appendix 15.

¹¹⁵ *Ibid.*, p. 487.

Traditional views held about the nursing profession identify Florence Nightingale as the founder of modern nursing within a secular framework. Although the system introduced by Nightingale was not overtly religious, the moral training that probationers underwent, including prayers and Bible reading in the wards and the nurses' home, was certainly based on religious principles. Rather than seeing nursing as a secular activity, it is perhaps better to view it as nondenominational, but within a Protestant framework. This enabled the reform of nursing to continue without the controversy that had accompanied the development and work of the sisterhoods.¹¹⁶ However, the Nightingale system of training and nursing differed little in practice to that introduced by the sisterhoods and spread to other hospitals across the country.

The influence of religion on the practice of nursing did not end with the introduction of a new system of nursing and training within the voluntary hospitals. Indeed, most ladies who entered nursing and assumed a leading role had a religious vocation. Thus, the religious beliefs of Jane Shaw Stewart, appointed head of the Female Army Service in 1863, and Agnes Jones, sent by the Nightingale Fund to reform the nursing of the Liverpool Workhouse Infirmary in 1865, influenced their work.¹¹⁷ Religion still maintained its influence on the everyday work of nurses long after the sisterhoods had ceased to be a potent force.

For those nursing associations and institutions which were established in the 1860s and early 1870s, religion was one of the driving forces in their creation, but it also influenced

¹¹⁶ Nelson, *Say Little*, pp. 27-29; S. Nelson, 'From salvation to civics: service to the sick in nursing discourse', *Social Science & Medicine*, 53 (2001), pp. 1217-25.

¹¹⁷ Summers, 'Ministering Angels', p. 31.

their form and function. Thus, the organizations in this study adopted the practices which had been developed by district visiting societies, principally the use of paid working-class women supervised by middle-class ladies, along with the ideas of training nurses for their role and the establishment of nursing homes, which had come from the work of the sisterhoods. However, because religious sisterhoods were not popular, secular training institutions seemed to ‘better suit the genius of the English people’ and became the most acceptable way of organizing care in the middle of the nineteenth century.¹¹⁸

Summary

This chapter has traced the development and reform of nursing in the context of social, economic and religious change in Britain throughout the nineteenth century. Demand for nurses and calls to reform nursing were linked to changes in society at both a local and national level. The changing nature of the urban environment and the widening gap between the rich and poor was seen to require new methods of mediating between the different classes. Nursing reform was implemented, like all charitable activity at this time, through the medium of the voluntary society. Organised efforts to deliver nursing care to the poor followed both evangelical and High Church ways of intervening in their lives and offering charitable support. District visiting influenced, in part, the nature and form of district nursing, whilst the hospital systems introduced by the sisterhoods emphasised the need for training and close supervision of nurses. Leadership was seen as crucial to the success of this new system of nursing, first introduced at St Thomas’s Hospital. The principle of educated superintendents as advocated by Nightingale was to influence the management of subsequent nursing organisations. Increased wealth and the

¹¹⁸ B. Parkes, ‘Nursing, past and present’, *Englishwoman’s Journal*, 10 (2 February 1863), p. 386.

growth of the middle classes stimulated demand for specialised workers, such as nurses. They had to be both health educators in the homes of the poor and obedient and useful servants in those of the rich. During the 1860s and 1870s, increasing numbers of nursing associations were set up in provincial towns and cities. These were places that had the necessary resources and commitment to social reform. The next chapter will examine the emergence of nursing associations in a select group of urban districts in greater depth.

3. THE EMERGENCE OF LOCAL NURSING ASSOCIATIONS

By the 1860s, a movement toward the reform of hospital nursing was emerging. Home care of the sick was also identified as in need of reform and this developed as a result of the efforts of a number of eminent people in some towns and cities. Nursing associations were similar to other voluntary societies as they were dependent on leading citizens for their development and, to a certain extent, their funding. Home nursing was an important and significant service that the rich were willing to purchase and most nursing associations were created to directly benefit local elites as well as offering a service to the poor. For doctors, nursing was an important adjunct to medical practice which enabled practitioners to improve care, but also to develop and maintain their private practices. From a religious point of view, nursing provided opportunities for meeting with the poor, who were often resistant to organised religion. It was also seen as an important way in which the better-off could connect with the poor and have a positive effect on the domestic conditions, home life, health and moral behaviour of the working classes. The involvement of middle-class women, in many places, was crucial in the management of some associations. Hence, home nursing became central in efforts to improve the medical care for both the rich and poor, in an increasing number of urban areas. This chapter will examine the emergence and development of local nursing associations and discuss the role of local elites, religious groups, medical professionals and women in the reform of nursing.

The emergence of local nursing associations

The founding of local nursing associations in the 1860s cannot be examined in isolation from the initiatives that preceded them, such as the work of the nursing sisterhoods, the reform of hospital nursing as recommended by Nightingale and the various initiatives in home visiting by religious and secular groups. The development of nursing associations can also be seen as part of a movement to increase medical aid to the poor through the provision of hospitals, dispensaries and outpatient facilities. In addition, the increased demand for suitably qualified nurses by the middle and upper classes spurred some to action.

Table 3.1 indicates the number of hospitals that offered care and treatment to the working classes during the second half of the nineteenth century. The large numbers of voluntary hospitals opened after 1860 is partly due to the establishment of cottage hospitals in small towns.¹ These together with specialist hospitals in the larger urban areas were founded on the enthusiasm of local middle-class philanthropists, but also by enterprising medical practitioners, based in part, on 'naked self-interest' in order to boost their own 'profile and reputation'.² Working in parallel to the hospitals were the public dispensaries. These offered out-patient care and home visits by doctors, but were eventually eclipsed by outpatient departments in the hospitals.³ Other initiatives included a network of medical

¹ M. Gorsky, J. Mohan and M. Powell, 'British voluntary hospitals, 1871-1938: the geography of provision and utilization', *Journal of Historical Geography*, 25, 4 (1999), p. 465; S. Cherry, 'Change and continuity in the cottage hospitals c.1859-1948: the experience in East Anglia', *Medical History*, 36, 3 (1992), pp. 272-75.

² Gorsky *et al.*, 'British voluntary hospitals, 1871-1938', p. 467.

³ I. S. L. Loudon, 'The origins and growth of the dispensary movement in England', *Bulletin of the History of Medicine*, 55, 3 (1981), p. 341.

missions, based on Christian charity, in the large urban centres.⁴ Hospital outpatient numbers rose rapidly from the mid-century onward and this along with developments already discussed, demonstrates increased voluntary medical activity orientated toward the treatment of the poor, outside of the Poor Law provision.⁵

Table 3.1: The foundation of healthcare institutions, 1850-1899

| Decade | Voluntary Hospitals ⁶ | Nursing Associations ⁷ |
|---------|----------------------------------|-----------------------------------|
| 1850-9 | 49 | 1 |
| 1860 -9 | 119 | 18 |
| 1870-9 | 148 | 19 |
| 1880-9 | 138 | 49 |
| 1890-9 | 139 | 57 |

As diagnosis of disease and prescription of treatment improved, it was recognized that the actual care of the poor in their own homes required intervention. Sir Henry Acland, Professor of Medicine at Oxford University, therefore saw the development of home

⁴ K. J. Heasman, 'The medical mission and the care of the sick poor in nineteenth-century England', *The Historical Journal*, 7, 2, (1964), 230-45.

⁵ I. S. L. Loudon 'Historical importance of outpatients', *British Medical Journal*, 1, (1978), p. 974.

⁶This includes general, teaching, specialist and cottage hospitals., see M. Gorsky *et al*, 'British voluntary hospitals, 1871-1938', p. 466.

⁷ Most of these associations were located by using: H. H. Burdett *Burdett's Hospitals and Charities* (London, 1902). Others came from a variety of sources - see Figure 3.1. This is an underestimation of the numbers due to the difficulty in dating the foundation of some associations. Where this has occurred they have been omitted from the calculation. In addition, there were many more organizations offering nursing services. Private agencies and overtly religious organizations, such as sisterhoods, have also been omitted from these figures. Only those that could be identified as voluntary societies have been included.

nursing as more important than a 'revolution in hospital nursing'.⁸ The establishment of district nursing, which aimed to bridge the gap, occurred from the 1860s onward and can be seen as part of this widespread move to improve the health of the respectable poor.

Table 3.1 indicates that nursing associations originated from the 1860s, and that most growth seemed to occur in the latter two decades of the century. In the 1850s, women entered public debate about social issues and became more involved in action to ameliorate societal problems. Nursing, for both the rich and poor, became an issue of concern, and letters in journals started to appear in the 1850s.⁹ Interest in the training of nurses for the rich coincided with other initiatives in the training of working-class women, orphans, destitute girls, prisoners and prostitutes to be domestic servants.¹⁰ A perceived lack of suitable women to be servants, as well as the availability of a surplus of young female inmates of institutions, spurred a number of philanthropists to promote training. As a result, a large number of organizations were founded in the 1850s, including the Reformatory and Refuge Union and the Metropolitan Association for Befriending Young Servants, which trained girls for domestic service. Similar institutions were established in the provinces.¹¹ There was also a drive to provide education in skills

⁸ H. W. Acland, *Thoughts on provincial hospitals: with special reference to Oxford* (Oxford, 1875), p. 20.

⁹ 'Training of nurses', *The British Mothers' Magazine*, 1 January 1852, p. 21; 'The sick-nurse and the sick-room', *Chamber's Journal of Popular Literature, Science and Arts*, 19, 13 May 1854, pp. 291-94; 'Hospital nurses', *The Observer*, 9 September 1855, p. 5; 'Hospital nurses' *Scottish Review*, 4, 13 (1856), pp. 29-40; 'Educated nurses' *The British Mothers' Journal*, 1 February 1857, p. 47; 'Hospital and workhouse nurses', *The Lady's Newspaper*, 4 December 1858, p. 335.

¹⁰ F. K. Prochaska, 'Female philanthropy and domestic service in Victorian England', *Historical Research*, 54, 129 (1981), pp. 79-85; F. Driver, 'Discipline without frontiers? Representations of the Mettray reformatory colony in Britain, 1840-1880', *Journal of Historical Sociology*, 3, 3 (1990), pp. 272-93.

¹¹ 'Female servants home and training institution: inaugural meeting' *Birmingham Daily Post*, 28 May 1862; 'Free registry and temporary home for destitute girls' *Birmingham Daily Post*, 13 November 1868.

such as cookery,¹² and domestic education was also promoted in elementary and charity schools from mid-century onwards.¹³ Literate working-class women were also trained as elementary schoolmistresses through the pupil-teacher apprenticeship scheme, founded in 1846, and some undertook further training in colleges run by voluntary organizations.¹⁴ The Diocese of Lichfield had a training institution for schoolmistresses at Derby and prominent members of the future nursing association were involved in its work.¹⁵ Some middle-class women promoted the teaching of sanitary knowledge, the laws of health and the care of children to the poor through the training of pupil teachers and schoolmistresses and the publishing of simple and practical tracts.¹⁶ The movement towards nurse reform and training should be seen in the light of these wider initiatives in the reform and training of working-class women.

There had been initiatives regarding the employment of nurses prior to the establishment of associations, such as the use of nurses by the Poor Law guardians of Oxford during a cholera epidemic in 1854,¹⁷ but the importance of nursing as an issue for society came to prominence with reports from the Crimean War in the mid 1850s. Newspaper accounts regarding hospital conditions and the progress of Nightingale's party, together with widespread publicity at home, ensured that Florence Nightingale was feted as a 'secular

¹² 'School for cookery and domestic servants', *The British Mothers' Journal*, 1 May 1859, p. 109; 'Miss Martineau on cook-training', *The Englishwoman's Review and Home Newspaper*, 29 October 1859, p. 187; 'Schools of cookery' *The Englishwoman's Review of Literature, Science and Art*, 3 December 1859, p. 262.

¹³ V. Heggie, 'Domestic and domesticating education in the late Victorian city' *History of Education*, 40, 3, (2011), pp. 273-90.

¹⁴ J. Purvis, *Hard lessons: the lives and education of working-class women in nineteenth-century England* (Cambridge, 1989), p. 38.

¹⁵ 'Diocesan institution for training schoolmistresses at Derby', *Derby Mercury*, 12 October 1864.

¹⁶ 'Ladies National Association for the Diffusion of Sanitary Knowledge', *The Englishwoman's Review and Home Newspaper*, 17 April 1858, p. 555.

¹⁷ R. Dingwall, A. M. Rafferty and C. Webster, *An introduction to the social history of nursing* (London, 1988), pp. 174-75.

saint¹⁸ and that nursing subsequently became a legitimate subject for thought, discussion and action. The issue of care in the workhouses was a concern, but an initiative by Dr Edward Sieveking and others from the Epidemiological Society in London, in 1856 which proposed that able-bodied women in workhouses should be trained to care for sick paupers in the workhouse was rejected by the Poor Law Board.¹⁹ From this time onward, informed public opinion looked towards the training of respectable women, not paupers, to be nurses. Further publicity was drawn towards hospital and nursing reform from 1857 in the published accounts of the proceedings of the National Association for the Promotion of Social Science. Here, papers regarding nursing were presented to the congress of the Association by both men and women.²⁰ The Workhouse Visiting Society, founded by Louisa Twining in 1858 and dominated by educated, middle-class women, gave encouragement and confidence to women to be involved in other voluntary projects.²¹ For instance, in Manchester in 1862, the Ladies Sanitary Association, a branch of the Manchester and Salford Sanitary Association, was founded with the aim to visit the homes of the poor in order to educate them in the principles of health and hygiene. Two years later, on the suggestion of the parent association, a nurse training institution was established to give direct care to the poor.²²

¹⁸ M. Bostridge, *Florence Nightingale: the woman and her legend* (London, 2008), pp. 251-56.

¹⁹ G. Anderson, 'An oversight in nursing history', *Journal of the History of Medicine*, Vol 3 (1948), pp. 417-26; R. G. Hodgkinson, *The origins of the National Health Service* (London, 1967), pp. 559-60.

²⁰ L. Goldman, *Science, reform and politics in Victorian Britain: the Social Science Association, 1857-1886* (Cambridge, 2002), p. 116.

²¹ M. J. D. Morris, *Making English morals: voluntary association and moral reform in England, 1787-1886* (Cambridge, 2004), pp. 204-6.

²² V. Heggie, 'Health visiting and district nursing in Victorian Manchester; divergent and convergent vocations', *Women's History Review*, 20, 3 (2011), p. 407.

Demand for private nurses can be seen to have played an important part in the development of local associations. In the early 1860s, there was a shortage of suitable nurses for private families and this meant that people in the provinces often sent to London, to either the Institute of Nursing Sisters or one of the sisterhoods to try and secure the services of a reliable nurse.²³ The institution in Birmingham is said to have originated as result of Timothy Kenrick, the founder and principle benefactor, being unable to employ suitably trained nurses when he was ill. On recovery, he was reputedly determined to deal with the problem and pressed for an institution for the town.²⁴ Other individuals and organizations used agencies to provide suitable nurses. For instance, the Royal Berkshire Hospital recruited all of its nurses from the Metropolitan Servants Institution in High Holborn, London, during the early 1860s.²⁵ Manuals advising householders about the employment of servants contained information about institutions for the training of servants.²⁶ However, many private agencies or registry offices had a poor reputation as they were thought to be the haunt of prostitutes.²⁷ By 1860, it would appear that demand for suitably behaved and skilled nurses was well in excess of the supply, and this was recognized in a number of towns.

The earliest and the most significant developments in this movement occurred in Liverpool. The city already had a tradition of promoting nursing reform, as it had seen an

²³ Speakers at the annual general meetings in Derby spoke of having to obtain nurses from London prior to the establishment of their own association, see 'The County Nursing Association', *Derby Mercury*, 10 June 1868; and 'The Town and County Nursing Association', *Derby Mercury*, 7 April 1869.

²⁴ I. H. Morris, *A century of district nursing in Birmingham, 1870-1970* (Birmingham, 1970), p. 2.

²⁵ M. Railton and M. Barr, *The Royal Berkshire Hospital, 1839-1989* (Reading, 1989), p. 76.

²⁶ See, for instance, T. Baylis, *The rights, duties, and relations of domestic servants, their masters and mistresses. With a short account of servant's institutions and their advantages* (London, 1857).

²⁷ P. Horn, *The rise and fall of the Victorian servant* (Dublin, 1975), p. 40.

unsuccessful attempt to establish a training school for nurses in 1829,²⁸ and also had a private nursing institution, founded in 1855²⁹ on similar lines to that of the Institute of Nursing Sisters in London. The Liverpool initiative was influenced by the latter institution and other religious orders in London, in that it intended the use of the income from private nursing to subsidise the care of the poor. This was an important influence on the subsequent reform of nursing in Liverpool and elsewhere. However, a more ambitious scheme was begun by William Rathbone, a wealthy philanthropist. This was created in order to fulfill the needs of the poor, not those of the rich, and remained the main reason for its foundation.

Following the death of his first wife, in 1859, Rathbone employed a nurse to care for and teach the sick poor in their own homes. His attempts to recruit trained nurses to continue this work failed and he wrote to Florence Nightingale for advice in 1860. She recommended that he train his own nurses.³⁰ He took further advice from the two religious orders in London and, in 1861, the Liverpool Training School and Home for Nurses was established. Along with like-minded philanthropists, he formed a committee and issued a prospectus, which had three aims: to provide trained nurses for the Liverpool Infirmary, to provide district or missionary nurses for the sick poor and to provide nurses for private families.³¹ The latter was expected to subsidise the costs of both training and district nursing. Rathbone paid for the construction of the Liverpool Training School and

²⁸ R. G. Huntsman, M. Bruin and C. Gibbon, 'A school for nurses founded in Liverpool in 1829', *Medical Historian: The Bulletin of the Liverpool Medical History Society*, 14, (2002-2003), pp. 44-61.

²⁹ J. S. Howson, 'Liverpool institution for the training and employment of nurses', *Englishwoman's Journal*, 3, 1 March 1859, pp. 20-26; B. Parkes, 'Nursing, past and present', *Englishwoman's Journal*, 10, 2 February 1863, p. 389.

³⁰ W. Rathbone, *Organization of nursing: an account of the Liverpool Nurses' Training School* (Liverpool, 1865), p. 25.

³¹ *Ibid.*, p. 27.

Home for Nurses, which opened in May 1863. Mary Merryweather, who had limited nursing experience in London, was appointed Lady Superintendent.³² The nurses undertook one year of training in hospital before being allocated to one of the three branches of practice. In addition to the Training School and home, Rathbone was instrumental in introducing trained nurses into the workhouse in 1865.³³ Thus, Liverpool became a significant centre for the reform of nursing and a model to other prospective associations.

In terms of the nursing association's practical work, committee members divided the city into districts with an average population of 24,000 people. Each district was supervised by a Lady Superintendent who was, more than likely, the wife of a member of the committee. She was to supervise the nurse in her work and to receive a weekly report concerning the cases visited. She also reported back to the Central Committee, distributed medical comforts and equipment and, along with a local committee, was responsible for paying the nurse's board and lodgings. The central organization undertook to train and pay the nurse's salary. There was close co-operation with the Liverpool Central Relief Society which provided food for patients, relief for deserving families and convalescence for patients at Southport. In 1863, 14 out of 17 districts had been functional.³⁴ Thus, the term 'district nursing' was born.

Following the seeming success of the Liverpool initiative, different phases of development in nursing can be seen in England. The first is the rapid establishment of

³² See Appendix 8 for a brief biography.

³³ G. Hardy, *William Rathbone and the early history of district nursing* (Ormskirk, 1981), pp. 13-15.

³⁴ Rathbone, *Organization of nursing*, p. 68.

nursing institutions devoted to the training of nurses, the provision of nurses for private families and, finally, the free nursing of the sick poor in their own homes. Some of these institutions only employed trained nurses and may never have participated in training. Thus, a number of towns and cities followed the example of Liverpool (see Figure 3.1).

On first examination of the 34 towns and cities where nursing associations were founded in the 1860s and 1870s, it does not seem that there is much in the way of common characteristics that might account for them being amongst the first places to establish this new type of organization. There are towns that represent traditional urban areas, such as the 14 county towns including Nottingham and Northampton, and eight of the associations were based in cathedral cities. These towns had an elite group consisting of bankers, professional men, resident gentry and retired families of independent means.³⁵ Similarly, the spa and retirement towns of Bath, Cheltenham and Tunbridge Wells had a large number of annuitants. Traditional urban areas and the county towns, in particular, were the centre of affairs for the county or immediate region and had a thriving public culture.³⁶ This consisted of a round of assizes, quarter sessions, horse races, elections, assemblies, balls, the theatre and numerous cultural organisations, such as scientific, literature and philosophic societies. They also had reserves of wealth and a concentration of men and women who were committed to social action. In contrast to the county towns, there were the large industrial and commercial towns and cities, such as Liverpool, Manchester, Leeds, Birmingham, Sheffield and Bradford. These regional metropolises

³⁵ R. J. Morris, 'The middle class and British towns and cities of the industrial revolution, 1780-1870', in D. Fraser and A. Sutcliffe (eds.), *The pursuit of urban history* (London, 1983), p. 289.

³⁶ P. Elliott, 'Towards a geography of English scientific culture: provincial identity and literary and philosophical culture in the English county town, 1750-1850', *Urban History*, 32, 3 (2005), pp. 391-412.

Figure 3.1: Geographical Distribution of Nursing Associations, 1862-1879³⁷

| | |
|------|--|
| 1862 | Liverpool Training School and Home for Nurses Bath Training Institution and Home for Nurses ³⁸ |
| 1863 | Bristol Nurses' Institution and Nursing Home ³⁹ |
| 1864 | Manchester Nurse Training Institution |
| 1865 | Derby and Derbyshire Nursing and Sanitary Association Nursing Association for the Diocese of Lichfield Tunbridge Wells Nurses' Institution ⁴⁰ |
| 1866 | Exeter Institution for Trained Nurses ⁴¹ Institute of Trained Nurses for the Town and County of Leicester Lincoln Nurse Training Institution |
| 1867 | Cheltenham Nursing Institution The London Training School for Nurses ⁴² Sheffield Nurses' Home and Training Institution Southampton – Hampshire Nurses' Institution |
| 1868 | East London Nursing Society ⁴³ |
| 1869 | Birmingham and Midland Counties Training Institution for Nurses The Buckingham Nurses' Home and Hospital ⁴⁴ Chester District Nursing Home |
| 1870 | York Home for Nurses Ladywood (Birmingham) District Nursing Society |
| 1871 | Salisbury Diocesan Institution for Trained Nurses |
| 1872 | Bradford Incorporated Nurses' Institution Fakenham (Norfolk) Nurses Home Newcastle on Tyne Nurses Home and Training School ⁴⁵ Stratford upon Avon Nursing Institute Staffordshire Nursing Institution |
| 1873 | Cambridge Nursing Institution ⁴⁶ St Alban's Diocesan Institution for Trained Nurses |
| 1874 | Ipswich Nurses Home |
| 1875 | West Malling – Kent Nursing Institution for Hospital Trained Nurses Metropolitan Nursing Association |
| 1876 | Leeds Trained Nurses Institution Nottingham and Nottinghamshire Nursing Association |
| 1877 | Northampton Town and County Nursing Association Torquay Nurse Institution |
| 1878 | Oxford – The Acland Home |
| 1879 | Worcester City and County Nursing Institution |

³⁷ Dates of most institutions are from H. H. Burdett, *Burdett's Hospitals and Charities* (London, 1902).

³⁸ British Library, Bath Training Institution and Home for Nurses, *Annual Report*, 1863 (Cup 401c10(7)).

³⁹ *Medical Times and Gazette*, 25 April 1863.

⁴⁰ LMA, Tunbridge Wells Nursing Institution, *Annual Report*, 1865 (H01/ST/NC/02/V/16/62-V/14/067).

⁴¹ *Lancet*, 3 April 1869, Vol. 1, pp. 472-73 and 17 July 1869, Vol. 2, p. 101.

⁴² Z. Cope, *A hundred years of nursing at St Mary's Paddington* (London, 1955), pp. 55-56.

⁴³ E. Ramsay, *East London Nursing Society 1868-1968: history of a hundred years* (London, 1968).

⁴⁴ 'The Buckingham Nurses' Home and Hospital', *British Medical Journal*, 25 February 1871, p. 204.

⁴⁵ Tyne & Wear Archives, Newspaper cuttings: A Training School for Nurses 1872 (HO/RVI/82/ 1-3).

⁴⁶ A. Kenny, *The Cambridge District Nursing Association, 1873-1945* (Cambridge, 1952), p. 2.

were dominated by a middle class comprising manufacturing, mercantile and commercial interests and civic pride ensured that they were fully committed to a broad range of services, organizations and charities.

All of these urban areas had a well established middle class, including professionals, such as doctors. They also had thriving local philanthropic, cultural and religious organizations. All but four were committed to the medical care of the poor through the provision of at least one voluntary hospital prior to the establishment of a nursing association, 20 of which were founded in the eighteenth century. Religion was of heightened importance in the nineteenth century, and most of these towns represent those that maintained levels of church attendance that exceeded the national average. Religious adherence as measured by the 1851 census of church attendance shows that the highest attendance was in the county towns or cathedral cities, in places such as Exeter, Bath, York and Derby. Here, the Anglican church predominated. Lowest attendance was measured in the industrial cities represented by Sheffield, Manchester and Birmingham.⁴⁷ Here, it was the working classes that had largely abandoned organized religion, but the middle classes continued to believe and attend. These larger cities had a greater mix of denominations and sects, and nonconformists were well represented within the middle classes. In particular, the Unitarians, Quakers and Congregationalists were particularly influential in Birmingham, Sheffield, Newcastle, Manchester and Bristol. These groups were especially orientated toward philanthropic activity and interventions in the lives of the poor. Irrespective of denomination, the middle classes were active church members

⁴⁷ K. S. Inglis, 'Patterns of religious worship in 1851' *Journal of Ecclesiastical History*, 11, (1960), pp. 74-86.

who supported religious causes and found meaning in charitable work.⁴⁸ Commitment to social causes in these towns is illustrated by the fact that 16 out of 28 congresses of the National Association for the Promotion of Social Science, the forum for the discussion of social questions and the advisor of governments, were held in 12 of these towns between 1857 and 1884.⁴⁹ Hence, there was the commitment and the resources to establish nursing associations within these towns and cities in the vanguard of nursing reform.

The Liverpool experiment was well publicized, with both Rathbone and Nightingale giving advice about the scheme and also distributing Rathbone's book on the development of nursing in Liverpool to interested enquirers, treasurers of large hospitals, bishops and chairmen of boards of guardians.⁵⁰ The national prominence of nursing achieved through Nightingale's work, connected to the significant development of reformed nursing in Liverpool, aroused interest across the country. Morris has indicated that fashion and innovations in the creation of new voluntary societies was often a stimulus to other urban centres to take up the cause.⁵¹ Liverpool was a direct influence on other places, such as Manchester, Derby and Lichfield. In the same year that the Liverpool organization opened, a smaller home was founded in Bath, which used the Bath United Hospital, staffed by two Nightingale nurses, to train its own nurses. Although both Nightingale and Mrs Wardroper,⁵² the matron at St Thomas's, had grave doubts about the quality of this enterprise, it directly influenced the development of

⁴⁸ H. Mcleod, *Religion and society in England, 1850-1914* (Basingstoke, 1996), p. 22.

⁴⁹ Goldman, *Science, reform and politics in Victorian Britain*, p. 382.

⁵⁰ British Library (hereafter BL), Nightingale Papers, Additional Manuscript 47753, Letter from Rathbone to Nightingale, 30 October 1865, Ff189.

⁵¹ R. J. Morris, 'Voluntary societies', p. 98.

⁵² L. MacDonald (ed.), *Florence Nightingale: extending nursing*. Collected works of Florence Nightingale, Volume 13 (Waterloo, 2009), pp. 196-98.

nursing in Bristol and particularly Lincoln. The latter city embarked upon nursing reform following a visit to Bath by Mrs Bromhead, who galvanised middle-class women into action. Information about initiatives was widely reported and visits and communication from interested individuals was an important factor in the spread of this type of institution. For instance, in 1865, representatives from Derby visited the nursing homes at Liverpool, Bath and Bristol, as well St Thomas's Hospital, St John's House and the Institution of Nursing Sisters in London.⁵³ Other networks were probably at work. Since before the nineteenth century, towns had become part of a system which linked neighbouring urban centres and towns and cities both nationwide and internationally.⁵⁴ For example, close business, philanthropic and family ties between the commercial and manufacturing elites of Liverpool and Manchester probably contributed to the development of the nursing institution in the latter city in 1864. The organisation of district nursing in Manchester mirrors the one established earlier in Liverpool. This influence continued throughout this period, the rules of the Cheltenham Nursing Institution, founded in 1867, being a direct copy of those in Liverpool and Manchester. These associations were in advance of nursing reform at the hospitals in their localities. During the 1860s, although hospitals considered the reform of nursing, their efforts did not necessarily conform to the pronouncements of Nightingale and others. Indeed, Margaret Goodman, who had nursed in and had written a book about her experiences in the Crimea, when Matron of the Birmingham General Hospital, in 1864, still conformed

⁵³ Derby Local Studies Library (hereafter DLSL), Derby and Derbyshire Nursing and Sanitary Association, *Annual Report 1865* (A610.73), p. 7.

⁵⁴ J. Stobart, *The first industrial region: north-west England c1700-60* (Manchester, 2004), p.223.

to the old view of the matron's role, being concerned mainly with housekeeping duties.⁵⁵ Matrons and nurses were sent from London and St Thomas's in particular, to the provinces, but appear initially to have had limited impact on the reform of nursing. This is a point of contention as the records of the Nightingale Fund clearly show that nurses were sent to hospitals across England from the 1860s onward. Lynn McDonald has disputed Monica Baly's use of a quote by Henry Bonham Carter, the secretary of the Nightingale Fund, indicating that the Nightingale School only produced two good superintendents in its first ten years.⁵⁶ McDonald points to the large number of hospitals to which nurses were sent as evidence of the success of the school.⁵⁷ However, an important factor is not whether nurses went to hospitals it is whether they were effective in reforming nursing. Records from hospitals in the towns in this study show that reform of nursing did not occur until later in the century, and that the matrons from St Thomas's Hospital and elsewhere were less than effective in the early years. For instance, Fanny Lovesay, a Nightingale nurse from the class of 1861, was matron at both the Staffordshire Infirmary in the 1860s and the Birmingham General Hospital in the 1870s, but she seems to have done little to reform nursing in either hospital. Changes in the latter hospital were only accomplished by Alice Fisher, another Nightingale nurse, in 1884.⁵⁸ Similarly, the nurses sent to the Lincoln County Hospital in 1866 were disastrous and reform of nursing

⁵⁵ Birmingham Archives and Heritage (hereafter BAH), General Hospital, Birmingham, *Notes of evidence taken before the special committee considering the general, medical and financial conditions and administration of the hospital, and the laws and regulations affecting its constitution and management*, 1863-4, p. 104 (MS 23479).

⁵⁶ M. E. Baly, *Florence Nightingale and the nursing legacy*, Second Edition (London, 1997), p. 64.

⁵⁷ L. McDonald, *Florence Nightingale: The Nightingale School*, Collected Works of Florence Nightingale, Volume 12 (Waterloo, 2009), pp. 6-8; L. McDonald, *Florence Nightingale: extending nursing*, Collected Works of Florence Nightingale, Volume 13 (Waterloo, 2009), pp. 38-39.

⁵⁸ S. Wildman, 'Changes in hospital nursing in the west midlands, 1841-1901', in J. Reinartz (ed.), *Medicine and society in the midlands, 1750-1950* (Birmingham, 2007), pp. 110-11.

in that hospital did not occur until 1879.⁵⁹ Thus, it would appear that the initial impetus for reform in many provincial towns came from local nursing associations and not the hospitals. It is not sufficient to plot the geography of local associations; it is important to answer the question why did nursing reform occur in the towns and cities in this study? These organisations came about because of the commitment of dedicated individuals or small groups of people. Associations were established through the active involvement of local elites, the strong presence of the Anglican church or other protestant groups within local life, the activities of prominent medical practitioners and the presence of significant middle-class support, including the participation of middle-class women. The next part of this chapter will analyse these groups in detail.

Local elites

Nursing associations in the provinces, like other voluntary societies and charities, were established, supported and managed by local elites who held leadership roles in the major institutions of the town, its immediate district or the county. It is useful to refer to theories regarding social stratification as a tool to understand the involvement of the middle and upper classes in philanthropic activity. According to Bourdieu, a person's station in life or status is determined by a combination of economic, social and cultural capital.⁶⁰ Local elites comprised, in part, the wealthiest members of a town, having the necessary economic capital and resources to support an appropriate lifestyle and a number of charities and societies. Social capital refers to membership and involvement in social networks and relationships. Cultural capital is linked to social capital and consists

⁵⁹ See the section below for details of the attempted reform in the hospital, 1864-6.

⁶⁰ R. Jenkins, *Pierre Bourdieu* (London, 2002), p. 85.

of dispositions, skills, assets and resources obtained through social learning, education, leisure and consumption. Economic, social and cultural capital conferred power, status and resources on individuals and helped to maintain their position within society.

Furthermore, people who held prominent positions in local organisations, particularly civic institutions, religious groups and charitable societies, earned widespread respect.⁶¹

This is known as symbolic capital. The local elites involved in all of these associations had considerable social, cultural and symbolic capital within the particular urban environments that they lived or worked.

Elites in the towns in this study had extensive social networks and were members of a number of organisations that brought them into contact with each other. The elite in many towns could be found supporting various societies associated with the arts, education, literature, the sciences and statistics, as well as being associated with philanthropic associations concerned specifically with support for the working classes. In addition, businessmen in large towns were often members of the local chamber of commerce or other trade organisations. Religious worship brought men and women together regularly either in parish churches or non-conformist chapels. An example was the Unitarians, who were very active in charitable organisations, even though they made up a very small proportion of the populations of the towns in this study.⁶² Thus, the Renshaw Street Chapel in Liverpool, the Cross Street Chapel in Manchester and the Church of the Messiah in Birmingham were important centres which responded to perceived social

⁶¹ R. H. Trainor, *Black country elites: the exercise of authority in an industrialized area, 1830-1900* (Oxford, 1993), pp. 18-19.

⁶² For instance, the Unitarians made up only 1.8% of the church-going population in Manchester in 1851, see V. A. C. Gatrell, 'Incorporation and the pursuit of liberal hegemony in Manchester, 1790-1839', in D. Fraser (ed.), *Municipal reform and the industrial city* (Leicester, 1982), p. 25.

problems. Influential members of these congregations were actively involved in nursing reform. Not only this, but the Unitarian elite had connections with other towns through business and intermarriage.⁶³ In fact, most professional men, irrespective of religious adherence, had wide geographical networks, and some local campaigners were linked to influential individuals, national movements and organisations which promoted social reform. Members of the local elite in the large towns in this study had connections with the National Association for the Promotion of Social Sciences, a ‘think-tank’ concerned with practical policy making on subjects such as poverty and medical reform.⁶⁴ Thus, religious, business and social networks within an area enabled those individuals and groups promoting the establishment of voluntary societies, such as nursing charities, to seek information at a national level and recruit local support for their projects.

The composition of elites varied from town to town. In the large industrial cities, including Liverpool, Manchester and Birmingham, men who were involved in the productive economy, such as wealthy manufacturers, merchants and commercial entrepreneurs, or the professions, dominated associations. Shapely has identified such a ‘charitable elite’ within Manchester during the nineteenth century. This group of men held both honorary and management positions in an extensive range of charities. The Manchester Nurse Training Institution was no exception, as five out of fifteen of the officers or members of the first committee appear in a list identified by Shapely as the charitable elite, and the wives of six of these charitable leaders were involved in the

⁶³ K. D. M. Snell and P. S. Ell, *Rival Jerusalems: the geography of Victorian religion* (Cambridge, 2000), p. 114.

⁶⁴ R. Gray, ‘The platform and the pulpit: cultural networks and civic identities in industrial towns, c. 1850-70’, in A. Kidd and D. Nicholls (eds), *The making of the British middle class: studies of regional and cultural diversity since the eighteenth century* (Stroud, 1998), pp. 132, 135.

ladies committee.⁶⁵ The reform of nursing was therefore an important activity supported by Manchester's most prestigious citizens. In Liverpool, a 'local aristocracy of merchant princes', led by Unitarians such as William Rathbone, fulfilled a similar role.⁶⁶

Likewise, in Birmingham, the promoters of nursing reform came from those 'substantial burgesses' of the town who were involved in municipal activism known as the 'civic gospel'.⁶⁷ In other areas, such as the county towns, the local elite came from professional and commercial interests, but also from the traditional leaders such as landowners and wealthy farmers. In all associations, ministers of religion were involved and held a significant presence. Table 3.2 demonstrates the composition of the first management committee for each association. The dominance of industry and commerce in the large industrial towns is further demonstrated by examining the status of the husbands or male relatives of those women who held responsibilities within associations. Table 3.3 shows that these male relatives came predominantly from the commercial classes. Irrespective of who took part in these associations, the elites dominated committees, took most of the elected posts and were instrumental in directing the day-to-day work. For instance, like other charitable societies, the treasurers were mainly drawn from those in commercial trade.⁶⁸ Those from Manchester, Salisbury and Stratford-on-Avon were bankers, whilst Timothy Kenrick, the treasurer for the institution in Birmingham, was a wealthy industrialist.

⁶⁵ Manchester Archives and Local studies (hereafter MALS), Manchester Nurse Training Institution, *Annual Report*, 1866 (362.1 M85); Shapely, *Voluntary charities*, pp. 403-4.

⁶⁶ M. Simey, *Charity rediscovered: a study of philanthropic effort in nineteenth-century Liverpool* (Liverpool, 1992), p. 50.

⁶⁷ A. Briggs, *Victorian cities* (London, 1968), p. 220.

⁶⁸ Shapely, *Voluntary charities*, p. 75.

Table 3.2: Composition of the first management committee of the nursing associations in this study, c.1862-72⁶⁹

| | C of E Clergy | Women | Doctors | Professional | Commerce & Industrial | Land owners & Farmers | Other / or not known | Total |
|---------------------|---------------|-------|---------|--------------|-----------------------|-----------------------|----------------------|-------|
| Birmingham | 2 | 15 | 7 | 3 | 3 | 0 | 2 | 32 |
| Cheltenham | 3 | 0 | 2 | 1 | 0 | 0 | 3 | 9 |
| Derby | 3 | 0 | 3 | 1 | 2 | 1 | 0 | 10 |
| Lichfield | 11 | 0 | 2 | 1 | 2 | 1 | 3 | 20 |
| Lincoln | 0 | 3 | 0 | 0 | 0 | 0 | 0 | 3 |
| Liverpool | 1 | 0 | 0 | 0 | 5 | 0 | 1 | 7 |
| Manchester | 2 | 0 | 5 | 0 | 5 | 0 | 3 | 15 |
| Salisbury | 9 | 0 | 3 | 0 | 1 | 2 | 4 | 19 |
| Stratford-upon-Avon | 5 | 0 | 2 | 0 | 3 | 5 | 0 | 15 |

⁶⁹The names of committee members were taken from the relevant annual reports and their status determined using the following sources: W. E. A. Axon, *The annals of Manchester: a chronological record from the earliest times to the end of 1885* (Manchester, 1886); *Birmingham Faces and Places*, Volume 5, (1893), p. 165; BAH Birmingham Collection, *Newspaper Cuttings, Birmingham Biography*, Volume 1, 1 (1875), pp. 156-7; Volume 1, 2 (1878), pp. 66-72, 90; Volume 1, 2 (1886), pp. 265-70; Volume 2 (1893), pp. 35-38; Volume 5 (1905), pp. 132, 138a-9; Volume 8 (1912), pp. 90-102; E. Cassey & Co. *Directory of Shropshire* (Shrewsbury, 1871); G. Cox, *The clergy list for 1870* (London, 1870); E. S. Drake & Co., *Drake's Directory of Derby* (Sheffield, 1862); R. E. H. Duke, 'An account of the family of Duke, of Lake', *Wiltshire Notes & Queries*, 8, June 1915, p. 249; *Edgbastonion*, 5, 51 (January 1885), pp. 99-101; 9, 93 (January 1889), pp. 1-5; H. Edwards, *Royal Cheltenham and County Directory 1872/3* (Cheltenham, 1872); W. Gaskill, *Wiltshire leaders: social and political* (London, 1906), pp. 193-94; A Green & Co., *Directory for Liverpool and Birkenhead* (London & Liverpool, 1870); J. G. Harrod & Co., *Directory of Derbyshire 1870* (London, 1870); E. R. Kelly & Co., *The Post Office Directory of Hampshire, Wiltshire & Dorsetshire* (London, 1875); E. R. Kelly & Co., *Post Office Directory of Warwickshire* (London, 1876); *Manchester Faces and Places*, Volume 1, 3 (1889), pp.33-37; Volume 1, 5 (1890) pp. 79-80; Volume 1, 6 (1890), pp. 90-93; Volume 3 (1892), pp. 129-133; Volume 3 (1892), p. 191; Volume 5 (1894), pp. 186-188; Morris & Co., *Commercial Directory & Gazetteer of Lincolnshire* (Nottingham, 1863); J. Mawdsley, *Gore's Directory of Liverpool and Its Environs* (Liverpool, 1862); B. G. Orchard, *Liverpool's Legion of Honour* (Birkenhead, 1893); W E Owen & Co., *Directory for the counties of Wiltshire, Somersetshire, with the cities of Bristol and Bath* (Leicester, 1878); *Palmer's Stratford on Avon Almanack and Directory* (Stratford, 1875); I. Slater Slater's *Royal National Commercial Directory of Manchester & Salford 1877-8* (Manchester, 1877); I. Slater, *Slater's Royal National Commercial Directory of Manchester & Salford 1883* (Manchester, 1883); Francis White & Co., *History, Gazetteer and Directory of Warwickshire* (Sheffield, 1874).

Table 3.3: Occupations of husbands or male relatives of the first women involved in the management of an association, c.1862-1870⁷⁰

| | C of E Clergy | Minister of religion | Doctor | Professional | Commerce & Industrial | Not known | Total |
|------------|----------------------|-----------------------------|---------------|---------------------|----------------------------------|------------------|--------------|
| Birmingham | 1 | 0 | 2 | 3 | 8 | 1 | 15 |
| Liverpool | 1 | 1 | 1 | 1 | 10 | 0 | 14 |
| Manchester | 1 | 0 | 4 | 1 | 27 | 6 | 39 |

Committee members were drawn from those who supported other major medical charities, such as the local voluntary hospitals. The Manchester institution's committee consisted in part of members who were the president and vice president of the Salford Hospital, the president of the Children's Hospital, the treasurer, deputy treasurer and trustees of the Manchester Royal Infirmary and committee members, physicians and surgeons of all three hospitals. In addition, some committee members or male relatives of the members of the ladies committee were officers or subscribers to the voluntary hospitals or to the Manchester and Salford Sanitary Association. A similar pattern existed in Birmingham, where committee members of the nursing institution were office holders or subscribers to other medical charities such as the General, Queen's, Children's, Eye, Ear, Nose and Throat and Women's hospitals, as well as the General Dispensary.

⁷⁰ Information is drawn from those sources used for Fig. 3.1.

This situation was not just confined to the industrial towns, for the first committee of the Salisbury institution (1872) comprised of two landowners, two surgeons, one physician, five clergymen and the ex-officio members were the Bishop of Salisbury (president), the three archdeacons, the mayors of Salisbury and Dorchester, and the president, treasurer and chairman of Salisbury Infirmary.⁷¹ Four of the committee were magistrates. There were strong connections with the infirmary as three out of the ten named members of the association's committee were office holders in the infirmary, nine were subscribers and there was one consulting physician and one consulting surgeon. In addition, seven members of the committee subscribed to the 'Medical Club and Provident Dispensary for Salisbury', and one member was its secretary.⁷² The Church of England dominated the association with fourteen of the cathedral clergy featuring in the first list of those promising to subscribe to the new association.⁷³ Salisbury's local elite were represented and had strong connections with the church. They included one influential businessman, William Pinckney, a banker and prominent churchman, who acted as treasurer to the Association, the infirmary and the Medical Club.⁷⁴ Thus, the medical charities in and around Salisbury were interconnected and heavily influenced by a group of people representing the church, the medical profession and the local landed gentry and who constituted the local elite.

⁷¹ Wiltshire and Swindon Record Office (hereafter WRSO), Salisbury Diocesan Institution for Trained Nurses, Minute Book 1871-1876, 21 November 1871, (J8/109/1).

⁷² Sources: G. Cox, *The clergy list for 1870* (London, 1870); E. R. Kelly & Co., *The Post Office Directory of Hampshire, Wiltshire & Dorsetshire* (London, 1875); W E Owen & Co., *Directory for the counties of Wiltshire, Somersetshire, with the cities of Bristol and Bath* (Leicester, 1878); R. E. H. Duke, 'An account of the family of Duke, of Lake', *Wiltshire Notes & Queries*, 8, June 1915, p. 249; WRSO, Medical Club and Provident Dispensary for Salisbury and its neighbourhood, 1873, Report for 1872 (776/586).

⁷³ WRSO, Salisbury Diocesan Institution for Trained Nurses, Minute Book, 1871-1876, 21 November 1871 (J8/109/1).

⁷⁴ W. Gaskell, *Wiltshire leaders: social and political* (London, 1906), pp. 193-94.

It has been suggested that voluntary associations united the middle classes during a time when different levels of status, religious adherence and political views might lead to fragmentation and conflict.⁷⁵ Different groups within local society were more likely to work together in a ‘civilising mission’ to the poor from the middle of the century onward.⁷⁶ Medical charities were relatively uncontroversial in the larger towns and were often supported by a number of groups and sects.⁷⁷ This was certainly the case in Birmingham, Bristol, Liverpool and Manchester, where nursing associations were supported by the urban elite from different Protestant denominations and different political parties. In Birmingham, the committee members of the nursing institution, although dominated by those who were Liberals and members of nonconformist sects, including the Unitarians, Quakers, Congregationalists and those of independent congregations such as that of George Dawson, also included Conservative party supporters and prominent Anglicans. This situation can be seen elsewhere including Manchester.⁷⁸ However, it was different in the county towns where associations, and the diocesan associations in Lichfield and Salisbury in particular, were controlled by Anglicans who did not accept the involvement of other denominations. These associations insisted that the nurses had to be members of the Church of England, but tried to temper this by insisting that they could nurse patients from other Protestant sects and that they were forbidden to proselytise.⁷⁹ Sensitivity regarding different religious views led the Salisbury association to insist that nurses should refrain ‘from extremes of

⁷⁵ R J Morris, ‘Voluntary societies and British urban elites, 1750-1850: an analysis’, *The Historical Journal*, 26, 1 (1983), pp. 99-118.

⁷⁶ S. Gunn, *The public culture of the Victorian middle class: ritual and authority and the English industrial city, 1840-1914* (Manchester, 2000), p. 22.

⁷⁷ Trainor, *Black country elites*, p. 324.

⁷⁸ Shapely, *Voluntary charities*, p. 29.

⁷⁹ See, for instance, Shakespeare Birthplace Trust Archive (hereafter SBTA), Nursing Institute, Stratford-upon-Avon, *Rules for Nurses* c.1872 (DR 27/511).

dress, phraseology, or thought', and Miss Michell, the lady superintendent was censured by the bishop for introducing confession into the nurses' home.⁸⁰ The exclusive Anglican nature of the management of the Lichfield association resulted in conflict within the diocese and ended in the creation of a separate association in Derby (see below).

Many members of these urban elites gained reputations and considerable social standing as a result of their commitment to local charities and they accumulated considerable symbolic capital as a result. Men such as Oliver Heywood, the treasurer of the Manchester institution, received both the freedom of the city and had a statue erected in his honour as a result of his exemplary philanthropic work over a number of years.⁸¹ Not only was it important for associations to have prominent people in leading roles, sufficient subscribers within the locality were also needed for the charity to be viable. Associations looked to the local nobility, bishops, members of parliament and other prominent citizens who held symbolic capital to take on the role of patron, president or trustee of an association in order to persuade members of the public that nursing was a cause deserving their support.⁸² Meetings were often held in prestigious locations, such as mayors' parlours, town halls or other prominent local buildings. As annual general meetings were widely reported in the local press, they were often presided over by the mayor, bishop, or other local notable whose symbolic capital gave the association an air of esteem.

⁸⁰ WRSO, Salisbury Diocesan Institution for Trained Nurses, Minute Book, 1871-1876, 21 November 1871 and 15 March 1873 (J8/109/1).

⁸¹ Shapely, *Voluntary charities*, pp. 217-21.

⁸² For instance in 1869 the Derby association enjoyed the patronage of a duke, 4 lords a bishop, 2 countesses and 5 ladies. In addition 2 members of parliament were vice presidents. By 1891, the Prince and Princess of Wales were the patrons and the association had a 'Royal' prefix.

The latter point is illustrated by contrasting the situation in towns such as Ipswich and Leeds. In both cases, there was a failure to attract sufficient numbers of supporters and the economic capital required to set up an association in the late 1860s. In Ipswich, the governors and medical staff of the local voluntary hospital were particularly hostile to the idea and there was a poor turn out at meetings to discuss the issue.⁸³ It was not until the mid 1870s that these towns had adequate support for the establishment of nursing associations.⁸⁴

Religion

Religious groups were important in the establishment and support of nursing associations. In the three largest cities in this study - Liverpool, Manchester and Birmingham - adherents of nonconformist sects described as 'old dissent', in particular the Congregationalists, Unitarians and Quakers, were particularly active in spite of their small numbers. These groups were well represented within the wealthy upper-middle classes. For instance, the Rathbones of Liverpool and Kenricks of Birmingham were Unitarians who were prominent in nursing reform in their respective cities and had been active in philanthropy since the early part of the nineteenth century. By mid-century, in large urban areas, alliances between the nonconformists and members of the Church of England took place in the support of charity. This also prevented philanthropy from becoming a source of political conflict as the nonconformists were more likely to be Liberals, whilst the Anglicans were primarily Tory. In contrast, in the county towns, it was the Anglicans or the Church of England that was instrumental in promoting nursing

⁸³ 'The dispensary and nursing home movement', *Ipswich Journal*, 1 June 1867.

⁸⁴ 'Ipswich nurses home', *Ipswich Journal*, 23 December 1876; *Leeds Mercury*, 3 November 1875.

associations. In Lincoln, Lichfield and Salisbury, the clergy of the respective cathedrals were deeply involved in nursing reform. In Cheltenham and Stratford-upon-Avon, local vicars and prominent lay members of the parishes took the lead. It is unsurprising that ministers of religion were involved in nursing reform as ‘men with opinions, skills and time, ministers were an integral part of the machinery of relief and welfare provision’ in most towns.⁸⁵ Appendix 9 reveals that the local clergy made contributions amounting to about ten percent of subscriptions and donations to the associations in Derby, Lincoln and Stratford-upon-Avon where they were particularly active. The value of this support is likely to be an underestimate as they were crucial in mobilising members of their respective congregations. They were part of the local elite with many connections within the locality and were able to recruit a team of lay church workers, especially women. Some middle-class women found meaning in charitable work and gave their time as voluntary district visitors to dispense charity, visit the sick and persuade people to attend church.⁸⁶

A diocesan revival occurred within the Church of England between 1800 and the 1870s in which new opportunities for clergy and laity to participate in the collective life of the diocese occurred.⁸⁷ Not only was diocesan administration and influence improved and also extended through the foundation of boards of education and colleges of education and theology, but many societies and charities, some aimed at supporting the poor, were set up as diocesan initiatives.⁸⁸ It was this revival that probably accounts for the proposals

⁸⁵ S. Yeo, *Religion and voluntary organisations in crisis* (London, 1976), p. 57.

⁸⁶ H. Mcleod *Religion and society in England, 1850-1914* (MacMillan, 1996), p. 26.

⁸⁷ A. Burns, *The diocesan revival in the Church of England, c1800-1870* (Oxford, 1999), p. 2.

⁸⁸ *Ibid.* pp. 114, 122 & 148

to set up nursing associations in the Lichfield and Salisbury dioceses in 1864 and 1871 respectively. The Lichfield initiative came from two clergymen who had been instrumental in the proposal and establishment of a theological college in the 1850s.⁸⁹ One of these, E. J. E. Edwards, was already active in attempting to reform nursing in the North Staffordshire Infirmary.⁹⁰ In Salisbury, the proposal to set up a nursing association was circulated widely amongst members of the diocesan synod by those members connected to the Salisbury Infirmary and actively supported by the bishop.

In Lincoln, the cathedral's involvement in nursing reform appears not to be part of an organised diocesan revival but an orientation of the clergy toward the 'physical and cultural, as well as the spiritual, well-being of the working classes' from the 1860s onward.⁹¹ They were mainly at the forefront of educational initiatives, but did provide relief in the form of soup kitchens for the poor.⁹² The meetings of the committee of the fledgling Ladies Nursing Fund were actively supported by people connected with the cathedral and the wider church including four wives of the clergy in Lincoln and four clergymen, but following the creation of the Institution of Nurses, management came under the control of women not directly connected to the clergy.⁹³

The initiatives in Cheltenham and Stratford-upon-Avon were generated by the Anglican church. In both towns, the activity of Evangelical incumbents enabled the respective

⁸⁹ E. C. Inman, *History of Lichfield Theological College* (Lichfield, 1928), p. 14.

⁹⁰ E. J. Edwards, 'Preface', in Dr T. Arlidge, *Suggestions on hospital nursing and visiting: being an address read at Trentham Parsonage on Wednesday May 24th 1864* (Newcastle, 1864).

⁹¹ D. Mills, 'A 'tech' school for Lincoln', *Family and Community History*, 7, 2 (2004), p. 133.

⁹² F. Hill, *Victorian Lincoln* (Cambridge, 1974), pp. 142, 277-278; D. M. Thompson, 'Historical Survey, 1750-1949', in D. Owen (ed.), *A History of Lincoln Minster* (Cambridge, 1994), p. 251.

⁹³ Lincolnshire Archives (hereafter, LA), Committee of the Ladies Nursing Fund, Draft minute book, 1865-1867, 1 December 1865 (Bromhead 1/1).

institutions to develop. In Cheltenham, the Reverend Fenn, the vicar of Christ Church, had built up thriving parish activities and organizations which included district visiting, the distribution of money and materials to the sick and working poor, schools, a lying-in charity, a mission room, which included a reading room and parochial library, and, importantly, the provision of a district nurse for the sick in the parish.⁹⁴ In Stratford-upon-Avon, a similar situation arose with the nursing institution being created as a branch of the Church Workers Association an organization under the presidency of the vicar J. D. Collis.⁹⁵

It would appear that there was widespread activity in parishes and towns initiated by the local clergy or ministers of religion that provided the right conditions and thus enabled nursing associations to be formed. This required the active involvement of members of the appropriate congregations who had both the necessary economic, social and symbolic capital to support such developments. Whilst missions to the poor existed in most towns across England, relatively few in the 1860s and early 1870s established nursing associations. The religious context of reform must be seen as particular to each locality and dependent upon the agency of motivated individuals and groups, with access to sufficient resources. In addition, the strength of feeling about religious faith which lead to disputes between and within the different Christian denominations could lead to conflict. Within the Anglican church, religious or ‘party’ divisions between the Evangelicals and

⁹⁴ J. K. Cavell, *Story of Christ Church, Cheltenham* (Cheltenham, n.d.), p. 14.

⁹⁵ SBTA, Nursing Institute, No. 23 West Street, Stratford-upon-Avon. Circular regarding the founding of the institute, its purpose, costs of nurses and appeal for donations, c1872 (DR 406/67); *Palmer's Stratford on Avon Almanack and Directory* (Stratford, 1875).

Tractarians, as seen in the controversy over nursing sisterhoods, resulted in a bitter dispute within the Lichfield diocese over the founding of a nursing association.⁹⁶

The diocese of Lichfield was made up of the counties of Staffordshire, Derbyshire and part of Shropshire. Sometime during the latter part of 1864, two clergymen (the Reverend E. J. E. Edwards of Trentham and the Reverend E. T. Codd of Cotes Heath in Staffordshire) suggested to John Lonsdale, the Bishop of Lichfield, that he should approve the development of a nursing association for the diocese. Over ten years previously they had proposed the formation of a Diocesan Theological College for the training of future parish clergy.⁹⁷ This proposal proved to be contentious and was opposed by evangelicals across the diocese who thought that it would turn into a ‘Jesuit seminary’.⁹⁸

There is little biographical information regarding Edwards or Codd and, therefore, their position in terms of adherence to a church party cannot be ascertained.⁹⁹ Edwards was a member of the diocesan establishment being a prebendary of the Cathedral and a member of the Diocesan Board of Education.¹⁰⁰ John Lonsdale had been bishop since 1843 and

⁹⁶ Much of this discussion has been published in S. Wildman ‘Nursing and the issue of ‘party’ in the Church of England: the case of the Lichfield Diocesan Nursing Association’, *Nursing Inquiry*, 16, 2, 2009, pp. 94-102.

⁹⁷ E. C. Inman, *History of Lichfield Theological College* (Lichfield, 1928), p. 14; A. Burns, *The diocesan revival in the Church of England c1800-1870* (Oxford, 1990), p. 154.

⁹⁸ M. A. Crowther, *Church embattled: religious controversy in mid-Victorian England* (Newton Abbot, 1970), p. 21.

⁹⁹ Codd may have been a Tractarian, for he contributed to the proceedings of the Cambridge Camden Society in 1841. This was an organisation in which the Tractarians were active in promoting a Gothic style which adhered to Catholic ideas about church architecture. In addition, he composed twenty-five chants for Anglican services, an endeavour that would never have been approved by evangelical Anglicans. Sources: ‘University Intelligence’, *Cambridge University Magazine*, 2 (1841), p. 302; E. T. Codd, *Twenty five chants, single and double* (London, 1859).

¹⁰⁰ *Staffordshire Sentinel*, 20 May 1865, p. 4.

tried to be fair to people of all beliefs within the church. He was active in reviving the diocese by promoting the establishment of diocesan organisations and a diocesan assembly, something which aroused the suspicions of evangelicals.¹⁰¹ He showed little sympathy with ritualism, but apparently in private he preferred Tractarians to evangelicals as they were more likely to be gentlemen.¹⁰²

Preliminary meetings were convened in November and December 1864 in Shropshire, Staffordshire and Derbyshire to canvas support amongst members of the Church of England for an association.¹⁰³ Opposition surfaced at the preliminary meetings at Derby and in Ashbourne, located ten miles to the northwest of Derby. It was led by Francis Wright of Osmaston Manor, near Ashbourne, who was joined by Dr William Ogle, a physician at the Derbyshire General Infirmary, other leading landowners and citizens and also a majority of the clergy in and around the town of Derby. These people, rather than being a random collection of individuals, were part of a highly organised group of Evangelicals who were determined to protect the English Protestant church from the assault of the Tractarians, and, as such, Derby was known as one of the ‘fortresses of Evangelical doctrine and discipline’.¹⁰⁴ Opposition centred on the idea that the association if organised on an ecclesiastical or diocesan basis could be subverted into a sisterhood by a future bishop or controlling clergy.

¹⁰¹ Burns, *The diocesan revival*: p. 253

¹⁰² E. B. Denison *The life of John Lonsdale, Bishop of Lichfield* (Lichfield, 1868), p. 240

¹⁰³ *The Derby Mercury*, 11 January 1865, p. 2

¹⁰⁴ E. H. Bickersteth, *Evangelical churchmanship and evangelical eclecticism* (London, 1883), p. 13.

Francis Wright came from a well-connected family, was a very wealthy industrialist, but was generous in his support of worthy causes and was involved in a number of charitable schemes including the building of schools, churches, houses for his workers and the Derbyshire General Infirmary.¹⁰⁵ He opposed ritualism in the Church of England and, accordingly, built a new church in Ashbourne when the incumbent introduced high church services.¹⁰⁶ In 1860, he purchased the living of St Peter's, Derby in order to re-evangelise the church and with the 'purpose of extinguishing ritualism'.¹⁰⁷

William Ogle was appointed physician to the Derbyshire General Infirmary in 1860. He was a committed Evangelical Christian and his religion was the mainspring of his life. He actively supported charitable organisations, including the Young Men's Christian Association. According to a biographer, he was doctrinaire, pedantic, tactless, formidable and humourless despite his integrity.¹⁰⁸ However, he was a man of great energy and enthusiasm for reform particularly in the field of health care including the management of hospitals and the modernisation of nursing.

Wright and Ogle were allied to the evangelical clergy of Derby and its immediate vicinity. Vicars, such as Edward Foley and William Wilkinson, held appointments in parishes in the centre of the town and were active churchmen in terms of their religion,

¹⁰⁵ G. Smith, *Recollections of the late Francis Wright of Osmaston Manor, Derbyshire* (Derby, 1873), p. 52; R. Christian, *Butterley brick: 200 years in the making* (London, 1990), p. 87.

¹⁰⁶ G. Turbutt, *A history of Derbyshire* (4 volumes, Cardiff, 1999) Volume 4, p. 1579.

¹⁰⁷ C. J. Payne, *Derby churches: old and new* (Derby, 1893), pp. 52, 118-120.

¹⁰⁸ D. Hubble, 'William Ogle of Derby and Florence Nightingale', *Medical History*, 3 (1959), p. 205.

but also in their social action to support the poor, particularly in the field of education.¹⁰⁹ In 1859, these men joined with like-minded clergymen, members of the county elite and prominent citizens of the town to form the Midland branch of the Clerical and Lay Association for the Maintenance of Evangelical Principles.¹¹⁰ This association promoted an annual conference where biblical topics were discussed and perceived threats to the Protestant religion debated. It was particularly prominent in its opposition to *Essays and Reviews*, a publication of 1860 that questioned the literal truth of the Bible.¹¹¹ It opposed ritualism in all forms. It also promoted the idea of education for the middle classes, which resulted in the establishment of Trent College in 1868.¹¹² Thus, the idea of a nursing association that could become a ‘Puseyite sisterhood’ would inevitably be opposed within Derbyshire.¹¹³

Rather than accept the proposal for a diocesan association, Wright and Ogle canvassed the town and county of Derby for support for a rival organisation. This would, like most voluntary charitable organisations, such as the voluntary hospitals, invite people from all Protestant denominations (established church and nonconformists) to subscribe to and participate in the management of the new organisation. Ogle wrote to Nightingale for her advice and forwarded a prospectus he had written for her consideration in late December

¹⁰⁹ For Foley, see N. Scotland, *Evangelical Anglicans in a revolutionary age 1789-1901*, p. 387; for Wilkinson’s work, see DLSL: W. F. Wilkinson, *Address to the parishioners and congregation of St Werburgh’s, Derby, 1852-1865* (BA283).

¹¹⁰ K. Harris, *Evangelicals and education: evangelical Anglicans and middle-class education in nineteenth-century England* (Milton Keynes, 2004), p. 145.

¹¹¹ *The Record*, 30 January 1861, p. 3.

¹¹² K. Harris, *Evangelicals and education*, p. 146.

¹¹³ M. A. Crowther, *Church embattled: religious controversy in mid-Victorian England* (Newton Abbot, 1970), p. 21.

1864.¹¹⁴ In this prospectus, Ogle put forward two objections to the planned diocesan association. The first was that ‘the work of the Nurse must not be confounded with religious teaching, or it will be swallowed up by it’ and, second, that the three counties of Shropshire, Staffordshire and Derbyshire were not geographically and commercially linked enough for an association across the diocese to be successful.¹¹⁵

A formal meeting to approve the diocesan scheme was arranged to take place in Derby on 3 January 1865. At this meeting, considerable opposition to the exclusive nature of the scheme was raised by a large number of lay and clerical members of the church. Wright pleaded with the bishop, who chaired the meeting, to discuss this issue. The Bishop stated that the meeting had been called to formally inaugurate the diocesan association and that he regretted the ‘insinuation of latent design in our proceedings this day’ and could not see ‘why such a supposition should have been hazarded’ as the organisation would treat both churchmen and dissenter if properly recommended.¹¹⁶ A debate, in the Bishop’s opinion, would lead to trouble and contention and so he indicated that those who opposed the scheme should leave the room.¹¹⁷ Wright left with a large number of like-minded clergymen and lay members, including one Member of Parliament and one member of the House of Lords. Dr Ogle remained in the room to take notes and was openly criticised for being ‘no friend of the scheme’, for his conduct which was ‘unbecoming of a Christian Gentleman’ and for circulating information about the rival scheme at the

¹¹⁴ BL, Add. MSS. 47758. *Nightingale Papers*. Vol. CLVI. Correspondence with William Ogle, MD, Physician of the Derbyshire General Infirmary; ff106-7 December 1864 & ff108, 28 December 1864; W. Ogle, *Proposed Derby and Derbyshire or Midland Counties Sanitary Association and home for training of nurses* (Derby, 1864).

¹¹⁵ *Ibid.*, p. 1.

¹¹⁶ *The Record*, 11 January 1865, p. 3.

¹¹⁷ *Ibid.*

beginning of the meeting.¹¹⁸ The formation of the diocesan association was approved and the Reverend E. J. E. Edwards was appointed secretary.

The *Derby Mercury* was deeply critical of the opponents of the scheme, indicating that they were influenced by bigotry and describing them and others elsewhere in the country as an ‘organized opposition dictated by party spirit’.¹¹⁹ *The Derbyshire Advertiser* offered a different view, stating that it would have been wiser to have discussed the issues with the opponents given their ‘high position in the county’ in order to provide a satisfactory explanation to the points that they had made. According to this editorial, the refusal to discuss and debate the issues ‘showed little confidence in the soundness of the proposal’.¹²⁰ Dr Ogle in a letter to the *Derby and Chesterfield Reporter* claimed that, in correspondence with the Reverend Edwards, he had been promised that the meeting would be public and the proposal would be open to discussion and, as a result, the bishop had been put in a false position in denying debate.¹²¹

The Derby group were the first to act and, at a meeting on the 20 January, they elected a committee. The meeting agreed to investigate ‘the possibility of making without sacrifice of principle, an arrangement for general cooperation’ with the diocesan association.¹²² The committee met on 27 January and agreed to write to the Archdeacon to outline their request for a reconsideration of the diocesan scheme as no reasons were given as to why the association should be exclusively a church-based organisation in contradiction to the

¹¹⁸ Ibid.

¹¹⁹ *Derby Mercury*, 1 March 1865, p. 5.

¹²⁰ Editorial in the *Derbyshire Advertiser*, quoted in *The Record*, 11 January 1865, p. 3.

¹²¹ Correspondence from W. Ogle, *Derby and Chesterfield Reporter*, 6 January, 1865, p. 5.

¹²² *Castle Donnington Telegraph and Leicestershire and Derbyshire Advertiser*, 4 February 1865, p. 4.

way in which hospitals were normally managed. In addition, they felt that the request was reasonable as so many influential people and the majority of the clergy of Derby had objected to the diocesan association. Finally, they asked for the title to be changed to a ‘Midland Counties Association’ and that both nonconformists and churchmen should work together in promoting and managing the association. The Archdeacon replied in February stating that the Bishop wanted the two sides to meet, but subsequently the Reverend Edwards stated that no diocesan committee had been formed and that he could not act on behalf of the association. On 9 March, the Derby group had a private meeting with the Bishop who advised them to use the name of ‘Derby and Derbyshire’ instead of Midland Counties and to leave Staffordshire to Mr Edwards. The Bishop agreed to be a vice-patron of the association, but regretted that there would now be two organisations within Derbyshire.¹²³ Following this, the Derby and Derbyshire Nursing and Sanitary Association gathered a lot of support with £450 being donated in the first week and the Duke of Devonshire, the leading aristocrat and probably the most influential individual in the county, agreed to become the association’s patron.

In contrast, the diocesan association was much slower in its development. On 25 January, the Reverend Edwards announced the formation of a diocesan nursing association and published a list of subscribers,¹²⁴ but it was only on 6 May 1865 that a meeting in Stafford formally set up the association and appointed a committee.¹²⁵

Although the Bishop’s biographer speaks of his impartiality in diocesan disputes, the Bishop himself seems to have favoured the diocesan association. He accepted a

¹²³ DLSL, Derby and Derbyshire Nursing and Sanitary Association, *Annual Report*, 1865, p. 3.

¹²⁴ *Derby Mercury*, 29 March 1865, p. 2.

¹²⁵ *Staffordshire Sentinel*, 13 May 1865, p. 4.

figurehead role in both associations, but he only ever gave donations to the diocesan association and participated as its president and chairman of the annual meetings up until his death in 1867.¹²⁶ He also approved of its foundation as an ecclesiastical organisation. In May 1865, he stated that, 'if the religious element was not to be introduced...he was free to confess that he would not be there'.¹²⁷ At a meeting in Stoke-on-Trent in December 1865, he stated that the home for nurses 'must be under religious observances, and there must be religious worship within its walls'.¹²⁸

The controversy over the formation of two associations had repercussions. The town of Derby was divided, the evangelical clergy supporting the Derby association, whilst those who subscribed to the diocesan association came from the incumbents who practised ritualism.¹²⁹ Twice as many individuals subscribed to the Derby association than those who lived in Derbyshire and subscribed to the diocesan association and they pledged almost four times as much in donations and subscriptions.¹³⁰ However, of more significance was the fact that both sides had interests in the Derbyshire Infirmary. Five out of seven of the infirmary's surgeons subscribed to the Derby association, whilst none

¹²⁶ Staffordshire Archives Lichfield (hereafter SAL), *Second annual report of the Nursing Association for the Diocese of Lichfield, 1866* D30/11/118.

¹²⁷ *Staffordshire Advertiser*, 13 May 1865, p. 7.

¹²⁸ *Staffordshire Advertiser*, 16 December 1865, p. 7.

¹²⁹ Incumbents from six out of the eight Anglican churches of Derby supported one side or another. The incumbents from All Saints [E W Foley], St Werburgh's [W F Wilkinson] and St John's [J Chancellor] subscribed and actively supported the Derby Association, whilst those known for ritualist practices, J. Erskine Clarke [St Michael's] and F. Utterson [St Anne's], joined the Reverend E. H. Abney as subscribers to the diocesan association. [Sources – C. J. Payne, *Derby churches: old and new*, pp. 118-120; SAL, *Second annual report of the Nursing Association for the Diocese of Lichfield, 1866*, pp. 12-13, (D30/11/118); DLSL, Derby and Derbyshire Nursing and Sanitary Association, *Annual Report*, 1865, pp. 11-12; J G Harrod & Co., *Directory of Derbyshire 1870* (London, 1870)].

¹³⁰ 102 people subscribed and donated £592 and 9 shillings to the Derby association, whilst 50 people subscribed and donated £158 17 s. 2d. to the diocesan association [sources: SAL, *Second annual report of the Nursing Association for the Diocese of Lichfield, 1866*, pp. 12-13, (D30/11/118); DLSL, Derby and Derbyshire Nursing and Sanitary Association, *Annual Report*, 1865, pp. 11-12].

supported the diocesan association. Of the two consulting physicians, Dr Ogle was the secretary to the Derby association, whilst Dr Heygate was an enthusiastic member of the diocesan association's committee of management. Both sides had members who were governors of the infirmary, and some were members of the weekly board of management.¹³¹

Both organisations solicited advice and support from Florence Nightingale and she was willing to provide them with her views. In reply to a letter from Dr Ogle, Nightingale declined to become involved in the religious controversy. She stated

I do not of course enter into the ecclesiastical question. I have helped rampant catholics, rampant Puseyites, rampant Nonconformists of all kind, rampant Evangelicals – all, as far as I am able to obtain good nurses and all local organisations should be left to arrange themselves.¹³²

She also declined an invitation to become the 'patroness' of the Derby association.¹³³ In letters to both associations in 1865, she advised them to centre the organisation of the nursing and the training of nurses on the hospital and warned against trying to set up a separate nursing home. Thus, both associations started to look to the hospital as the focus of training and they clashed over the control of nursing within the Derbyshire General Infirmary. As early as 11 January 1865, Francis Wright proposed that the infirmary needed to review the nursing arrangements within the Derbyshire General Infirmary.¹³⁴ In June, Dr Ogle had read Nightingale's latest views on hospital nursing systems and he

¹³¹ DLSL, Annual Report of the Derbyshire General Infirmary, 1866-67, (BA 362); SA, Second annual report of the Nursing Association for the Diocese of Lichfield, 1866, pp. 12-13, (D30/11/118); Derby and Derbyshire Nursing and Sanitary Association, *Annual Report*, 1865, pp. 11-12.

¹³² Royal College of Physicians (hereafter RCP), *Florence Nightingale to William Ogle*, 29 May 1865, (OgleJ/2415/2).

¹³³ RCP, *Florence Nightingale to William Ogle*, 2 June 1865, OgleJ/2415/3.

¹³⁴ Derbyshire Record Office (hereafter DRO), *Derbyshire General Infirmary, Order Book, January 17 1861- October 24 1870*, 11 January 1865, (D1190/2/11).

became convinced that they needed an independent and efficient superintendent of nurses.¹³⁵ However, an attempt to alter the arrangements by which a matron would replace the master and mistress who supervised the administration of the hospital was defeated.¹³⁶ In letters to Nightingale, Francis Wright complained that attempts to appoint a lady superintendent had been defeated and that

we have many governors who cannot see that so much reform is necessary. Who think that we have done fairly and have no need to strike off into new fangled notions of nursing.¹³⁷

However, an opportunity arose in November. The diocesan association enquired about the possibility of the infirmary training its nurses. Although the committee refused to help, a motion that the Derby association would pay the salary of a Lady Superintendent was approved,¹³⁸ but only ‘after a good bit of jealous bickering’.¹³⁹ At this point, Wright and Ogle contacted both Nightingale and Mrs Wardroper, the matron at St Thomas’s Hospital, with the view to recruiting a Lady Superintendent.¹⁴⁰ However, the supporters of the diocesan association objected to the scheme, and Ogle reported in January 1866 ‘We have had a skirmish at the Infirmary and have suffered something like a defeat’.¹⁴¹ This was the last time that there was conflict over the nursing arrangements within the hospital. Both sides came together in April 1866 to reform the nursing arrangements and

¹³⁵ BL, Add. MSS. 47758. *Nightingale Papers*. Vol. CLVI. Correspondence from William Ogle, MD, Physician of the Derbyshire General Infirmary; Ff116-117, 5 June 1865.

¹³⁶ DRO, *Derbyshire General Infirmary, Order Book*, 3 July 1865, (D1190/2/11).

¹³⁷ BL, Add. MSS. 47758. *Nightingale Papers*. Vol. CLVI, Correspondence from Francis Wright, of the Derbyshire General Infirmary; Ff47, 9 October 1865 and Ff53, 31 October 1865.

¹³⁸ DRO, *Derbyshire General Infirmary, Order Book*, 16 November 1865, (D1190/2/11).

¹³⁹ BL, Add. MSS. 47758. *Nightingale Papers*. Vol. CLVI, Correspondence from Francis Wright, of the Derbyshire General Infirmary; Ff70-74, 22 November 1865.

¹⁴⁰ BL, Add. MSS. 47758. *Nightingale Papers*. Vol. CLVI, Correspondence from Francis Wright, of the Derbyshire General Infirmary; Ff75-76, 25 November 1865; London Metropolitan Archives (hereafter LMA), Correspondence from William Ogle to Mrs Wardroper, 15 December 1865 (H01/ST/NC/18/06/10).

¹⁴¹ LMA, Correspondence from William Ogle to Mrs Wardroper, January 1866 (H01/ST/NC/18/007/042).

approve the appointment of a Lady Superintendent.¹⁴² Ogle formally asked Nightingale to find a suitable lady. She refused again to be drawn into any controversy over party affiliations and could not help teasing Ogle by stating

I believe that we shall be able to furnish you with a Lady Supt. (certainly the lady we propose will not lend herself to the charge of being the 'ecclesiastical' head of a 'sisterhood'). Mrs Wardroper, our Matron of St Thomas' and I had a good laugh over that paragraph of your letter, tho' I did not tell her it was yours.¹⁴³

Miss Kilvert, the new Lady Superintendent, was appointed in October 1866 and arrived with four nurses from St Thomas's in January 1867.¹⁴⁴ In June of that year, Ogle formally approached the infirmary to train nurses for the Derby association and this was finally approved in October.¹⁴⁵

Religion was crucial in nursing reform and the example of Derby illustrates this fact. The Derby association only came into being because of factional conflict within the Lichfield diocese. Here, the evangelical clergy and prominent lay people of Derby objected to being part of the Lichfield Diocesan Nursing Association as they thought that it was being created by the Tractarians or Anglo-Catholics and they feared that the nurses would belong to a religious sisterhood deeply involved in ritualistic practices more associated with the Roman Catholic Church. This example illustrates the fact that place is also important when considering new developments in health care.

¹⁴² DRO, *Derbyshire General Infirmary, Order Book*, 23 April 1866 (D1190/2/11).

¹⁴³ RCP, *Florence Nightingale to William Ogle*, 18 May 1866 (OgleJ/2415/7).

¹⁴⁴ DRO, *Derbyshire General Infirmary, Order Book*, 25 October 1866 & 28 January 1867 (D1190/2/11).

¹⁴⁵ *Ibid.*, 1 July 1867 & 24 October 1867.

Medical Profession

The involvement of medical practitioners was crucial in the establishment and management of most associations in this study. By the middle of the nineteenth century, there were two separate groups of practitioners. There was an elite holding honorary appointments in hospitals and having extensive private practices and an emerging class of general practitioner dependent on treating a less wealthy clientele, mainly the working-classes, and holding appointments as medical officers in the poor law medical services and with sick clubs.¹⁴⁶ It is the former practitioners who were involved in the founding of nursing associations.

In all but two of the associations in this study, leading doctors were prominent in the establishment and management of an association. The two exceptions were Liverpool and Lincoln. In Liverpool, the initiative for an association came from William Rathbone and was largely supported by wealthy philanthropists from commerce and industry. However, the medical board of the Liverpool Royal Infirmary did support the establishment of the training school and home.¹⁴⁷ In Lincoln, the hostility of the medical staff of the County Infirmary in response to attempts by the Ladies Nursing Fund to reform nursing in the hospital resulted in the ladies setting up their own nursing institution and subsequently severing contact with County Infirmary.

¹⁴⁶ H. Marland, *Medicine and society in Wakefield and Huddersfield 1780-1870* (Cambridge, 1987), p. 300; A. Digby, *Making a medical living: doctors and patients in the English market for medicine, 1720-1911* (Cambridge, 1994), p. 38; K. Waddington, *Charity and the London hospitals, 1850-1898* (Woodbridge, 2000), p.162.

¹⁴⁷ W. Rathbone, *Organization of nursing: an account of the Liverpool Nurses' Training School* (Liverpool, 1865), p. 29.

In all other towns, doctors were actively involved in nursing associations. They tended to be men of some standing who held appointments in the local voluntary hospitals, in medical schools or as medical officers of health, and usually had extensive private practices. For instance, the prospectus for the institution in Bristol contained the names of 10 physicians holding the M.D. qualification from the city, the west of England and south Wales, out of 17 distinguished men supporting the establishment of a nursing institution.¹⁴⁸ Those from Bristol itself were physicians at either of the city's general hospitals and said to be 'part of a provincial social elite' similar in standing to the governors¹⁴⁹ Again, in Birmingham, the supporters of the nursing institution were drawn from, in part, senior medical practitioners who held honorary positions within the voluntary hospitals and had significant and profitable private practices. These included Dr T. P. Heslop, the founder of the Children's Hospital; Dr Fleming, a professor in the medical school, Mr Alfred Baker, surgeon to the General Hospital, Dr Bell Fletcher, founder of the town's second medical school and physician to the General Hospital, Mr Sampson Gamgee, a leading surgeon at the Queen's Hospital and Mr Oliver Pemberton, professor of surgery.¹⁵⁰ Doctors who supported associations in other localities were on a similar social and professional standing as those in Bristol and Birmingham.

¹⁴⁸ BL, Bristol Nurses' Training Institution and Home: Prospectus, c.1862 (Cup 401i 6).

¹⁴⁹ Waddington, *Charity and the London hospitals*, p. 160.

¹⁵⁰ 'Dr T. P. Heslop', *Edgbastonian*, 5, 51 (January 1885), pp. 99-101; BAH, Birmingham Collection, Newspaper Cuttings, Birmingham Biography, Volume 1, 1, 1875, pp. 156-57; BAH, Birmingham Collection, Newspaper Cuttings, Birmingham Biography, Volume 2, 1893, pp. 35-38; *Birmingham Faces and Places*, Volume 5, 1893, p. 165; BAH, Birmingham Collection, Newspaper Cuttings, Birmingham Biography, Volume 1, 2, 1878, p. 90; BAH, Birmingham Collection, Newspaper Cuttings, Birmingham Biography, Volume 1, 2, 1886, pp. 265-70; 'Mr Oliver Pemberton', *Edgbastonian*, 9, 93 (January 1889), pp. 1-5.

In three associations, doctors were the driving force behind the establishment of a nursing association. William Ogle's contribution in Derby has already been described earlier in this chapter, but, as the secretary of the Derby and Derbyshire Nursing and Sanitary Association, he gave 28 years of 'untiring zeal and conscientious devotion' as secretary and was on the board of management for a total of 40 years.¹⁵¹ In Manchester, Arthur Ransome, a highly regarded general practitioner and later professor of public health at the Victoria University, had proposed the establishment of a nursing institution to the Manchester and Salford Sanitary Association.¹⁵² He, along with Dr Edward Morgan, a physician at the Salford Hospital,¹⁵³ and Murray Gladstone, the chairman of the hospital's management committee, sought an introduction to Florence Nightingale in order to discuss the proposal.¹⁵⁴ Morgan had prolonged contact with the Nightingale Fund and subsequently arranged for women to be trained at both St Thomas's Hospital and by the St John's sisterhood at King's College Hospital.¹⁵⁵ The women returned to Manchester in January 1866 to staff the voluntary hospitals, but also to form the core of both the private and district nursing services. In Cheltenham, Dr Edward Wilson, a physician to the dispensary and prominent citizen, first suggested a nursing institution in 1867.¹⁵⁶ He took on the role of secretary, laid out the rules and arranged for the nurses to be trained in the

¹⁵¹ DRO, Derby and Derbyshire Nursing and Sanitary Association, Board of Management minute book, 1896-1914, 22 May 1905 (D4566/1/1).

¹⁵² W. J. Elwood and A. F. Tuxford, *Some Manchester doctors: a biographical collection to mark the 150th anniversary of the Manchester Medical Society, 1834-1984* (Manchester, 1984), pp. 93-97; MLSA, Manchester & Salford Sanitary Association, *Annual Report* 1864, p. 11 (614.06 M1).

¹⁵³ W. Brockbank, *The Honorary Medical Staff of the Manchester Royal Infirmary 1830-1948* (Manchester, 1965), pp. 54-56.

¹⁵⁴ BL, Nightingale Papers, Add Mss 45771: Letter from Miss Agnes Ewart to Edwin Chadwick, 28 September 1864, Ff53-54.

¹⁵⁵ LMA, Letters about Manchester to Henry Bonham Carter, Secretary of the Nightingale Fund, August – December 1864 (H01/ST/NC/18/04/025 – 28).

¹⁵⁶ D. Elder, 'He went about doing good': the life of Dr. Edward T. Wilson', *Cheltenham Local History Society Journal*, 22 (2006), pp. 13-21.

Gloucestershire Infirmary.¹⁵⁷ Although the institution failed, he was a keen supporter of its successor, the district nursing association, which was founded in the 1880s and became ‘one of the most important and useful institutions in the town’.¹⁵⁸

As members of the middle class and certain religious groups, doctors probably had the same philanthropic motives as many other middle-class men with whom they associated, but their work and experience also equipped them to advise other members of the community regarding the implementation of public health measures and of the needs of the sick poor.¹⁵⁹ For instance, Mr J. Nason and Dr H. Kingsley, surgeon and physician respectively to the Stratford-upon-Avon Infirmary and committee members of the nursing institution, were part of the social and political elite of the town. Both men were magistrates, on the Board of Health and members of the town’s Corporation. They were also members of the council of the Church Workers Association, the parish body which promoted district visiting and other charitable interventions with the poor, as well as founding the nursing institution.¹⁶⁰ They had considerable social and cultural capital within the town and district and their involvement was probably a result of professional, social and religious motives.

¹⁵⁷ Gloucestershire Record Office (hereafter GRO), Cheltenham Nursing Institution, Minutes 1867-72, 17 November 1869 (D2465 3/1); GRO, Gloucestershire Infirmary, Weekly Board Minutes, 29 September 1870 & 7 March 1872 (HO19/1/20).

¹⁵⁸ Cheltenham Art Gallery and Museum, Wilson Collection, E.T. Wilson *My life. Volume I: 1832-1888* (Manuscript), 10 October 1867 (1995.550.35A).

¹⁵⁹ S. Dierig, J. Lachmand and J. A. Mendelsohn, ‘Introduction: toward an urban history of science’, *Osiris*, 18 (2003), pp. 6 and 8; Marland, *Medicine and society*, p. 364.

¹⁶⁰ See E. R. Kelly, *Post Office Directory of Warwickshire* (London, 1876); *Palmer’s Stratford on Avon almanack and directory* (Stratford, 1875); Francis White & Co., *History, Gazetteer and Directory of Warwickshire* (Sheffield, 1874).

Much like holding an honorary appointment in a hospital, being a committee member of an association would bring the medical practitioner into contact with members of the local and, occasionally, the sometimes more prestigious county elite. This would enable the doctor to cultivate social networks and maybe gain new influential clients.¹⁶¹ For instance, Dr Ogle, who treated Lady Parthenope Verney, Florence Nightingale's sister, seems to have benefited from his longstanding correspondence about nursing reform and hospital design in Derby with Nightingale, as it was she who recommended him.¹⁶² As well as this possibility, it was of advantage to the medical profession if they could secure skilled and trustworthy nurses for their clients. Having access to competent and obedient nurses would help wealthy clients receive a consistent standard of care, but also enhance the reputation and, possibly, the income of the doctor. Dr Fleming of Birmingham saw that the supply of 'well-trained and technically-educated nurses' would ensure that his wishes and directions would be 'intelligently carried out in his absence'.¹⁶³ Once the institution was in operation, it was claimed that the introduction of trained nurses in Birmingham had enhanced the reputation and work of doctors in private practice.¹⁶⁴ Whether the motives for the medical profession's participation in nursing associations were altruistic or pragmatic, doctors were an important group in the establishment and ongoing work of these organisations.

Philanthropic Women

In his preface to the 1867 edition of *Martin Chuzzlewit*, Charles Dickens described the portrait of Mrs Gamp as a fair representation of a nurse 24 years previously. However, he

¹⁶¹ Marland, *Medicine and society*, p. 364; A. Digby, *Making a medical living: doctors and patients in the English market for medicine, 1720-1911* (Cambridge, 1994), pp. 249-50.

¹⁶² M. Bostridge, *Florence Nightingale: the woman and her legend* (London, 2008), p. 490.

¹⁶³ 'Proposed training institution for nurses', *Birmingham Daily Post*, 10 December 1868.

¹⁶⁴ C. Lord, 'Training institution for Nurses', *Birmingham Daily Post*, Tuesday, 16 May 1876.

thought that nursing had been improved since by ‘private humanity and enterprise’ and principally through the ‘agency of good women’.¹⁶⁵ The active support of upper- and middle-class women was of most importance to the success of nursing reform and was twofold. There were those who were engaged as lady superintendents, such as some women in this study, but also those who gave their time voluntarily and who initiated and supported nursing reform.

Those ladies involved in philanthropy tended to be the wives and female relatives of the charitable elite and were more likely to be involved in an organisation if a male relative was on the committee or held a management post.¹⁶⁶ The female members of the Kenrick, Mathews, Marshall and Beale families in Birmingham actively supported the same hospitals as their male relatives and were amongst the principal supporters and managers of both the nursing institution and the district nursing society. Participation in nursing reform seemed to offer middle-class women new opportunities to initiate and participate in the management of these new institutions. For instance, in four of the associations in this study, the initial contact with other centres for advice, particularly with the Nightingale Fund, came from ladies.¹⁶⁷

These women often had previous experience in philanthropic activity, including visiting hospitals and the poor in their own homes. Those who undertook roles as unpaid lady

¹⁶⁵ C. Dickens, *The life and adventures of Martin Chuzzlewit* (London, 1867), Preface.

¹⁶⁶ This point has been made in regard to hospital visiting, see J.Reinarz, ‘Receiving the rich, rejecting the poor: towards a history of hospital visiting in nineteenth-century provincial England’, in G. Mooney and J.Reinarz (eds.), *Permeable walls: historical perspectives on hospital and asylum visiting* (Amsterdam, 2009), p. 43.

¹⁶⁷ Requests for information and advice to Nightingale came from Miss A. S. Ewart, Manchester (1864), Miss L Boucherett, Lincoln (1866), Miss L. E. Edwards, Bristol (1867) and Mrs G. C. Mathews, Birmingham (1868). Source: L. MacDonald (ed.), *Florence Nightingale: extending nursing*. Collected works of Florence Nightingale, Volume 13 (Waterloo, 2009), pp. 200, 240, 271, 853-54.

superintendents for district nursing in Liverpool, from 1862 onwards, had previous experience in a number of charitable organisations, primarily to do with women and children, but also with workhouse visiting.¹⁶⁸ In addition, the private nursing institution in Liverpool, founded in 1855, was managed by a small executive committee of ladies, who visited King's College Hospital, in 1858, to study the rules for the nurses.¹⁶⁹ Similarly, in Manchester, the Ewart sisters, like other ladies who were involved in the foundation of the nursing institution, were active in relief efforts during the cotton famine in the early 1860s, charitable works including sewing schools for pauper girls, and members of the ladies committees of the women's and eye hospitals.¹⁷⁰ In Birmingham, the core of women came from the Unitarian community and had experience of Sunday school teaching, administration of the Protestant Dissenting Charity School for poor girls and some became actively involved in the movement to promote women's education and suffrage.¹⁷¹ One of these ladies, Mrs Laura Marshall, a member of the Church of the Messiah, was on the committee of the Training Institution, was a lady superintendent of the District Nursing Society, a lady visitor at the Children's Hospital, a committee member of the Edgbaston Mendicity Society and a subscriber to the Women's, Children's and General hospitals. Most Unitarian women along with others, who were mainly Anglicans, sat on charitable committees and subscribed to a number of medical charities.

¹⁶⁸ 'Workhouse Committee', *Liverpool Mercury*, 19 November 1858; 'Liverpool Governesses Institution', *Liverpool Mercury*, 18 January 1860; 'The Ladies Charity', *Liverpool Mercury*, 7 February 1862.

¹⁶⁹ J. S. Howson, 'Liverpool institution for the training and employment of nurses', *Englishwoman's Journal*, 3, 1 March 1859, p. 21. Helmstadter and Godden, *Nursing before Nightingale*, p. 157.

¹⁷⁰ 'Manchester Board of Guardians', *Manchester Guardian*, 28 November 1862, p. 2; 'Miss Mary Alicia Ewart', *Manchester Guardian*, 11 June 1901.

¹⁷¹ BAH, Minute Book of the Ladies Committee of the Protestant Dissenting Charity School, Volume 1, 1869 (ZZ70B/471926); BAH, Church of the Messiah, Calendar, January 1870 (UC2/70); BAH, *Report of the first meeting of the Birmingham Ladies Education Association, March 30 1871* (L48. 130511); H. Plant, 'Ye are all one Christ Jesus': aspects of Unitarianism and feminism in Birmingham, c. 1869-90', *Women's History Review*, 9, 4 (2007), pp. 721-42.

Those who were lady visitors to the Birmingham Children's Hospital in 1865 put forward detailed proposals to train the hospital's nurses, the first such initiative in the city.

However, the proposal was rejected and training was delayed until the opening of the training institution in 1869.¹⁷² All in all, many philanthropic women had considerable experience in charitable enterprises prior to the formation of a nursing association. These were mainly activities that were seen to be within a lady's traditional philanthropic remit, such as district visiting, involvement in institutions to inspect or supervise the domestic arrangements, educating children or training women for some type of domestic role.

In Birmingham, women involved in the training institution were responsible for the introduction of district nursing, which was initially established in the Ladywood district, employing one nurse. Ladywood was in close proximity to Edgbaston, which was the 'epicentre' of Birmingham life in mid-century and the suburb in which the great Unitarian families, the Beales, Chamberlains and Kenricks who intermarried and who dominated Birmingham public life, resided.¹⁷³ Female members of these families combined with other Edgbaston Unitarians, principally from the Mathews and Marshall families, to introduce district nursing to Birmingham.¹⁷⁴ By 1874, they had formed the Ladywood District Nursing Society, which received a nurse free of charge from the training institution.¹⁷⁵ This arrangement continued until 1876, when it was decided to

¹⁷² BAH, Birmingham and Midland Free Hospital for Sick Children, *Annual Report*, 1866 (HC/BCH/1/14/1); Birmingham and Midland Free Hospital for Sick Children, Management Committee Minute Book, 1861-1870, 21 April & 10 May 1865 (HC/BCH/1/2/1)

¹⁷³ D. Cannadine, 'Victorian cities: how different?', in R. J. Morris and R. Rodger (eds), *The Victorian City: a reader in British urban history, 1820-1914* (London, 1993), p. 134.

¹⁷⁴ Five out of six of the lady superintendents who supervised the district nurse between 1871 and 1876 were Unitarians. Source: BAH, Birmingham and Midland Counties Training institution for Nurses, *Annual Report*, 1871-77.

¹⁷⁵ 'Ladywood District Nursing Society', *Birmingham Daily Post*, 15 June 1874.

establish the Birmingham District Nursing Society, which would receive funds from the training institution to employ more district nurses.¹⁷⁶ At this point, the men associated with the training institution exerted more influence over district nursing and the value of their contributions grew until, by 1900, they gave more than women.¹⁷⁷ Similarly, men took the leading role in all institutions, with the exception of Lincoln. In Derby, Cheltenham and Stratford-upon-Avon women were not represented on the management committees at all and this may be linked to fact that these associations were controlled by evangelical Anglicans who had strong views about the role of women in the public sphere. In others, like Salisbury, only one woman on average was appointed to the committee from the mid-1870s onward. Women's involvement in the management of associations was more marked in the larger towns and cities of Birmingham, Bristol, Manchester and Liverpool, which had a greater tradition of Liberal politics and a larger proportion of non-conformists involved in philanthropy than the more Conservative and Anglican dominated county towns. However, even in the radical circles of Birmingham Unitarianism, most women were often confined within a role which was based on domestic management, limiting their own development and opportunities.¹⁷⁸

Although women in most cases seemed to occupy subservient positions within the associations, their support and activity was crucial. Some associations had a ladies' or house committee that was involved in the day-to-day management of the nurses' home and the nurses themselves. In Liverpool, Manchester and Birmingham middle-class women directly supervised the district nurses in their work and were responsible for

¹⁷⁶ 'Proposed extension of gratuitous nursing', *Birmingham Daily Post*, 3 July 1876.

¹⁷⁷ See Appendix 9 for subscriptions to the Birmingham District Nursing Society.

¹⁷⁸ H. Plant, 'Ye are all one in Christ Jesus', pp. 722-23.

raising the capital to fund their activities. Women were an important source of funding for the associations and analysis of subscription lists in the annual reports of associations illustrates the extent and scope of female philanthropy (see Appendix 9). Although women usually contributed lesser amounts than men, they were often more numerous than their male counterparts. In the Lincoln and Stratford-upon-Avon associations, women made up the majority of subscribers and donors in each of the years 1870, 1880, 1890 and 1900. In Derby, women made up the majority of subscribers by the end of the nineteenth century.¹⁷⁹ In Liverpool and Manchester, where there were separate committees for private and district nursing, and in Birmingham, where there was a separate district nursing society, more women supported the nursing of the poor than private nursing. A comparison of subscriptions to the nursing associations and those to local voluntary hospitals shows that, in the main, women made up a greater percentage of the donors of the former with the exception of Liverpool, throughout the period, and Derby and Stratford-on-Avon in 1900.¹⁸⁰ Women were more likely to support a nursing association than a hospital and to favour district rather than private nursing. Large numbers of subscriptions and donations from women were given directly to the lady superintendents or women who administered individual districts. The support of women for district nursing corresponds to the traditional role of women in philanthropy, in that they undertook work concerned with domestic aspects of charitable work and, particularly, the poor. This, along with their knowledge of household management and domestic skills, including the supervision of working-class servants, something of which

¹⁷⁹ See Appendix 9 for details of subscriptions for those associations for which records exist.

¹⁸⁰ Ibid.

men were often ignorant, made them ideal members of house committees and supervisors of districts nurses.¹⁸¹

Lincoln was an important exception to the way in which women were normally involved in nursing associations. Here, a small group of assertive women undertook the reform of nursing. The Ladies Nursing Fund, the forerunner to the Lincoln Institution of Trained Nurses, was established to support the Lincoln County Hospital in 1864. It was created by Mrs Annie Bromhead, who had a lifelong interest in caring for sick servants and the local poor. Following a visit to the Bath Training Institution and Home for Nurses, she was determined to set up something similar in Lincoln.¹⁸² On asking the doctors at the County Hospital about the prospects for training nurses, she was told that nursing within the hospital was in such a poor state that it would be impossible to start training unless the system was reformed.¹⁸³ She was supported by the cathedral clergy, the urban upper middle classes who lived close to the cathedral and the landed aristocracy and gentry of the county.¹⁸⁴

The hospital's Board of Governors approved a new system of nursing under the control of the Ladies Committee on 14 July 1864. It would appear that, in its first year, the Ladies Fund provided material resources only. A ward in the upper story of the hospital was converted into bedrooms and the ladies purchased items of clothing and equipment

¹⁸¹ F. K. Prochaska, *Women and philanthropy in nineteenth-century England* (Oxford, 1980), p. 142.

¹⁸² A. F. Bromhead, 'Institution for Trained Nurses, Lincoln', *The Monthly Packet of Evening Readings for Members of the English Church*, 1 August 1867, p. 199.

¹⁸³ Cutting from the *Lincoln, Rutland and Stamford Mercury*, 19 October 1866, pasted into LA, Committee of the Ladies Nursing Fund, Draft Minute Book, 1865-1867 (Bromhead 1/1).

¹⁸⁴ LA, Committee of the Ladies Nursing Fund, *Annual Report*, 1865 (Bromhead 4/1), List of subscribers.

for the benefit of the patients. New boilers were installed to prevent nurses having to carry hot water upstairs to some of the wards.¹⁸⁵ In December 1865, Mrs Bromhead took on the role of superintendent with the power to hire and dismiss nurses and a head nurse was appointed. However, the old matron remained in post and seemingly took on the traditional housekeeping role. Things seemed to proceed well initially, but the first head nurse, Miss Lucy Nevile, who trained at King's College Hospital, died from diphtheria in June 1866, as did the next superintendent.¹⁸⁶ The third head nurse, Annie Henna, who was provided by the Nightingale Fund in August, proved to be dishonest and was dismissed following a tirade of abuse aimed at the chancellor of the cathedral who, as a governor of the hospital, was standing in for Mrs Bromhead.¹⁸⁷ Throughout this period, continual strife between the Ladies Committee and the new head nurses on one side and the existing matron and the house surgeon on the other was reported. Nightingale was informed that the 'dissensions are so constant and violent as to make every arrangement impossible'.¹⁸⁸ The reform of nursing within the hospital proved difficult and opposition became more strident. Mrs Wardroper, the matron at St Thomas's Hospital reported to Nightingale that there were too many heads; Mrs Bromhead was the lady superintendent and daily visitor, there was a matron and also a head nurse who managed the day-to-day nursing.¹⁸⁹ Proposals by the Ladies Committee to appoint one head nurse in charge of all aspects of nursing and domestic arrangements, as advised by Nightingale, were

¹⁸⁵ LA, Committee of the Ladies Nursing Fund, *Annual Report*, 1865 (Bromhead 4/1); T. Sympson, *A short account of the old and new Lincoln County Hospital* (Lincoln, 1878), p. 18.

¹⁸⁶ 'Lucy Nevile, the Hospital Nurse', *The Monthly Packet of Evening Readings for Members of the English Church*, 1 August 1866, p. 198.

¹⁸⁷ Hill, *Victorian Lincoln*, p. 152.

¹⁸⁸ BL, Nightingale Papers, Additional Manuscript 47758, Vol. CLVI, Correspondence from Louisa Boucherett, of Willingham, Co. Linc.; Ff142-143, 5 October 1866.

¹⁸⁹ BL, Nightingale Papers, Additional Manuscript 47729, Vol. CXXXII, Correspondence from Sarah Wardroper, Matron, St Thomas's Hospital, London.; Ff188, 9 October 1866.

vehemently opposed by some of the doctors, governors drawn from the ordinary townspeople and some of the clergy. At successive quarterly board meetings, the Ladies Fund was criticized for increasing hospital expenditure, for trying to usurp the power of the hospital's governors, for undermining the position of the existing matron and for exaggerating the benefits of the new system.¹⁹⁰ Mrs Bromhead replied to all of these accusations in letters to the board of governors, setting out the facts as she saw them. Things were made worse when part of a letter from Florence Nightingale to Louisa Boucherett, implying that the worst systems of management of hospitals were found in those controlled by doctors, was read out at a meeting and reported in the local press.¹⁹¹ At the quarterly meeting of the governors in December 1866, the Reverend J. S. Gibney, whose wife had been a member of the Ladies Committee, believed that the head nurse 'should be entirely separated from any influence of the Ladies Nursing Committee, for he believed many of the evils existing arose from that source'.¹⁹² At the meeting on 11 January 1867, a proposal by the supporters of the Ladies Fund to put the hospital under the control of one nurse was defeated by an alliance of the resident surgical officer and a section of male subscribers, who objected to 'petticoat government' by ladies.¹⁹³ Alderman Harvey, a local surgeon, declared that he 'would not shut the doors against the indigent poor he would shut them, firmly but respectfully, against those rich ladies who would bring the hospital almost to ruin.'¹⁹⁴ Part of the problem for the women who were

¹⁹⁰ Cutting from the *Lincolnshire Chronicle*, 14 December 1866, pasted into LA, Committee of the Ladies Nursing Fund, Draft Minute Book, 1865-1867, (Bromhead 1/1).

¹⁹¹ L. McDonald, *Florence Nightingale: extending nursing*, Collected Works of Florence Nightingale, Volume 13 (Waterloo, 2009), pp. 203-4.

¹⁹² Cutting from the *Lincolnshire Chronicle*, 14 December 1866, pasted into LA, Committee of the Ladies Nursing Fund, Draft Minute Book, 1865-1867 (Bromhead 1/1).

¹⁹³ *Ibid.*, 18 January 1867, pasted into LA, Committee of the Ladies Nursing Fund, Draft Minute Book, 1865-1867 (Bromhead 1/1).

¹⁹⁴ *Ibid.*

on the Ladies' Committee was that they had alienated powerful interests within the hospital and the city. There were, in fact, two 'Lincolns'. The ladies came from the elite that lived 'uphill' around the cathedral or were members of the 'county set', whereas the less wealthy professionals, merchants and tradesmen lived 'downhill', amongst the artisans.¹⁹⁵ This latter group were evidently hostile to middle-class women having control over part of the hospital's business. Secondly, the ladies had alienated the medical staff and, in particular, made an enemy of the house surgeon and, finally, the clergy of the town parishes and the cathedral seemed to be divided in their support for the ladies committee. What was also evident was that the hospital's finances were in a parlous state and that it had been poorly managed for some time. Boucherett claimed that the Ladies' Committee was defeated by 'the influence of the drunken doctor over his farmer friends, and thro' the anger of some of those governors whose mismanagement we had exposed'.¹⁹⁶ At this point, the ladies withdrew from the hospital. Subsequently, a head nurse was appointed, but under the superintendence of the house surgeon.¹⁹⁷

The ladies then concentrated upon the Institution for Nurses which had been established in May 1866, with its own home and a lady in charge.¹⁹⁸ Mrs Bromhead was actively supported by female members of the Sibthorp and Boucherett families, who were part of the county elite. Both Louisa and Jessie Boucherett were firm believers in the rights of

¹⁹⁵ C. Cooper, 'Housing and social structure in Lincoln 1842-2000', *Journal of Regional and Local Studies*, 22, 1 (2002), p. 20.

¹⁹⁶ LMA, Correspondence from L. Boucherett to Nightingale, January 1867, (H01/ST/NC/02/V/14/067).

¹⁹⁷ LA, Lincoln County Hospital, Minute Book of the Weekly Board and Quarterly Board of Governors 1861-1868, 13 May 1867 (Hosp/Lincoln 8).

¹⁹⁸ LA, Committee of the Ladies Nursing Fund, Draft Minute Book, 1865-1867, 6 June 1866 (Bromhead 1/1).

and the franchise for women.¹⁹⁹ Jessie was an active feminist, an associate of the leading members of the then women's movement and a founder of the Society for Promoting the Employment of Women.²⁰⁰ She had some involvement with the Ladies Nursing Fund in Lincoln, but seemingly had little to do with the Institution, other than being a subscriber from its foundation in 1866. However, through her work with the Society for Promoting the Employment of Women, she may have helped with the recruitment of suitable nurses for the Institution.²⁰¹ Her sister, Louisa, participated in local charitable activities, including measures to 'board out' pauper girls and find suitable employment for them in domestic service.²⁰² She was an active manager of the nursing institution in its early days and had an extended correspondence with Florence Nightingale regarding the nursing arrangements in the Lincoln County Infirmary in 1866.²⁰³ When she inherited the family estate, following the death of her brother, she had less involvement with the institution. Mrs Waldo Sibthorp, was a member of the county gentry and, like the Boucherett sisters, subscribed to the Society for Promoting the Employment of Women and, more than likely, supported the movement for the rights of women.²⁰⁴

¹⁹⁹ J. Cartwright (ed.), *The journals of Lady Knightley of Fawsley, 1856-1884* (London, 1915), pp. 129-30.

²⁰⁰ E. Jordan and A. Bridger, 'An unexpected recruit to feminism: Jessie Boucherett's "Feminist Life" and the importance of being wealthy', *Women's History Review*, 15, 3 (2009), pp. 385-412.

²⁰¹ See Cecilia Quinney's biography in Appendix 7.

²⁰² L. Boucherett, 'Out-relief for workhouse children', *Transactions of the National Association for the Promotion of Social Science* (1867), p. 696.

²⁰³ BL, Nightingale Papers, Additional Manuscript 47758, Vol. CLVI, Correspondence from Louisa Boucherett, of Willingham, Co. Linc.; Ff142-143 Oct 5 1866, Ff145-148 Oct 7 1866 and Ff189-192 December 1866; Nightingale Papers, Additional Manuscript 47729, Vol. CXXVII, Ff206 24 Oct 1866.

²⁰⁴ Girton College, Cambridge, Archives, Society for Promoting the Employment of Women, *Annual Reports 1864-1870* (GCIP 2/1/1).

There is no evidence in the annual reports or other documents, including newspapers, that the Lincoln Nurses' Institution ever held annual general meetings or had a management committee. In reality, it seems that the institution was controlled by Mrs Bromhead:

She carried on the management and the secretarial work in her drawing-room, amidst all the distractions of family life...Here she interviewed nurses and looked out all their journeys in Bradshaw, furnishing them with a complete itinerary wherever they were going.²⁰⁵

Following Mrs Bromhead's death in 1886, her daughter, Henrietta, took on the mantle and the institution only reverted to having a management committee and an appointed lady superintendent, who was a trained nurse, following her own death in 1907.²⁰⁶ The institution had no formal links with the Lincoln County Hospital following its establishment. Mrs Bromhead preferred to have nurses trained elsewhere, principally at University College Hospital, London and the institution supplied nurses to the workhouse, though never to the hospital.

The role of individual agency

This chapter demonstrates that the successful establishment of a local nursing association depended upon the support of certain groups within local society to come together to provide the resources for the creation of a nursing association. However, agency through the efforts of individuals within certain localities cannot be overlooked and the success of associations was often dependent upon the initiative, support and resources of committed individuals. Thus, the efforts of philanthropists, such as William Rathbone in Liverpool and Francis Wright in Derby, doctors, such as Edward Morgan in Manchester and

²⁰⁵ D. Robertson, *A Victorian venture: an account of the Bromhead Nursing Institution* (Lincoln, 1937), p. 6.

²⁰⁶ LA, Lincoln Institution of Nurses, *Annual Reports*, 1907 & 1908 (Bromhead 4/1).

Edward Wilson of Cheltenham, clergymen, such as E. J. E. Edwards in Staffordshire or H W Yeatman in Salisbury and women, like Mrs Bromhead in Lincoln and Miss Ewart in Manchester, were crucial to the success of their respective organisations. Thus, the interplay between social structure and the agency of certain individuals within the different towns created a transformation in the provision and quality of nursing to both the rich and poor. However,

Just how the relations between social structure and human agency fall out is evidently different from place to place and depends crucially on the particular arena of encounter.²⁰⁷

Although organised in similar ways, following the example of the pioneering centres of Liverpool and Bath, the circumstances of their creation and the operation of nursing associations differed, albeit slightly in most instances. This was dependent on local decisions and resources. Two examples have been given in this chapter, which stand out as being established as a result of strife and not by consensus. These were due to the strength of will of confident, independent-minded women in Lincoln and the religious zeal of committed evangelicals in Derby. Secondly, the way in which associations organised nursing depended on local circumstances. The creation of a separate district nursing society in Birmingham was the result of the actions of philanthropic women who wanted to ensure that the sick poor benefited from nursing reform.

Summary

Nursing associations emerged in the 1860s and were a manifestation of increasing interest in nursing that had been stimulated in the previous decade by the Crimean War,

²⁰⁷ D. N. Livingstone, *The geographical tradition* (Oxford, 1992), p. 357.

the perceived need for better skilled domiciliary nurses for the rich and to improve nursing in institutions and the homes of the poor. Associations were supported by leading members of local society (those holding economic, social, cultural and symbolic capital) who were, in the main, active in other medical charities, particularly the voluntary hospitals. The provision of nursing was, therefore, seen as an important activity in these towns. Religion was one of the driving forces behind middle-class participation. The support of organised religion from the nonconformist chapel, parish church or diocesan cathedral often gave the impetus required to found an association, but in those associations where religion was not the obvious driving force, those in charge were active Christians who publicly affirmed their religious motives. Philanthropic women were important agents for change who assumed roles similar to those they held in the home.

Evidence presented in this chapter demonstrates that nursing reform did not emanate from London as indicated by traditional accounts of nursing history. Although Nightingale strongly influenced the work of these associations, the initiative came from local people seeking solutions to local issues. Nightingale was only involved after decisions were made to proceed with the reform of nursing in these towns and cities and this involvement rarely went beyond providing initial advice. The next chapter will move from the formation of these associations and will discuss the characteristics of the workforce and the way in which the associations were managed.

4: MANAGEMENT AND WORKERS

Introduction

This chapter examines the organisation of the nursing associations within this study and discusses the recruitment, training and coordination of the nursing work force. It demonstrates that the associations were similar, in terms of organisational structure and management, to other voluntary societies that operated in the social and medical field. However, they differed in terms of the increased involvement of women in the everyday management and control of both the organisation and workforce. In order to gain a greater understanding of the nurses and superintendents who were employed by the nursing associations, a prosopographical approach was used to generate data about the two groups. Prosopography or collective biography is a method by which biographical details of individuals are used in order to build up a picture of the 'common background characteristics' of a group under study.¹ As a result of such a comparison, the nurses and the lady superintendents or matrons are revealed as two groups of women from different backgrounds. To date, research concerning the nursing work force has concentrated upon hospitals and, in particular, the situation in London, in the context of the Nightingale School,² or the other London voluntary hospitals.³ Less work has been undertaken on

¹ L. Stone, *The past and present revisited* (London, 1987), p. 45.

² M. E. Baly, *Florence Nightingale and the nursing legacy*, second edition (London, 1997).

³ A. Simmet, 'The pursuit of respectability: women and the nursing profession, 1860-1900', in R. White (ed.), *Political issues in nursing: past, present, and future*, 3 vols. (Chichester, 1986), Vol 2, pp. 1-24; J. Likeman, *Nursing at UCH, 1862-1948*. Unpublished PhD thesis, University College London, 2002; Hawkins, S., *Myth and reality: uncovering the nurses at St George's Hospital, London, 1850-1900*. Unpublished PhD thesis, Kingston University, April 2007; and S. Hawkins *Nursing and women's labour in the nineteenth century: the quest for independence* (London, 2010); see also the extensive work of Carol Helmstadter.

provincial hospitals and those associations providing nurses for work within the patients' homes during this period.⁴

Management

Information concerning management has been derived from the annual reports, committee minutes and regulations of the various organisations. As outlined in Chapter 2, they were organised in a similar way to other voluntary societies that were founded in the eighteenth and nineteenth centuries. With the exception of Lincoln, these were democratic associations, which were controlled by annual general meetings of all subscribers where committees and officers were elected. In reality, the elite members of the town controlled the association, officers' posts and membership of committees.

Heggie has suggested a model of management, based on her study of the district nursing and health visiting organisations in Manchester, which had similar operating systems to those outlined here. Associations had a hierarchical structure, consisting of men in supervisory roles either as philanthropists controlling finances and decision making or as doctors directing the clinical work and then female philanthropists in middle positions offering supervision to the paid women at the bottom.⁵ This is an oversimplification, as associations employed women of a superior status to the nurses to superintend the domestic arrangements of the home, manage the day-to-day business, to maintain

⁴ However, some work has been undertaken: J. Brooks, 'Structured by class, bound by gender; nursing and special probationer schemes, 1860-1939', *International History of Nursing Journal*, 6, 2 (2001), pp.13-21; C. J. Maggs, *The origins of general nursing* (London, 1983); S. Wildman, 'Changes in hospital nursing in the west midlands, 1841-1901', in J. Reinartz (ed.), *Medicine and society in the midlands, 1750-1950* (Birmingham, 2007), pp. 98-114; C. Howse, "'The ultimate destination of all nursing": The development of district nursing in England, 1880-1925', *Nursing History Review*, 15 (2007), pp. 65-94.

⁵ V. Heggie, 'Health visiting and district nursing in Victorian Manchester: divergent and convergent vocations', *Women's History Review*, 20, 3 (2011), p. 412.

discipline and to coordinate the work of the nurses. In the smaller associations, such as Derby and Stratford-upon-Avon, the lady superintendent managed all the nurses, private and those for the sick poor, but in the large centres, including Liverpool, Manchester and Birmingham, a different model was employed. Here, during the 1860s and 1870s, wealthy female volunteers assumed supervisory roles for the district nurses. They raised and organised the finance for the work of nursing the poor, kept accounts and records, coordinated the distribution of relief to the deserving sick, met with the nurses at least weekly, inspected their registers and visited patients to ensure that they were being cared for adequately.⁶ Philanthropic women retained managerial input into the these associations throughout the period under investigation, but, from the late 1870s onward, the clinical supervision of the district nurses began to be handed over to salaried district matrons or superintendents who were trained nurses.⁷ Specific nurses' homes for the district nurses were also built which enabled the matron to maintain discipline and control over the workforce previously housed separately and supervised by volunteers.⁸

Nurses and Superintendents

Names of nurses, matrons and lady superintendents are identified within the records of the individual associations and institutions and also within the decennial censuses (1841 to 1901). Information contained in these sources was used in an attempt to trace an individual across time in the censuses. In doing this, more could be ascertained about an

⁶ W. Rathbone, *Organization of nursing: an account of the Liverpool Nurses' Training School* (Liverpool, 1865), p. 20; 'Nurse Training', *Manchester Guardian*, 8 January 1867, p. 5.

⁷ Liverpool Records Office (hereafter LRO), Liverpool Infirmary, Nursing Committee Minutes 1874-1938, 22 November 1880 (614 INF/4); Manchester Archives and Local Studies (hereafter MALS), Manchester Nurse Training Institution, *Annual Report*, 1879, p. 6 (362.1 M85).

⁸ I. H. Morris, *A century of district nursing in Birmingham, 1870-1970* (Birmingham, 1970), p. 5.

individual's life and career than was contained within the records of individual associations. In total, 608 nurses were identified within the records of the nine associations in this study, but meaningful information about background or career could only be found for 252 nurses (see Table 4.1).⁹ In addition, 42 women were identified as either the appointed head or assistant head of an association.

Table 4.1: Number and type of nurses traced in records, 1862 -1901, and the numbers of nurses for whom a partial life history can be constructed

| | Names located in records | Hospital Nurses | District Nurses | Private Nurses | Monthly Nurses | Nurses with a partial life history |
|----------------------------|---------------------------------|------------------------|------------------------|-----------------------|-----------------------|---|
| Birmingham | 80 | 0 | 14 | 66 | 0 | 53 |
| Cheltenham | 17 | 0 | 2 | 12 | 3 | 3 |
| Derby | 84 | 0 | 4 | 80 | 0 | 9 |
| Lichfield | 21 | 8 | 6 | 5 | 2 | 6 |
| Lincoln | 40 | 0 | 1 | 39 | 0 | 28 |
| Liverpool | 149 | 0 | 149 | 0 | 0 | 45 |
| Manchester | 92 | 7 | 75 | 10 | 0 | 63 |
| Salisbury | 114 | 0 | 0 | 109 | 5 | 42 |
| Stratford-upon-Avon | 11 | 0 | 0 | 11 | 0 | 3 |
| Total | 608 | 15 | 251 | 332 | 10 | 252 (41%) |

⁹ For Liverpool, the district nurses only have been traced as it is not clear whether other nurses were private or hospital nurses. District nurses have been obtained from a list identified by Gwen Hardy in Liverpool Record Office, District Nurses in Liverpool 1862-1900, 1973 & 1985 (Hq 610.730922 HAR). For all other associations, all nurses (hospital, private or district) were included.

These women had the titles of lady superintendent, superintendent or matron. Figures 4.2 and 4.3 show the numbers of nurses, lady superintendents and matrons for whom meaningful data could be identified. Unsurprisingly, these were lower than in a similar study by Hawkins which utilized the nursing registers of St George's Hospital, London.¹⁰ Invariably, these registers contain information about age, address and occupation before employment for the majority of nurses. Thus, Hawkins was able to positively identify a greater percentage of nurses (52%) than was possible in this study (41% of named nurses). However, it is relatively easier to trace the matron or lady superintendent than the nurses in this study, as records often give full names and some information about their lives and careers before and after taking up their appointments.

The main problem in identifying nurses in this study is that insufficient information has survived about individuals. The numbers of nurses identified is considerably less than those who were employed across the period, as not all nurses' names were present within the surviving records of associations or institutions. Registers, with the exception of Liverpool and within the two remaining annual reports of the Lichfield association, have not survived. In many documents, only surnames were recorded which made any attempt at tracing individuals very difficult, especially for those with common names.¹¹ To be able to positively identify a nurse there needed to be a match between name, age and place of birth in at least one census and the institutional records. For many nurses, the

¹⁰ S. Hawkins, *Nursing and women's labour in the nineteenth century: the quest for independence* (London, 2010).

¹¹ This has been found by other researchers; P. Jalland, *Death in the Victorian family* (Oxford, 1996), p. 103 indicates that most nurses mentioned in the letters and diaries of the middle and upper classes were not identified using their full names.

lack of data prevented positive identification of individuals and probably accounts for the low rate of detection.

In addition, some nurses for whom there is reasonable surviving information were still not traced within the censuses. This could, in part, be attributed to the quality of the census data as a record of the individual. Under-enumeration has been identified, both in the United Kingdom and the U.S.A. and, in the latter, it has been estimated that at least 15% of the population may have been omitted from the mid-nineteenth-century censuses.¹² Reasons include being resident outside of the country or away from their normal residences on the night of the census. Private nurses formed a mobile population, only occasionally returning to the nursing home and may have not been enumerated on census night. Some nurses who are not traceable from census to census may have had a different name in two consecutive censuses. Some women's subsequent lives may not be identifiable as they married between one census and the next, whilst, for others, who had been widowed and subsequently undertook a career as a nurse, their earlier lives may not be traceable. In addition, tracing those not born in England and Wales makes verification of individuals more difficult, as those returned for Scotland or Ireland were often recorded by country only, rather than a specific place of birth. It is difficult to check many census records for people from Ireland as those for 1861 to 1891 were destroyed by the government and only a few sections of the returns from 1821 to 1851 survived a fire in 1922.¹³

¹² R. Steckel, 'The quality of census data for historical enquiry: a research agenda', *Social Science History* 15, 4 (1991), pp. 579-599.

¹³ D. Herber, *Ancestral trails: the complete guide to British genealogy and family history* (Stroud, 1997), p. 561.

There is evidence to show that women's occupations outside of the home have been omitted from the census returns. For instance, out of eight women identified as being charwomen or scrubbers in the pay books of the Hackney Infirmary, London, only four could be positively identified as such in the 1881 census returns using their home addresses.¹⁴ This may have come about because of prevailing attitudes towards the employment of women within society. Indeed, the process of conducting a census was entirely a male activity. All the officials in central and local government were men, and women were prohibited from being enumerators until 1891. This probably influenced the recording of women's occupations with some enumerators not recording married women's occupations outside the home.¹⁵ This impacted on the recording of the nursing workforce, especially married district nurses who lived in their own homes.

The accuracy of data regarding age has been identified as a particular problem.¹⁶ This is due to several reasons including the fact that, during the earlier years of the century, many working-class people had only an approximate idea of their date of birth, but others were likely to falsify their age in order to gain employment or benefits. Women, in particular, are said to have been more prone to this than men. For instance, Lee and Lam identified over-enumeration of women in the age group 20-29, a pattern that was absent for men. Some young women (around twenty years old) seem to have inflated their ages, perhaps to gain better wages, whilst some above thirty seemed to have reduced their

¹⁴ E. Higgs, 'Women, occupations and work in the nineteenth century censuses', *History Workshop Journal*. 13,(1987), pp. 59-80.

¹⁵ E. Higgs, *A clearer sense of the census* (London, 1996), pp. 97-99.

¹⁶ A. Hinde, *England's population: a history from the Domesday survey* (London, 2003), p. 276.

ages.¹⁷ At the other end of the scale, there is evidence of inaccurate reporting by older people who declared younger ages in order to lengthen periods of employment.¹⁸ Given that most nursing associations had upper and lower age limits for entry, some women may have falsified their ages in order to obtain a nurse's career. The reported place of birth is also problematic, not only due to inaccurate reporting, but as a result of individuals not knowing their place of birth or presuming that the places where they grew up were synonymous with their birthplaces. Anderson found that 14 percent of people had a discrepancy of birthplaces between the 1851 and 1861 censuses. Some of these errors have been attributed to mistakes in copying from the household schedules by the enumerators.¹⁹ Thus, factors such as age and birthplace may have been incorrectly recorded in the census, making it difficult to verify the true identities of some individuals.

Difficulties in tracing nurses may have been the result of errors made when recording personal details. Important information given by nurses to those who completed schedules may have been incorrect or inaccurately recorded. This included misspelling of names, missing out initials or second forenames, or recording the wrong age or birthplace. Clerical errors by enumerators when transcribing the household schedules into enumerators' books may have compounded any mistakes or created new problems for anyone attempting to trace individuals subsequently. The enumerator's handwriting is sometimes difficult to read and additional writing in schedules, particularly the checking marks left by clerks in the Census Office, may further obscure ages in particular. These

¹⁷ R. Lee and D. Lam, 'Age distribution for English Census, 1821-1931', *Population Studies*, 37, 3 (1983), pp. 445-64.

¹⁸ D. Thomson, 'Age reporting by the elderly and the nineteenth-century census', in D Mills and K Schurer (eds), *Local communities in the Victorian census enumerator's books* (Oxford, 1996), pp. 86-99.

¹⁹ M. Anderson, 'The study of family structure', in E. A. Wrigley (ed.), *Nineteenth-century society: essays in the use of quantitative methods for the study of social data* (Cambridge, 1972), p. 75.

problems may make the tracing of some individuals impossible or, at best, uncertain. In addition, census records in this study were viewed using the online database, which were copied from the original census enumerators' books. This additional process of transcription from the copies of the enumerators' books into a database will have resulted in further unintended errors. As well as the problems associated with the accuracy of the data, it is sometimes impossible to distinguish between two or more people with identical names and birthplaces. Given the potential problems with the census data and the paucity of the archive material, it is unsurprising that it is difficult to reconstruct the careers of the majority of nurses within the employ of the nursing associations during this period. Nevertheless, there is sufficient information for those individuals identified in this study to compare the characteristics of the nurses with the superintendents, and to compare both groups with those from other studies of nurses at this time.

Once data about individuals was located, it was categorized in terms of social class, occupation before employment by a nursing association and the reason for leaving the employment of an association (see Appendices 5 and 6). Whilst the latter two categories were relatively easy to identify, social class had to be determined from either the nurse's own employment before recruitment, or that of her father, if single, or husband if widowed. The classification of occupations was revised with each new census, and, for the nineteenth and early twentieth-centuries, this reflected, in the main, occupational titles under broad headings such as 'Domestic', 'Agricultural' or 'Industrial'. Although this classification referred to productive activity, it also reflected the social hierarchy within

society.²⁰ However, it is not possible to use these categories to examine the social standing of recruits to nursing as the classification of the term ‘nurse’ differed from census to census.²¹ Thus, a means of identifying social class that could be applied consistently throughout the period of this study was required, and the classification scheme developed by Armstrong was utilised.²² This is based on five social classes derived from the Registrar General’s 1950 classification of occupations and adapted for use with the nineteenth-century censuses (see Figure 4.1). This application has been supported by other historians in spite of difficulties applying the criteria to farmers, businessmen and shopkeepers”.²³ In this study, all farmers and those people in business who had more than one employee, other than domestic servants, were placed in Class II according to Armstrong’s classification. In addition, any person employing more than 25 people was placed in Class I. This system was adopted by Hawkins, thus facilitating comparisons of her data with the results of this study.²⁴

²⁰ C. Davies, ‘Making sense of the census in Britain and the USA: the changing occupational classification and the position of nurses’ *Sociological Review*, 28, 3 (1980), pp. 584-9.

²¹ B. Mortimer ‘Counting nurses: nursing in the 19th century census’ *Nurse Researcher*, 5, 2 (1997/8), pp. 39-42.

²² W. A. Armstrong, ‘The use of information about occupation’, in E. A. Wrigley (ed.), *Nineteenth-century society: essays in the use of quantitative methods for the study of social data* (Cambridge, 1972), pp. 198-225.

²³ K. Schurer and D. Mills, ‘Employment and occupations’, in D. Mills and K. Schurer (eds), *Local communities in the Victorian census enumerator’s books* (Oxford, 1996), pp. 136-60.

²⁴ S. Hawkins, *Nursing and women’s labour in the nineteenth century: the quest for independence* (London, 2010), pp. 184-87.

Figure 4.1: Armstrong’s classification of social class

| Social Class | Descriptive Terms | Examples of Occupations |
|---------------------|--------------------------|---|
| I | Professional | Clergymen, army and naval officers, doctors and other professions. All employers of over 25 persons |
| II | Intermediate | Teachers, managers, officials of railways and government. All proprietors of retail businesses employing staff. |
| III | Skilled Occupations | Carpenters, blacksmiths, cooks, dressmakers, shop assistants, nurses |
| IV | Semi-Skilled Workers | Housemaids, agricultural labourers, laundresses |
| V | Unskilled Workers | Charwomen, general labourers, rail porters |

Recruitment

According to Rafferty, the first initiatives in the reform of nursing aimed to develop ‘a class of deferential and disciplined labour’.²⁵ In order to achieve this, hospitals and nursing associations sought to recruit women of good character and behaviour from the respectable working classes who were used to hard work.²⁶ In the early years, associations recruited women who were able to read and write and had references that attested to their satisfactory character, conduct and health.²⁷ Locating recruits of this calibre proved challenging, for instance, in Derby, of the 27 who applied in 1865, only

²⁵ A. M. Rafferty, *The politics of nursing knowledge* (London, 1996), p. 19.

²⁶ *Ibid.*, p. 30.

²⁷ Staffordshire Archives, Lichfield (hereafter SAL), Nursing Association for the Diocese of Lichfield *Annual Report*, 1869, p.14 (B/A/19/2/106); Birmingham Archives and Heritage, Birmingham and Midland Counties Training Institution for Nurses, *Annual Report*, 1870, p. 29 (L46.6 12811); Lincolnshire Archives (hereafter LA), Lincoln Institution of Nurses, *Annual Report*, 1873 (Bromhead 4/1).

three were permanently recruited with the rest being described as too old, not strong enough, or providing unsatisfactory references.²⁸ Associations found it easier to recruit women who satisfied their requirements with improvements in elementary education later in the century. By 1874, the Derby association claimed that recruitment was aimed at three distinct groups of women: those from ‘the class who form the bulk of our best domestic servants, sober, straightforward, intelligent, truthful and trustworthy women’; second, gentlewomen who were said to have no other outlet other than to be governesses, but could qualify as superintendents following training; and, third, ladies who wanted to know more about nursing, not for employment, but for the purposes of Christian service.²⁹ Although there are occasional instances of ladies undertaking some form of experience it would appear that the majority of recruits came from the working classes.

Appendix 5 indicates that recruits to the associations came mainly from the working classes, in particular social classes III and IV. However, only one nurse, the daughter of a clergyman, can be positively identified as being from social class I, but increasing numbers of women came from social class II as the century progressed. This is a trend found to have existed in the London teaching hospitals during the late nineteenth century. Hawkins demonstrates a decline in those women from social classes IV and V and a spectacular increase of recruits from social classes I and II, who, by 1900, made up over 60% of all nursing staff at St George’s Hospital.³⁰ This ‘gentrification’ of nursing has been reported by both Likeman and Simnett in their studies of University College and St

²⁸ ‘Derby and Derbyshire Nursing and Sanitary Association’, *Derby Mercury*, 30 May 1866.

²⁹ ‘The Derby Nursing and Sanitary Association’, *Derby Mercury*, 15 April 1874.

³⁰ Hawkins, *Nursing and women’s labour*, pp. 54-55.

Bartholomew's hospitals.³¹ Simnett claims that working-class women were absent amongst the ranks of probationers by 1892, and Likeman concludes that recruits came from the upper social classes by the end of the century. However, analysis of the results of both of these studies by Hawkins reveals that most probationers at St Bartholomew's Hospital did not join the hospital staff after training and their impact on the overall social structure of the nursing staff was therefore likely to have been negligible. Also, Likeman seems to have ignored the significant proportion of recruits from social classes III, IV and V who collectively made up just under 40 percent of the workforce, thus leaving a similar proportion of recruits from classes I and II, as found at St George's Hospital.³² It is difficult to ascertain whether the situation in the London hospitals was typical of those in the rest of the country, as social class has not been thoroughly investigated.³³ Vicinus claims that upper-class trainees were mainly recruited to the major voluntary hospitals and that working-class nurses tended to dominate unreformed hospitals and private nursing.³⁴ This could explain the differences in the social class of the workforce between the associations in this study and those of the London voluntary hospitals. Research that has analysed district nurses belonging to the Queen Victoria's Jubilee Institute for Nurses, who were employed across the country at the end of the nineteenth and the beginning of the twentieth century, indicates that it recruited predominantly women from middle-class backgrounds.³⁵ The prestigious Queen's Institute attracted a higher class of recruit, which was probably due to both an increased acceptance of nursing as a

³¹ Simnet, 'The pursuit of respectability'; Likeman, *Nursing at UCH*.

³² Hawkins, *Nursing and women's labour*, pp. 35-36.

³³ Both Maggs, *The origins of general nursing* and Wildman, 'Changes in hospital nursing in the west midlands' did not include social class in their analyses of the nursing workforce.

³⁴ M. Vicinus, *Independent women: work and community for single women, 1850-1920* (London, 1985), p. 86.

³⁵ Howse, 'The ultimate destination of all women', p. 76.

legitimate career for educated women, not to mention the policies of its first superintendent, Florence Lees later Mrs Dacre Craven, who maintained that working-class women were incapable of advising and supervising the sick poor.³⁶ However, by the 1920s, it appears that the majority of the Institute's nurses were from social class III.³⁷ In contrast to research in both hospital and district nursing, local associations in this study, although recruiting increasing numbers of women from social class II during the period, continued to derive the greatest proportion of its workforce from the working classes. Brooks, in her study of Leeds and London, identified a two-tier system in operation in which nurses were supervised by matrons and sisters from a higher social class, but her data is mainly from the early twentieth century.³⁸ Similarly, in this study there is a distinct difference in the origins of the lady superintendents and their assistants as opposed to the nurses (see Appendices 5 and 6). No head of an association came from below social class II. Only three assistants came from social class III and none at all from social classes IV and V. The social make up of this group is unsurprising as professional nursing was the first occupation that allowed significant numbers of educated women from the middle and upper classes to pursue paid employment.³⁹ Ladies were engaged to impose a moral influence, strict discipline and appropriate behaviour on working-class recruits just as a middle-class housewife would do with her servants.⁴⁰

In the main, the ladies engaged by these associations also had experience of nursing, mission or social work prior to their appointments. Nursing gave them a sense of purpose

³⁶ F. Dacre Craven, *Servants of the sick poor* (London, 1885), pp. 4-10.

³⁷ Howse, 'The ultimate destination of all women', p. 77.

³⁸ Brooks, 'Structured by class, bound by gender', p. 13.

³⁹ A. Young, 'Entirely a woman's question'? Class, gender, and the Victorian nurse', *Journal of Victorian Culture*, 13, 1 (2010), p. 19.

⁴⁰ G. Holloway, *Women and work in Britain since 1840* (London, 2005), p. 20.

and self fulfilment.⁴¹ Employment also afforded them the means to earn a living as all the women who worked for these associations received a salary.

Geography of recruitment

The decennial census returns were used to determine the birth places of nurses in this study as it was not possible to obtain accurate information regarding the place of residence of a nurse immediately prior to commencement with one of the associations. Birthplace is not synonymous with place of residence, but it does give an indication of the origins of recruits which can be compared to other studies that have investigated hospital recruitment.⁴² These indicate that there was a shift away from the local and regional origin of recruits throughout the century in the voluntary hospitals. In contrast, Table 4.2 indicates that, in this study, local and regional recruitment remained strong across the time period and was similar to that in Poor Law infirmaries as identified by Maggs.⁴³

⁴¹ M. Vicinus, *Independent Women: work and community for single women, 1850-1920* (London, 1985), pp. 86-87.

⁴² Maggs, *The origins of general nursing*, pp. 74-76; S. Wildman, 'The development of nursing at the General Hospital, Birmingham', *International History of Nursing Journal*, 4, 3 (1999), p. 24; Wildman, 'Changes in hospital nursing in the west midlands', p. 106; Hawkins, *Nursing and women's labour*, pp. 69-71.

⁴³ Maggs, *The origins of general nursing*, p. 76.

Table 4.2: Birthplace of Nurses employed between 1862 and 1901⁴⁴

| | 1862- 1871 | 1872- 1881 | 1882- 1891 | 1892- 1901 | Total |
|----------------------------|-----------------------|-----------------------|-----------------------|-----------------------|--------------|
| Local | 14 | 29 | 40 | 23 | 106 |
| Regional | 13 | 23 | 27 | 24 | 87 |
| Rest of England | 20 | 28 | 30 | 33 | 111 |
| Scotland | 2 | 3 | 4 | 5 | 14 |
| Wales | 2 | 6 | 6 | 4 | 18 |
| Ireland | 2 | 0 | 6 | 2 | 10 |
| Empire | 2 | 0 | 1 | 1 | 4 |
| Total | 55 | 89 | 114 | 92 | 350 |

Recruitment Strategies

Recruitment of nurses in the Lichfield diocese was sought, in the main, through the local clergy who were expected to consult both lay and medical members of the candidate's local community.⁴⁵ Similarly, the associations in Derby and Salisbury preferred this method.⁴⁶ It was a process which is said to have existed across the country, whereby the local clergyman and his wife were often involved in certifying young women as suitable

⁴⁴ A total of 350 nurses' birthplaces were traced in the decennial censuses. The following classification was used: local - those born in the same county as the hospital, and regional – those born in neighbouring counties.

⁴⁵ E. J. E. Edwards, *Nursing Association for the Diocese of Lichfield* (London, 1865), p. 8.

⁴⁶ Derby Local Studies Library (hereafter DLSL), Derby and Derbyshire Nursing and Sanitary Association, *Annual Report*, 1884 (A610.73); Wiltshire and Swindon Record Office (hereafter WRSO), Salisbury Diocesan Institution for Trained Nurses, Minute Book 1871-1876, 18 December 1872 (J8/109/1).

for domestic service.⁴⁷ A small number of women have been identified in the census returns as working within the households of clergymen prior to their recruitment to nursing, an example being Sarah Greenleaf, a servant in the house of the Curate of Enford, Wiltshire, who trained as a nurse for the Salisbury association in 1877. Religious motivation was one of the factors behind the creation of many of these associations and those controlled by Anglicans insisted that the nurses be members of the Church of England and regularly attend services.⁴⁸ Even those associations that were not organised on a denominational basis aimed to recruit Christian women whose character would ensure they had an appropriate approach and attitude towards the sick.⁴⁹ For many, religion was the driving force behind their decision to pursue a career in nursing and it is seen as the primary motivation of the early lady superintendents from the Crimean war onwards.⁵⁰ Misses Brumwell, Minet and Woodhead, who were lady superintendents, participated in religious and mission work prior to employment in their respective associations.⁵¹ Emily Minet, who died in 1892, was said to have given her life to ‘works of charity, usefulness, and self-dedication to the service of God’.⁵² This was not an attribute confined to the lady superintendents as many nurses also had a vocation stemming from their religious beliefs. For instance, it was reported that nurse Kirk who worked in Derby ‘will be long remembered by us and by the poor, among whom she

⁴⁷ P. Horn, *The rise and fall of the Victorian servant* (Dublin, 1975), p. 37; F. K. Huggett, *Life below stairs: domestic servants in England from Victorian times* (London, 1977), p. 59.

⁴⁸ A. M. R. Kenny, *The Cambridge District Nursing Association* (Cambridge, 1952), p. 3; WSRO, Salisbury Diocesan Institution for Trained Nurses Minute Book July, 5 February 1873 (J8/109/1); LA, Institution of Nurses, Lincoln, *Annual Report* 1873 (Bromhead 4/1).

⁴⁹ W. Rathbone, *Organization of nursing: an account of the Liverpool Nurses' Training School* (Liverpool, 1865), p. 82; MALS, Manchester Nurse Training Institution, *Annual Report*, 1866, p. 27 (362.1 M85).

⁵⁰ C. Helmstadter, ‘From the private to the public sphere: the first generation of lady nurses in England’, *Nursing History Review*, 9 (2001), p. 136; A. Summers, ‘Ministering angels – Victorian ladies and nursing reform’, *History Today*, 39, 2 (1989), pp. 31-37.

⁵¹ See Appendix 8 for biographies.

⁵² C. G. Gepp, *A Short Memoir of Emily Minet: For Twenty Years Lady Superintendent of the Nursing Home, Stratford-On-Avon* (London, 1894), p. 82.

laboured as long as she had strength to do so, and for whom she prayed with her last breath'.⁵³

A connection between nursing and domestic service is evident. Those who undertook private nursing were seen to be on a par with upper domestic servants,⁵⁴ and the most sought after nurses in the 1890s were said to have had experience as children's nursemaids within the domestic setting.⁵⁵ Some early reformers recognised that the two could be promoted through the creation of local institutions that coordinated training for domestic and caring skills.⁵⁶ Although these were never established, domestic servants remained one of the most significant occupational groups of women recruited into nursing. At St George's Hospital, London, over one third of probationers had experience of domestic service prior to employment in the hospital.⁵⁷ This was something that was common to many other institutions, including asylums.⁵⁸ Appendix 5 shows that the largest group of women recruited into nursing associations were domestic servants. However, in Maggs' study of four hospitals, women who had been nurses elsewhere were the most numerous group of those trainees who had prior work experience.⁵⁹ In this study, women with previous nursing experience became more significant towards the end of the century and those who were employed in other occupations traditionally associated

⁵³ DLSL, Derby and Derbyshire Sanitary and Nursing Association, *Annual Report*, 1876/7, p. 5 (A610.73).

⁵⁴ LA, 'Prospectus for the Institution for Nurses, Grecian Terrace, Lincoln', pasted into the Minute Book of the Ladies Nursing Fund Committee, 1 August 1866 (2 AMC. 6/1); WSRO, Salisbury Diocesan Institution for Trained Nurses Minute Book 1871-1876, 12 February 1875 (J8/109/1).

⁵⁵ Derbyshire Record Office (hereafter DRO), Derby and Derbyshire Nursing and Sanitary Association, House and Management Committees Minute Book, 3 December 1896 (D4566/2/1).

⁵⁶ Gloucestershire Record Office (hereafter GRO), Cheltenham Nursing Institution, Minutes 1867-72 (D2465 3/1), copy of a letter from Dr E. T. Wilson to the Rev. J. F. Fenn, October 1867; L. Twining, *Nurses for the sick with a letter to young women* (London, 1861), p. 23.

⁵⁷ Hawkins, *Nursing and women's labour*, pp. 88-92.

⁵⁸ D. Wright, *Mental disability in Victorian England: the Earlswood Asylum, 1847-1901* (Oxford, 2001), pp. 108-110.

⁵⁹ Maggs, *The origins of general nursing*, p. 78.

with women's employment, such as teaching, dressmaking and shop work were certainly recruited but only in smaller numbers. Domestic servants seemingly remained the largest group of recruits in spite of the fact that there were greater opportunities for women in other sectors in the latter part of the nineteenth century.

Nightingale's claim that sanitary science or hygiene, in which disease was kept at bay by rigorous attention to cleanliness, was the province of the nurse and thus, for many, the nurse's 'ability and willingness to perform household tasks became the hallmark of good nursing.'⁶⁰ For most institutions, whether hospital or local associations, servants were seen to make ideal nurses as they were used to acting on orders from both women and men and accustomed to hard work. They were involved in all aspects of the 'polluting fundamentals of life: birth, infancy, illness, old age and death' and 'dealt with the recurring by-products of daily life: excrement, ashes, grease, garbage, rubbish, blood, vomit'.⁶¹ They knew how a private home functioned and those who had been employed as general servants or housemaids were used to long and unremitting hours of dusting, washing, and cleaning. This experience was of great value to future employers, as probationers' work in the hospital and that of trained nurses in private homes, involved a significant amount of cleaning, as well as observing and disposing of excrement, body fluids and soiled dressings.⁶²

⁶⁰ E. Gamarnikow, 'Sexual division of labour: the case of nursing', in A Kuhn and A. M. Wolpe (eds), *Feminism and materialism: women and modes of production* (London, 1978), p. 118.

⁶¹ L Davidoff, 'Mastered for life: servant and wife in Victorian and Edwardian England', *Journal of Social History*, 7, 4 (1974), p. 413 and note 41, p. 425.

⁶² C. Helmstadter, 'Old nurses and new: nursing in the London teaching hospitals before and after the mid-nineteenth-century reforms', *Nursing History Review*, 1 (1993), pp. 64-65.

To the upper and middle classes, the nurse was seen and treated as a specialised and skilled servant. There is a similarity between the preferred characteristics and qualities of the ideal servant and those of the nurse in manuals offering advice to the public. Qualities such as ‘truthfulness, honesty, sobriety, industry, punctuality, neatness, cleanliness, good temper, a willing disposition and intelligence’ were expected equally of the servant as well as the nurse.⁶³ Advice to both servants and probationer nurses was given in regard to the ways they should show deference by, amongst other things, standing in the presence of a superior, be it the householder or the doctor, and to speak only when asked to do so.⁶⁴ It is unsurprising that nursing associations prized servants who had developed such characteristics and qualities.

Training in the hospital

From the 1860s, the nursing associations in this study arranged for recruits to be trained within voluntary hospitals. Nightingale emphasised the importance of the hospital to the development of nursing in response to enquiries from various committees.⁶⁵ Apart from Liverpool, which created its own school in association with the Liverpool Royal Infirmary, most associations had their nurses trained, initially, in the leading training schools of the time. By utilizing voluntary hospitals and in particular the more prestigious

⁶³ E. Lewis, *Domestic service in the present day. Hints to mistresses and maids* (London, 1888), p. 12; a similar list can be seen in W. R. Smith, *Lectures on Nursing* (London, 1875), p. 5.

⁶⁴ E. A. Patmore, *The servants behaviour book or, hints on manners and dress for maid servants in small households by Mrs Motherly* (London, 1859), pp. 31-46; E. C. E. Lückes, *Lectures on general nursing: delivered to the probationers of the London Hospital Training School for Nurses*, fourth edition (London, 1892), pp. 17-19.

⁶⁵ See, for instance, Royal College of Physicians (hereafter RCP), Letter from Florence Nightingale to William Ogle of Derby, 2 January 1865 (OgleJ/2415/1); Letter from Florence Nightingale to Rev. E. J. E. Edwards, Trentham, Staffs., 13 April 1865. Reprinted in E. J. E. Edwards, *Nursing Association for the Diocese of Lichfield* (London, 1865), p. 1; Letter from Florence Nightingale to Mrs G. C. Mathews (Birmingham), 17 November 1868, reprinted in L. MacDonald (ed.) *Florence Nightingale: extending nursing*, Collected works of Florence Nightingale, Volume 13 (Waterloo, 2009), pp. 853-54.

London ones, these associations could and did claim that their nurses were superior to those available to both the rich and poor within the immediate locality. Thus, the Manchester institution sent some of its first cohort of recruits to St Thomas's Hospital and the rest to King's College Hospital, whilst Lincoln used University College Hospital. When the Staffordshire General Infirmary reformed its nursing service and appointed Miss Lovesay, a trained nurse from St Thomas's Hospital, as matron in 1864, the Lichfield association sent its recruits there, as well as to King's College and University College hospitals.⁶⁶ Apart from its initial recruits, the Derby association avoided placing them in the hospitals that were controlled by nursing sisterhoods and used hospitals free from an association with such religious orders in Liverpool, Derby and Chesterfield for training.⁶⁷

The standard training period was set at one year in the 1860s and remained essentially the same for these associations until the 1890s. However, this period was cut short in some instances as there is evidence that the Salisbury association curtailed the training period in its early years in order to ensure it had enough nurses available to meet demand.⁶⁸

Training was based on an apprenticeship model in which the nurses were allocated to wards and expected to be taught by both the doctors and the nurses in charge. Initially, only those nurses who went to St Thomas's Hospital would have had any formal lectures. In Liverpool, a probationer nurse's training consisted of the nurse gaining experience in

⁶⁶ Staffordshire Archives, Stafford (hereafter SAS), Staffordshire General Infirmary, Quarterly General Board, Minutes 11 November 1864 (D685/1/2).

⁶⁷ DLSL, Derby and Derbyshire Sanitary and Nursing Association, *Annual Report*, 1869 and 1870 (A610.73).

⁶⁸ WSRO, Salisbury Diocesan Institution for Trained Nurses Minute Book, 20 January and 14 March 1874 (J8/109/1), 7 August 1876 (J8/109/2).

four wards: two months surgery, two months medicine; four months surgery and four months medicine.⁶⁹ A similar system was put in place at the Children's Hospital in Birmingham when it agreed to train nurses for the Birmingham institution in 1869. This included the stipulation that probationers were to undertake the care of male and female patients, medical and surgical cases including attendance at operations and the care of individual children on night duty. The education of the probationers was said to be the 'primary object' of this training and that they should not be 'diverted from their proper work...by having to scrub floors, clean grates and the like'.⁷⁰

The hospital was seen as the place in which the nurse would develop knowledge and skills associated with medical therapeutics and these were to be taught by the doctors (see chapter 5 for a discussion of the knowledge and skills expected of a trained nurse). Just as important, it was intended that nurse training would inculcate a disciplined way of working:

Hospital training in the full sense of the word, means careful discipline or drill. In other words, order, quickness, punctuality, truthfulness, trustworthiness, method, cleanliness, neatness, implicit and intelligent obedience to those in authority over them, an obedience so absolute and so well understood that a doctor can as fully depend upon his orders being carried out by the nurse as if he himself were present.⁷¹

This moral training was provided by the matron or lady superintendent and ward sisters of the hospital.⁷² Nightingale devised a system at St Thomas's Hospital for observing the

⁶⁹ Rathbone, *Organization of nursing*, p. 50.

⁷⁰ BAH, Birmingham and Midland Free Hospital for Sick Children, Management Committee Minute Book, 8 March 1869 and 27 October 1869 (HC/BCH/1/2/1).

⁷¹ National Association for Providing Trained Nurses for the Sick Poor, *Report of the sub-committee of reference and enquiry* (London, 1875), p. 17.

⁷² Helmstadter, 'Old nurses and new', pp. 52-53; E. J. E. Edwards, *Nursing Association for the Diocese of Lichfield*, p. 8.

probationers' conduct and performance based on a personal record sheet that asked for a report about the nurses' ability to undertake patient care, but also about their character in terms of punctuality, quietness, trustworthiness, neatness, cleanliness, sobriety, honesty and truthfulness.⁷³ Nightingale's views on the ideal qualities required by nurses were taken up by nursing associations and hospitals from the 1860s onward and were expected of both the new recruit and the established nurse.⁷⁴ The nurse was expected to 'act in complete obedience to the instructions of the Sister and Staff-Nurses' and to develop a work ethic that stressed punctuality, hard work and long hours.⁷⁵ Women were trained within hospitals which had strict regulations, timetables that dictated a nurse's activity throughout the twenty-four hour day and a regime that demanded absolute obedience to authority.⁷⁶ For instance, the probationers who were trained at the Salisbury Infirmary for the diocesan nursing association worked seven days a week starting each day at 7am and finishing at 9pm. They either finished at 6pm on a Friday or 5.30pm on a Sunday and had a two-hour break for recreation on a Tuesday or Thursday afternoon.⁷⁷ This does not include meal breaks and other activities such as changing aprons after heavy cleaning tasks, but equates to a presence within the hospital consisting of approximately 93 hours

⁷³ M. E. Baly, *Florence Nightingale and the nursing legacy*, Second Edition (London, 1997), Appendix 1, pp. 229-30.

⁷⁴ The following texts span the last quarter of the nineteenth century and show a consistent attitude to the qualities and behaviour expected of nurses: F. S. Lees, *Handbook for hospital sisters* (London, 1876), pp.1-27; C. J. Wood, *A handbook of nursing for the home and Hospital* Second Edition (London, no date), pp. 7-19; I. Stewart and H. E. Cuff, *Practical Nursing* (2 vols., Edinburgh, 1889), I, pp. 4-5; P. G. Lewis, *Nursing: its theory and practice* (London, 1895), pp.1-7.

⁷⁵ A. Blissett, 'The relative positions of the sister, staff-nurse and probationer and what their hours of duty and work should severally be in a properly organised ward of thirty beds', *Nursing Record*, 21 June 1888, p. 140.

⁷⁶ Vicinus, *Independent women*, pp. 90-91.

⁷⁷ WSRO, Salisbury Diocesan Institution for Trained Nurses Minute Book 1871-1876, 5 December 1876 (J8/109/2).

in each week. Long working hours in wards typified the work routine of probationers well into the twentieth century and occurred in both London and provincial hospitals.⁷⁸

Discipline was applied to all aspects of the nurses' lives in the hospital and a code of behaviour, known as 'nursing etiquette', which included politeness, deference to superiors and obedience to orders developed.⁷⁹ Nightingale saw moral discipline as crucial for the advancement of nursing and even advocated the design of both hospitals and the nurses' accommodation in such a way as to enable the hospital matron and her subordinates to keep the ordinary nurses and probationers under constant observation and discipline.⁸⁰ Thus, those nurses who underwent training for nursing associations would have developed knowledge and skills as well as a work ethic that prepared them for work in the homes of both the rich and poor.

Life in the Nurses' Home

Traditionally, hospital nurses had lived within the hospital, taken all their meals in the wards and slept in rooms attached to the wards or in attics or cellars. With the reform of nursing from mid-century onward things began to change and better provision was being advocated for the nurses. In 1856, the lady superintendent of St John's House insisted on a separate common room and dining room, as well as private bed spaces in dormitories for the nurses at King's College Hospital.⁸¹ By 1865, Nightingale was advocating that

⁷⁸ Maggs, *The origins of general nursing*, pp. 110-13.

⁷⁹ 'Nursing etiquette', *Nursing Record*, 9 December 1893, pp. 297-98.

⁸⁰ M. E. Baly, 'The Nightingale nurses and hospital architecture', *Bulletin of History of Nursing*, 11 (Autumn 1986), p. 6.

⁸¹ C. Helmstadter, 'The first training institution for nurses: St John's House and 19th century nursing reform, Part 1: the origins of St John's House and its new central nursing system', *History of Nursing Journal* 4, 6 (1992/93), p. 298.

hospitals should have a nurses' home in order to ensure the comfort, safety and instruction of the probationers and nurses.⁸² The Liverpool Training School and Home opened in 1863 with the nurses housed in purpose-built accommodation.⁸³ This initiative was paid for by William Rathbone and a similar home was opened in Stoke-upon-Trent in 1879 by the Staffordshire Institution for Nurses, the successor organization of the Lichfield Diocesan Nursing Association, at a cost of £2,200. This latter building had sufficient space for the nurses for living, dining, sleeping and storage of their luggage boxes with separate, more spacious accommodation for the lady superintendent.⁸⁴ Other organizations did not have such generous founders or the ability to call upon such wealth. The Derby association discussed the need for a new home from 1872 onward.⁸⁵ They set up a building fund, as a normal house adapted as a nurses' home was deemed inadequate because:

it used to be thought that an ordinary house could be converted into a hospital . But this is a mistake: a hospital that is a building for sick people requires special construction...So also a Nursing Institution should be especially contrived to be healthy, comfortable, and, if possible, a cheerful home for the inmates, as the work in its nature is very depressing...⁸⁶

In the 1890s, the accommodation was still said to be inadequate and it was not until 1905 that a new home together with medical and surgical facilities was opened.⁸⁷

Accommodation did affect morale in some instances. A public dispute occurred in 1888 in Sheffield and was referred to as the 'Sheffield Nurses' Strike'. During April of that

⁸² Baly, *Florence Nightingale and the nursing legacy*, pp. 52-53.

⁸³ G. Hardy, William Rathbone and the early history of district nursing (Ormskirk, 1981), p. 6.

⁸⁴ *Church Calendar and General Almanack for the Diocese of Lichfield*, 1876 and 1879.

⁸⁵ 'Derby and Derbyshire Nursing and Sanitary Society', *Derby Mercury*, 10 April 1872; 'Derby and Derbyshire Nursing and Sanitary Association', *Derby Mercury*, 27 April 1881.

⁸⁶ 'Derby and Derbyshire Nursing Association', *Derby Mercury*, 7 April 1875.

⁸⁷ DRO, Derby and Derbyshire Nursing and Sanitary Association, House and Management Committees minute book, 16 August 1892 (D4566/2/1); Derby and Derbyshire Nursing and Sanitary Association, Board of Management minute book, 1896-1914, 16 June 1905 (D4566/1/1).

year, the Lady Superintendent complained about the inadequate and overcrowded accommodation in the Sheffield Nurses' Home and, in particular, the way that the management committee occupied her own room for committee meetings once a week and the lack of quiet rooms for nurses who were ill. The committee dismissed her complaint. She resigned and 31 nurses informed the committee that, unless she was asked to remain, they would leave with her.⁸⁸ She was forced to leave the home one month early, but enough middle-class people believed she was hard done by and set up a rival charity in which she and the nurses could continue their work. To Mrs Bedford Fenwick, the self-styled leader of professional nursing and the owner of the *Nursing Record*, this was a clear case of exploitation of nurses by a charity. Nurses earned large amounts of money for the Home, but received poor pay and accommodation in return.⁸⁹

In the main, the associations in this study were able to cope with the pressures on the accommodation. Only a small number of private nurses were in the homes at anyone time, as the majority were out living with private families or sent to other institutions for work. In Birmingham, Liverpool and Manchester, the district nurses were separated from the private nurses, originally living in separate houses or in their own homes and then, as more resources became available, they were housed in purpose-built nurses' homes. However, it was not unusual to have larger than expected numbers in a home, putting pressure on both the accommodation and the resources. The lady superintendent played a crucial role in this aspect of management. For instance, Mrs Diamond, the lady superintendent in Birmingham, was praised for her 'economical management' when as

⁸⁸ 'Sheffield Nurses' Home, resignation of the matron and nurses', *The Sheffield and Rotherham Independent*, Wednesday, 16 May 1888.

⁸⁹'Nursing echoes', *Nursing Record*, 7 June 1888, pp.114-15.

many as thirty people sat down to dinner during a period when the health of the town was unusually good and demand for nurses was low.⁹⁰ Servants were employed to help with the day-to-day running of the home, but, in most associations, the nurses themselves were expected to help with domestic tasks whilst they were between jobs.⁹¹

Not only was the lady superintendent charged with the running of the nurses' home, but in most places she was responsible for the recruitment of the probationers, the allocation of trained staff to jobs, the maintenance of staff discipline, giving a progress report on the nursing staff to the appropriate committee and ensuring that the nurses were suitably prepared to work in the houses of the rich or those of the poor. Miss Brumwell of Derby was praised for her day-to-day management of the homes in several annual meetings of the association and in particular for the high standards she set in the recruitment of nurses.⁹²

The nurses, mainly from working-class backgrounds, were taught ways in which to behave in the households of the rich. As a result of this, a doctor in London preferred to recommend the nurses from Stratford-on-Avon, rather than local ones due to his 'high opinion of their general tone and capacity'.⁹³ In Salisbury, one of the local surgeons praised the lady superintendent, Miss Hussey:

Her management of the nurses could not be too highly spoken of. The accurate way in which she did the business, the judgement with which she decided which

⁹⁰ BAH, Birmingham & Midland Counties Training Institution for Nurses, House Committee, Minute Book, 13 October 1885 (MS807/6/6).

⁹¹ MALS, Manchester Nurse Training Institution, *Annual Report* 1867, p. 29 (362.1 M85).

⁹² 'Derby and Derbyshire Nursing Association', *Derby Mercury*, 11 April 1877; 'Derby and Derbyshire Nursing and Sanitary Association', *Derby Mercury*, 28 April 1880.

⁹³ C. G. Gepp, *A Short Memoir of Emily Minet: For Twenty Years Lady Superintendent of the Nursing Home, Stratford-On-Avon*, (London, 1894), p. 34.

nurse to send, the way in which she kept them together and refined them was highly commendable. He thought it of the greatest importance that those who went to nurse ladies, or refined people, should have house manners that were most agreeable to that class... He attributed a great deal of devotion, a great deal of the refinement of the nurses to the management of Miss Hussey, who was herself a refined lady and devoted woman'.⁹⁴

Standards were rigorously applied and nurses were kept under a strict regime and those that did not conform to expectations were disciplined or dismissed. Some, like Kate Morgan, were reprimanded for their behaviour by the Cheltenham institution following a complaint; others like Emily Jaye of the Salisbury association, who refused to go to an urgent case in place of a sick nurse, was dismissed immediately; and nurses in Birmingham were dismissed, during 1886, for 'general untruthfulness and failure to return to the home in the evenings', 'misconduct whilst away nursing' and 'mischief making and untruthful slander'.⁹⁵

Working in the homes of the rich and poor

The regulations for the nurses in all of these associations demanded that there should be strict obedience to the doctor and his prescriptions.⁹⁶ The nurse was not expected to question the medical attendant's decisions as it was 'no part of the nurse's duty to offer an opinion'.⁹⁷ Nurses were expected to demonstrate an appropriate manner in the sick room, including 'self-denial, forbearance, gentleness, and good temper, so essential in

⁹⁴ WRSO, Salisbury Diocesan Institution for Trained Nurses, Minute Book 1879-1907, 28 February 1884, (J8/109/3).

⁹⁵ GRO, Cheltenham Nursing Institution, Minutes 1867-72, 2 May 1871 (D2465 3/1); WRSO, Salisbury Diocesan Institution for Trained Nurses, Minute Book 1879-1907, 7 June 1881 (J8/109/3); BAH, Birmingham & Midland Counties Training Institution for Nurses, House Committee, Minute Book, 11 May 1886, 8 June 1886, 14 December 1886 (MS807/6/6).

⁹⁶ See, for instance, GRO, Cheltenham Nursing Institution, Committee of Management, Minutes 1869-72, 17 November 1869 (D2465 3/1).

⁹⁷ D. Turner, *A manual of diet for the invalid and dyspeptic with a few hints on nursing* (London, 1869), p. 49.

their attendance on the Sick'.⁹⁸ They were also charged with maintaining confidentiality regarding the information about the private households and individuals they attended.⁹⁹ Reports were expected from doctors and clients regarding the competence and demeanour of the private nurse. In the main, feedback was positive, but one nurse from Derby was dismissed for administering medicines that were not prescribed to a patient and concealing this from the doctor.¹⁰⁰ In 1878, Mr Coates, a Salisbury surgeon, did not think that Jane Sheppard was capable of discharging her duties after seeing her nurse several serious cases; she resigned. Action was also taken if individuals were found not to conform to the expected behaviour in the homes of private patients. For instance, in 1877, a doctor wrote to the Institute of Nursing Sisters in London on behalf of his clients, demanding a replacement for Mrs Smith because of her 'excessive talkativeness (both in the sickroom and out of it) and her great affection of manners and flaunting ways'.¹⁰¹ In 1880, Frances Greenwood was deemed not suitable for private nursing and given one month's notice to leave the Salisbury home, as was Bertha Westwood, in 1891, about whom it was recorded 'from her temperament she is quite unfitted for the class of work she is required to do'.¹⁰²

District nurses were also subject to control and discipline. Those women working for the smaller associations either lived in the nurses' home and were subject to the normal

⁹⁸ This was first stated in the Liverpool regulations (Rathbone, *Organization of nursing*, p. 82) and copied extensively elsewhere. See, for instance, DLSL, Derby and Derbyshire Nursing and Sanitary Association, *Annual Report*, 1869/70, p. 4 (A610.73).

⁹⁹ Ibid.

¹⁰⁰ Ibid.

¹⁰¹ Wellcome Archives, Institution of Nursing Sisters: letter from Dr Davey, 3 December 1877 (SA/QNI/W6/4).

¹⁰² WSRO, Salisbury Diocesan Institution for Trained Nurses, Minute Book 1879-1907, 3 May 1880 & 13 March 1891 (J8/109/3).

discipline or were supervised directly by the lady superintendent in their work. In Derby, Miss Brumwell, the lady superintendent, allocated new cases to the district nurses, gave them instructions about the care required and visited each patient weekly.¹⁰³ As stated earlier in the three large cities of Liverpool, Manchester and Birmingham, they were supervised by untrained wealthy ladies who were used to dealing with domestic servants. Although most nurses were praised for their work, small numbers were disciplined. For instance, the district nurse in Cheltenham was dismissed following ‘irregularities’ in her conduct and, in Liverpool, a small number of district nurses were dismissed for misdemeanours including falsification of records and drunkenness.¹⁰⁴

Control of the district nurses extended to the entire day with them expected to adhere to specified activities and timetables for their working hours, irrespective of whether they lived in the nurses’ home or not. The district nurses in Manchester, who lived within the districts they served, were expected to leave their houses at half-past nine in the morning to commence their visits and return for lunch at half-past twelve. They went out again at two o’clock and returned at five. Following this, they were instructed to write up their case notes and prepare food for the patients for the next day. In addition, they were expected to clean their rooms on Fridays or Saturdays.¹⁰⁵ A similar regime existed in Birmingham, but, by 1880, all the nurses were housed in a purpose-built home and the 1893 report featured a set timetable (see Figure 4.2).

¹⁰³ National Association for Providing Trained Nurses for the Sick Poor, *Report of the sub-committee of reference and enquiry* (London, 1875), p. 39.

¹⁰⁴ GRO, Cheltenham Nursing Institution, Minutes 1867-72, 7 June 1870 (D2465 3/1); LRO, Liverpool Training School and Home for Nurses, Register of Trainee Nurses 1862- 1876 (614 INF/26/2/1).

¹⁰⁵ MALS, Manchester Sick-Poor and Private Nursing Institution, *Annual Report* 1883, p. 33 (362.1 M85).

In Birmingham, as elsewhere, the nurses' lives were governed by rules which stipulated the behaviour expected of them, both on and off duty. The lady superintendent had absolute control of the day-to-day running of the institution. The nurses were required to wear their uniforms on week-days and their caps at all times when in the home. They were not allowed to be absent from the home or to receive visitors without special permission from the lady superintendent.¹⁰⁶

Figure 4.2: Nurses' Time Table, Birmingham District Nursing Society, 1893¹⁰⁷

| Monday to Saturday | | Sunday | |
|---------------------------|----------|---------------|---------|
| Rise | 6.30am | Rise | 7.30am |
| Breakfast and Prayers | 7.30am | Breakfast | 8.30am |
| Go on Duty | 8.30am | Dinner | 1.0pm |
| Dinner | 1.0pm | Tea | 4.30pm |
| Off Duty | 2 to 4pm | Supper | 9.0pm |
| Tea | 4.0pm | Bed | 10.0pm |
| Go on Duty | 4.30pm | Lights out | 10.30pm |
| Supper | 8.0pm | | |
| Bed | 10.0pm | | |
| Lights Out | 10.30pm | | |

Some work has related this approach to the organization of nursing, both inside and outside of the hospital, namely the work of Michel Foucault and, in particular, his work:

¹⁰⁶ BAH, Birmingham District Nursing Society, *Annual Report*, 1888, p. 19 (L46.6).

¹⁰⁷ BAH, Birmingham District Nursing Society, *Annual Report*, 1893, p. 20 (L46.6).

Discipline and Punish.¹⁰⁸ In this book, Foucault outlines two themes, the punishment of crime and the growth of discipline within society. He claims the latter not only was seen in prisons, but also in the army, schools, hospitals and some charities concerned with health and welfare of the poor, spaces which he refers to as the carceral archipelago.¹⁰⁹ Foucault characterized discipline as the process whereby authority defines where and when actions take place, but also prescribes how actions should be carried out. This utilises time and trains the individual to do tasks in certain ways and leads one to learn skills through repetition. New behaviour is learned through training, not through punishment. In this way, both technical and general skills of behaviour are developed.¹¹⁰ These skills are determined by the bourgeoisie and aim to produce a compliant and reformed prisoner, juvenile offender, soldier, factory worker, pupil, or, indeed, a nurse. Discipline creates 'docile' bodies that are economically, socially and politically useful.¹¹¹ They are produced in three ways: by 'hierarchical observation', 'normalizing judgement' and through examination.¹¹² According to Foucault, behaviour can be changed through observing people or by instilling the belief that they are being observed. He discusses Jeremy Bentham's Panopticon, a design for a prison that could use minimum staff to potentially observe every individual prisoner, thereby changing their behaviour by instilling the thought that they were being observed. Second, individuals are judged on the basis of being compared to everyone else and ranked accordingly. This 'normalizing judgement' has no absolute measure of achievement and there a higher level will always

¹⁰⁸ M. Foucault, *Discipline and punish: the birth of the prison*. Trans. A. Sheridan (London, 1977).

¹⁰⁹ *Ibid.*, p. 298.

¹¹⁰ C. Lucas, 'Power and the panopticon', *Times Literary Supplement* (1975), 26 September, p.1090, reprinted in P Burke, (ed.), *Critical essays on Michel Foucault, Critical thought series: 2* (Aldershot, 1992), pp. 135-38.

¹¹¹ Foucault, *Discipline and punish*, p. 138.

¹¹² *Ibid.*, pp. 170-194.

seem possible. Thus, many will be encouraged to do better. It can also determine what is seen as normal and abnormal behaviour and the threat of being labelled abnormal invariably alters the behaviour of most individuals. The examination combines hierarchical observation and normalizing judgement in determining the truth about those undergoing examination and by its very nature exerts control over the behaviour of individuals.¹¹³

According to Bashford, nurses in the nineteenth century could be described, in Foucauldian terms, as ‘docile bodies’ with the imposition of timetables, intense scrutiny and systems of discipline similar to those employed in military settings.¹¹⁴ Certainly, the reform of nursing can be seen in this light, as accounts that contrasted the new reformed practitioner with the old type of nurse, typified by Mrs Gamp, refer to the need to impose strict disciplinary regimes and training of nurses.¹¹⁵ It would appear that the way that hospitals and the associations in this study operated demonstrates, to a certain extent, Foucault’s thesis regarding the use of discipline. The system of order and obedience introduced from the 1860s onward has been identified as a reasonable solution to deal with women who were relatively poorly educated and unprepared for regular working hours.¹¹⁶ Discipline was unduly harsh in some institutions. For instance, a clergyman was recorded as criticizing the training at St Thomas’s Hospital under Mrs Wardroper, which aimed

¹¹³ G. Gutting, *Foucault: a very short introduction* (Oxford, 2005), pp. 81-86.

¹¹⁴ A. Bashford, *Purity and pollution: gender, embodiment and Victorian medicine* (Basingstoke, 1998), pp. 44-48.

¹¹⁵ E. M. Fox, ‘What the twentieth century nurse may learn from the nineteenth’, *The British Journal of Nursing*, 26 November 1910, pp. 432-34.

¹¹⁶ C. Helmstadter, ‘Old nurses and new’, p. 62.

to crush all enthusiasm and spirit...and was calculated to turn young women into automatic machines – discipline was too severely directed against natural affection.¹¹⁷

As nurses were considered to be servants, they were expected to work for the convenience of the organization and discipline was imposed in order to develop a productive and trustworthy workforce.¹¹⁸ Some have suggested that it was introduced to meet the challenges of the 1860s, but did not change much until after the First World War. For Monica Baly, this system prevented innovation in practice and education, whilst Carol Helmstadter puts its survival down to economics because of a need to maintain the productivity of nurses and economy of expenditure in a period of severe underfunding of hospitals and health care.¹¹⁹

Although strict discipline was employed by the associations within this study, they did make efforts to provide for their staff by improving the terms and conditions of both work and home life. This was all done within an economic climate of limited resources. Most organizations accepted gifts for the nurses, for instance, in a five-year period between 1887 and 1892, subscribers to the Birmingham District Nursing Society gave gifts including books, Christmas dinner, New Year's treats, illustrated papers and tickets for entertainments to the nurses and a piano, pictures and furniture for the nurses' home.¹²⁰

¹¹⁷ S. A. Tooley, *The history of nursing in the British empire* (London, 1906), p. 102.

¹¹⁸ Helmstadter, 'Old nurses and new', p. 63.

¹¹⁹ M. Baly, *Florence Nightingale and the nursing legacy* (London, 1986), p.219; C. Helmstadter, 'Building a new nursing service: respectability and efficiency in Victorian England', *Albion*, 35, 4 (2003), pp.594-95; Helmstadter, 'Old nurses and new', pp. 64-65.

¹²⁰ BAH, Birmingham District Nursing Society, *Annual Reports*, 1888-1892 (L46.6).

Rather than always being ‘docile bodies’, nurses made decisions about their own futures and careers and many left with the blessing of the respective associations for alternative employment, whilst others remained in their employ over long periods of time. There are isolated incidences of nurses reacting to strict disciplinary regimes. Finding evidence of the existence of conflict is not easy as disputes happened within closed institutions which were not likely to reveal problems to the outside world. However, in 1876, the nurses of the Salisbury Diocesan Nursing Association objected to the Lady Superintendent’s disciplinary regime within the nurses’ home and forced her resignation. The management committee felt that, although she maintained a high moral tone within the home, she had failed to consider the comfort of the nurses and should have had more ‘sympathy with the lesser and greater trials of their calling’.¹²¹ The nurses were informed of the outcome, but were told that their behaviour would not be tolerated in the future. In subsequent years, they made representations for wage increases but never challenged the decisions of the committee.

Life and Careers beyond employment in a nursing association

For some women employed by the associations, nursing was a lifelong career from which they retired or died in service. For instance, Miss Cora Marshall, of the Lincoln institution, retired in 1907, having been employed for 35 years as the ‘lady in charge’. Her colleague and contemporary, Mrs Hemsworth, the matron of the nurses’ home, died in 1906, having given over twenty years in service and been bedridden for over a year.¹²²

¹²¹ WSRO, Salisbury Diocesan Institution for Trained Nurses, Minute Book 1871-1876, 26 February 1876, (J8/109/1).

¹²² LA, Institution of Nurses, Lincoln, *Annual Reports* 1907 and 1908 (Bromhead 4/1). See Appendix 8 for a short biography of Cora Marshall.

Retirement was either granted as a result of age or infirmity. Examples from the records include Ann Atkinson, employed as a district nurse in Manchester from 1869 until 1890 when she was granted a pension of £12 per year and nurse Naomi, 'whose name has long been a household word among the poor in the city of Lincoln, has been obliged by her health to give up the work which she has carried on with devoted zeal for 19 years'.¹²³ Some associations made provision for retirement by setting up separate funds for nurses who qualified and by the end of the century.¹²⁴ However, there are few examples of retirement in the records. It would seem that most nurses left before age or illness prevented them from working. For many nurses, employment by these associations was only one stage in their work and life. This same pattern can be seen in the careers of many domestic servants.

McBride identified domestic service as being an activity which facilitated both social and occupational mobility. Some young women were prepared to move quite long distances in order to acquire skills and experience, as well as the opportunity to accumulate working capital, in order to start a business, buy property or to get married. It enabled them to improve their basic education and, in some cases, enhance their skills in cookery and household management.¹²⁵ Domestic service was seen as a bridging occupation which facilitated mobility from one occupation to another.¹²⁶ Given that associations in

¹²³ MALS, Manchester and Salford Sick Poor and Private Nursing Institution, Minutes, 17 March 1890 (M504/1/1); LA, Institution of Nurses, Lincoln, *Annual Report*, 1894 (Bromhead 4/1).

¹²⁴ WSRO, Salisbury Diocesan Institution for Trained Nurses, Minute Book July, 18 July 1898 (J8/109/3).

¹²⁵ T. M. McBride, *The domestic revolution: the modernisation of household service in England and France 1820-1920* (London, 1976), pp. 82-85.

¹²⁶ L. Broom and J. H. Smith, 'Bridging occupations', *The British Journal of Sociology*, 14, 4 (December, 1963), pp. 321-34.

this study identified domestic servants as ideal recruits to nursing and that they seem to have constituted the largest single occupational group of women recruited into these organisations, it is not surprising that this type of career pattern can be identified for nurses themselves. Wright has demonstrated that nurses within asylums had a distinct career pattern. Many entered domestic service from rural backgrounds for two to three years and then gained employment in an institution where they acquired attending and nursing skills before acquiring a more lucrative position elsewhere or marrying.¹²⁷ This pattern can also be seen in the careers of some of the women within this study, as marriage¹²⁸ and positions both within and outside of nursing were taken up by nurses following a period of time employed by a nursing association. Some nurses went from nursing into domestic service. This is illustrated in the career of Jane Cryer of the Cheltenham Nursing Institution. She is recorded in the 1861 census, aged 17, as a domestic servant. In 1870, she was employed as a private nurse by the institution after receiving some training at the Gloucestershire Infirmary. In 1872, she left to take up a position as a servant with the family she had been attending and was recorded as their housekeeper in the 1901 census.¹²⁹ This was a common occurrence according to the annual reports of the Derby association in the 1870s and 1880s.¹³⁰ However, few nurses identified in the surviving records or the census returns appear to have done this (see Appendix 5). Rather than revert back to domestic service, Maria Field left the employment of the Lichfield Diocesan Nursing Association to become a private nurse in

¹²⁷ D. Wright, *Mental disability in Victorian England: the Earlswood Asylum, 1847-1901* (Oxford, 2001), pp. 108-10.

¹²⁸ See Appendix 7 for a biography of Cecilia Quinney.

¹²⁹ See Appendix 7 for a biography of Jane Cryer.

¹³⁰ DLSL, Derby and Derbyshire Sanitary and Nursing Association, *Annual Report*, 1870, 1871, 1876, 1882 (A610.73).

a household in Surrey for over twenty years, accompanying a member of the household to Malvern to attend a water cure establishment in 1871.¹³¹

Appendix 5 indicates, of those nurses that could be traced, a small group that left employment and went into business on their own, mainly private nursing practice. The latter is frequently given as the cause of resignation of nurses within the records.¹³²

Private nursing was a good way for nurses to earn an independent living, especially for those who could demonstrate that they had both training and extensive experience. Such was the rising demand for private nurses during the latter part of the nineteenth century that even those who had been dismissed by associations were able to make a living from nursing. Mary Mackie, trained at St Thomas's Hospital and one of the first nurses employed by the Manchester Nurse Training Institution, was still earning a livelihood as a private nurse some 35 years after her dismissal in 1866,¹³³ and Catherine Scurrah, dismissed from her post as a district nurse in Liverpool in 1876 for drunkenness, similarly was recorded as a midwife or monthly nurse in and around the city in the censuses up to 1901.¹³⁴ Some nurses worked in direct competition with their former employers. By 1878, the Manchester institution was reporting that 20 nurses who had been trained at their expense had made contact with doctors and patients whilst employed by the

¹³¹ See Appendix 7 for biographies of Maria Field and Louisa Case, who also entered domestic employment as a nurse.

¹³² Examples include MALS, Manchester Nurse Training Institution, *Annual Report*, 1868 (362.1 M85); DLSL, Derby and Derbyshire Sanitary and Nursing Association, *Annual Report*, 1876 (A610.73); WSRO, Salisbury Diocesan Institution for Trained Nurses, Minute Book July, 10 November 1884 (J8/109/3); LA, Institution of Nurses, Lincoln, *Annual Report*, 1893 (Bromhead 4/1).

¹³³ See Appendix 7 for a brief biography.

¹³⁴ LRO, Liverpool Training School and Home for Nurses, Register of Trainee Nurses 1862- 1876 (614 INF/26/2/1).

institution were living and working in Manchester.¹³⁵ Similarly, in 1888, the Salisbury association noted that many nurses who had left to work independently had settled in the vicinity of the city and, therefore, threatened the income of the association. The committee considered ways in which this problem could be prevented.¹³⁶ By the 1890s, the Derby association had a written agreement with its nurses that they should pay a fixed sum of £10 if they wished to take up private nursing with existing clients.¹³⁷ In contrast, in 1884, the Lincoln institution, having trained 33 monthly nurses since its inception, decided to discontinue this type of service as many nurses in their previous employ were living in Lincoln and there was no need for the institution to be involved in that type of work.¹³⁸

Some women left to undertake nursing work within other institutions. Some nurses were attracted to employment in workhouses, public infirmaries and fever hospitals, especially after 1897 when nurses became entitled to a pension.¹³⁹ Others found employment in charitable institutions, such as voluntary hospitals, district nursing associations, orphanages, or in public schools.¹⁴⁰ This type of employment gave some women the prospect of promotion, an increase in salary and improved conditions that would

¹³⁵ 'Manchester Nurse Training Institution', *Manchester Guardian*, 24 January 1878.

¹³⁶ WSRO, Salisbury Diocesan Institution for Trained Nurses, Minute Book July, 22 February 1888 (J8/109/3).

¹³⁷ DRO, Derby and Derbyshire Nursing and Sanitary Association, House and Management Committees minute book, 3 August 1899 (D4566/2/1).

¹³⁸ LA, Institution of Nurses, Lincoln, *Annual Report*, 1884 (Bromhead 4/1).

¹³⁹ C. Maggs, *The origins of general nursing* (London, 1983), p. 151.

¹⁴⁰ This point is illustrated by the careers of Mary Stuart, Alice Spence and Elizabeth Baker, three nurses who were trained and employed by the Salisbury Institution during the 1890s, and who were recorded as nurses in the Cannock Workhouse, Southampton Isolation Hospital and the Sanatorium at Marlborough College, a public school, respectively in the 1901 census.

accompany such a post.¹⁴¹ The empire also gave opportunities for women seeking employment, but there are only a few records of nurses leaving these associations to emigrate. Unusually, one nurse left the Birmingham institution in 1892, following 12 years of service, to take up the post of matron in a hospital in New York.¹⁴² Promotion, as in this example, did not seem to occur very often, but some working-class nurses were able to gain better positions. For instance, Eliza Leek, a district nurse, left Manchester to become matron of the Bradford Eye and Ear Hospital in 1873.¹⁴³

It seems that only a very small number of nurses left nursing altogether and took up occupations other than domestic service. Of these, Elizabeth Walton, who was trained at the expense of the Manchester association and who was the matron of the Salford Hospital and Dispensary from 1866 until 1879, was recorded as a shopkeeper in the 1881 census and Harriet Stone, a nurse, who left the Salisbury association in 1891, was listed as a partner in a stables and a cab proprietor in Paddington, London in 1901.¹⁴⁴ Elizabeth Alsop, the first lady superintendent responsible for private nursing for the Manchester institution from 1866, was dismissed in 1879. Following a period as the lady principal of a medical and surgical home in Manchester, she was recorded as a lodging-house keeper

¹⁴¹ See Eliza Leek's biography in Appendix 7. A similar example can be seen in S. Hawkins, *Nursing and women's labour*, p. 34.

¹⁴² BAH, Birmingham and Midland Counties Training Institution for Nurses, Minute Book of the House Committee, 11 October 1892 (MS807/6/6).

¹⁴³ See Appendix 7 for her biography.

¹⁴⁴ Greater Manchester Records Office, Salford and Pendleton Royal Hospital and Dispensary, Minute Book, 23 July 1879 (G/HSR/AM4); WSRO, Salisbury Diocesan Institution for Trained Nurses, Minute Book, 13 March 1891 (J8/109/3).

in St Leonard's on Sea in the 1891 census.¹⁴⁵ Setting up one's own business, especially shop keeping, has been found in at least one other study.¹⁴⁶

Maggs describes marriage as a 'non-career' move that some nurses made.¹⁴⁷

Contemporary views and accounts postulated that many women entered nurse training with marriage in mind, but this may have been a myth more related to the motives of upper- and middle-class paying probationers in the hospitals.¹⁴⁸ In this study, where nurses were drawn mainly from the working class, only small numbers left to be married, but too few accurate records survive to determine exact numbers. The minutes of the Salisbury association reveal only two records of nurses leaving to be married in 28 years (1872-1900) and only four nurses left the Birmingham institution between 1885 and 1899 to do likewise.¹⁴⁹ It is likely that marriage was the reason why more nurses resigned from their employment and left. However, this seems to have involved a small proportion of the overall workforce, as verified by the results of Hawkins' study by of St George's Hospital, London where less than three percent of nurses normally left each year to be married.¹⁵⁰

Although the evidence from both records and the census is fragmentary, making it difficult to identify and trace nurses, it would seem that women who were nurses adopted a model of career development similar to those who went into domestic service. This is

¹⁴⁵ See Appendix 8 for her biography.

¹⁴⁶ Hawkins, *Nursing and women's labour*, pp. 108 and 165.

¹⁴⁷ Maggs *The origins of general nursing*, p. 156.

¹⁴⁸ S. Hawkins, *Nursing and women's labour*, pp. 144 and 148.

¹⁴⁹ WSRO, Salisbury Diocesan Institution for Trained Nurses, Minute Books 1871-76 (J8/109/1); 1876-1878 (J8/109/2); 1879-1907 (J8/109/3). BAH, Birmingham and Midland Counties Training Institution for Nurses, Minute Book of the House Committee, 1885-1899 (MS807/6/6).

¹⁵⁰ Hawkins, *Nursing and women's labour in the nineteenth century*, p. 148.

unsurprising as these nurses, in the main, came from similar backgrounds to domestic servants. Hospital nursing has also been identified as offering similar career opportunities.¹⁵¹ Therefore, nursing can be seen as a bridging occupation, allowing women to gain skills and knowledge or capital that could be transferred to other settings. There is some evidence to show that many nurses had a flexible approach to earning a living and that experience as a nurse could facilitate a move through a variety of institutions, and potentially lead to new occupations.

Summary

Nursing associations were voluntary societies and were managed in the same way as other charitable institutions. Once established, the new nursing associations adopted the spirit of nursing reform by recruiting women of good character and with, in the main, a religious vocation. There is no evidence in this study to support the findings from research into nursing in the London hospitals that suggests the nursing workforce became dominated by the middle classes by the end of the century. In these provincial local associations, the reform of nursing was based on moulding working-class women into an efficient and useful workforce who were treated as and expected to fulfil the role of the servant, albeit a superior one. These nurses were trained in hospitals, were supervised in their practice by ladies who were either employed or acted as unpaid superintendents and were expected to give unswerving obedience and loyalty to the doctor. Most were housed in a nursing home which provided a comfortable, secure and disciplined environment. The need for this type of nurse was promoted by most contemporary commentators and

¹⁵¹ Helmstadter, 'Building a new nursing service', p. 614.

reformers, including Nightingale. The salaried superintendents were recruited from the middle classes and were either single or widowed and usually in need of an income. They tended to be women with a religious vocation and had more in common with the local elites that ran the associations than with the nurses. Like their unpaid colleagues they were used to dealing with servants. Whilst some nurses looked to make a career from their work with an association, many used it as a bridging occupation which enabled them to move to other nursing jobs or out of nursing into another activity. The next chapter will move from the nurses themselves to address nursing care and practice.

5: NURSING PRACTICE

This chapter examines the practice that was undertaken by nurses employed by nursing associations from the middle to the end of the nineteenth century. The influence of sanitary science and medical knowledge are discussed in this period otherwise defined by significant change. The nurse's role within the homes of the poor and the rich, with patients undergoing operations and those suffering from infectious diseases is presented. The influence of the location of care on nursing practice is addressed in terms of the differences in the care received by the rich and poor in their own homes. The specific place of the sick room in the care and management of patients and the lives of nurses is discussed. The effects of work on the nurses themselves is also examined.

Accounts of nursing practice in the surviving documents are limited.¹ These are mainly concerned with organisational and financial aspects of the associations, rather than the day-to-day care clients received. As a result, a wide range of contemporary sources from other nursing associations, newspaper reports and textbooks are utilised to supplement the surviving information for those associations included in this study.

The Nature of Nursing Practice

Florence Nightingale was a sanitarian, a believer in miasma and a collaborator of Edwin Chadwick who suggested that she should write a book about nursing for the masses.² In

¹ This point is made in M. Currie, *Fever hospitals and fever nurses* (Abingdon, 2005), p. 117, which notes that evidence of nursing practice for smallpox is 'scanty and scattered'.

² J. G. Widerquist, 'Sanitary reform and nursing: Edwin Chadwick and Florence Nightingale', *Nursing History Review*, 5 (1997), pp. 149-60.

1860, Nightingale first published *Notes on Nursing* in which she distinguished between two types of nursing: nursing as a handicraft and sanitary nursing.³ The handicraft of nursing consisted of the skilled techniques that nurses employed to care for the patient and prevent problems from occurring, such as dressing wounds, applying poultices, as well as methods to prevent complications, such as pressure sores. Some of these practices would have been developed over many years and passed on from nurse to nurse and from doctor to nurse. Sanitary nursing, on the other hand, was essentially environmental in that it concentrated on cleanliness, fresh air and diet. Both types of nursing were seen to be vital for the recovery and well-being of patients.⁴

Nursing associations needed trained nurses and therefore secured places for small numbers of women in hospitals, initially in London, where they undertook a year long training. This was intended to equip them with the necessary knowledge and skills required to care for patients before returning to their respective organisations. An examination of the syllabus of training used at St Thomas's Hospital for the probationers, records of nursing associations in this study and textbooks that were written in the nineteenth century advocated that nurses should be able to undertake a number of duties that included the application of sanitary principles, patient observation, patient nourishment, care of the dependent patient and technical skills (see Figure 5.1).⁵

³ F. Nightingale, *Notes on Nursing: what is, and what it is not* (London, 1860). The version used in this study is V. Skretkowicz, (ed.), *Florence Nightingale's notes on nursing* (London, 1992).

⁴ Skretkowicz, *Florence Nightingale's notes on nursing*, pp.159-60.

⁵ An early version of some of the material presented in this chapter was published in S. Wildman, 'Nurses for all classes: home nursing in England, 1860-1900' in S. Hähner-Rombach (ed.), *Medizin, Gesellschaft und Geschichte – Beiheft 32* (Stuttgart, 2009), pp. 47-62.

Figure 5.1: Knowledge and skills required for nursing practice, c.1860⁶

Sanitary Principles:

- Ventilation
- Lighting
- Temperature
- Cleanliness and use of disinfectants

Diet and sick cookery

- Invalid cookery
- Feeding patients
- Nutrient enemata

Carrying out instructions:

- Obedience to the medical practitioner and his prescription
- Observation of patients' condition
- Reporting progress and changes to the doctor

Patient Care:

- Maintaining patient comfort
- Beds - changing linen for operations etc.
- Use of appliances e.g. water beds
- Undressing and washing patients
- Prevention of bed sores
- Care of the dying and the dead

Treatment:

- Wound dressings, bandages
 - Enemata and suppositories
 - Therapeutic baths
 - Applying leeches, lotions, fomentations, poultices, blisters
 - Giving medicines (oral, injections, sprays and inhalations)
 - Operations and care after the operation
 - Special treatment and care in cases of accidents, emergencies, fractures, burns, fevers, etc.
-

It is not known how much of this knowledge was acquired by nurses during their year in a hospital or what was taught by the doctors. Indeed, Rebecca Strong, who attended St Thomas's Hospital in 1867, later wrote that she was not able to learn much as the medical students did most of the technical tasks, leaving the ordinary nurses the menial work such as bed-making and the washing of patients.⁷ Having said this, nurses who trained in London in the 1860s and 1870s, for example at King's College, University College and

⁶ The sources for this table come from a range of contemporary textbooks and the syllabus at St Thomas's Hospital, reproduced in M. Baly, *Florence Nightingale and the nursing legacy*, second edition (London, 1997), pp. 229-30.

⁷ C. Helmstadter. 'Two centuries of clinical knowledge', in *Knowledge development, Proceedings of Workgroup of European Nurse Researchers* (Helsinki, 1988), p. 13.

St Thomas's hospitals, would have attended the leading training hospitals in the country, if not the world, at that time and, more than likely, left with a repertoire of useful skills and a disciplined way of working that would have proved beneficial to their future employers and patients.

Once employed by an association, nurses received further instruction and teaching, usually from the doctor in charge of an individual case. Nelson and Gordon have emphasised the fact that trained nurses were practising nursing based upon the latest scientific and medical knowledge of the time and, although these practices may seem flawed today, they were at the cutting edge of practice in the nineteenth century. At this time, the care of patients was a difficult and complex endeavour.⁸ As outlined in Chapter 2, medical care had changed towards the middle of the nineteenth century by adopting treatments that supported the patient's constitution and replacing those based on depleting therapies. However, it should be remembered that there were probably no sudden changes in practice and that new methods more than likely co-existed with older techniques as there was probably no simple way of linking innovations with uptake.⁹ Therefore, nurses needed to be skilled in a variety of practices, especially home nurses who were under the supervision of a number of medical practitioners with different levels of knowledge and not necessarily cognisant of, or in agreement with, the latest treatments.

⁸ S. Nelson and S. Gordon, 'The rhetoric of rupture: nursing a practice with a history?' *Nursing Outlook*, 52, September/October (2004), pp. 255-61.

⁹ J. V. Pickstone, 'Introduction', in J. V. Pickstone (ed.) *Medical innovations in historical perspective* (Basingstoke, 1992), pp. 9-11.

Nursing associations did attempt to update the nurses and keep them abreast of new methods of practice, but no institution seems to have had a systematic approach. The most common way was to provide written information in the form of books and pamphlets for the nurses to read. The district nurses in Manchester had a 'library' in each of their houses containing a few medical books,¹⁰ whilst the nurses in Birmingham, in 1878, were issued with a 'pamphlet of instruction' and were to be examined by the lady superintendent.¹¹ Seven years later, in 1885, each Birmingham nurse received a series of printed health lectures, whilst, in 1892, the district nurses in Derby were instructed to read and study a printed lecture on cholera.¹² Formal lectures from medical staff regarding the duties of the nurse in the sickroom were delivered in Birmingham in 1879, but later moves to implement these were rejected because most nurses were away from the home caring for private patients.¹³ The Lincoln institution had good links with University College Hospital, London, where a number of its nurses were trained. In 1898, six of the older nurses were sent there to take charge of wards during holidays, enabling the 'nurses to see all the newest methods of nursing'. This was repeated in 1901 and 1902.¹⁴ Updating the nurses in these associations does not seem to have been a regular activity. However, nurses were supervised directly by doctors and instruction and teaching from a doctor to an individual nurse was probably of more value.

¹⁰ 'Our lesser charities, No.8, The Nurse Training Institution', *Manchester Guardian*, 13 January 1870.

¹¹ Birmingham Archives and Heritage(hereafter BAH), Birmingham and Midland Counties Training Institution for Nurses, *Annual Report* 1878, p.12 (L46.6 12811).

¹² BAH, Birmingham and Midland Counties Training Institution for Nurses, House Committee Minutes 1885-1899, 27 February 1885 (MS 807/6/6); Derbyshire Record Office (Hereafter DRO), Derby and Derbyshire Nursing and Sanitary Association, House and Management Committees minute book, October 31 1892 (D4566/2/1).

¹³ BAH, Birmingham and Midland Counties Training Institution for Nurses, *Annual Report* 1879, p. 12 (L46.6 12811); BAH, Birmingham and Midland Counties Training Institution for Nurses, Minute Book of the House Committee, 16 February 1892 (MS 807/6/6).

¹⁴ LA, Lincoln Institution of Nurses, *Annual Reports*, 1898, 1901 and 1902 (Bromhead/4/1).

Nursing Practice in the Home

In the main, nurses who were employed by the associations undertook nursing in either the homes of the middle and upper classes or those of the sick poor. The status and location of the patient had a significant influence on the role and work of the nurse. In households where there were servants, the nurse was used as a specialist and devoted her time to the care of the patient whilst the household servants undertook most of the domestic tasks and cooking. The annual report of the Lincoln institution in 1869 questioned the standard of care in the houses of the rich:

How often in the highest houses are patients lost because no one knows how to carry out the doctor's orders properly! Think, those who have witnessed it, of fomentations applied by the unskilled hand and then think of the comfort a good nurse sheds over the sick room! – how every order given by the medical man is carried out; how every symptom is noticed and reported to him; how a good nurse instantly falls into her place.¹⁵

The practice of the nurses was usually judged as highly satisfactory and they were praised by reformers, doctors and the public. For instance, Mr Coates, surgeon to the Salisbury Infirmary, in Wiltshire lauded the nurses from the Salisbury Diocesan Institution in the following manner

They proved themselves most efficient, most useful and most devoted. He believed that, in many cases, they had been the means under Providence, of saving the lives of patients: at all events, they had reduced the discomfort of severe sickness in many a family.¹⁶

In Birmingham, it was reported that the work of medical men with private families had been undermined by poor nursing and carelessness, something which the introduction of

¹⁵ LA, Lincoln Institution of Nurses, *Annual Report*, 1869 (Bromhead/4/1).

¹⁶ Wiltshire and Swindon Records Office (Hereafter, WSRO), Salisbury Diocesan Institution for Trained Nurses, Minute Book, 1879–1903, 3 May 1880 (J8/109/3).

trained nurses from the local training institution had rectified.¹⁷ In Derby, the positive effect of the private nurses was frequently reported upon by influential members of the association at annual general meetings.¹⁸ Private nursing was seen as much more than ‘mere technical knowledge’,¹⁹ indicating that the nurse’s application of sanitary principles and her command of the sickroom were of great benefit in private homes.

In contrast, nurses employed to care for the sick poor in their own homes had both a technical role associated with the treatment of disease and a public health role which was intended to facilitate recovery and prevent disease from occurring or spreading. In Derby, this was taken one step further with the establishment of the Nursing and Sanitary Association in 1865, which aimed to provide nursing as well as disseminating information about the cause of sickness and the needs of the sick to householders. It was intended to deliver simple and practical lectures and pamphlets offering advice on fresh air, pure water, cleanliness, rest and exercise, food and prevention of disease by vaccination.²⁰ Lectures on health and practical classes on dealing with emergencies were delivered to the public from the late 1870s onwards.²¹ In Birmingham, ladies who managed district nursing gave sanitary lectures of instruction to the working classes.²² In Newcastle, this educational function was carried out by the lady superintendent, who organised a series of classes about nursing for women, with reduced rates offered to the poor. The classes included discussion of sanitary principles, technical skills, caring for

¹⁷ C. Lord, ‘Training institution for Nurses’, *Birmingham Daily Post*, Tuesday, 16 May 1876.

¹⁸ See, for instance, ‘Derbyshire Sanitary and Nursing Association’, *Derby Mercury*, 23 April 1873 and ‘The Derby Nursing and Sanitary Association’, *Derby Mercury*, 15 April 1874.

¹⁹ LA, Lincoln Institution of Nurses, *Annual Report*, 1879, p. 5 (Bromhead/4/1).

²⁰ W. Ogle, *Proposed Derby and Derbyshire or Midland Counties Sanitary Association and home for the training of nurses* (Derby, 1864), p. 3.

²¹ ‘Derby and Derbyshire Nursing and Sanitary Association’, *Derby Mercury*, 28 April 1880.

²² ‘Ladywood District Nursing Society’, *Birmingham Daily Post*, 3 July 1876.

patients confined to bed, dealing with wounds, bedsores and feeding the sick.²³ In the Ancoats district of Manchester, the Lady Superintendent emphasised the need for nurses to:

impress on the minds of people, especially the women, a few common sanitary principles....Therefore to encourage the Nurses to give this advice is another very important item of their work.²⁴

Similar advice was given in Stratford-upon-Avon in 1873, suggesting nurses visit homes:

to see that the poor are properly tended and dieted – their wounds dressed – poultices carefully made and applied. Instruction is, at the same time, given in matters of order, cleanliness, ventilation and sick-cooking.²⁵

These examples highlight the teaching role of the nurse, a recurrent theme in annual reports and the literature of the time. An anonymous physician went further, expecting the nurse to be an adviser to the poor, not only in matters of health, but also ‘in all that concerns their daily life and temporal welfare’. He anticipated that nurses would provide information about the function and working of provident and friendly societies and answer questions about other aspects of patients’ lives, such as pawnbrokers’ shops, lending libraries and useful, cheap reading matter. He also felt that they should have some knowledge of the law, ‘as far as it concerns the poor, such as the law of settlement and removal; marriage and judicial separation; the recovery of debts, and other similar questions.’²⁶

²³ Tyne and Wear Archives (Hereafter, TWA), Cathedral Nursing Society for the Sick Poor of Newcastle upon Tyne, *Our Quarterly Record*, No. 10 June 1888, pp. 28 and 56 (CHX20/2/9).

²⁴ MALS, Manchester Nurse Training Institution, *Annual Report*, 1866, p. 19 (362.1 M85). Also, see Appendix 7 for the biography of Eliza Leek, a Manchester district nurse.

²⁵ Shakespeare Birthplace Trust Archives (Hereafter SBTA), Nursing Home for Convalescent Women and Sick Children, Stratford-upon-Avon, *Annual Report*, 1873 (87.35 5485).

²⁶ A Physician, *On the employment of trained nurses among the labouring poor, considered chiefly in relation to sanitary reform and the arts of life* (London, 1860), p. 28.

Nurses were also expected to have knowledge of agencies that might be of use in providing help to the sick poor, such as charities and the local sanitary authorities. In Liverpool, the lady superintendents and district nurses worked closely with the Liverpool Central Relief Society which supported the sick through the provision of food and convalescence at the seaside, as well as supporting families.²⁷ Elderly patients were often referred to lady visitors and Bible women in parishes to provide additional help.²⁸ Similarly, in Birmingham, the Ladywood District Nursing Society was able to support poor patients with help from the Charity Organisation and Mendicity Society.²⁹ District nurses were also expected to refer concerns about the immediate environment of the patient's dwelling, such as defective drains, poor water supply, unemptied cess pits and accumulations of rubbish and other waste, to the local medical officer of health.³⁰ It is not known whether individual district nurses were able to fulfill this role, but much of this type of work would have, more than likely, been undertaken by the lady superintendent.

District nursing was only aimed at a certain section of the population. Most nursing associations would only receive referrals for the 'deserving poor'. This meant that care was often aimed at working families in order to save the industrious from pauperism. Nightingale was one of many who stressed the role of the nurse in saving families from the 'pauperising influence of the workhouse'.³¹ However, there was care not to be drawn into treating poverty as it was assumed widely that this would come under the scope of

²⁷ Rathbone, *Organization of nursing*, p. 57.

²⁸ Liverpool Record Office (Hereafter LRO), Memorandum on nursing the sick in their homes by E. M. Farrell, Superintendent, Liverpool District Nurses, p. 9 (610 RAT/5/5).

²⁹ 'Ladywood District Nursing Society', *Birmingham Daily Post*, Monday, 15 June 1874.

³⁰ F. Dacre Craven, *A guide to district nurses and home nursing* (London, 1889), p. 10.

³¹ Rathbone, *Organization of nursing*, p. xiv.

the poor law provision. This can be seen in Leicester, in 1878, where the Institution of Trained Nurses reported a reduction in the numbers of cases attended by the district nurses as a result of confining their services to nursing and not attending cases where poor relief only was required.³² Policies like this probably meant that the services of trained district nurses were not, in the main, aimed at people such as the chronically ill, the aged or the pauper who would all have to seek support from the poor law. This would also almost certainly mean admission to the workhouse rather than domiciliary care. However, whilst records indicate that various institutions were wary of treating anybody other than the deserving poor, individual associations toward the end of the century did offer nursing to children, the chronically ill and the aged, including the dying.³³ By this time, it was recognised that a good proportion of the work of district nurses comprised caring for the chronically sick and the terminally ill.³⁴

The sickroom

To Nightingale, ‘A nurse is first to nurse. Secondly, to nurse the room as well as the patient – to put the room in nursing order’.³⁵ She placed great emphasis on the patient’s immediate environment when nursing the rich or the poor and the sickroom was an important element of nursing practice. Its importance in the lives and minds of the Victorians cannot be underestimated. Bailin has noted ‘the pervasive presence of the

³²Leicestershire Archives (hereafter LeA), Institution of Trained Nurses for the Town and County of Leicester, *Annual Report 1878* (L610.73 Pamphlets, Volume 76).

³³LA, Lincoln Institution for Nurses, *Annual Report*, 1891; SBTA, Stratford-Upon-Avon Nursing Home, *Annual Report 1899* (87.35 5485); ‘A round of visiting with a district nursing’, *Manchester Guardian*, 30 May 1890, p. 8.

³⁴TWA, Cathedral Nursing Society for the Sick Poor of Newcastle upon Tyne, *Annual Report 1902*, p. 6 (CHX20/1/ 13).

³⁵F. Nightingale, ‘On trained nurses for the sick poor’ a pamphlet reprinted from the *Times*, 14 April 1876, reprinted in L. R. Seymer (ed.), *Selected writings of Florence Nightingale* (New York, 1954), p. 314.

sickroom scene in Victorian fiction'.³⁶ Indeed, Mrs Gaskell's *Ruth* contained twelve 'pivotal illnesses' and, outside of fiction, many well known men and women, including Charles Darwin, Harriet Martineau and Florence Nightingale, were themselves known to have been invalids at some time in their lives.³⁷ Thus, the sickroom played its part in the lives of those who were acutely ill, convalescing or suffered from some type of chronic, long-term condition. In the homes of the upper and middle classes, nurses were involved in caring for all types of cases.

The houses of the wealthy had distinct and separate spaces, based on gender and status, including those for the husband, wife, children, relatives, visitors and servants.³⁸ Set apart from the rest of the household, the sickroom was a different place in terms of both its layout and the expectations of the behaviour and activities of the patient, the family, servants and the attending nurse. Recommendations regarding the choice of rooms were made by the authors of many medical and nursing manuals. The rich who were about to build a new home were recommended to build an annexe with two doors, an outer door for the doctor and an inner one made of glass to ease the observation of the family and household servants. This was beyond the means of all but the wealthiest households and, as such, some set aside an empty room for this specific purpose, whilst the majority adapted the patient's own bedroom for care.³⁹ Where possible, by the 1890s, it was expected that the sick room should have an adjoining room opening into it for a nurse and

³⁶ M. Bailin, *The sickroom in Victorian fiction* (Cambridge, 1994), p. 1.

³⁷ *Ibid.*, pp. 2 and 5.

³⁸ D. Spain, *Gendered Spaces* (Chapel Hill, 1992), p. 112; J. Flanders, *The Victorian house* (London, 2003), p. xlvii.

³⁹ A. Adams, *Architecture in the family way: doctors, houses and women, 1870-1900* (Montreal, 1996), pp. 89-91.

access to a lavatory on the same floor.⁴⁰ Although the choice of room was not usually made by the attending nurse, she was regarded as responsible for its physical and social environment.⁴¹

Nurses were advised to keep only necessary furniture in the room, including a table, bed-table, two comfortable chairs and a cupboard in which to store medicines and other supplies. The bed was to be placed in such a way as to ensure that the patient could be approached from either side.⁴² Other items that nurses were advised to have at the ready included an oilcloth to ensure that bed linen was kept dry when washing patients, a tea kettle and small saucepan to heat water quickly, a bed rope, to enable the patient to move himself, and a footstool.⁴³ Specialist equipment, such as bed pans, water beds, air mattresses, bed cradles and bed rests, may have been kept in an existing sickroom or ordered from specialist firms when the need arose. Noise was seen as something that would hinder the recovery of patients and, therefore, it was recommended that the sickroom should be kept quiet and the nurse herself should do her utmost to prevent unnecessary noise by wearing a dress that did not rustle, shoes that did not creak and not whispering within the sickroom.⁴⁴ Some doctors even recommended that coal ought to be wrapped in newspaper in order that it might be placed quietly on the fire by hand.⁴⁵ In addition, one author exclaimed that it was the nurse's duty to understand and protect the patient, even from those who provided her wages, by ensuring 'real curative quiet in the

⁴⁰ L. Humphry, *A manual of nursing: medical and surgical* (London, 1895), p. 1.

⁴¹ J. C. Lory Marsh, *Lectures on nursing: short notes addressed to nurses on what to do and what to avoid in the management of the sick and the sick-room* (London, 1865), Lecture 2, p. 1.

⁴² I. Stewart and H. E. Cuff, *Practical Nursing* (2 vols, Edinburgh, 1889), I, p. 42.

⁴³ E. Le Hardy, *The home nurse and manual for the sick-room* (London, 1863), Chapter 7.

⁴⁴ S. E. Pease, *Hints on Nursing the sick and other domestic subjects* (London, 1871), p. 8.

⁴⁵ H. Crookshank, *Home nursing and hygiene* (London, 1881), p. 23.

sick-room'.⁴⁶ This did not apply in the homes of the poor where the nurse's role was to create as comfortable an environment as possible in which the patient could be nursed, but care was left in the hands of relatives beyond the nurse's control.

Sanitary Principles

According to Nightingale, providing the sick room with pure air from outside was the first rule of nursing.⁴⁷ This view had long been accepted as crucial in the control of miasma, which was thought to cause a number of infectious diseases.⁴⁸ Miasma was said to result from 'poisonous emanations from the sick, being confined in a close, dirty room, only requiring an open window for their prevention'.⁴⁹ By the end of the century, miasma was no longer accepted as a credible theory in medical practice, but ventilation of the sickroom was still seen as an important part of not only providing comfort to the patient, but a way of preventing nurses and family members from contracting infectious diseases, such as tuberculosis, by diluting the air within the sickroom.⁵⁰ Optimum ventilation was achieved by keeping doors closed, windows open and the use of a fire;⁵¹ open doors were thought to allow impure air into the room from the rest of the house, thus harming the patient. Some nursing manuals recommended that sash windows be kept open by using a piece of wood fixed to the lower sash, thereby creating a gap

⁴⁶ H. Jones, *An essay on nursing* (London, 1864), pp. 11-12.

⁴⁷ Skretkovicz, *Florence Nightingale's notes on nursing*, p. 21.

⁴⁸ This view was expressed from as early as the 1830s in home nursing texts. See, for instance, *The Nurse's manual; or instructions for the sick chamber, together with some hints for the avoidance of colds and other diseases* (Cambridge, 1836), pp. 6-7; R. Barwell, *The Care of the sick: a course of practical lectures delivered at the Working women's College* 2nd ed. (London, 1857), p. 11; and *How to nurse the sick* (London, 1863), p. 32.

⁴⁹ Lory Marsh, *Lectures on nursing*, Lecture 2, p. 9.

⁵⁰ A. Hardy, *The epidemic streets: infectious diseases and the rise of preventive medicine, 1856-1900* (Oxford, 1993), pp. 238-40.

⁵¹ S. Mosley, 'Fresh air and foul: the role of the open fireplace in ventilating the British home, 1837-1910', *Planning perspectives*, 18 (2003), pp. 15-19.

between the upper and lower windows and allowing air into the room without causing a draught. The use of a lighted fire further improved the removal of air from the room via the chimney.⁵² This system ensured the quickest renewal of air in the room. It would equally have been the nurse's responsibility to ensure adequate ventilation in private homes. In the homes of the poor, the restricted circulation of air was a recognised problem as they were more likely to shut houses tightly, in order to prevent draughts both at night and at times of illness.⁵³ This practice was condemned by medical practitioners and the appointment of trained district nurses aimed to improve the situation through the instruction of housewives and relatives of the sick.⁵⁴ In addition to its adequate ventilation, the sickroom was to be kept at a temperature of 60 to 65 degrees Fahrenheit. Natural light was deemed important to the patient's support and, where possible, the room was to be light and sunny and not north facing.⁵⁵

Although the atmosphere was the most important way of transmitting diseases according to Nightingale and her contemporaries, cleanliness was also considered to be vital in the treatment and prevention of disease.⁵⁶ In the middle of the century, fever was thought to be associated with filth and Nightingale advised that, 'Without cleanliness, within and without your house, ventilation is comparatively useless'.⁵⁷ It was expected that the sickroom would be cleaned daily. This was easy enough where there were servants in the household, but the task fell to the nurse if there were none. In the homes of the poor, the

⁵² Crookshank, *Home nursing and hygiene*, p. 27.

⁵³ Hardy, *The epidemic streets*, p. 232.

⁵⁴ A Physician, *On the employment of trained nurses among the labouring poor*, pp. 5-6.

⁵⁵ C. J. Cullingworth, *The nurse's companion: a manual of general and monthly nursing* (London, 1876), p. 5.

⁵⁶ C. E. Rosenberg, 'Florence Nightingale on contagion: the hospital as moral universe', in C. E. Rosenberg, (ed.), *Healing and history: essays for George Rosen* (New York, 1979), p. 120.

⁵⁷ Skretkovicz, *Florence Nightingale's notes on nursing*, p. 44.

district nurses faced a greater challenge as the poor were said to have ‘no proper idea of the importance of cleanliness in their persons, clothing and surroundings’.⁵⁸ According to Professor Acland, Regis Professor of Medicine at Oxford, a district nurse

finds, too often, a room wholly unfit, and a mass of filth, which I forbear now to describe. The first thing is to cleanse it, remove what is removable and useless; wash the floor, clean the grate, make the bed, if there be one; in fact re-form and create a home.⁵⁹

Once the nurse had attended to the room, she could then care for the patient. Examples were given in annual reports of nursing associations of the results of nurses’ intervention. In Birmingham, the beneficial influence of the nurse in the Ladywood district was said to be seen ‘not only in the care of the sick, but in the marked improvement in the cleanliness and order in the homes she has visited’.⁶⁰ Later in the century, heavy cleaning was not necessarily seen as the role of the nurse and some organizations paid charwomen or neighbours to clean the houses of the poor if this was required.⁶¹ The nurse was expected to instruct the poor in good habits regarding household cleanliness and to tell them ‘that these evils are not remedied by pushing the dirty matter, whatever it be, under the bed, or hiding it...’.⁶²

Nursing Care

As there were few effective cures for disease, many people including Nightingale believed that the role of treatment and nursing was to support the patient during illness to

⁵⁸ T. L. Nichols, *Human physiology: the basis of sanitary and social science* (London, 1872), p. 41.

⁵⁹ H. W. Acland, *District Nursing: substance of remarks made by desire at the Church Congress Reading 1883* (London, 1883), p. 3.

⁶⁰ BAH, Birmingham and Midland Counties Training Institution for Nurses, *Annual Report 1871*, p. 11 (L46.6 12811).

⁶¹ Dacre Craven, *A guide to district nurses and home nursing*, p. 37.

⁶² Barwell, *The care of the sick*, p. 11.

allow the body to recover and repair itself. One physician clarified the role of the nurse accordingly:

One law in disease you should ever bear in mind, namely, that in all cases it tends to cure itself. You are to be the observer of nature and the handmaid of the physician, to assist in restoring the afflicted one to health.⁶³

One of the important skills of the nurse was careful observation, detailed reporting of changes in the patient's condition and the effects of the treatment. This had been noted before the 1860s by both doctors and nurses, but became a regular feature of nursing manuals published from 1860 onwards.⁶⁴ Nurses were expected to be able to make an initial assessment of a patient's condition and document any changes during the period of care. Textbooks gave detailed information regarding the important aspects that needed to be considered.⁶⁵ In particular, home nurses were instructed to observe the volume and colour of the urine, the frequency and consistency of the stools, the character of any other bodily matter, such as sputum, the condition of the skin of the patient, the appetite and the duration and nature of sleep.⁶⁶ They were also expected to measure and record both temperature and pulse. Previous to reforms in Victorian nursing, this would have been the role of the medical attendant. This change took place in Salisbury when the nurses were given watches with second hands and thermometers in September 1876.⁶⁷ However, in many places, nurses were only expected to measure the pulse rate as the doctor saw it as his role to make judgements about its rhythm and strength.⁶⁸ Temperature was seen to be an important indicator in diagnosis and treatment. Wunderlich's study of 25,000 patients,

⁶³ Marsh, *Lectures on nursing*, p. 7.

⁶⁴ C. West, *How to nurse sick children* (London, 1854), p. 22; Anon, *The nurse* (London, c.1850), p. 88.

⁶⁵ See, for instance, H. W. Acland, 'On studying cases and reporting on them' in F. S. Lees (ed.), *Handbook for hospital sisters*, pp. 189-213; Stewart and Cuff, *Practical Nursing*, pp. 61-92.

⁶⁶ R. A. Neuman, *Home nursing* (London, 1886), p. 43.

⁶⁷ WSRO, Salisbury Diocesan Institution for Trained Nurses Minute Book, July 1876–Nov 1878, 4 Sept. 1876 (J8/109/2).

⁶⁸ Cullingworth, *The nurse's companion*, pp. 50-51.

published in 1868, demonstrated that temperature could be used to distinguish between different types of fever and that complete accuracy in measurement was not necessarily important. Therefore, nurses were instructed to monitor and record patients' temperatures twice a day or more frequently, in order to furnish doctors with useful clinical data from which a diagnosis could be determined and a treatment regime implemented.⁶⁹

It was expected that nurses would keep notes on the condition of their patients, as well as maintain a record of the treatment given. For instance, Nurse Quinney, who was employed by the Lincoln institute, documented the care of her patient, Mrs Dixon, in May 1872.⁷⁰ These are similar to the sample pages provided in Neuman's book.⁷¹ Nurses were encouraged to keep accurate records and instructed to communicate the important aspects concerning the patient to the doctor 'in a short, concise manner'.⁷² In the case of private nurses, a report would be provided directly to the doctor, but district nurses saw doctors less frequently. As a result, in Liverpool and Manchester, the doctor wrote his instructions on a slate by the patient's bed on which the nurse also entered any questions she wished to have answered.⁷³ Nurses were advised to record the doctor's instructions, including the times that medicines were to be administered, and seek explanation if necessary.⁷⁴ In the main, doctors visited private patients once a day, and it was expected

⁶⁹ R. Porter *The Greatest Benefit to Mankind: a medical history of humanity from antiquity to the present* (London, 1999), pp. 344-45.

⁷⁰ LA, Lincoln Institution for Nurses: Nurses' Memoranda, Cecilia Quinney's Case Book, 1872 (Dixon 22/11/20).

⁷¹ Neuman, *Home nursing*, pp. 43-45.

⁷² W. R. Smith, *Lectures on Nursing* (London, 1875), p. 11.

⁷³ W. Rathbone, *Sketch of the history and progress of district nursing from its commencement in the year 1859 to the present day* (London, 1890), p. 29; MALS, Manchester Nurse Training Institution Annual Report, 1866, pp. 35-36 (362.1 M85).

⁷⁴ Anon., *The nurse* (London, c.1850), p. 10; Pease, *Hints on Nursing the Sick*, p. 8.

that nurses would observe the patient and react to changes between the doctors' attendances.

During the nineteenth century, there were few curative treatments available to the sick, but there were improvements in the clinical management of patients based upon more accurate diagnoses, better knowledge of the aetiology of diseases, improved management of symptoms and the use of stimulants and supportive therapies.⁷⁵ Alcohol was widely used in the treatment of patients and, although its use was controversial within society at large, physicians saw it as useful substance in treating patients.⁷⁶ In the 1850s and 1860s, its use was linked to the change in the way diseases were viewed and treated. Depleting therapies gave way to supportive therapy, utilising better nutrition, and stimulation with alcohol which was thought to promote the body's natural processes.⁷⁷ Although the actions of alcohol on the body were subject to research and fierce debate, in the middle of the century, it was considered a vital aspect of treatment. By the 1890s, alcohol continued to be seen as a way of stimulating the rate and output of the heart in conditions such as pneumonia, acute fevers, heart failure and haemorrhage.⁷⁸ In addition, as in earlier generations, it was administered in order to provide a ready source of energy for those who were debilitated or suffered from exhausting diseases or treatments.⁷⁹ It was also seen as a way of 'producing a sensation of warmth and comfort' in the patient.⁸⁰ Nurses were charged with giving small amounts of alcohol at frequent intervals to seriously ill

⁷⁵ W. F. Bynum, *Science and the practice of medicine in the nineteenth century* (Cambridge, 1994), p. 226.

⁷⁶ H. W. Paul, *Bacchic medicine: wine and alcohol therapies from Napoleon to the French paradox* (Amsterdam, 2001), pp. 70-92.

⁷⁷ J. H. Warner, 'Physiological theory and therapeutic explanation in the 1860s: the British debate on the medical use of alcohol' *Bulletin of the History of Medicine*, 54, 2, (1980), p. 236, footnote 4.

⁷⁸ A. M. Hart, *Diet in sickness and in health* (London, 1896), p. 19.

⁷⁹ J. D. Comrie, *Black's medical dictionary*, 6th edition (London, 1920), p. 26.

⁸⁰ Hart, *Diet in sickness and in health*, p. 16.

patients.⁸¹ An examination of Cecilia Quinney's casebook indicates that her patient received regular amounts of brandy, sherry and champagne throughout the day and night.⁸² Sherry was usually prescribed as a tonic to stimulate the appetite, whilst champagne was thought to have a more rapid action, proving particularly useful in cases of nausea.⁸³ Both tea and coffee were also recognised as stimulants and restoratives. They were used both to relieve hunger and counteract fatigue by stimulating the circulation and brain activity.⁸⁴

Food was also regarded as an important supportive therapy in the management of disease, in both medical and surgical cases.⁸⁵ It was administered in order to prevent the breakdown of the body's tissues and increase the energy available to patients with acute illnesses. Some nurses learned about diet during their hospital training, whilst the probationers engaged by the Bristol and Liverpool institutions were trained to cook for the sick in the nurses' home and School of Cookery respectively.⁸⁶ Usually, easily digested food was provided to the patients, of which there were many different preparations and recipes.⁸⁷ Milk and beef-tea were seen as useful for the acutely ill, especially those with fever. Milk was regarded as a complete food on which a patient could subsist for an extended period, whilst beef-tea was thought to prevent muscle

⁸¹ *Ibid.*, p. 19.

⁸² LA, Lincoln Institution for Nurses, Nurses' Memoranda: Cecilia Quinney's Case Book, 1872 (Dixon 22/11/20).

⁸³ Comrie, *Black's medical dictionary*, p. 26.

⁸⁴ Hart, *Diet in sickness and in health*, pp. 28-39.

⁸⁵ J. S. Bristowe, *A Treatise on the theory and practice of medicine* (London, 1876), p. 121.

⁸⁶ British Library (Hereafter BL), Bristol Nurses' Training Institute and Home, *Annual Report*, 1866 (Cup 401.i.6.8); LRO, Liverpool Training School and Home for Nurses, *Annual Report* 1875 (614 INF/5/4).

⁸⁷ E. M. Worsnop, *The nurse's handbook of cookery*, (London, 1897).

wastage and the breakdown of protein within the tissues.⁸⁸ Special recipes and diets were prescribed for many different types of diseases and conditions, including antiphlogistic diets (for fever), invalid diets for the chronically sick, diets for the dyspeptic patient and those for people recuperating from illness. Food was administered to the acutely ill in small amounts and at very frequent intervals, including throughout the night. Feeding along with the administration of stimulants and medicines meant that nursing was an intensive and tiring activity for the private nurse caring for an acutely ill patient.

Figure 5.2: Nurse Quinney's attendance on Mrs Dixon, 1872⁸⁹

30th April 1872

22.30 Champagne
23.45 Barley water and brandy, medicine

1st May 1872

01.15 Sherry and egg. Biscuit
02.00 Barley water. Tea
03.45 Barley water and medicine
05.30 Arrowroot
06.00 Barley water etc.
07.45 Chocolate breakfast. Egg and Toast
09.00 Barley water and medicine
10.00 Beef -tea and toast.
11.55 Half glass champagne, 2 oysters and bread & butter
13.00 Chicken and Asparagus
14.30 Jelly and Champagne
17.00 Egg

Figure 5.2 shows Cecilia Quinney's attendance on Mrs Dixon, her patient, over an eighteen-hour period in 1872, demonstrating the frequent and continuous nature of the interventions made by nurses. Nurse Quinney's record does not include any physical

⁸⁸ Hart, *Diet in sickness and in health*, pp. 197-99.

⁸⁹ Source: LA, Lincoln Institution for Nurses: Nurses' Memoranda, Cecilia Quinney's Case Book, 1872 (Dixon 22/11/20).

interventions that she made during this period. There is no record of the type of medicines that were given to Mrs Dixon, but the food and drink were all recommended in medical and nursing texts. For instance, chocolate was deemed a useful substance in the care of the sick as it contained fat, carbohydrate and protein and could be provided as a snack to prevent hunger.⁹⁰ Similarly, oysters, served raw, were thought to be a nutritious and easily digestible meal for the sick,⁹¹ whilst jellies were considered to be pleasant to the palate.⁹² The sheer variety of the diet as seen in this case was recommended in order to induce the patient to eat.⁹³ There were obviously class differences implied in such feeding schedules, as this type of diet could only be afforded by the affluent, and the poor, whether in hospital or their own homes, would not receive such treatment.

Ensuring that the sick poor received adequate nutrition was an important role of the district nurse. However, rather than the nurse feeding the patient herself, it was expected that relatives and friends would undertake this task. A description in the *Manchester Guardian* in 1870 described the work of the district nurse as not only dressing wounds and applying bandages and poultices, but also cooking meals or supervising the cooking of meals to aid the recovery of the patient.⁹⁴ In Manchester, at the end of each day, the district nurses were expected to write up their case notes and prepare soup or beef tea for their patients for the following day. They were provided with satchels that had sufficient room for dressings and were fitted with side pockets for meat chops that could be

⁹⁰ Hart, *Diet in sickness and in health*, p. 41.

⁹¹ Worsnop, *The nurse's handbook of cookery*, p. 21.

⁹² Stewart and Cuff, *Practical Nursing*, p. 98.

⁹³ Worsnop, *The nurse's handbook of cookery*, p. 103.

⁹⁴ *Manchester Guardian*, 13 January 1870.

distributed to, or cooked for, the patients.⁹⁵ Food was seen as essential to the care of the poor and was, therefore, provided by some associations to their patients. The Ladywood District Nursing Society in Birmingham appealed directly for ladies to donate the remnants of food from dinners and balls for the aid of the sick poor.⁹⁶ Other associations were more organised. The Stratford-upon-Avon Convalescent Home distributed beef-tea, broth, arrowroot puddings, milk, wine and brandy from the institution's kitchen to the acutely ill and dinners to those who were recovering from sickness.⁹⁷ Similarly, the Cathedral Nursing Society for the Sick poor of Newcastle upon Tyne operated an invalid kitchen and, in 1886, the six district nurses saw 1,211 cases, made 13,218 visits and distributed 1,654 pints of beef tea, 5,135 pints of milk, 1,571 dinners and 117 puddings.⁹⁸

Some district nursing organisations provided a more comprehensive service, co-operating with local charitable bodies to supply equipment and convalescence to their patients. For instance, the Lincoln institution loaned blankets, beds, water beds, horse-shoe pillows, cradles for bad legs and bandages.⁹⁹ The poor of Derby were able to obtain waterproof sheeting, blankets, dressing gowns, air pillows, air beds, bed rests, couches, crutches, perambulators and easy chairs.¹⁰⁰ In 1868, the Manchester institution sent recovering patients to a village in the hills close to the city for a 'change of air', whilst Lincoln sent men to Scarborough who returned 'full of gratitude, and generally with a stock of health' and in 1878, the Birmingham District Nursing Society appealed for funds to provide

⁹⁵ MLSLA Manchester Sick-Poor and Private Nursing Institution *Annual Report* 1883, p. 33 (362.1 M85)

⁹⁶ BAH Ladywood District Nursing Society *Annual Report*, 1877, p. 9

⁹⁷ SBTA Stratford-Upon-Avon Convalescent Home *Annual Report*, 1875, p. 4 (87.35 5485)

⁹⁸ TWA Cathedral Nursing Society for the Sick Poor of Newcastle upon Tyne *Annual Report* 1887, p.5 (CHX20/1/1)

⁹⁹ LA Lincoln Institution for Nurses *Annual Report*, 1868 (Bromhead/4/1)

¹⁰⁰ 'Derby and Derbyshire Nursing and Sanitary Association' *The Derby Mercury*, 10 April 1872

accommodation for convalescents in the country.¹⁰¹ By the 1890s, the care of patients at all associations clearly went beyond the delivery of sanitary principles and the purely technical tasks of nursing patients in an acute phase of illness.

Nursing work - wound care and surgical operations

It is difficult to quantify the type of cases that associations were called on to nurse and this applies to both private and district nursing work. Associations presented cases in annual reports in different ways, if at all, and comparisons are therefore difficult to make. Furthermore, the labels given to diseases changed over time. However, the majority of patients suffered from medical conditions. It is possible to identify some types of cases, such as wounds, surgical care and fever patients. For instance, in 1870, Eliza Leek, a district nurse in Salford, had 23 cases on her books, eleven of which were medical, five fever and seven cases that required dressings or bandages.¹⁰² An important part of a nurse's work was caring for patients with wounds. Table 5.1 reveals the number of patients who received wound care, dressings or bandages from district nurses in Liverpool. This table indicates that wounds, dressings and bandages were a significant aspect of the work of the nurses in Liverpool throughout the century. Nurses required knowledge and skill in dressing wounds. Many of the wounds that nurses treated often became chronic in nature, taking many months to heal. For instance, in Lincoln, one boy received five months' continuous care for ulcers around his knee before they healed and

¹⁰¹ MALS, Manchester Nurse Training Institution, *Annual Report* 1868, p. 13 (362.1 M85); A. F. Bromhead, 'Institution for Trained Nurses, Lincoln', *The Monthly Packet of Evening readings for members of the English Church*, 1 August 1867, p. 199; I. H. Morris, *A century of district nursing in Birmingham, 1870-1970* (Birmingham, 1970), p. 9.

¹⁰² 'Our lesser charities, No. 8. The Nurse Training Institution', *Manchester Guardian*, 13 January 1870. See Appendix 4 for her biography.

he was able to walk.¹⁰³ Infected wounds were common, and nurses used disinfectants to clean the wound and would then apply some form of dressing.

Table 5.1: Numbers of Liverpool patients requiring wound care, dressings or bandages and as percentage of the total cases, 1870, 1880, 1890 and 1899¹⁰⁴

| | Skin Abscesses | Ulcers | Accidental wounds | Fractures and sprains | Burns and scalds | Total |
|------|---------------------------|---------------|------------------------------|--------------------------------------|---------------------------------|-----------------|
| 1870 | 149 (3.0%) | 77 (1.6%) | 97 (2.0%) | 71 (1.4%) | 78 (1.6%) | 472 (9.6%) |
| 1880 | 199 (7.0%) | 143 (5.0%) | 77 (2.7%) | 40 (1.4%) | 168 (5.8%) | 627 (22.0%) |
| 1890 | 253 (8.6%) | 160 (5.4%) | 255 (8.7%) | 34 (1.2%) | 233 (7.9%) | 935 (31.8%) |
| 1899 | 309 (5.2%) | 209 (3.5%) | 233 (3.9%) | 83 (1.4%) | 242 (4.0%) | 1076 (18.0%) |

Jessie Holmes, a private nurse, cleaned leg ulcers with carbolic lotion and occasionally used a charcoal poultice to reduce the smell.¹⁰⁵ Different kinds of poultices were applied to reduce inflammation in the newly infected wounds or to separate the slough from those that were chronically infected.¹⁰⁶ From the 1880s onwards, the use of Listerian practices in wound care began to permeate through medical practice, and private and district nurses

¹⁰³LA, Lincoln Institution for Nurses, *Annual Report*, 1874 (Bromhead/4/1).

¹⁰⁴ The statistics are from the annual reports of the Liverpool Training School and Home for Nurses. The percentages for 1870 are proportionately lower because of the great number of fever cases that were attended in that year.

¹⁰⁵ J. Holmes, *The private nurse: some reminiscences of eight years private nursing* (London, 1899), p. 27.

¹⁰⁶ J. F. South, *Household surgery or hints on emergencies*, fourth edition (London, 1859), pp. 13, 100-2.

would undoubtedly have been using dressings soaked in carbolic acid or newly manufactured products which improved the absorbency of dressings or were impregnated with disinfectants.¹⁰⁷

Nurses were also involved in caring for patients following surgical operations. Private patients received treatment at home with the exception of those of the Lincoln institution, which opened facilities for private patients in 1869 in a building known as the 'White House'. This was replaced in 1887 by a new building called the 'Red House'. In 1870, five operations were undertaken, ten in 1880, 56 in 1890, and, by 1900, there 95.¹⁰⁸ In 1890, surgeons in Lincoln performed three ovariectomies, an operation which would subsequently have required intensive and skilled nursing care. However, most procedures were minor and routine with nearly half of all operations in 1900 being tonsillectomies.¹⁰⁹ Whatever the operation, nurses who undertook this work would have been skilled in preparing patients for surgery, assisting at the operation and in caring for post-operative patients. It was probably more challenging for nurses assisting at operations in the patient's own home, as they remained on-call 24 hours per day. As early as 1850, the nurse's important post-operative role was recognised:

she will not fail to lend a constant sleepless eye upon the exhausted patient. If the case be one in which loss of blood be apprehended, she will observe the patient's colour and mode of breathing...she will follow the directions she may have received from the surgeon.¹¹⁰

¹⁰⁷ M. Worboys, *Spreading germs: disease theories and medical practice in Britain, 1865-1900* (Cambridge, 2000), p. 184.

¹⁰⁸ LA, Lincoln Institution for Nurses, *Annual Reports*, 1871, 1881, 1891 and 1901 (Bromhead/4/1).

¹⁰⁹ *Ibid.*, 1901.

¹¹⁰ Anon., *The nurse* (London, c.1850), p. 110.

In Leicester, a district nurse cared for a man who had been operated on because he was too ill to be admitted to hospital. She nursed him night and day until he recovered.¹¹¹ Similarly, in the 1890s, a nurse attended a child in Derby, who had laryngeal diphtheria and required a tracheotomy.¹¹² This was an onerous task as the maintenance of the patient's airway was of the utmost importance due to the possibility of asphyxiation should the tracheotomy tube become blocked. The job of ensuring that the tube remained free from blockage by thick mucus was usually delegated to an experienced and trustworthy nurse. She would clean the tube using a feather dipped in a solution of bicarbonate of soda, or remove the inner tube and unblock it by washing it in boiling water. In addition, much skill was required to feed the patient as the presence of a tube made it difficult for the patient to swallow and thereby increasing the risk of aspiration of food or fluid into the lungs. If all else failed, the patient was fed fluids through an India-rubber tube inserted into the pharynx and oesophagus via the nose.¹¹³ Surgical care required the attendance of experienced and knowledgeable nurses.

Nursing Fever patients

Infectious diseases and fever were common occurrences in Victorian Britain; some diseases, now rare, were endemic and there were also regular epidemics of other diseases, such as smallpox and cholera. This ensured that the demand for nurses from associations remained constant throughout the nineteenth century. Table 5.2 shows the proportion of

¹¹¹LeA, Institution of Trained Nurses for the Town and County of Leicester, *Annual Report*, 1878 (L610.73 Pamphlets, Volume 76).

¹¹²DRO, Derby and Derbyshire Nursing and Sanitary Association, House and Management Committees minute book, 18 December 1893 (D4566/2/1).

¹¹³Humphry, *A manual of nursing*, pp. 181-83.

cases with infectious diseases for those associations which included such cases in their annual reports.

Table 5.2: Fever cases as a percentage of all cases, 1870, 1880, 1890 and 1900¹¹⁴

| | Birmingham* | | Birmingham# | | Lincoln* | | Liverpool # | | Manchester# | |
|------|--------------------|------------|--------------------|------------|-----------------|------------|--------------------|------------|--------------------|------------|
| | Fever Cases | % of Total | Fever Cases | % of Total | Fever Cases | % of Total | Fever Cases | % of Total | Fever Cases | % of Total |
| 1870 | 59 | 23.7 | No data | | 113 | 52.3 | 2300 | 46.7 | 481 | 23.2 |
| 1880 | 72 | 10.8 | No data | | 151 | 28.8 | 344 | 12.1 | 480 | 12.1 |
| 1890 | 68 | 13.7 | 43 | 7.5 | 169 | 22.6 | 229 | 7.8 | 111 | 7.6 |
| 1900 | 80 | 13.7 | 281 | 19.6 | 166 | 14.7 | 285 | 6.7 | 300 | 3.9 |

* Private Nursing # District nursing

Initially, infectious diseases were grouped together as zymotic diseases, or described simply as ‘fever’. However, by 1880, most associations were identifying separate diseases, such as diphtheria, influenza, measles, scarlet fever, smallpox, typhoid, typhus and whooping cough. Although detailed, these lists excluded tuberculosis, rheumatic fever, pneumonia or wound and skin infections. The very high rate of fever recorded in Liverpool in 1870 was due to a severe epidemic, with upwards of 1,373 people being admitted to the fever hospitals per week in October, which also would have increased the referrals to the district nurses.¹¹⁵ Similarly, the high rate of fever cases in Birmingham in

¹¹⁴ Data comes from the annual reports of the respective associations. For 1890, the statistics for Manchester are only available for the Ardwick district and do not represent the entire work of the institution. The figures in 1900 for Liverpool are for 1899 as the report for 1900 is missing.

¹¹⁵ R. G. Hodgkinson, *The origins of the National Health Service* (London, 1967), p. 536.

1900 can be traced to a local outbreak of typhoid. Although it is not possible directly to compare district and private nursing in the four towns, the lower rates of fever cases in district nursing is probably accounted for by the provision of fever hospitals for the sick poor following the 1866 Public Health Act. In Birmingham, Manchester and Liverpool, new hospitals and an increased number of beds were available from 1870 onwards, thus making it more likely that fever cases would have been removed to a hospital devoted to infectious diseases.¹¹⁶ The Cambridge Home and Training School for Nurses declined referrals for infectious patients for the district nurse it employed, as it was felt such cases should be admitted to the local hospital.¹¹⁷ Private patients continued to be nursed at home and this certainly accounted for a higher proportion of infectious diseases amongst this category of patients being cared for by the respective associations. In addition, the overall decline in the number and proportion of cases attributed to infectious diseases was probably also due to the reduction in the incidence of cases in society as a result of socioeconomic factors, such as an improvement in the standard of living and better nutrition, as well as improved environmental conditions, widespread public health legislation and the application of sanitary science.¹¹⁸

In spite of precautions, nursing was a dangerous activity for those women who cared for infectious cases. Nightingale provided evidence that hospital nurses in London were over three times more likely to die of fever and cholera than the general population of women

¹¹⁶ J. Reinartz, *Health care in Birmingham: the Birmingham teaching hospitals, 1779-1939* (Woodbridge, 2009), p. 120; J. V. Pickstone, *Medicine and Industrial Society: a history of hospital development in Manchester and its region, 1752-1946* (Manchester, 1985), pp. 156-183; T. H. Bickerton, *A medical history of Liverpool from the earliest days to the year 1920* (London, 1936), pp. 116-18.

¹¹⁷ Cambridge City Library, Cambridge Home and Training School for Nurses, *Annual Report*, 1878, p. 7.

¹¹⁸ Bynum, *Science and the practice of medicine*, pp. 222-26; S. Szreter, 'The importance of social intervention in Britain's mortality decline c. 1850-1914: a re-interpretation of the role of public health' *Social History of Medicine*, 1 (1988), pp. 1-37.

in the capital between 1848 and 1857.¹¹⁹ Although not reported frequently, deaths of nurses due to infectious diseases are recorded by most of the associations included in this study. Between 1868 and 1870, seven Manchester nurses contracted typhus, three of whom died. They were buried in plots in a local cemetery especially purchased by the local institution ‘where lies the remains of those who so cheerfully gave up their lives to serve the good cause’.¹²⁰ Typhoid, which appears to be the main cause of serious infection of nurses up to 1900, claimed two nurses’ lives in both Birmingham and Lincoln between 1885 and 1900, whilst unspecified fever killed a nurse in Lincoln in 1890 and two more nurses in Salisbury in 1877 and 1882.¹²¹ Interestingly, there are no records of any nurses having died of smallpox, a situation not unknown in hospitals towards the end on the nineteenth century.¹²² This was probably due to associations ensuring that nurses were vaccinated or revaccinated against smallpox when an outbreak occurred.¹²³ Where possible, nurses were allocated to infectious cases from which they had previously suffered, in order to protect them.

The risk of infectious diseases to the nurse and its possible spread to the patient’s family and to others in the nurses’ home on completion of the case meant that strict procedures were adopted. These seem to have remained fairly consistent, even when bacteriology replaced miasmatic theory. It was recommended that patients be isolated in a designated

¹¹⁹ F. Nightingale, *Notes on hospitals*, third edition (London, 1863), pp. 20-21.

¹²⁰ MALS, Manchester Nurse Training Institution, *Annual Report* 1870, p. 6. (362.1 M85); MALS, Philips Park Cemetery, Burial Registers 1867-1876 (Microfilm copy) (MFPR 687); Also, see the biography of Agnes Chambers in Appendix 4.

¹²¹ BCA, Birmingham and Midland Counties Training Institution for Nurses, House Committee Minutes 1885-1899 (MS 807/6/6); LA, Lincoln Institution of Nurses, *Annual Reports*, 1867-1900; WSRO, Salisbury Diocesan Institution for Trained Nurses, Minute Book July 1876–Nov. 1878 (J8/109/2); WSRO, Salisbury Diocesan Institution for Trained Nurses, Minute Book July 1879–1907 (J8/109/3).

¹²² Currie, *Fever hospitals and fever nurses*, pp. 128-30.

¹²³ LA, Lincoln Institution of Nurses, *Annual Report*, 1883 (Bromhead/4/1).

sickroom in order that mixing with the rest of the household would be curtailed. Preparation for a fever case 'required that the sickroom have either a small fire or none at all, thorough ventilation, and minimal furniture'.¹²⁴ It was thought that infection could penetrate soft furnishings and that the removal of curtains and carpets and thorough scrubbing of the floors would help to eliminate its spread.¹²⁵ All but the necessary furnishings, such as a bed table, wash-stand and a few plain wooden chairs, were removed from the room.¹²⁶ Thus, a nurse in Lincoln, who attended an outbreak of fever in a family where the father, mother and six children were all ill, 'took up the carpet in the sitting room, scrubbed the floor, and moved four children downstairs, and so separated the fever cases' from the rest of the household.¹²⁷ Disinfection was essential to ensure infection did not leave the sickroom. A sheet soaked in a weak solution of carbolic acid was recommended to be hung at the sickroom door as it was thought that it would prevent infection entering the rest of the house.¹²⁸ In the 1870s, containers of disinfectant were often left in the sickroom as a means to counteract infection¹²⁹ and, by the 1880s, some were advising on the use of carbolic sprays.¹³⁰ However, by the 1890s, both of these methods were thought to be ineffectual and were not advocated.¹³¹ In cases of typhoid, the Institution in Lincoln recommended that all bowel discharges should be disinfected with chloride of lime, and that carbolic powder be used to disinfect both the bed and sickroom. Bed linen and the patient's clothes were to be placed in a vessel containing disinfectant, boiled and then washed. Household drains were to be disinfected

¹²⁴ Adams, *Architecture in the family way*, p. 92.

¹²⁵ Crookshank, *Home nursing and hygiene*, p. 19.

¹²⁶ *Ibid.*, p. 20.

¹²⁷ LA, Lincoln Institution of Nurses, *Annual Report*, 1870 (Bromhead/4/1).

¹²⁸ Stewart and Cuff, *Practical Nursing*, p. 215; Neuman, *Home nursing*, p. 93.

¹²⁹ F. S. Lees, *Handbook for hospital sisters* (London, 1874), p. 187.

¹³⁰ Crookshank, *Home nursing and hygiene*, p. 54.

¹³¹ Stewart and Cuff, *Practical Nursing*, p. 215.

twice daily with carbolic acid.¹³² All equipment, such as bedpans and sputum pots, were also disinfected after use. The association at Derby ensured a supply of disinfectants were available in the nurses' home for those nurses who were sent to households at some distance from a chemist's shop.¹³³ On recovery of the patient, the room was to be thoroughly cleaned, crockery and cutlery washed in boiling water and soaked in a solution of carbolic acid and other equipment, such as nail brushes, tooth brushes and the broom used to sweep the room, were burnt. Finally, it was recommended that the sickroom be fumigated using sulphur.¹³⁴

Nursing care of patients with fever was an intensive activity. Many patients who were diagnosed with fever were on strict bed rest, which increased the workload of the nurse in terms of feeding, washing and implementing measures to prevent bed sores. Care was needed to ensure that bed clothes were changed at frequent intervals due to excessive sweating. Patients were given nourishment and stimulating therapy to support the body in curing itself.¹³⁵ Thus, nurses were involved in administering small quantities of fluid, food and alcohol at frequent intervals, using feeding cups or spoons, in some cases as often as every half an hour throughout the day and night.¹³⁶

Temperature control through adequate ventilation, a reduction in the amount of bed clothes, the provision of larger than normal volumes of fluid and the use of methods of

¹³² LA, Lincoln Institution of Nurses, *Annual Report*, 1881 (Bromhead/4/1).

¹³³ DRO, Derby and Derbyshire Nursing and Sanitary Association, House and Management Committee, minute book, 29 September 1893 (D4566/2/1).

¹³⁴ Stewart and Cuff, *Practical Nursing*, pp. 218-20.

¹³⁵ W. F. Bynum, 'Hospital, disease and community: the London Fever Hospital, 1801-1850', in C. E. Rosenberg (ed.), *Healing and disease: essays for George Rosen* (New York, 1979), p. 111.

¹³⁶ Lees, *Handbook for hospital sisters*, p. 177.

externally cooling the skin became a normal feature of nursing patients with fever.¹³⁷ Different methods to lower the temperature were used. One involved sponging the body with cold or tepid water, thereby cooling it through evaporation of moisture from the skin. The second placed the patient in either a cold bath or involved pouring cold water directly over the patient. Finally, moistened cloths, known as wet compresses were applied to the skin.¹³⁸ The timing of the various interventions was dependent upon the patient's temperature and often the nurse would have had to use her own judgement, based on the doctor's orders, when to intervene. In the 1860s and 1870s, alcohol in large quantities was utilised to lower the temperature, but, by the 1890s, this approach was discredited.¹³⁹

Specific treatments were designed for particular infectious diseases. This could be as simple as providing mouth and eye care and the use of lotions to prevent disfigurement in smallpox or skilled tasks such as maintaining the airway in those patients with diphtheria who had received tracheotomies.¹⁴⁰ Patients who had typhoid or enteric fever were put on bed rest and prevented from sitting upright. A water bed was recommended for use to prevent bed sores. Because of widespread ulceration of the bowel, typhoid patients were kept horizontal to reduce pressure and thereby the likelihood of perforation of the bowel. Thus, the nurse would have had to feed and wash her patient as well as change the bedclothes with the patient lying flat in the bed.¹⁴¹ Patients with scarlet fever were

¹³⁷ Currie, *Fever hospitals and fever nurses*, p. 7.

¹³⁸ Lees, *Handbook for hospital sisters*, pp. 174-76.

¹³⁹ Warner, 'Physiological theory and therapeutic explanation', pp. 253-56; Hart, *Diet in sickness and in health*, p. 16; Paul, *Bacchic medicine*, p. 92.

¹⁴⁰ Currie, *Fever hospitals and fever nurses*, p. 7.

¹⁴¹ Humphry, *A manual of nursing*, pp. 118-24.

considered infectious until all the skin had peeled away and, thereafter, were given warm baths containing carbolic soap and then covered in carbolised oil to kill any infective agents. Renal failure was a complication associated with scarlet fever and, as such, examination of the urine for albumin was required.¹⁴² Infectious diseases clearly required nurses to develop specific knowledge and skills in order to care for their patients.

Nurses were encouraged to preserve their own health when attending infectious cases by gargling with a mild disinfectant, as well as washing hands and finger nails thoroughly.¹⁴³ They were advised to keep themselves infection free by rinsing the whole body with a weak solution of chloride of lime, followed by normal washing with soap and water. It was believed that, if these guidelines were 'carried out, a nurse need not be kept from her work longer than a week'.¹⁴⁴ The Manchester institution ensured that nurses' clothes were disinfected on completion of infectious cases.¹⁴⁵ On return to the nurses' home, it was common practice for nurses to be isolated in some form of quarantine quarters in order to ensure they did not convey diseases to their colleagues. In such cases, the Institution of Nursing Sisters in London utilised a private house run by a woman who was paid a yearly retainer to provide lodgings for one week to any sister, who did not have her own home. In October 1870, one nurse was not admitted to this home after caring for a case of smallpox and it resulted in 'serious illness and inconvenience'.¹⁴⁶ Unusually for this time, the Lincoln institution used the 'White House', which provided beds for private patients

¹⁴² Ibid., pp. 114-16.

¹⁴³ Neuman, *Home nursing*, p. 93.

¹⁴⁴ C. J. Cullingworth, *The nurse's companion: a manual of general and monthly nursing* (London, 1876), p. 67.

¹⁴⁵ MALS, Manchester Nurse Training Institution, *Annual Report*, 1866, p. 6 (362.1 M85).

¹⁴⁶ Wellcome Library, Institution of Nursing Sisters, Committee Minute book, 21 Oct. 1870 (SA/QNI/W.2/6).

with infection and those requiring operations and as well as containing quarantine facilities for the nurses.¹⁴⁷ More typical were other institutions, for example, Salisbury, which used the attic of the nurses' home for the purposes of quarantine. This was something that was recommended by a number of medical experts, as it was thought that infectious air rose within houses.¹⁴⁸ Birmingham utilised a separate annex, while Manchester and Derby rented houses for the purpose. However, by 1892, the house at Derby was deemed inadequate and arrangements were made to provide quarantine rooms above the stables at the nurses' home. This was equipped with, amongst other things, a speaking tube for communication with the main home, measures which enabled strict quarantine to be maintained.¹⁴⁹ In terms of district nursing, both Lincoln and Derby during the 1870s employed nurses who did not live in the nurses' home, in order to prevent the possible spread of infection. Other Lincoln nurses cared for the sick poor, but one nurse was used exclusively to care for those with fever.¹⁵⁰ In Derby, the nurse presented her report to the lady superintendent and received orders over the garden wall of the nurses' home. Her work was supervised by the parish doctor, who, in turn, issued a report to the lady superintendent.¹⁵¹

Not only did the associations nurse patients with fever in their own homes, but they also provided nurses to other organisations. At Bristol, in 1863, two nurses cared for fever patients in the 'most miserable streets and courts' of St Jude's parish and afterwards took

¹⁴⁷ D. Robertson, *A Victorian venture: an account of the Bromhead Nursing Institution* (Lincoln, 1937), p. 10.

¹⁴⁸ Crookshank, *Home nursing and hygiene*, p. 17; Neuman, *Home nursing*, p. 86.

¹⁴⁹ DRO, Derby and Derbyshire Nursing and Sanitary Association, House and Management Committees, minute book, 29 August 1892 and 19 December 1892 (D4566/2/1).

¹⁵⁰ LA, Lincoln Institution of Nurses, *Annual Report*, 1872 (Bromhead/4/1).

¹⁵¹ National Association for Providing Trained Nurses for the Sick Poor, *Report of the sub-committee of reference and enquiry* (London, 1875), p. 40.

charge of a temporary fever hospital.¹⁵² Stratford-upon-Avon was willing to provide nurses to neighbouring parishes during epidemics in order to superintend the care of the sick and to assist medical men, provided that adequate funding was provided to cover any incurred expenses.¹⁵³ In 1887, Miss Minet, the Lady Superintendent opened a temporary fever hospital in conjunction with the medical officer of health at Copham's Hill Farm, Henley-in-Arden during an epidemic of scarlet fever and successfully nursed all patients without a single fatality.¹⁵⁴ Similarly, at the village of Rowington, Warwickshire a trained nurse had been engaged by several of the better-off residents during an outbreak of scarlet fever. The nurse supplied by the Birmingham and Midland Counties Training Institution for Nurses was reported as having had a positive effect on the children with a marked reduction in fatal cases since her appointment.¹⁵⁵ Later, the Birmingham institution provided nurses to the Asylum for Idiots at Knowle during an epidemic of scarlet fever in 1885 and to Rugby School for pupils with mumps between March and May 1888. The Lincoln institution provided a nurse for the smallpox hospital in 1872 and 1876, and a nurse for the Lincoln Workhouse to care for 15 cases of typhoid in 1879.¹⁵⁶ In 1899, the institution purchased an iron building to serve as a temporary fever hospital to be operated in conjunction with the Lincoln Corporation. Nurses were provided free of charge and the arrangements lasted until the Corporation erected a new fever hospital; it purchased the structure in 1905 during another typhoid epidemic.¹⁵⁷ As one might expect,

¹⁵² BL, Bristol Nurses' Training Institution and Home, *Annual Report*, 1866 (Cup 401.i.6.8).

¹⁵³ SBTA, Nursing Institute, No. 23 West street, Stratford-upon-Avon (Circular regarding the founding of the institute, its purpose, costs of nurses and appeal for donations, c.1872) (DR 406/67).

¹⁵⁴ P. Spinks, 'The Stratford-upon-Avon convalescent home', *Warwickshire History*, Winter (2005/6), p. 99.

¹⁵⁵ BAH, Birmingham and Midland Counties Training Institution for Nurses, *Annual Report* 1875, p. 11 (L46.6 12811).

¹⁵⁶ LA, Lincoln Institution of Nurses, *Annual Report*, 1887 (Bromhead/4/1).

¹⁵⁷ *Ibid.*, *Annual Reports*, 1899 and 1906 (Bromhead/4/1).

the provision of nurses was much appreciated by local communities. In 1895, Nurse Martin of the Derby association received a silver tea service from the Ripley Urban District Council for nursing during a smallpox epidemic from June to September of that year in recognition of the ‘conscientious devotion to the fifteen suffering patients under your care and it is also well known that each is grateful to you for your skilful nursing’. In reply, Nurse Martin stated that ‘this occasion will ever be linked in my memory as one of the great events in my nursing career.’¹⁵⁸ This incident illustrates that infectious diseases were significant in the lives of patients and nurses, but also consumed a lot of the associations’ time and resources.

Nursing the chronically ill, the mentally ill and the dying

Although the majority of patients that were allocated to nurses were acutely ill or had an acute condition, such as a wound, that required immediate intervention, nurses were also assigned to nurse the chronically ill, the mentally disturbed and invalids. Moreover, some institutions provided monthly nurses and massage nurses. In Lincoln, the aged and debilitated usually never comprised more than five percent of all cases in any one year, whilst those with a mental health problem never accounted for more than two percent.¹⁵⁹ As householders were at liberty to hire a nurse without recourse to a doctor, some nurses may have been employed to care for aged relatives, as well as those who required companions. Thus, not all nursing work would have been intense and demanding. Towards the end of the nineteenth century, nursing was thought to have become an exciting and fashionable occupation for young women, as depicted in popular fiction. The

¹⁵⁸ DRO, Derby and Derbyshire Nursing and Sanitary Association, House and Management Committees, minute book, 30 September 1895 (D4566/2/1).

¹⁵⁹ LA, Lincoln Institution of Nurses, *Annual Reports*, 1870, 1880, 1890 and 1900 (Bromhead/4/1).

experience of one nurse, however, painted an entirely different story - 'As lived from day to day in the seclusion of one sick room after another, it seems anything but exciting or romantic – often painfully monotonous.'¹⁶⁰

Given that there were few effective treatments and cures for many longstanding and life threatening diseases, the death of a patient would have been a common occurrence for the nurses in this study. As such, they would have developed both extensive knowledge and skill in caring for the dying. The care and treatment delivered by Cecilia Quinney to a terminal case, Mrs Dixon (see Figure 5.2), seems typical of treatment regimes prescribed by doctors in the middle of the nineteenth century and corresponds with that ordered for dying patients elsewhere, consisting primarily of regular nourishment with judicious amounts of alcohol.¹⁶¹ Traditionally in upper and middle class households, the female members of the family often nursed dying relatives, but, after 1870, there is evidence to show that this was often shared with trained nurses.¹⁶² This was the case with Mrs Dixon, whose unmarried daughter shared the care with Cecilia Quinney, with the latter always accompanying the patient at night.¹⁶³ In Derby, when family members were unable to care for a dying patient, the nursing association supplied a nurse who took command of the household and provided 'tender care' at a time of 'trouble and sorrow'.¹⁶⁴ When a patient died, the nurse, along with the household servants, sometimes prepared the body. This included the use of bandages to close the mouth, placing wet pads on the eye lids to

¹⁶⁰ M. Gardner, 'Nurses in modern fiction' *The Nursing Record & Hospital World*, 7 April 1900, p. 279.

¹⁶¹ P. Jalland, *Death in the Victorian family* (Oxford, 1996), pp. 83-84.

¹⁶² *Ibid.*, p. 103.

¹⁶³ LA, Lincoln Institution for Nurses, Nurses' Memoranda: Cecilia Quinney's Case Book, 1872. Entries by Miss Ann Dixon (Dixon 22/11/20).

¹⁶⁴ 'The Derby and Derbyshire Nursing Association', *Derby Mercury*, 11 April 1877.

keep them closed, straightening the limbs, washing the body and dressing the corpse.¹⁶⁵

Cecilia carried out these final tasks, reporting that Mrs. Dixon ‘looked so pretty and kept so very nice till Wednesday’ when the coffin was sealed.¹⁶⁶

The effect of work on the nurses

Private nurses often worked long periods without rest both during each day and also in terms of the duration of each case. The nurses belonging to the Cheltenham Nursing Institution on average worked 80 percent of all available days (932 out of a possible 1,166) in the first six months of 1872. One nurse, Jane Cryer, worked every day, whilst, on seven occasions, one of the other nurses worked an entire month without a break.¹⁶⁷

The average duration of cases was also quite lengthy. For instance, when Rebecca Kenrick was taken ill, she secured a nurse from the new institution in Birmingham in January 1869 and was bedridden for five weeks.¹⁶⁸ This was not an unusual length of engagement, as the average duration of each case in Derby in 1884 was just over six weeks.¹⁶⁹ Cases could be of much longer duration, the nurses in Salisbury were said to spend ‘night after night in their duty, sometimes six weeks running and sometimes three or four months’.¹⁷⁰ An extreme case was that of Sister Potter from the Institution of Nursing Sisters who was given two months leave following a case that had lasted four

¹⁶⁵ Jalland, *Death in the Victorian family*, pp. 211-12; C. J. Wood, *A handbook of nursing for the home and Hospital* 2nd Edition (London, n.d.), pp. 96-99.

¹⁶⁶ LA, Dixon 22/11/20.

¹⁶⁷ GRO, D2465 3/1, Cheltenham Nursing Institution, Minutes 1867-72. See Appendix 7 for a short biography of Jane Cryer.

¹⁶⁸ BAH, Diaries of Rebecca Kenrick, 1839-1889, Volume 2, 28 January 1869 (MS 2024/1/2).

¹⁶⁹ DLSL, Derby and Derbyshire Nursing and Sanitary Association, *Annual Report*, 1884/85, p. 5 (A610.73). This was calculated by dividing the number of weeks of nursing undertaken – 1,714 by the 269 families attended.

¹⁷⁰ WRSO, Salisbury Diocesan Institution for Trained Nurses Minute Book, 28 February 1883 (J8/109/1).

years.¹⁷¹ Nurses in Liverpool attended, on average, ten cases each year during the 1880s and about eight cases each in the following decade.¹⁷² Nurses often did not have much rest between cases, unless they had been attending an infectious patient and, even then, the turn-around could be quite quick. For instance, the lady superintendent of the Mildmay Mission in London, which supplied private nurses, in reply to a question concerning their response rates, reported the following:

We send them off at half an hour notice to any part of the country – England, Scotland, Ireland or Wales, sometimes even to the Continent... how soon can you be ready, Nurse C? I must send you to Aberdeen; your train starts in an hour, and it will take you half that time to reach Kings Cross. Are your boxes packed?¹⁷³

In 1872, an anonymous author described private nurses as ‘women of superior type of character with strong minds, with active bodies, with great powers of endurance’.¹⁷⁴

However, nursing took its toll on the physical and mental health of many women because of the unrelenting nature of nursing patients both night and day:

Her duties are often in their very nature repulsive and disagreeable. Patients are too often ungrateful, exacting, and difficult to please, and their friends selfish and inconsiderate. The work entails long confinement, disturbed rest, and constant harass and anxiety.¹⁷⁵

This view was similar to that held by Florence Nightingale, who felt that ‘the Nurses are made “to run up & down stairs” & “to sit up” till they are unfit for anything’.¹⁷⁶ Indeed, in the early days of many of these associations, it was expected that nurses would help with domestic duties in households where there were no servants, provided that the

¹⁷¹ WL, SA/QNI/W.2/5, Institution of Nursing Sisters, Committee Minute Book, 29 January 1864.

¹⁷² LRO, Liverpool Training School and Home for Nurses, *Annual Reports 1880-1900* (614 INF/ 17/8).

¹⁷³ ‘How a day is spent at the nursing home’, *Service for the King*, July 1881, pp. 129-30.

¹⁷⁴ *Hints on nursing the sick for the rich and poor* 2nd Ed. (London, 1872), p. 16.

¹⁷⁵ C. J. Cullingworth, *The nurse’s companion*, p. 2.

¹⁷⁶ Nightingale to Harriet Martineau, 8 February 1860, reprinted in M. H. Frawley (ed.), Harriet Martineau, *Life in the sick-room* (Toronto, 2003), Appendix E, p. 218.

nursing was not too onerous.¹⁷⁷ This was not advocated by all, as one source advised that the employer and servants should treat the nurse with sympathy and care and that she be provided with her own room, sufficient time to rest, an under servant to provide for her needs, regular mealtimes with the other servants and sufficient access to fresh air at least once a day.¹⁷⁸ Later in the century, the Lincoln institution expected that nurses would have six hours rest per day and, if continuous nursing over a twenty-four-hour period was required, two nurses would have to be employed.¹⁷⁹ This also seems to have been the policy of the Salisbury association, as nurses Louise King and Sarah Hancock were recorded together at Clavenden Park, Wiltshire at the time of the 1881 census, and sisters Louise and Charlotte Case were working together at Houston House, Renfrewshire, Scotland during the 1901 census.¹⁸⁰ However, the reality of nursing for many district and private nurses was one of continuous hard work which had a deleterious effect on the health of some individuals.

Illness was an occupational hazard for most nurses at this time. In 1879, the Birmingham institution reported that sickness was rife amongst the workers, and one nurse in particular had contracted typhoid and was unfit to work for five months, whilst many others contracted long-term illnesses which necessitated care in the nurses' home, or in the General Hospital.¹⁸¹ Alternatively, nurses were periodically sent for convalescence. The Birmingham institution, in February 1885, sent a nurse who was 'thoroughly over

¹⁷⁷ MALS, Manchester Nurses' Institution, *Annual Report 1866*, pp. 27-28 (362.1 M85); DLSL, Derby and Derbyshire Nursing and Sanitary Association, *Annual Report 1869-70*, p. 4 (A610.73).

¹⁷⁸ *Hints on nursing the sick for the rich and poor*, p. 16.

¹⁷⁹ LA, Lincoln Institution of Nurses, *Annual Report 1885* (Bromhead/4/1).

¹⁸⁰ See Appendix 7 for biographies of Louise and Charlotte Case.

¹⁸¹ 'Birmingham and Midland Institution for Training Nurses', *Birmingham Daily Post*, 26 February 1879.

done from a case' to a sanatorium in Llandudno, where two of her colleagues already resided.¹⁸² The Liverpool Training School and Home for Nurses used a cottage in Huyton for convalescing nurses over several years in the 1880s.¹⁸³ In 1897, the Birmingham institution negotiated an arrangement to send all nurses who needed care to the Sutton Coldfield Convalescent Institution.¹⁸⁴ More seriously, there are instances in the records of nurses who had to relinquish their posts because of problems with their health. In Salisbury, one nurse who had consumption was discharged in 1876, whilst another who had an 'internal complaint', and was deemed not fit for private nursing which involved 'much standing and lifting', was dismissed in 1882 on full salary for two months and a one-off payment of £10.¹⁸⁵ Undertaking a career in nursing was not without risks.

Summary

By the end of the century, nursing was an organized and disciplined activity. The associations referred to in this study had been in the vanguard of reforming the practice of nursing in terms of applying knowledge, being technically skilled and demonstrating appropriate behaviour. Where records exist, it is clear that up-to-date practice, as described in contemporary journals and textbooks, was offered to their patients. There is insufficient detail in the available documents to detect significant changes in nursing practices over the course of the nineteenth century, but the management of illness did alter in significant ways. There was a movement away from the therapeutic scepticism

¹⁸² BAH, Birmingham and Midland Counties Training Institution for Nurses, House Committee Minutes, 27 February 1885 (MS 807/6/6).

¹⁸³ LRO, Liverpool Training School and Home for Nurses, *Annual Report*, 1886 (614 INF/ 17/8).

¹⁸⁴ BAH, Birmingham and Midland Counties Training Institution for Nurses, House Committee Minutes, 12 January 1897 (MS 807/6/6).

¹⁸⁵ WRSO, Salisbury Diocesan Institution for Trained Nurses Minute Book, 2 October 1876 (J8/109/2) and 31 July 1882 (J8/109/3).

that existed in mid-century medical practice, which expected the body to cure itself. By the end of the century, nurses were actively involved in applying, in the first instance, sanitary principles and, then, ensuring antisepsis and asepsis to protect patients from disease and, second, in implementing treatment regimes aimed at disease management and therapeutic support of the patient's constitution.¹⁸⁶

Managers, subscribers and doctors all praised the associations' nurses for implementing high quality care to both the rich and poor. However, nursing was a dangerous activity and the high risk of infection from acute cases, not to mention the sheer physical hard work associated with nursing all types of patients, including the chronically ill and the invalid, exacted a toll on the health of a number of nurses. Although the core of what constituted nursing duties remained largely the same irrespective of where the nurses worked, the location of care must be seen as an important factor in influencing nursing practice. There was a clear difference in the role of the nurse in the households of the middle and upper classes compared to those who worked with the sick poor. The private patient saw the nurse as a skilled servant, whilst the district nurse was expected to be both an agent of sanitary reform, as well providing nursing care to the sick poor. Although sections of this chapter appear to attest to the importance of individual nurses' work, an evaluation of the relative success of the work of the associations will be presented in the next chapter.

¹⁸⁶ M. Worboys, *Spreading germs*, p. 289.

6: SUCCESS AND FAILURE

The term ‘success’ is laden with connotations associated with the idea of history as progress. The linear nature of professional progress as described in traditional accounts of nursing and medical history promotes an idea that nursing had improved from the mid-nineteenth century onwards. Although this is true, the idea of progress needs to be tempered by examining the actual developments within the associations included in this study. It is possible to evaluate the record and impact of nursing associations in terms of the services they delivered and on their impact on nursing in the nineteenth century. This will be achieved by analysing why the associations in Cheltenham and Lichfield failed, and the ability of all associations to meet their aims in forging links with hospitals, and in providing nurses to the rich and poor. In addition, a postscript will trace the fate of these associations in the twentieth century. This indicates that most survived until mid-century, and that district nursing services, in particular, were absorbed into the new National Health Service, founded in 1948.

The failures of Cheltenham and Lichfield

Two of the associations in this study failed. Both faced particular issues, but also shared some of the problems of finance and support common to the other larger organisations. The Cheltenham Nursing Institution was operational from October 1867 until October 1872, but closed because of the ‘lamentable want of support which the institution has met in the town of Cheltenham’.¹ Analysis of the one surviving annual report indicates that the subscribers and donors to the association were mainly confined to the Christ Church

¹ Gloucestershire Record Office (hereafter GRO), Cheltenham Nursing Institution, Minutes 1867-1872, 15 October 1872 (D2465 3/1).

parish, were Church of England incumbents or prominent members of institutions in the town, such as Cheltenham College.² This was quite a narrow subscriber base to support an ambitious project such a nursing institution. The annual report shows that the institution also lacked patrons and, as such, was probably isolated from the county gentry and aristocracy. It, therefore, can be seen to have lacked the symbolic capital generally needed to attract supporters. Cheltenham had a large middle-class population, and the size of the town was similar to that of Derby and much bigger than Lincoln (see Appendix 3), yet the institution did not command much support in comparison to those other associations. In 1870, the costs of maintaining a nursing home were matched by subscriptions, donations and the earnings from the nurses, but the association had ambitions to employ a district nurse and also paid for three of its nurses to be trained as midwives.³ As time went on, its committee members had to consider closing the home and they dispensed with the services of its district nurse and lady superintendent in January 1872.⁴ In spite of its private nurses being in work for most of that year, the institution closed in October. Finance was an issue for all associations and was a major factor that tempered their ambitions and limited the work they could undertake.

As discussed in Chapter 3, the Nursing Association for the Diocese of Lichfield had a troubled time during its foundation, mainly due to the problems that the protracted dispute with evangelical elements of the Anglican community in Derby created.

However, the problems for the association lay, like Cheltenham, with a distinct difficulty

² Sources: GRO, Cheltenham Nursing Institution, *Annual Report*, 1870 (H03/8/4); H. Edwards, *Royal Cheltenham and County directory* 1872/3 (Cheltenham, 1872).

³ GRO, Cheltenham Nursing Institution, Minutes 1867-1872, 7 November 1871 (D2465 3/1).

⁴ *Ibid.*, 9 January 1872.

with finance, but also partly due to the ambitions of its founders and the geography of the diocese. From the outset, the association wanted to provide nurses for hospitals, private families and parish nurses for the poor. It aimed to set up a nursing home under the management of a lady superintendent, who would co-ordinate training and supply nurses to those in need. Initially, the association raised over £600 and had a healthy surplus, but, by 1869, the amount of support had fallen to under £200 and expenditure exceeded income.⁵ This was partly due to the fact that many people in Derbyshire had switched allegiances to the association in Derby, but partly due to its own circumstances. By 1869, the nurses were scattered between parishes in Wolverhampton, Stoke on Trent and Shrewsbury, two different hospitals and numerous private homes. There was no central home or lady superintendent, but the day-to-day work of the nurses was co-ordinated by lady secretaries in Wolverhampton, Derby and Shrewsbury. There was a central committee and three separate ones for each of the counties in the diocese.⁶ The central committee took responsibility for training of the probationers, whilst the district committees were expected to obtain subscriptions, recruit probationers and supervise their work.⁷ At the annual meeting of the Wolverhampton branch in February 1869, the Reverend J. H. Iles lamented that the association received insufficient support from both the public and the local hospitals.⁸ This situation had been foretold by Lord Harrowby, who, in supporting the diocesan association, advocated that a diocesan structure would be difficult in terms of geography. He suggested that there should be local centres within Staffordshire based upon the voluntary hospitals in Wolverhampton, Stafford and Stoke

⁵ Staffordshire Archives, Lichfield, Nursing Association for the Diocese of Lichfield, *Annual Report*, 1866, p.8 (D30/11/118); and *Annual Report*, 1869, pp. 6-8. (B/A/19/2/106).

⁶ *Ibid.*, 1869, pp. 1-5.

⁷ *Ibid.*, 1869, pp. 12-13.

⁸ 'Training of Nurses', *British Medical Journal*, 27 February 1869, pp. 192-93.

upon Trent.⁹ For him, ten trained nurses within the diocese would be a ‘drop in the ocean’, whilst ten in one centre would ‘excite attention and enlist support’.¹⁰ The association received similar advice from Nightingale. She advised them to situate the organisation and the training of nurses in the hospital and warned against trying to set up a separate nursing home. Of great importance to her was that the home should be attached to a hospital as her experience demonstrated this was the only way of successfully providing good nurses to the poor on the outside.¹¹ It is interesting to note that Lord Harrowby’s idea, that an association needed a specific location and it needed to be part of a community, resonates with present-day discussions about place as a useful concept in the study of history. To most historians currently engaging with this issue, places are not just locations on a map, but locales where people interact and which give a particular location a sense of meaning to the local population.¹² Lord Harrowby grasped the idea that an association should locate itself in the voluntary hospitals in the large urban areas of Staffordshire, as it would become more meaningful to the public. Only such towns could root an association in the diocese as they engendered an appropriate sense of place or community which could provide the necessary social agents and the resources required for the success of a nursing association.

The diffuse nature of the diocese robbed it of a geographical heartland in which to develop nursing and generate support and, as a result, it went out business sometime in 1871. It was replaced by a new organization, the Staffordshire Institution for Nurses in

⁹ *Derby Mercury*, 29 March 1865, p. 2.

¹⁰ *Staffordshire Advertiser*, 13 May 1865, p. 7.

¹¹ Letter from Florence Nightingale to E. J. Edwards, 13 April 1865, reprinted in E. J. Edwards, *Nursing association for the Diocese of Lichfield* (London, 1865), p. 1.

¹² T. Creswell, *Place: a short introduction* (Oxford, 2004), pp. 7-12.

November 1872, which was based in a nurses' home attached to the North Staffordshire Infirmary.¹³ It had a committee of twenty, including eight ladies, largely made up of members of the old diocesan committee who resided in the north of the county.¹⁴ This association was said to be modeled on one at Lincoln and had appointed a full-time Lady Superintendent, who had served an apprenticeship in Lincoln in order to learn how to manage a nursing institution.¹⁵ In 1876, it opened a new building to house the nurses. This new institution, like its counterpart in Derby, became quite successful and it survived into the twentieth century, mainly in the field of private nursing.¹⁶

Finance was a particular problem for the associations in Lichfield and Cheltenham, ultimately leading to their closure, but this was an issue that affected all associations. Like most charities, nursing associations competed in a market for public support in the form of subscriptions and donations. Initially, there was a heavy reliance upon this form of support, but this was limited by the number of people who could be recruited as subscribers. As the century proceeded, it became obvious that fees for private work were the single most important aspect of the income of the associations (See Appendix 10). Dependence on this commercial activity limited the amount of philanthropic work that could be undertaken, as private nursing required investment in a nurses' home, including the housekeeping costs, the funding of training and the paying of wages, bonuses and pensions. All of these consumed the majority of the income that the private nurses raised.

¹³ *Lichfield Diocesan Directory* (Church Calendar and General Almanac for the Diocese of Lichfield), 1872, p. 261.

¹⁴ *Ibid.*, 1873, p. 316.

¹⁵ London Metropolitan Archives, Nightingale Collection, Letter from G. Wedgewood to Henry Bonham Carter, 8 February 1873 (H01/ST/NC/18/011/056).

¹⁶ The last date for existence of this organisation is 1920, when it had 120 nurses and 18 probationers. Source: *Lichfield Diocesan Directory*, 1920.

Associations looked for other ways to increase funds, but congregational collections and bazaars could only raise a small amount of income. Shapely has indicated that good financial management, in the form of investments, became more important for charities as the century proceeded.¹⁷ Only the Stratford institution was able to make about 10% or more from investments, and virtually all associations were totally dependent on the fees from private nursing. Hospital Sunday and Hospital Saturday collections taken in churches and workplaces respectively on one day per year did become more important for some associations towards the end of the century; collections were organised within a town or city and the proceeds were shared amongst the various medical charities, including nursing associations in Birmingham, Liverpool, Manchester and Stratford.¹⁸ These were given for nursing the sick poor. There was a constant plea for funds throughout the period and the perceived shortfall influenced the amount and type of work that could be undertaken.

Relations with the hospitals

Hospitals were important to the work of nursing associations. The role of the hospital as a venue to train both private and district nurses was already in place from the 1840s when the Institute of Nursing Sisters first sent its nurses to hospitals in London to gain experience. The work of the sisterhoods and the opening of the Nightingale School in 1860 reinforced the idea of training and the prominent place of the hospital in nursing reform. Nightingale, who regarded hospitals to be dangerous places, still saw them as the only possible site for the training of both district and private nurses, as it was only here

¹⁷ P. Shapely, 'Voluntary charities in nineteenth-century Manchester: organisational structure, social status and leadership'. Unpublished PhD thesis, (Manchester Metropolitan University, 1994), pp. 84, 95.

¹⁸ See Appendix 9 and Appendix 10.

that there was a sufficient concentration of cases from which to learn.¹⁹ This information was acted upon by William Rathbone, who secured training for district and private nursing in Liverpool by amalgamating the training school and nurses' home with the Royal Infirmary through his generous funding of a new building. Salisbury was the only other association that established lasting links with a hospital. The promoters of the diocesan institution approached the Salisbury Infirmary about the training of nurses prior to its launch in 1871 and secured an agreement to train probationers.²⁰ This was an arrangement that lasted throughout the nineteenth century with the institution taking a house near to the infirmary and the training of the probationers organised around the requirements of the hospital. Other associations endeavoured to develop good working relations with local hospitals. Resistance by hospitals to the requests of local associations to participate in ventures to reform nursing was common. Hospital governors and officials often did not want to submit to an outside authority and preferred to remain independent and to continue in their own way. Hospitals in Manchester, Derby, Birmingham, Lincoln and Stratford-upon-Avon all rejected such overtures. Nursing reform in these institutions, in the main, took place later than that attempted by the nursing associations.

In early 1864, the Manchester and Salford Sanitary Association determined that there should be a training school for nursing within Manchester. This school was to provide private nurses for those that could pay and gratuitous nursing for the sick poor. The

¹⁹F. Nightingale, 'Introduction', in W. Rathbone, *Organization of nursing: an account of the Liverpool Nurses' Training School* (Liverpool, 1865), p. 10; F. Nightingale, 'On trained nurses for the sick poor', reprinted from the *Times*, 14 April 1876, in L. R. Seymer (ed.), *Selected writings of Florence Nightingale* (New York, 1954), p. 317.

²⁰ Wiltshire and Swindon Record Office (hereafter WSRO), Salisbury Diocesan Institution for Trained Nurses, Minute Book 1871-1876, 20 October 1871 (J8/109/1).

officers of the association wrote to the weekly board of the Manchester Royal Infirmary to suggest some cooperation, in order to train the nurses, as the hospital was the most appropriate place in which nurses would be able to receive instruction in patient care. They did not expect the hospital to bear the cost of the training of the nurses.²¹ In October, when the Manchester Nurse Training Institute was founded, the weekly board referred the matter of training to the medical committee. The committee reported that the hospital was not in a position to train outside nurses, as those in the hospital required closer supervision and training themselves. They suggested that the hospital secure a nurse from 'Devonshire House' (Institution of Nursing Sisters) in London, as had happened at the Salisbury Infirmary, to teach the nurses and provide discipline. If this could be achieved, they thought that they might be in a position to discuss training with the Manchester and Salford Sanitary Association.²² After a year of attempts to reform nursing in the Infirmary, a system was devised and a lady superintendent was employed to supervise the nursing. The infirmary committee felt it could only meet their own requirements for nursing and it was also determined to employ a number of nurses to provide care in private households as a potential source of income.²³ By this time, the Nurse Training Institute had arranged for nurses to be trained in London at St Thomas's and King's College hospitals. It offered some of the nurses who would be trained at St Thomas's to the Royal Infirmary so that they could be deployed in wards, which would be then able to receive probationers from the Training Institution.²⁴ The weekly board

²¹ Manchester Royal Infirmary Archive (hereafter MRIA), Weekly Board Minutes, Volume 32, 1863-65, 22 February 1864.

²² MRIA, Special Medical Committee, Minutes 1861-75, 13 October 1864.

²³ Manchester Archives and Local Studies (hereafter MALS), Manchester Royal Infirmary, *Annual Report* 1865, p. 5 (362.1 MI).

²⁴ MRIA, Weekly Board Minutes, Volume 33, 1865-67, 20 November 1865.

refused to be drawn and indicated that it had introduced a new system of nursing in the hospital and that they already had seven nurses undertaking private work. Whilst they accepted the offer of the nurses, they were only willing to train women for district nursing, and this would be the limit of their cooperation.²⁵ The training institution had also approached the Salford and Pendleton Royal Hospital and Dispensary and offered it some of the trained nurses. This was a much easier proposition as the chairman of the hospital, Murray Gladstone and Dr Morgan, an honorary physician, were officers of the training institution. Unsurprisingly, this offer was accepted and one of the nurses, Elizabeth Walton, was appointed matron and the hospital then anticipated that it would be able to introduce training for the institution.²⁶ This arrangement probably continued until at least 1879, when Miss Walton resigned and the hospital decided to introduce a new form of training.²⁷ The situation in Manchester and those in Derby and Lincoln, described in Chapter 3, shows that attempts by associations to influence nursing in hospitals were resisted if the authorities felt threatened by an outside body. This same situation occurred in Stratford-upon-Avon, when the Nursing Institute offered to take over the nursing and administration of the Stratford-upon-Avon Infirmary. Two of the hospital's honorary staff, Mr. Nason and Dr Kingsley who were amongst the founders of the Nursing Institute, proposed the new arrangements, whilst Drs Rice and Dowson opposed the proposal. The issue was discussed at the management committee on three occasions and rejected twice. Nason and Kingsley wanted to ensure that the hospital employed only trained and qualified nurses. In an open letter to the hospital's governors, Rice and

²⁵ *Ibid.*, 27 November 1865.

²⁶ Greater Manchester Records Office (hereafter GMRO), Salford and Pendleton Royal Hospital and Dispensary, Minute Book 1849–June 1870, 15 December 1865 and 7 February 1866 (G/HSR/AM3).

²⁷ GMRO, Salford and Pendleton Royal Hospital and Dispensary Minute Book, July 1870–July 1880, 23 July 1879 (G/HSR/AM4).

Dowson pointed out that there was only one nurse and, although not officially trained, she had been taught by the medical officers and had experience of nursing over 200 cases, including railway, machinery and other accidents, operations and other 'severe cases'. She was 'a respectable, middle aged, sober woman', who was 'anxious to perform her duties'. For them, the Nursing Institute could not offer anything better as it only had a superintendent and one assistant, and suggested that the divided authority over the nursing of the hospital, between the two institutions, might cause complications.²⁸ This matter did not go any further and, in 1872, the Nursing Institute opened a nursing home for convalescent women and sick children. These were two groups not catered for by the infirmary and, therefore, this new institution did not impinge on its work.²⁹ However, the home did not train probationers and women from Stratford had to go to Birmingham or Stoke-on-Trent for training. An earlier initiative to provide nursing in the Royal Berkshire Hospital occurred in June 1866. Here, the hospital authorities looked for ways of introducing nurse training, as it used a private agency, which proved to supply nurses of a poor quality. They entered an agreement with the Bath institution to supply a superintendent nurse, three trained nurses and probationers. It soon became obvious that the hospital had lost control over nursing to the Bath institution and the quality of the nurses was little different than before. The agreement was, therefore, terminated in December 1866.³⁰

²⁸ Shakespeare Birthplace Trust Archives (hereafter SBTA), Stratford-upon-Avon, Printed Open Letter, August 1872, to the Governors of the Stratford-upon-Avon Infirmary (DR328/14/9).

²⁹ SBTA, Nursing Home for Convalescent Women and Sick Children, Stratford-upon-Avon, *Annual Report*, 1873, p. 4 (87.35 5485).

³⁰ M. Railton and M. Barr, *The Royal Berkshire Hospital, 1839-1989* (Reading, 1989), pp. 77-78.

In contrast to these failed initiatives to either influence or take over the nursing of hospitals, the institution in Birmingham commenced on a positive footing. Prior to its establishment, advice given by Nightingale, to the effect that the probationers must live in the hospital and be trained by the lady superintendent, seems to have been taken up.³¹ Members of the committee of the new institution were also members of the committees of the local hospitals and this may have made the situation easier. Four hospitals agreed to participate in the scheme by accepting probationers from the new institution. Mrs. Tindall,³² who trained as a nurse in King's College and Charing Cross hospitals and who had previously established a training institution in Exeter, was appointed lady superintendent.³³ Probationers were placed in the General, Queen's, Children's and Women's hospitals. The General hospital, whilst accepting probationers, did not take the arrangement any further. The Queen's hospital took probationers and a few qualified nurses to take charge of some of the wards and these were said to be 'greatly superior in education and cleanliness' to the nurses normally engaged by the hospital.³⁴ However, a proposal by the training institute to take over the nursing of the hospital was rejected because nurses provided by an 'extraneous authority' would not be under the 'governing authorities of the hospital'.³⁵ A dispute over the quality of the nursing resulted in the training institute withdrawing from the hospital in January 1873.³⁶ In contrast, within a

³¹ Letter from Nightingale to Mrs G. C. Matthews, Birmingham, 7 November 1868. Source: L. McDonald, *Florence Nightingale: extending nursing*, Collected Works of Florence Nightingale, Volume 13 (Waterloo, 2009), pp. 853-54.

³² See Appendix 8 for a brief biography.

³³ Birmingham Archives and Heritage (hereafter BAH), Birmingham and Midland Counties Training Institution for Nurses, *Annual Report*, 1870, p. 10 (L46.6 12811).

³⁴ BAH, Queen's Hospital Birmingham: House Committee minute book, 1869-1871, 24 February 1871 (HC/QU/1/2/3).

³⁵ *Ibid.*, 8 February 1871.

³⁶ BAH, Queen's Hospital Birmingham: House Committee minute book, 1861-1873, 10 January 1873 (HC/QU/1/2/4).

few months of its establishment in 1869, the training institution took over the administration of the Children's Hospital by supplying nurses and probationers and Mrs Tindall assumed the role of lady superintendent.³⁷ This was an arrangement that was to last until Mrs Tindall's retirement in 1875. At this point, the hospital appointed its own superintendent, who was not a trained nurse. This was followed by two difficult years with the probationers complaining that they were overworked, expected to undertake domestic duties, such as washing ward floors, and not receiving adequate instruction about nursing.³⁸ New arrangements, including a new training plan, were agreed and implemented. In 1881, the hospital decided to take its own probationers in addition to those from the training institution.³⁹ A dispute between the hospital and the training institution over the cost of the probationers to the hospital led to a decline in their relationship and the training institute finally ended the arrangements in May 1886.⁴⁰ Similarly, when the Women's Hospital was opened in October 1871 in the same street as the Training Institution, Mrs Tindall was made honorary lady superintendent and the training institution contracted to supply the hospital with one nurse and a probationer. The agreement was discontinued when the hospital decided to take its own probationers

³⁷ BAH, Birmingham and Midlands Free Hospital for Sick Children, Management Committee minute book, 1861-1870, 27 October 1869, 4 November 1869 and 13 December 1869 (HC/BCH/1/2/1).

³⁸ BAH, Birmingham and Midlands Free Hospital for Sick Children, House Committee minute book, 1874-1879, 8 December 1875 and 31 October 1877 (HC/BCH/1/5/2).

³⁹ BAH, Birmingham and Midlands Free Hospital for Sick Children, House Committee minute book, 1879-1884, 7 December 1881 (HC/BCH/1/5/3).

⁴⁰ BAH, Birmingham and Midland Counties Training Institution for Nurses, House Committee minute book, 1885-1899, 10 November 1885, 9 February 1886 and 25 May 1886 (MS 807/6/6).

in 1878.⁴¹ The General Hospital continued to take probationers until 1898 when it decided not to train women for other institutions.⁴²

Reports from the Birmingham hospitals indicated that the introduction of probationers actually improved the care of patients and that the nurses were seen to be better than those who had gone before.⁴³ However, once the hospitals determined that having their own probationers was beneficial in terms of finance and management of the workforce, they introduced their own systems and excluded the training institution. Probationers were more economical to employ and, because of their age, probably easier to control than the traditional nurses. For instance, in 1887, the matron of the General Hospital claimed to be able to reduce costs by £90 each year by employing probationers instead of trained nurses. By 1899, the hospital was charging an entrance fee of £21 for each probationer or lengthening the training period to four years for those who were unable to pay.⁴⁴ The training institution found itself without any influence within the hospital system and became dependent on the hospitals for the training of its probationers. Having been either denied or offered only curtailed access to most of the Birmingham hospitals, the institution looked to those in Wolverhampton and Worcester to fulfill this role. Given that most hospitals of a reasonable size had set up training schools by the end of the century, associations had to conform to the standards introduced by these institutions.

Thus, the Birmingham training institution lengthened the required training from one to

⁴¹ BAH, The Birmingham and Midland Hospital for Women, House Committee minute book, 1874-1879, 19 February 1878; and 13 March 1878 (HC/WH/1/3/1).

⁴² BAH, Birmingham General Hospital, Nursing Committee minute book, 1891-1904, 18 November 1898 (HC/GHB89).

⁴³ BAH, Birmingham and Midland Counties Training Institution for Nurses, *Annual Report*, 1871, p. 10; 1872, p. 9; and 1876, p. 11 (L46.6 12811).

⁴⁴ S. Wildman, 'The development of nursing at the General Hospital, Birmingham, 1779-1919', *International History of Nursing Journal*, 4, 3 (1999), pp. 24 and 26.

two years in 1895 and to three years in 1899. By 1903, it had decided to stop employing probationers altogether and decided to recruit trained nurses only.⁴⁵ By the end of the century, associations had gone from a situation where they had been instrumental in the promotion of reform of nursing within hospitals to one where they were marginal to reform and dependent on the hospitals for their nurses.

Private nursing

All nursing associations offered private nursing services. For most, this was intended to generate enough capital to pay for the nursing of the sick poor and fund a nursing home for the association. This precedent had been set by the Institute of Nursing Sisters and St John's House in the 1840s.⁴⁶ The number of private nurses employed by provincial associations increased over the period of study (see Table 6.1), with the exception of Liverpool and Manchester, which kept the numbers fairly constant after the initial decade of their existence. Both of these associations were committed to district nursing and it would seem that this activity was the most important aspect of their work. In Liverpool, the prospectus put the hospital and district work above private nursing in the stated aims of the training school and home.⁴⁷ The associations in Derby, Lincoln, Birmingham and Salisbury saw sustained growth in the numbers of private nurses and the income from this type of work (see Appendix 10).⁴⁸ Birmingham in particular seems to have developed into the largest institution with an average of 75 private nurses per year in the last two

⁴⁵ BAH, Birmingham and Midland Counties Training Institution for Nurses, *Annual Report*, 1895, p. 10; 1899, p. 9; and 1903, p. 10 (L46.6 12811).

⁴⁶ S. A. Tooley, *The history of nursing in the British Empire* (London, 1906), p. 265.

⁴⁷ Rathbone, *Organization of nursing*, p. 27.

⁴⁸ This appendix shows income and expenditure for each association for which accounts are available in the year of its founding and then 1870, 1880, 1890 and 1900, where applicable.

decades of the century. By 1900, its role in the city and beyond was dominated by its private work with 94% of income coming from fees for private nursing and over 87% of its costs were directly related to paying, feeding and housing the private nurses. In contrast, the grant it gave to the District Nursing Society to fulfill the third aim, established at its foundation, amounted to less than 5% of its costs and 4% of its income in 1900 (See Appendix 10).

Table 6. 1: Average numbers of nurses per year, in each association in the final four decades of the nineteenth century, 1862-1900⁴⁹

| | 1862-70 | | | 1871-1880 | | | 1881-1890 | | | 1891-1900 | | |
|-------------------------|---------|----|----|-----------|----|----|-----------|----|----|-----------|----|----|
| | PN | PR | DN | PN | PR | DN | PN | PR | DN | PN | PR | DN |
| Liverpool | 16 | 21 | 19 | 46 | 30 | 19 | 52 | 20 | 19 | 45 | 28 | 21 |
| Manchester | 16 | 4 | 8 | 20 | ? | 11 | 22 | ? | 16 | 23 | ? | 28 |
| Derby | 5 | ? | 1 | 21 | 6 | 4 | 40 | 12 | 5 | 46 | 12 | 7 |
| Lincoln | 11 | 3 | 4 | 31 | 3 | 3 | 44 | 4 | 5 | 48 | 3 | 6 |
| Birmingham | - | - | - | 27 | 17 | 1 | 75 | 16 | 4 | 75 | 11 | 8 |
| Salisbury | - | - | - | 8 | 3 | 0 | 19 | 4 | 0 | 37 | 5 | 0 |
| Stratford – on- Avon | - | - | - | 7 | 2 | 0 | 7 | 2 | 0 | 11 | 2 | 0 |

Key: PN = Private Nurse, PR = Probationer, DN = District Nurse, ? = not known

⁴⁹ Most of this data has been derived from annual reports, but other documents, such as newspapers, have also been utilised. Cheltenham and Lichfield have been omitted as neither association survived beyond 1872 and there is too little archival material remaining.

The Stratford association remained a small organization, but income from private nursing was the single largest source of funding for all but its initial years during the nineteenth century. This, together with income derived from charging patients for care within the nursing home, accounted for over 60% of all income. For some organisations, being able to find sufficient funds to maintain a home and the staff of private nurses was challenging. In Bristol, following an appeal for more funds for the nursing institution, Dr J. Addington Symonds declared that, if more money was not forthcoming, people would have to ‘take their chance of getting, according to their good luck or ill luck, either a Florence Nightingale or a Sarah Gamp.’⁵⁰ In the 1880s, the Bristol institution attempted to increase its funding by opening a private nursing home, but this closed in 1891 due to a lack of paying patients.⁵¹

Many of these associations seem to have put more energy into the provision and subsidy of private nursing at the expense of free nurses for the poor. This is a criticism made of the Institute of Nursing Sisters and St John’s House, whereby the home needs of the sick poor, which were labour intensive and unprofitable, were given a low priority.⁵² The first attempts to introduce nurses for the sick poor in Liverpool, in 1829, ended in failure because the nurses, once trained, were diverted to caring for the rich and, as a result, the principal supporters of the scheme withdrew.⁵³ The annual reports of the associations lend credence to the argument that priority was given to private patients. The cost of the

⁵⁰ British Library, Bristol Nurses’ Training Institute and Home, *Annual Report*, 1866 (Cup.401.i.6(8)).

⁵¹ ‘Nurses’ Training Institution’, *The Bristol Mercury and Daily Post*, Friday, 23 March 1888; ‘Nurses’ Training Institution’, *The Bristol Mercury and Daily Post*, Friday, 20 March 1891.

⁵² A. Summers, ‘The costs and benefits of caring: nursing charities, c.1830-c.1860’, in J. Barry and C. Jones (eds), *Medicine and charity before the welfare state* (London, 1991), pp. 140-41.

⁵³ R. G. Huntsman, M. Bruin and C. Gibbon, ‘A school for nurses founded in Liverpool in 1829’, *Medical Historian: The Bulletin of the Liverpool Medical History Society*, 14 (2002-2003), p. 54.

private nurses and probationers in Manchester Nurse Training Institution outweighed the income derived from their services in eleven out of the first fifteen years of its existence.⁵⁴ Similarly, in Birmingham, the income from the private nurses did not cover their costs until the fifteenth year (1884). During this period, the numbers of probationers averaged about 18 per year, the number of private nurses increased to 71 from 14, but district nurses only reached four in 1883.⁵⁵ The surviving reports of the Cambridge, Leicester and Cornwall institutions also indicate that the income associated with the private nurses and probationers did not cover costs.⁵⁶ The Salisbury institution was still subsidising the cost of the nurses' home from subscriptions and donations intended for free nursing of the poor in 1896.⁵⁷ Other charitable organisations that tried to charge some people in order to subsidise services for the poor performed equally badly. In Manchester, a scheme to provide free meals to poor schoolchildren, through charging more affluent families, closed in 1892 because the scheme was not self-supporting.⁵⁸ For most nursing associations, finance was a struggle and the ability to support the nursing of the poor from the receipts from private nursing proved difficult.

Private nursing dominated and accounted for most of the work of all the associations with the exception of Liverpool. Here, the nurses for hospital, district nursing and private work were kept separate and the emphasis was on nursing the sick poor at home or in the Royal

⁵⁴ MALS, Manchester Nurse Training Institution, *Annual Report* 1866–1879.

⁵⁵ BAH, Birmingham and Midland Counties Training Institution for Nurses, *Annual Report* 1870–1884.

⁵⁶ Cambridge City Library, Cambridge Home and Training School for Nurses, *Annual Report* 1878, 1880 and 1886; Leicestershire Archives, Institution of Trained Nurses for the Town and County of Leicester, *Annual Report* 1878 (L610.73 Pamphlet Volume 76); *Royal Cornwall Gazette*, 26 January 1883, p. 8.

⁵⁷ WSRO, Salisbury Diocesan Institution for Trained Nurses, Minute Book 1879-1907, 9 November 1896 (J8/109/3).

⁵⁸ V. Heggie, 'Lies, damn lies, and Manchester's recruiting statistics: degeneration as an "urban legend" in Victorian and Edwardian Britain', *Journal of the History of Medicine and Allied Sciences*, 63, 2 (2008), p. 206.

Infirmary.⁵⁹ Table 6.1 demonstrates that, from 1870 onwards, there was no appreciable change in the numbers of private nurses employed. Manchester was different, in that private nursing seem to take precedent until nearly the end of the century when there was a move towards supporting district nursing with an increase in the number of nurses, but also the amount of money raised for nursing the sick poor. There was a spectacular increase in the numbers of subscribers and donors, reaching 1,300 individuals for the district nursing work by 1900, of which over 800 were women (Appendix 9); this was eight times the number that supported the private nursing part of the institution.⁶⁰ The income derived from subscriptions and donations rose sharply and this, together with money from both the Hospital Sunday and Hospital Saturday collections and bequests, accounted for almost 70% of the association's income (see Appendix 10). This was a reversal of the situation that had existed since the inception of the institution. This may have been due to Manchester's affiliation to the Queen Victoria Jubilee Nursing Institution in 1890.⁶¹ This probably did renew commitment and enthusiasm for nursing the sick poor, as it commanded widespread publicity for the nurses' work.

By the end of the century, the associations in this study were no longer alone in the marketplace in providing private nurses to the public. There was a myriad of individuals, private agencies and voluntary societies that offered similar care.⁶² This included the voluntary hospitals, such as the Queen's Hospital in Birmingham where an external

⁵⁹ E. Denny, 'The emergence of the occupation of district nursing in nineteenth-century England', Unpublished PhD thesis, University of Nottingham, 1999, p. 233.

⁶⁰ See Appendix 9 for details.

⁶¹ MALS, Manchester and Salford Sick Poor and Private Nursing Institution, committee minutes 1887-1894, 20 January 1890.

⁶² B. Abel-Smith, *A History of the Nursing Profession* (London, 1960), pp. 57-60.

department opened in 1891, staffed by the fourth-year probationers, provided private nurses. It made good profits and only closed in 1918 when there was a severe shortage of nurses.⁶³ By the end of the century, a new type of organization emerged. In 1883, the London Association of Nurses was founded which gave the bulk of fees derived from the work to the nurses; the organization kept a small commission from each case. This institution was the forerunner of co-operative associations set up for the benefit of the nurses. The first, the Nurses' Co-operation, was founded in 1891 in London and took 5% of the patient fees for administrative purposes.⁶⁴ The Registered Nurses' Society was set up by the Royal British Nurses' Association, through the initiative of Mrs Bedford-Fenwick, in 1894 to address the problem of the exploitation of nurses by private agencies and non-profit organizations.⁶⁵ She had previously commented on this issue following the Sheffield 'nurses' strike' in 1888.⁶⁶ In 1893, she complained about a situation in Leicester whereby the debt incurred by the district nursing part of the Institution of Trained Nurses for the Town and County of Leicestershire was to be paid by the private nursing section. For her, the debts fell on the nurses themselves:

Nurses are working women—who have, by the nature of their calling, only a few years of active life wherein to make provision for their old age; so few years, in fact, that, in most instances, they are quite unable to make any such provision for themselves. It is our duty, therefore as the recognized organ of the profession, to protest, as strongly as possible, against the assumption, involved in this Leicester scheme, that Nurses are marketable commodities from whom it is right and just to make as large profits as possible. To our mind, it is as bad, or even worse, to sweat Nurses in the name of charity as for commercial purposes.⁶⁷

⁶³ S. Wildman, 'The development of nurse training in the Birmingham teaching hospitals, 1869-1957', *International History of Nursing Journal*, 7, 3 (2003), p. 59.

⁶⁴ Tooley, *The history of nursing in the British Empire*, pp. 273-77.

⁶⁵ 'Registered Nurses' Society', *The Nursing Record and Hospital World*, 10 February 1894.

⁶⁶ See Chapter 4 for details.

⁶⁷ 'The nurse pays', *The Nursing Record & Hospital World*, 2 December 1893, pp. 282-83.

Associations became more aware of the needs of the staff and most introduced systems of paying bonuses to the nurses as part of their remuneration and either developed pension schemes of their own,⁶⁸ or enabled the nurses to subscribe to the Royal National Pension Fund from its inception in 1887.⁶⁹

The associations in this study appear to have acquired good reputations and they sent nurses considerable distances to care for patients. In its early days, the Salisbury institution was providing nurses to Wiltshire and Dorset. By the 1890s, it sent nurses to London and Devon and, by 1901, to Scotland.⁷⁰ Nurses increasingly travelled great distances from their home bases, for instance, in the 1890s, nurses from different associations accompanied clients to Canada, the south of France, Madeira, Lucerne and the Canary Islands.⁷¹ The private nurses worked for clients from diverse social backgrounds, in the homes of the lower middle class through to the grand houses of the aristocracy.⁷² Associations also supplied nurses to a variety of institutions, including hospitals and public schools.⁷³ Both Derby and Lincoln provided staff to the local workhouses, whilst the former association also supplied nurses to the Derby Children's

⁶⁸ For instance, in Birmingham, a pension fund first appears in the accounts in 1871 and bonuses in 1897. Source: BAH, Birmingham and Midland Counties Training Institution for Nurses, *Annual Report*, 1871 and 1897. See Louisa Case's biography in Appendix 7 for her salary, bonuses and pension.

⁶⁹ C. Maggs, *A century of change: the story of the Royal National Pension Fund for Nurses* (London, 1987), p. 1. WSRO, Salisbury Diocesan Institution for Trained Nurses Minute Book July, 18 July 1898 (J8/109/3).

⁷⁰ WSRO, Salisbury Diocesan Institution for Trained Nurses, Minute Book 1871-1876, 10 February 1874 (J8/109/1); Also, see the biography of Louisa Case in Appendix 7.

⁷¹ WSRO, Salisbury Diocesan Institution for Trained Nurses, Minute Book 1879-1907, 25 February 1895 (J8/109/3); BAH, Birmingham and Midland Counties Training Institution for Nurses, House Committee minute book, 1885-1899, 12 May 1896 (MS 807/6/6); DLSL, Derby and Derbyshire Nursing and Sanitary Association, *Annual Report*, 1897/8, p. 8 (A610.73).

⁷² See the biographies of Fanny Tunnington and Louisa Case in Appendix 7.

⁷³ WSRO, Salisbury Diocesan Institution for Trained Nurses, Minute Book 1871-1876, 10 February 1874 (J8/109/1); BAH, Birmingham and Midland Counties Training Institution for Nurses, House Committee minute book, 1885-1899, 8 May 1888 (MS 807/6/6).

Hospital, the Mansfield Union Hospital, the Chesterfield and North Derbyshire Hospital and the Burton upon Trent Infirmary.⁷⁴ A good reputation seems to have helped maintain the demand for private nurses from the associations. By the end of the century, there was widespread disquiet concerning the quality, behaviour and honesty of many women working for private agencies or advertising themselves as private nurses.⁷⁵ Reputable associations with a relatively long history of providing trained nurses seemed to have secured a place for themselves in this increasingly competitive market.

Nursing the sick poor

Liverpool has been upheld as the pioneer of nursing reform in the provinces and an exemplar for other towns to follow. It is the case that the first organised initiatives in district and workhouse nursing occurred in the city. The main sources of information utilised by historians come from accounts by William Rathbone and his family.⁷⁶ These have been used to generate a largely positive analysis of Rathbone's experiments.⁷⁷ There has yet to be a comprehensive evaluation of the partnership between the Liverpool Royal Infirmary and the Training School and Home, and the reform of nursing in the

⁷⁴ Lincolnshire Archives (hereafter LA), Institution of Nurses, Lincoln, *Annual Reports* 1880 and 1887 (Bromhead 4/1).

DRO, Derby and Derbyshire Nursing and Sanitary Association, House and Management Committees minute book, 27 July 1895 (D4566/2/1); 'The Derby Nursing and Sanitary Association', *Derby Mercury*, 15 April 1874; R. Bewick, *History of a provincial hospital: Burton upon Trent* (Burton-upon-Trent, 1974), p. 28.

⁷⁵ F. J. Gant, *Mock-nurses of the latest fashion, A.D. 1900* (London, 1900), pp. 11-18.

⁷⁶ W. Rathbone, *Organization of nursing: an account of the Liverpool Nurses' Training School* (Liverpool, 1865). W. Rathbone, *Sketch of the history and progress of district nursing from its commencement in the year 1859 to the present day including the foundation by the "Queen Victoria Jubilee Institute" for nursing the poor in their own homes* (London, 1890). H. R. Rathbone, *A short history and description of district nursing in Liverpool* (London, 1899); E. R. Rathbone, *William Rathbone: a memoir* (London, 1905).

⁷⁷ S. A. Tooley, *The history of nursing in the British empire* (London, 1906), pp. 285-88; M. Simey, *Charity rediscovered: a study of philanthropic effort in nineteenth-century Liverpool* (Liverpool, 1992), pp. 89-91; G. Hardy, *William Rathbone and the early history of district nursing* (Ormskirk, 1981).

workhouse and the homes of the sick poor, although Baly does give a balanced account of district nursing in her history of the Queen's Nursing Institute.⁷⁸

The organisation of district nursing in Liverpool, based on the allocation of nurses on a permanent basis to defined geographical districts and their supervision by middle-class ladies, acted as a model to other associations. However, there were problems, in that not all the nurses had completed a full year of training and experience in the Royal Infirmary before assuming the role in a district and not all the ladies particularly wanted trained nurses.⁷⁹ This was a situation that remained unchanged until 1876 when the committee of the School decided to employ trained nurses only and dismissed the untrained.⁸⁰ There was also little in the way of instruction in the hospital, and Mary Merryweather, the Lady Superintendent, had little to do with the running of the Royal Infirmary.⁸¹ Nightingale was quite critical of her record and ability, having asked, following a meeting with her in 1874, 'Does she know anything at all about nursing?'⁸² Nightingale's opinion, based partly on the testimony of Agnes Jones, the superintendent, who died whilst working in the Liverpool workhouse, was that discipline and training were poor and that the district nurses were worse than those in the Royal Infirmary. In summary, Nightingale said, 'I believe her to be a very good woman, in a post for which she was wholly unfit'.⁸³ To be fair to Merryweather, she was one of the first of the 'new type' of lady superintendent in

⁷⁸ M. E. Baly, *A history of the Queen's Nursing Institute: 100 years 1887-1987* (London, 1987), pp. 6-12.

⁷⁹ Letter from Charles Langton to Nightingale, 1869, cited in Baly, *A history of the Queen's Nursing Institute*, p. 9.

⁸⁰ Liverpool Record Office (Hereafter LRO), Liverpool Royal Infirmary Nursing Committee Minutes, 20 February 1876 (614INF/4). See also the biography of Ann Brodrick in Appendix 7.

⁸¹ 'Art.II. - Miss Merryweather', *The Englishwoman's Review*, 15 June 1880, p. 244.

⁸² BL, Add Mss 47719 ff68-69, Notes from Florence Nightingale to Henry Bonham Carter, 23 July 1874, reprinted in L. MacDonald, *Florence Nightingale: extending nursing*, Collected works of Florence Nightingale, Volume 13 (Waterloo, 2009), p. 266.

⁸³ *Ibid.*, 27 July 1874, pp. 267-68.

the country, and, although she had experience of supervising and teaching working-class women in a previous post, her own training in nursing consisted of two months at St Thomas's Hospital prior to her appointment in Liverpool. The generation that followed, typified by Emmeline Staines, one of her successors in Liverpool, were trained and gained experience as ward sisters and lady superintendents prior to taking on such important posts.⁸⁴ Part of Liverpool institution's problem was probably also due to Rathbone's involvement in a number of nursing and social projects in the city, and his commitments only increased when he became a member of parliament in 1868. From 1874, he was deeply involved with reform of district nursing at a national level. As a result, he probably did not have the time to scrutinize closely events in Liverpool and has been described as 'a doer, who went on enthusiastically to the next project without checking how well or badly the one just launched was doing'.⁸⁵

In spite of the early problems that occurred in Liverpool, other towns and cities struggled to match its commitment to the sick poor. Just like Manchester and Birmingham, the associations in Derby and Lincoln had difficulties in funding enough district nurses. In 1868, at the annual general meeting of the Derby association, Dr Ogle, the honorary secretary, declared that 'One district nurse in a town of 60,000 inhabitants is almost a mockery.'⁸⁶ The association slowly increased the numbers of district nurses, but some people objected to subscribing to the association as they concluded that they would be supporting the care of the rich, as illustrated by the size of the private nursing

⁸⁴ See Appendix 8 for a brief biography.

⁸⁵ MacDonald, *Florence Nightingale: extending nursing*, p. 250.

⁸⁶ 'The County Nursing Association', *Derby Mercury*, 10 June 1868.

department.⁸⁷ To a certain extent, the reports of the annual general meetings supported this supposition, as at least one of the distinguished speakers would attest to the skill and kindness of the private nurses who had been employed in their own households in the previous year.⁸⁸ Moreover, the cost of private nursing never dropped below 64% of the expenditure of the association during the century. The problem for Derby, like other associations, was one of resources. The income from donations and subscriptions was allocated to district nursing, along with any profits from the fees for private nursing. This could only support a small number of nurses. By 1900, Derby was able to support ten district nurses compared with 47 private nurses. Lincoln was similar, but it approached the situation in other ways. It was able to fund a small number of nurses within the city from its own resources, it also provided district nurses directly to parishes who could fund the cost of the nursing and it used the private nurses to care for the sick when they were not employed. By 1900, it too had ten district nurses. Both Derby and Lincoln compared favourably with Birmingham, a town some five times the size of Derby and ten times the size of Lincoln in 1901 (see Appendix 4). In Stratford-upon-Avon, the only attempt to employ a nurse exclusively for the poor in 1896 failed because of insufficient support and it reverted back to the system of using the resident nurses in the home to care for the sick poor.⁸⁹ Salisbury did not employ district nurses, but gave free and reduced cost nursing when requested and able to support such initiatives. This rarely amounted to more than 10% of the activity of the institution in any one year up to 1900.⁹⁰ Nursing in

⁸⁷ 'The Derby and Derbyshire Nursing Association', *Derby Mercury*, 11 April 1877.

⁸⁸ Sources: 'The Town and county Nursing Association', *Derby Mercury*, 7 April 1869; 'Derbyshire Sanitary and Nursing Association', *Derby Mercury*, 23 April 1873; and 'The Derby and Derbyshire Nursing Association', *Derby Mercury*, 26 April 1876.

⁸⁹ SBTA, Nursing Home for Convalescent Women and Sick Children, Stratford-upon-Avon, *Annual Report*, 1896 (87.35 5485).

⁹⁰ WSRO, Salisbury Diocesan Institution for Trained Nurses, Minute Books 1871-1907 (J8/109/1-3).

Stratford and Salisbury, and to a certain extent Birmingham, were open to criticism from Nightingale and Florence Lees (later Mrs Dacre Craven), and those associations that aimed to provide both private and district nursing consequently reverted to private nursing associations.⁹¹

Nationally, district nursing took on more prominence, and the first exclusive district nursing society was founded in East London in 1868.⁹² This amalgamated with the 'National Association for Providing Trained Nurses for the Sick Poor in London and Elsewhere', founded in 1874, to become the Metropolitan and National Nursing Association for Providing Trained Nurses for the Sick Poor. By 1887, the latter organisation had been associated with the development of district nursing in Newcastle upon Tyne, Gloucester, Portsmouth, Hertford, Hereford, Banbury, Bishop Auckland and Windsor.⁹³ The model promoted by the Metropolitan and National Association differed from the one in Liverpool in that it advocated a system whereby the district nurses were supervised by a lady superintendent who was a trained nurse. In 1889, following protracted negotiations, the Queen Victoria's Jubilee Institute for Nurses was founded by Royal Charter and a new era for district nursing came into being.⁹⁴ This body aimed to employ educated and trained nurses in the homes of the sick poor, overseen by trained superintendents and living within a central home. Each local society that affiliated to the Jubilee Institute had to be inspected and approved by the national body.

⁹¹ Denny, *The emergence of the occupation of district nursing*, p.232.

⁹² E. Ramsay, *East London Nursing Society 1868-1968: history of a hundred years* (London, 1968).

⁹³ Tyne and Wear Archives, Cathedral Nursing Society for the Sick poor of Newcastle upon Tyne, *Annual Report 1887* (CHX20/1/1); Gloucester District Nursing Society, *Gloucester District Nursing Society: its history and work described* (Gloucester, 1938); 'Institute for providing nurses for the sick poor', *British Medical Journal*, 16 April 1887.

⁹⁴ Baly, *A history of the Queen's Nursing Institute*, p. 27.

Florence Lees (later Mrs Dacre Craven) was influential in the development of district nursing.⁹⁵ Whilst preparing a report regarding district nursing in London, she visited several towns and cities to look at home nursing and was particularly critical of what she saw.⁹⁶ Views about district nursing were influenced by the prevailing attitudes to the poor and ideas of sanitary science. Nursing charities aimed to help those people who would be forced into poverty by illness and any intervention was aimed not to demoralise or pauperise the patients. The main function of district nursing was to nurse the patient and the room. Thus, skilled care, cleanliness and ventilation were needed.

This emphasis on the room leant heavily on ideas of sanitary reform as introduced by Chadwick and his allies in the 1840s and 1850s. Before the 1840s, there was a view within medical circles that nutrition, shelter, heating and clothing were all necessary for health and, in Ireland and Scotland in particular, doctors felt that adequate nutrition prevented most forms of disease, particularly fever. However, the idea of supporting the poor with food was attacked by people adhering to ideas of political economy. This resulted in the old necessities being left to market forces and to the workhouse option for the destitute.⁹⁷ The new public health was confined to a much narrower set of problems, centring around the environment and in particular drains, sewers and water pipes and a small group of people, namely working-class men of working age.⁹⁸

⁹⁵ An early version of some of the material presented in this and the next page was published in S. Wildman, 'Nurses for all classes: home nursing in England, 1860-1900' in S. Hähner-Rombach (ed.), *Medizin, Gesellschaft und Geschichte – Beiheft 32* (Stuttgart, 2009), pp. 47-62.

⁹⁶ National Association for Providing Trained Nurses for the Sick Poor, *Report of the sub-committee of reference and enquiry* (London, 1875).

⁹⁷ C. Hamlin, 'The "necessaries of life" in British political medicine, 1750 -1850' *Journal of Consumer Policy*, 29, (2006), pp. 373-397.

⁹⁸ C. Hamlin, *Public health and social justice in the age of Chadwick: Britain 1800-1854* (Cambridge, 1998), pp. 12-13.

This had an effect on home nursing for the poor. In the 1870s and 1880s, both Nightingale and Mrs Dacre Craven (nee Florence Lees) attacked established nursing organisations as they thought they were prone to give relief rather than confine themselves to nursing of the deserving poor. Dacre Craven in particular criticised them for giving too much relief in the form of tickets for groceries, coal, bread, milk, beef-tea and cooked dinners. But her most strident criticisms were reserved for the nurses themselves:

nurses of the same class as the poor among whom they had to work, would not generally undertake the task of contending against dirt and disorder in rooms destitute of the proper appliances for overcoming them.⁹⁹

And, secondly, these nurses were not properly trained in a hospital, they were not sufficiently intelligent to be private nurses and were often old monthly nurses. Kept in lodgings, they had to cook, clean and wash for themselves and were supervised by a lady who was not trained.¹⁰⁰ Following a visit, Miss Lees, particularly criticised the nursing in Derby in 1875, claiming the district nurses did little for the poor patients and, secondly, lived in their own homes, without supervision, a situation she regarded as regrettable.¹⁰¹ The Derby association defended their nurses and claimed they were under the strict control and supervision of the lady superintendent and replied accordingly:

The fact is our district nurses do generally live in their own homes, and some of them have children and family cares not a few. It is a special characteristic of our work throughout that it is natural, and we regard it as a special excellence that

⁹⁹ F. Dacre Craven, *Servants of the sick poor*, (London, 1885), p. 10

¹⁰⁰ *Ibid.*, p. 11.

¹⁰¹ National Association for Providing Trained Nurses for the Sick Poor, *Report of the sub-committee of reference and enquiry* (London, 1875), pp. 38-39.

women such as we have just described can and do give complete satisfaction and exhibit a zeal and oftentimes a self denial not to be surpassed by any.¹⁰²

With regard to their poor relief work, most associations went to considerable lengths to provide their patients and convalescents with adequate nourishment. As discussed in Chapter 5, diet was part of the normal therapeutic regimen in the care of the sick from mid-century onwards. Part of the problem for associations, particularly those in Liverpool and Manchester, was the sheer size of the population who were undernourished.

Malnutrition connected to unemployment, alongside poor living conditions, posed just as great a problem to the health of the poor as did specific diseases. It is unsurprising that the work of the untrained lady superintendents and the nurses in the 1860s gradually orientated toward the all round care of the patient, which included food and convalescence. However, associations were aware of the issue of supporting paupers and would only accept patients who did not come under the remit of the Poor Law and were seen, instead, as the deserving poor. These were seen to be industrious and honest people who needed health care in order to prevent them from sliding into pauperism. In

Manchester, the lady superintendent in St Stephen's district assured subscribers that:

we have been able to satisfy ourselves, by personal supervision, that the nurse's time was not occupied with cases not properly coming within our scope.¹⁰³

Annual reports, particularly in the 1860s and 1870s, sought to reassure the public that the objectives and actions of nursing charities were aimed at the deserving poor and did not

¹⁰² Derby Local Studies Library, Derby and Derbyshire Nursing and Sanitary Association, *Annual Report*, 1875/6, p. 7 (A610.73).

¹⁰³ MALS, Manchester Nurse Training Institution, *Annual Report*, 1866, p. 17 (362.1 M85).

make patients dependent on charity.¹⁰⁴ Dacre Craven and Nightingale continued to express doubts that working-class nurses could deliver the care and teaching required. From 1875 onwards, they advocated a new system of nursing the poor based upon the use of educated women of a higher social class than the patients and supervised by ladies who were trained nurses. Thus:

tact, discretion and good breeding are especially needed to introduce sanitary reforms, where laws of health, order, and cleanliness are neglected or wholly unknown, and to effect this without hurting the feelings of those who are to benefit by the change.¹⁰⁵

Nurses would be trained in a hospital, receive specific education to be district nurses and live in a nurses' home under strict supervision. This can be seen in the higher social class of recruits to the Queen Victoria's Jubilee Institute for Nurses, but the established nursing associations in this study seem to have continued to recruit respectable working-class women.¹⁰⁶

Local associations like Liverpool and Manchester, whilst retaining the input of untrained lady superintendents, had already made moves toward reforming district nursing prior to Dacre Craven and Nightingale's pronouncements. In Liverpool, a superintendent of district nurses was appointed in the late 1860s and, in 1880, there were three districts each with a matron and one inspector for the city.¹⁰⁷ These trained officers supervised the nursing work whilst the untrained ladies provided the finance, dietary support and

¹⁰⁴ This is a point made in relation to medical charities by P. Shapely, *Voluntary charities in nineteenth-century Manchester*, p. 49.

¹⁰⁵ Dacre Craven, *Servants of the sick poor*, p. 7.

¹⁰⁶ As outlined in Chapter 4.

¹⁰⁷ LRO, Liverpool Royal Infirmary, *Annual Report of the Training School and Home for Nurses*, 1868 (614 INF/ 17/1); Liverpool Royal Infirmary, Nursing Committee Minutes 1874-1938, 22 November 1880 (LRI 614INF/4).

arranged convalescence for patients. By the late 1890s, district nurses were housed in nurses' homes and supervised by the resident district matrons.¹⁰⁸ In Manchester, a similar process was developing. The district nursing became a separate department in 1876 and, in 1879, a central home for the district nurses was established.¹⁰⁹ By 1891, there were three nurses' homes, two in Manchester and one in Salford, each with a matron.¹¹⁰ Both Liverpool and Manchester had good contacts with London. Rathbone was at the heart of policy and decision-making with regard to district nursing at a national level. In 1890, Rathbone and Oliver Heywood from Manchester were appointed to the Council of the Queen Victoria's Jubilee Institute for Nurses.¹¹¹ Both cities were affiliated to the institute by 1890, and some of the long-standing nurses were awarded the title of Queen's Nurses. The Manchester nurses received their badges in the mayor's parlour in Salford in February 1891 and, in 1896, 30 nurses went to Windsor to be presented to the Queen.¹¹² Having provided district nursing for over thirty years, both of these cities continued to maintain their pioneering role in nursing the sick poor by being at the forefront of those places that affiliated to the Institute.

The scale of district nursing activity in Birmingham was less extensive than in Liverpool or Manchester. The Birmingham District Nursing society was established in 1879 and had grown out of the work of enthusiastic ladies employing one nurse in the Ladywood

¹⁰⁸ *Ibid.*, 28 July 1897.

¹⁰⁹ MALS, Manchester Nurse Training Institution, *Annual Report*, 1878 and 1879 (362.1 M85).

¹¹⁰ MALS, Manchester and Salford Sick Poor and Private Nursing Institution, minutes 1887-1894, 25 February 1891 (M504/1/1).

¹¹¹ Baly, *A history of the Queen's Nursing Institute*, p. 28.

¹¹² MALS, Manchester and Salford Sick Poor and Private Nursing Institution, Committee minutes 1887-1894, 25 February 1891 (M504/1/1); Manchester and Salford Sick Poor and Private Nursing Institution, Committee minutes 1894-1900, 15 June 1896 (M504/1/2).

district. In 1880, there were three nurses and a trained lady superintendent.¹¹³ The following year, it had secured a central home with capacity to house six nurses. As was the case in the other two cities, middle-class ladies supported the district nurses. It affiliated to the Queen's Institute in 1895. In 1896, members from the Society visited Liverpool and Manchester and it was decided to try and increase the numbers to achieve a ratio of one nurse to 10,000 of the population, as achieved in these two cities. The plan was to open four district homes within the city. As a result, in the 1890s, it expanded into the suburbs with nursing homes in Saltley and Moseley and the neighbouring borough of Aston also set up a service.¹¹⁴ The expansion of district nursing signals a shift of emphasis in Birmingham, from a 'private-philanthropic, *self-funding* form of charity',¹¹⁵ in the case of the training institution, to a charitable district nursing service. Both Derby and Lincoln made similar moves to increase the numbers of district nurses, and Derby employed its own trained superintendent of district nurses by the end of the century.¹¹⁶

Nursing the Rural Poor

If associations had difficulties providing district nurses in urban areas, there was little in the way of resources to make any meaningful contribution to the nursing of the rural poor. In contrast to other associations in this study, both Stratford and Salisbury were small in size and set in rural areas. From the outset, Stratford only made a commitment to

¹¹³ 'Birmingham District Nursing Society', *Birmingham Daily Post*, 26 May 1880.

¹¹⁴ I. H. Morris, *A century of district nursing in Birmingham, 1870-1970* (Birmingham, 1970), p. 13. C. Braithwaite, *The voluntary citizen: an enquiry into the place of philanthropy in the community* (London, 1938), pp. 205-6.

¹¹⁵ V. Heggie, 'Health visiting and district nursing in Victorian Manchester; divergent and convergent vocations', *Women's History Review*, 20, 3 (2011), p. 410.

¹¹⁶ See Appendix 8.

nurse the sick poor of the town and not its rural hinterland.¹¹⁷ In contrast, the Salisbury institution aimed to ‘to provide experienced and conscientious nurses for the use of the rich and poor throughout the diocese’ and to subsidise the care of the poor from the profits accrued from nursing private cases.¹¹⁸ This was something that the committee was very aware of, and, in the annual report for 1878, they planned to offer parishes a nurse for £30 per year and to train parish nurses.¹¹⁹ However, by 1879, the lack of provision for nursing the poor was recognised as a problem and the secretary, the Reverend H. W. Yeatman, wrote to Florence Nightingale for advice.¹²⁰ Her reply was read out at the annual general meeting in February of that year. According to Nightingale, the problem was financial, as the rural poor were distributed widely and the cost of a nurse was higher per patient than in a town, as a result of transport and accommodation costs. Nursing the rural poor only seemed to be feasible when there were outbreaks of fever in villages and the nurse could deal with several cases at once. This is something which other associations undertook, but there is no evidence of it happening in the Salisbury diocese.¹²¹ Nightingale thought that a central home might be able to work with local medical clubs financed by subscriptions from the workers themselves. This was certainly the case in some villages which organised their own provision, such as Thornbury, Gloucestershire, where the ‘sick fund’ administered by the vicar provided a nurse to

¹¹⁷ See founding objectives in SBTA, Nursing Home for Convalescent Women and Sick Children, Stratford-upon-Avon, *Annual Report*, 1873, p. 1 (87.35 5485).

¹¹⁸ Cutting from the *Dorset County Chronicle*, 18 April 1872, pasted into WSRO, Salisbury Diocesan Institution for Trained Nurses, Minute Book 1871-1876 (J8/109/1).

¹¹⁹ WSRO, Salisbury Diocesan Institution for Trained Nurses, Minute Book 1876-1878, 6 January 1879 (J8/109/2).

¹²⁰ Letter from F. Nightingale to H. W. Yeatman in *Salisbury and Winchester Chronicle*, 1 March 1879, p. 6, pasted into WSRO, Salisbury Diocesan Institution for Trained Nurses, Minute Book 1879-1903 (J8/109/3).

¹²¹ See Chapter 5.

attend cases of sickness.¹²² Yeatman thanked Nightingale and indicated that a committee had been set up to consider the matter. He proposed that the clergy could promote a ‘nurse club’ on similar grounds to a club that he knew of and that a central institution would provide the nurses at full cost. He pointed to the power of ‘poor peoples’ half pence’ by giving an example of a children’s Sunday school which had raised enough money for £70 worth of new clothes, £40 of coal and all the money for a fife and drum band which were ‘not bad results for the despised Dorsetshire labourer’. To him, this was an example of the way in which a ‘nurse club could be managed’.¹²³ Nothing seems to have come of these deliberations and the diocesan institution continued to nurse a few people gratuitously, but had no organised system for introducing nursing for the sick poor.

In contrast, schemes for the provision of care to poor people were being introduced on a provident or paying basis. The Cottage Benefit Nursing Association, founded in 1883 to promote rural nursing, utilised women who had some rudimentary training in nursing the sick and maternity cases. Its nurses lived in patients’ homes and did the necessary cooking and housework in addition to nursing. They were not usually hospital trained. By 1909, it had 137 affiliated branches and 500 nurses.¹²⁴ The work of this association was opposed by Elizabeth Malleon, who felt that the rural poor were ignorant of health matters, childbirth and the care of babies, and that the nurses of the Cottage Benefit Nursing Association were ‘ignorant common women [who] could be made doubly

¹²² GRO, Rules for the Sick Fund Nurse, 1873 (8/188/1).

¹²³ London Metropolitan Archives, Letter from H. W. Yeatman, of Netherbury Vicarage, Bridport, Dorset, to Florence Nightingale, 18 March 1879 (H01/ST/NC/18/13/086).

¹²⁴ C. Braithwaite, *The voluntary citizen: an enquiry into the place of philanthropy in the community* (London, 1938).

dangerous by a small amount of cheap and insufficient training'.¹²⁵ Accordingly, she set up her own experiment in nursing at Gotherington, Gloucestershire in 1885. Here, she employed a woman who was both a sick nurse and a midwife who 'proved herself to most kindly, energetic, devoted, and suited to her position'.¹²⁶ Following this success, she went on to campaign for an association for village nursing and succeeded in founding the Rural Nursing Association in 1890, which first affiliated with the Queen Victoria's Jubilee Institute for Nurses and then amalgamated with the Institute in 1897.¹²⁷ Rural districts differed in their needs from urban areas with most requiring nurses with skills in both nursing and midwifery. Although the Salisbury institution employed monthly nurses, it seems to have made no headway in providing support to the rural poor. It was obviously 'drifting into being an institution which merely nurses the rich',¹²⁸ as the subscriptions and donations for the nursing of the poor subsidised the private nursing work. Of all the associations in this study, it failed utterly in its attempts before 1900 to fulfil its obligations to the poor, as laid down in its founding aims.

Postscript

Seven of the nine associations in this study continued to function after 1900. Most of those that still offered a public service in the 1940s were taken over by the National Health Service. Liverpool was the first to alter. In 1897, a decision was made to separate district nursing from the Royal Infirmary and private nursing, and a new organization, the

¹²⁵ O. Stinchcombe, *Elizabeth Malleon (1828 - 1916): pioneer of rural district nursing* (Cheltenham, 1989), p. 5.

¹²⁶ GRO, *Trained Midwife and Village Nurse Report*, Gotherington, 1886 (D4057 14).

¹²⁷ Baly, *A history of the Queen's Nursing Institute*, pp. 50-53.

¹²⁸ Letter from F. Nightingale to H. W. Yeatman in *Salisbury and Winchester Chronicle*, 1 March 1879, p. 6, pasted into WRSO, Salisbury Diocesan Institution for Trained Nurses, Minute Book 1879-1903 (J8/109/3).

Queen Victoria District Nursing Association of the City of Liverpool, came into being.¹²⁹ Private nursing was still offered in the 1920s, whilst the district nursing association continued until 1959, when it was taken over by the Liverpool Corporation.¹³⁰ By 1900, Birmingham had two different nursing associations, one for private patients and one for district nursing. In 1908, a decision was made to close the training institution and transfer its assets to the district nursing society.¹³¹ From this point on, there was a steady expansion of the district nursing service and, in 1948, it transferred to the City of Birmingham Health Committee.¹³² Manchester was similar to the other cities in that district and private nursing separated into two different organisations in 1920.¹³³ With the inception of the National Health Service in 1948, district nursing was split between three different local authorities: Lancashire County Council, Salford Corporation and Manchester Corporation.¹³⁴ The district nursing service in Manchester continued under the management of the nursing institution until 1957 when an agreement was reached to transfer the service to the City Corporation.¹³⁵ The institution closed on 1 July 1958.¹³⁶ The Derby association did not affiliate with the Queen's Institute and continued in existence until 1954.

¹²⁹ LRO, Liverpool Royal Infirmary, *Annual Report of the Training School and Home for Nurses*, 1897 (614 INF/ 17/1); Liverpool Royal Infirmary, Nursing Committee Minutes, 11 January 1899 (614INF/4).

¹³⁰ Hardy, *William Rathbone and the early history of district nursing*, p. 26.

¹³¹ BAH, Birmingham and Midland Counties Training Institution for Nurses, *Annual Report* 1908.

¹³² Morris, *A century of district nursing in Birmingham*, p. 17.

¹³³ MALS, Manchester and Salford Sick Poor and Private Nursing Institution, Committee minutes 1916-1920, 19 January 1920 (M504/3/1).

¹³⁴ MALS, Manchester and Salford District Nursing Institution, *Annual Report*, 1949 (362.1 M85).

¹³⁵ MALS, Manchester District Nursing Institution, Committee minutes 1957-1958, 18 November 1957 (M504/6/7).

¹³⁶ MALS, Manchester and Salford District Nursing Institution, *Annual Report*, 1958 (362.1 M85).

The Lincoln institution continued expanding after 1900 and took private inpatients for treatment. In 1919, a district association for the city of Lincoln was formed, but the institute continued to manage the district nurses. In 1929, district nursing and private nursing were formally separated.¹³⁷ In 1927, a maternity home was opened and, in 1948, the institution was taken over by the National Health Service.¹³⁸ Similarly, the Stratford-upon-Avon home proceeded as an independent organisation until the Second World War, when it was converted into a maternity hospital for evacuees from Birmingham and Coventry. Following the war, district nursing services were taken over by the County Council and the home was sold. The remaining money was given to fund a charity for the welfare of the poor in Stratford.¹³⁹ The Salisbury institution started to take private patients into its nurses' home in 1904, but it seems that there was always a struggle to earn sufficient income to support the activity. Between the two world wars, it functioned mainly as a private surgical home, but, after the Second World War, it could not make ends meet and finally closed in 1952. The remaining assets were used to create a Diocesan Nursing Aid Fund that made grants to deserving cases.¹⁴⁰ It would appear that, only from this point, the institution finally devoted its resources to the support of the poor.

¹³⁷ LA, The Bromhead Institution for Nurses, Lincoln, *Annual Reports* 1919 and 1929 (Bromhead 4/2).

¹³⁸ LA, Records of the Bromhead Institution for Nurses, introductory material in catalogue; and LA, *Archivists Report 18* (1967-8), pp. 10-13.

¹³⁹ P. Spinks, 'The Stratford-upon-Avon convalescent home', *Warwickshire History*, Winter (2005/6), pp. 101-5.

¹⁴⁰ WRO, Salisbury Diocesan Institution for Trained Nurses, Minute Books 1879-1907 (J8/109/3); 1907-1923 (J8/109/4); and 1923-1954 (J8/109/5).

Summary

The associations in this study experienced both success and failure during the nineteenth century and beyond. Financial resources were essential for the ongoing work of these associations. Problems in securing funding accounted, in part, for the failure of the Cheltenham and Lichfield associations and were also implicated in restricting the expansion of most of the others, specifically in their attempts to provide free nursing for the poor. The case of the Lichfield association also demonstrates the importance of place in that associations could only thrive if there was a sense that they received support from and belonged within a particular community. Attempts by associations to take over the nursing work of local hospitals were rebuffed by the governors of local voluntary hospitals. However, in Liverpool and Salisbury close-working relationships ensured that a steady supply of trained nurses was available for their work. Voluntary hospitals went on to develop their own systems of training and became prominent in terms of nursing reform by the end of the century. Thereafter, local nursing associations seemed to become marginal in the reform arena. They were also challenged in their private work by the growth of a large number of other agencies offering nursing services to the paying public. However, most associations had acquired a positive reputation in private nursing and were able to expand the services they offered. The criticism leveled at associations by Nightingale and others, suggesting that associations drifted into being exclusively private institutions, is not borne out by the evidence presented in this chapter. Although associations found it difficult to expand services to the poor, those in Liverpool, Manchester and Birmingham seemed to have been invigorated by the creation of the Queen Victoria's Jubilee Institute for Nurses in the late nineteenth century. This national

interest in district nursing seems to have also prompted Derby and Lincoln to make greater efforts to improve services. Most associations became embedded in their communities and were able to be leaders in local nursing services right up to the point at which the National Health Service was founded.

7: DISCUSSION AND CONCLUSIONS

This study has brought to light the existence of a number of local nursing associations that were founded in England in the 1860s and early 1870s. The role of these organisations has largely been forgotten or ignored in the history of nursing and philanthropy. The records of a number of these associations have been examined and provide new insights into the reform, organisation and practice of nursing in nineteenth-century provincial England. In this chapter, a summary of the findings will be presented, addressing both the scope and value of the sources discussed. It will conclude with an examination of the significance of the results to the understanding of the history of nursing and philanthropy more generally.

Summary of Findings

The quality of nurses was seen as a serious problem in the early part of the nineteenth century, both in the hospital and the home. The fictional character, Sarah Gamp, became the symbol of all that was problematic about nursing. Moves to reform the nursing service in hospitals, in response to changes in medical practice, were initiated by both doctors and hospital administrators. The need for improved home nursing came to the fore following the Crimean War, as a result of demands for a nurse who could care for two different kinds of patient. The first, involved the rising demand for medical care and, in turn, the specialised private nurse, which came from the wealthy middle and established upper classes. This involved the training of women, recruited from the same class as the 'upper' servants, who worked in the houses of affluent clients, in order to produce deferential, skilled and useful nurses. Training institutions for servants had been

established in the 1850s and other initiatives that looked to train working-class women and girls in domestic work were also developed. Their existence indicate that the establishment of local nursing and training associations may have been part of general concerns in the upper echelons of society to ensure supplies of useful general and specialised servants. The need for a second type of nurse was a response to the perceived needs of the sick poor and part of a general movement to civilise the working classes and thereby promote the health and support the lives of those described as the ‘deserving poor’. District nursing was, in part, an extension of existing missions to the poor and it proved to be one way of facilitating access to and influence on their lives, primarily through the promotion of sanitary science, in the form of cleanliness, ventilation, nutrition and improved child care.

What this study reveals is that the reform of nursing did not adhere to a simplistic model of the development in one place, that is London, and in one particular site, the hospital, and then circulated to hospitals and organisations in other towns and cities. Instead, the reform of nursing can be seen as a complex phenomenon, occurring in multiple places and sites at roughly the same time from the 1860s onwards. Some of these locations were indeed hospitals, but reform also embraced the workhouse and the homes of the rich and poor. The work of these associations demonstrates that there was a significant move to initiate change in provincial England quite early in the national process of nursing reform. The early 1860s were an optimum time for the commencement of nursing reform because of the increased availability of information in terms of written reports in newspapers and journals; the postal system for interested parties to enquire about

developments; the railway to carry would be reformers to view new facilities and to question other reformers face-to-face; but also the postal service, the telegraph and, latterly, the telephone to summon nurses; as well as the railways to ensure their speedy dispatch to the four corners of the country and beyond. The diffusion of ideas about reformed nursing traveled from one town to another because of close relationships between individuals or towns irrespective of distance. Thus, information about nursing flowed between urban areas, such as Liverpool and Manchester, partly due to business, family and religious ties, or as a result of influential, well travelled individuals, such as Mrs Bromhead, whose connections with Bath, was critical in the establishment of a nursing institution in Lincoln. These were organisations that depended upon technological advances in communications and transport for their establishment, custom and income.

The reasons behind the establishment of nursing associations were varied. Associations aimed to train and provide nurses for all classes of people. They were all founded as voluntary associations, but they were mixed ‘private-philanthropic, *self-funding*’ forms of charity, hoping to raise funds from private nursing to subsidise the care of the sick poor.¹ Thus, the motives of the founders were, in one sense selfish, in that their own needs took precedent over those of the working classes. Second, they were pragmatic, in the sense that this was probably the only way that sufficient funds could be raised to offer care to the sick poor. Third, they were established as a result of acts of kindness by one class of persons to another. This kindness was based on Christian benevolence or religiously-

¹ V. Heggie, ‘Health visiting and district nursing in Victorian Manchester; divergent and convergent vocations’, *Women’s History Review*, 20, 3 (2011), p. 410.

inspired charity. Finally, for some, nursing associations were an ideal way to reform and change the lives of the working classes through the employment of paid district nurses, who would teach the poor how to live better lives through the application of the principles of sanitary science.

Religion was crucial to the development of nursing associations as they were founded and supported by people with strong religious convictions. Some associations were generated from within the Church of England, such as those in Cheltenham and Stratford-upon-Avon, which were parish organisations, and those in Lichfield and Salisbury, where the initiative came from within the respective diocesan hierarchies. Although the others included in this study were not overtly religious organisations, they were run by religious people. For instance, the Lincoln institution, which was independently controlled by Mrs Bromhead and her colleagues, was organised on Christian principles and, as part of its mission, it actively encouraged the poor to baptise their children.² In Liverpool, William Rathbone believed in the message that Christianity was a practical way of life. Paying heed to the pronouncements of the Unitarian minister J. H. Thom, in the 1830s and 1840s, he took up weekly visiting of the poor for the District Provident Society. This gave him experience of the real lives of the poor and spurred later social reform, in particular the establishment of district nursing.³ Ministers of religion were active supporters and managers of nursing associations and were crucial in rallying support for the work of these organisations in their respective congregations. Anne Summers is of the opinion that Christian charity was the originator of the reform of nursing in the homes of

² LA, Lincoln Institution of Nurses *Annual Report*, 1879, p. 8 (Bromhead 4/1).

³ Simey, *Charity rediscovered*, p. 87; E. R. Rathbone, *William Rathbone: a memoir* (London, 1905), pp. 139-41.

the poor and this research lends some support to this idea.⁴ Irrespective of whether religious groups were at the heart of the development of home nursing in these towns and cities or whether individuals supported nursing charities in order to fulfil their Christian commitment to the care of the poor, it is obvious that the reform of home nursing in mid-nineteenth-century provincial England could not have proceeded without the active support of certain religious groups and individuals. However, religious conflict and controversy, which was ever present in Victorian England, also caused particular problems in the Lichfield diocese, resulting in the establishment of two associations and ultimately contributed to the failure of the diocesan association.

The success of nursing associations depended upon the involvement of local elites. This included professionals, such as doctors, as well leading businessmen. These people were leaders in provincial society, active in other institutions and local medical charities and had the necessary economic, social, cultural and symbolic capital to found and support the ongoing work of nursing associations. Their involvement also sent a message to others, that nursing reform was an important activity that deserved the support of the wider community. Middle-class women, as part of the local elite, were also an important element in the associations they supported. Those who took on active management roles were involved in the domestic life of the nurses' homes and in the direct supervision of district nurses. Women were an important source of funding in all associations.

Associations helped to facilitate the entry of women into public life, as just described, but also through the paid employment of middle-class lady superintendents who had a role in

⁴ A. Summers, 'The costs and benefits of caring: nursing charities, c.1830-c.1860', in J. Barry and C. Jones (eds.), *Medicine and charity before the welfare state* (London, 1991), p. 145.

managing the nurses and the domestic economy of the nurses' home. These women were amongst the first generation of professional managers of nursing in the country. The system of administration and management employed was the same as nursing elsewhere, in that the lady superintendent dealt with the moral supervision and discipline of the nurses, whilst the clinical practice in the patient's home was the province of the doctor. Later, paid assistants were employed to oversee the work of the district nurses in all but two of the associations.

By the end of the nineteenth century, most had developed into organisations able to offer skilled nursing to private clients and 'holistic' support to the deserving sick poor in the form of technical nursing care, instruction in the principles of sanitary science, nutritional support and convalescence. The few records that exist affirm that nursing care conformed to the medical practices and treatments that were advocated at the time. However, associations were in a competitive market place for charitable donations and the availability of resources inevitably limited what they were able to achieve. Support was not always forthcoming and, for some people at the time, these were viewed as organisations founded and run for the benefit of the people who controlled them. Initial attempts by associations to control nursing or nurse training in local hospitals came to nothing and, by the end of the century, only the Liverpool Training School and Home was formally integrated with its local hospital. Most of these associations became dependent upon hospitals for the supply of trained nurses and, by the 1890s, had to adhere to an agenda about the length and nature of training set by those institutions. This is in contrast to the early period of their existence, when it seemed that nursing

associations were setting the pace in the development of professional nursing. Private nursing became the main activity for most associations, but there was a definite movement toward investing more in district nursing and expanding this service to the poor, with the larger associations affiliating to the Queen Victoria Jubilee Institution for Nurses, by the end of the century.

The use of sources

It is impossible in any historical account to reconstruct the entirety of events, the debates and the actions of individuals, groups and organisations during the past, and this study is no exception.⁵ The work presented here is based on sources that were generated in the nineteenth century, but not all the records written at the time in which these associations operated are available today. The sources that have survived were those written by people who managed the associations and consist, in the main, of official records in the form of annual reports and committee minutes and were supplemented through the use of letters and newspaper reports. These, together with the returns from the decennial censuses, which were also mediated by the middle classes, constitute the main sources found and utilized. These are records completed by the employers of the working-class nurses and the benefactors of the poor patients. The almost complete lack of any personal accounts by the nurses and patients inhibits the creation of a balanced view of the work of these nursing associations. Working-class patients who are used as illustrative examples in annual reports are invariably depicted as being grateful for the care and treatment they received and also almost always cured of their medical problems. Nurses appear as consistently competent and kind. There is, then, little information providing the historian

⁵ D. Lowenthal, *The past is a foreign country* (Cambridge, 1985), p. 217.

with an insight into the actual nurse-patient encounter, the experiences of nurses and patients, or the professional relations between nurses, superintendents and doctors.

In an attempt to learn more about the working lives and careers of the women who worked for these associations, a prosopographical analysis of data, principally from the decennial censuses, has been utilised. This reveals that the nurses and superintendents were from different social classes and that social mobility for working-class women was limited. This study has one advantage over those studies that are based on one particular institution, such as a hospital, in that it has examined associations in a number of differing towns and cities in provincial England. These are urban areas that differ in terms of size, location and social structure and the results of this study have been used to compare and contrast the establishment of and the issues involved in the work of a nursing association. Use of data within annual reports regarding subscribers and the financial accounts provides additional insight into the support that associations received and the resources available to fund the activity of the associations.

Discussion

The historiography of nursing evolved in the twentieth century. Initially, narratives adhered to a Whig interpretation of history, emphasising progress and professionalisation based on the idea of reform emanating from St Thomas's Hospital in London to the rest of the country and orchestrated by Florence Nightingale. The suggestion that the Nightingale School, founded in 1860, provided trained matrons from its beginning to

reform nursing in hospitals elsewhere has been disputed.⁶ Although Nightingale was heavily involved in advising associations in this study, they also looked toward the religious sisterhoods in London for advice and the local initiatives in Liverpool and Bristol as models for their development. What does emerge from the research about the period from 1860 to the end of the century is that a very complex picture of different initiatives and practices existed across the country. There was no definitive break with the past in 1860, but change in nursing was a ‘prolonged and difficult process’.⁷ It was not until the last two decades of the century that a more uniform system of nursing was developed on the lines of that advocated by Nightingale. By this time, nursing associations had been in existence for at least 20 years and had developed their own systems of nursing based on the training and employment of working-class women as domiciliary nurses. This is in contrast to the system in the London voluntary hospitals, whose recruits increasingly became dominated by women from social classes I and II by the end of the century. The findings from this study do not support the idea that there was a ‘gentrification’ of nursing in these provincial settings.

In contrast to a progressive discourse, accounts from the 1980s onwards advanced alternative explanations for the development of professional nursing. One explanation for the way in which nursing altered was that medical practitioners were at the forefront of nursing reform, in order to see off competition from independent domiciliary nurses in

⁶ L. McDonald, *Florence Nightingale: The Nightingale School*, Collected Works of Florence Nightingale, Volume 12 (Waterloo, 2009), pp. 36-40.

⁷ C. Helmstadter and J. Godden, *Nursing before Nightingale, 1815-1899* (London, 2011), p. xii.

the same way as they reacted to the challenges from independent midwives.⁸ There is no evidence from the records of the associations in this study to support the line of argument that doctors were in competition with independent nurses. In fact, nurses who left the employment of an association to pursue an independent career usually maintained contact with local medical practitioners in order to secure regular employment.⁹ If it was the case that competition existed, this struggle must have taken place prior to the 1860s and the formation of the associations in this study. More than likely, most women practising as independent nurses were similar to those in Edinburgh, as described by Mortimer. These nurses led independent lives, but worked closely with doctors to earn a living from the care of wealthy clients.¹⁰

The rules of all the associations in this study emphasised the primacy of the doctor and his prescriptions and demanded complete obedience by nurses. Anne Digby indicates that inter-professional disputes between doctors and midwives occurred in the late eighteenth and early nineteenth centuries and female practitioners of all types were marginalised at this time.¹¹ Prestigious physicians and surgeons connected to the associations were prominent in their support for reform of domiciliary nursing and they claimed that this was in order to enhance their own clinical work. The ability to call on a corps of 'well-trained and technically-educated nurses' who were willing to intelligently carry out the

⁸ A. M. Rafferty, 'Nursing, Medicine, quackery, and health care reform, 1844-1994', *Nursing research*, 45, 3 (1996), 190-91; A. Summers, *Female lives, moral states* (Newbury, 2000) pp. 109-10.

⁹ 'Manchester Nurse Training Institution', *Manchester Guardian*, 24 January 1878.

¹⁰ B. Mortimer, 'Independent women: domiciliary nurses in mid-nineteenth-century Edinburgh', in A. M. Rafferty, J. Robinson and R. Elkan, (eds.), *Nursing history and the politics of welfare* (London, 1997), pp. 133-149.

¹¹ A. Digby, *Making a medical living: doctors and patients in the English market for medicine, 1720-1911* (Cambridge, 1994), pp. 16-18.

doctor's orders was the public stance of many practitioners.¹² Helmstadter and Godden downplay the idea of professional control and exclusion of independent nurses. They assert that doctors working in the London voluntary hospitals were more interested to create a body of skilled nurses to implement a new scientific medicine which was based on supportive therapies and that this was the major reason for the introduction of nursing reform.¹³ Science is said to have had less impact on medical practice in the home.¹⁴ Here, skilled, attentive and well behaved nurses who obeyed the doctor's orders would more than likely have enhanced his reputation in a market where he was in competition with other medical men. It was, therefore, in the doctor's professional and economic interest to be involved in nursing reform and to keep nurses in a subordinate position. Anne Witz points to the use of exclusionary and demarcationary strategies, as ways in which a dominant occupational group such as medicine achieved closure against other groups and thereby maintained their superior position.¹⁵ Exclusionary strategies are concerned with the internal regulation of professional groups, and the medical legislation of the early and mid-nineteenth century ensured that recognised qualifications determined those who could be entered on the medical register. Women were excluded from medical education and thereby entry to the profession. In contrast, demarcationary strategies were concerned with inter-occupational control through the creation of boundaries between occupations. Doctors who wrote nursing textbooks were keen to distinguish between the role of the nurse and that of the doctor. The doctor's role was one of diagnosis and prescription of treatment and the nurse was to carry out technical tasks and personal care and was to

¹² 'Proposed training institution for nurses', *Birmingham Daily Post*, 10 December 1868.

¹³ Helmstadter and Godden, *Nursing before Nightingale*, p. xiii.

¹⁴ Digby, *Making a medical living*, p. 97.

¹⁵ A. Witz, *Professions and patriarchy* (London, 1992), pp. 44-48.

strictly follow directions and report changes in the condition of the patient.¹⁶ Thus, there were different roles for nurses and doctors. Eva Gamarnikow has suggested that the boundaries between medicine and nursing were not sufficiently distinct, as nurses were taught part of the medical curriculum and had a degree of autonomy as they were often left to make decisions in the absence of the doctor.¹⁷ This posed potential problems for the relations between doctors and nurses. For Witz, demarcationary closure between medicine and nursing was based on gender and mediated by patriarchal power relations.¹⁸ Equating the qualities of a good nurse with those of a good woman, because of the latter's supposed natural capacity and tendencies for caring, were exploited by both men and women. Nightingale and others used the concept of female qualities to facilitate the entry of women into the management of hospital nursing.¹⁹ However, it is said to have been used by male doctors to exact obedience from female nurses. This was carried out by emphasising that nursing was an occupation suited to women and since:

nurses were subordinate to doctors, and women to men, 'natural' female subservience to men could secure professional subservience to medicine. Thus, the nurse's skills and abilities were collapsed into female obedience to the male doctor.²⁰

In this discourse, nursing became an occupation based on the feminine qualities of caring and the subordination of women to men.²¹ Nursing associations, through the application

¹⁶ J. C. Lory Marsh, *Lectures on nursing: short notes addressed to nurses on what to do and what to avoid in the management of the sick and the sick-room* (London, 1865), p. 7; W. R. Smith, *Lectures on Nursing* (London, 1875), p. 11; C. J. Cullingworth, *The nurse's companion: a manual of general and monthly nursing* (London, 1876), p. 1.

¹⁷ E. Gamarnikow, 'Nurse or woman: gender and professionalism in reformed nursing 1860-1923', in P. Holden and J. Littlewood (eds.), *Anthropology and nursing* (London, 1991), p. 123.

¹⁸ Witz, *Professions and patriarchy*, p. 48.

¹⁹ E. Gamarnikow, 'Sexual division of labour: the case of nursing', in A. Kuhn and A. M. Wolpe (eds.), *Feminism and materialism: women and modes of production* (London, 1978), pp. 111-16.

²⁰ Gamarnikow, 'Nurse or woman', p. 124.

²¹ *Ibid.*, p. 125.

of rules and regulations, supported the ‘strict subordination on the part of the nurse to the medical authority’.²² Furthermore, the significance of gender in the operation of nursing associations can be seen in the subordination of middle-class women to their male counterparts in the management of an association. As described in earlier chapters, women were more likely to take on roles as supervisors of district nurses and members of house committees that were based on their roles in the home, such as supervision of domestic servants and housekeeping. Where gender was at play in the management of associations, it undoubtedly mediated in the relations between doctors and nurses. Doctors, then, were important agents in the formation and operation of most associations. Their motives may have been, in part, altruistic, but the imperative of earning a living would have influenced their attitude to the reform of nursing. Rather than competing with nurses in the medical marketplace, it would appear that doctors were actively involved in the creation of a pliant and useful occupational group.

Another area of debate stems from an interpretation that sees the dominant classes in Victorian Britain using their power and status to control the working classes and that nursing, as a form of philanthropy, was one way of imposing their will on the poor.²³ The nineteenth century was a time when the upper and middle classes, to a certain extent, feared the threats of revolution, epidemic diseases and moral degeneration. The poor were seen as an ignorant mass that threatened the rest of society.²⁴ The idea of social control has become a controversial topic, but it was central to ‘nineteenth-century

²² W. Rathbone, *Organization of nursing: an account of the Liverpool Nurses' Training School* (Liverpool, 1865), p. 37.

²³ F. K. Prochaska, ‘Philanthropy’, in F. M. L. Thompson (ed.), *The Cambridge Social History of Britain, 1750-1950, Volume 3: Social agencies and institutions* (Cambridge, 1990), p. 359.

²⁴ T. L. Nichols, *Human physiology: the basis of sanitary and social science* (London, 1872), pp. 31-43.

reformist liberalism', whereby education, religion and charity were seen to be ways in which the 'disorderly elements in British society could be tamed'.²⁵ The work of nursing associations and other agencies during the nineteenth century addressed in this study indicates that members of charities saw the reform of the lifestyle of the poor as an important aspect of philanthropic work. As such, district nurses were seen to be in a crucial position to educate the poor in order to change their habits. They worked alongside doctors, clergymen, district visitors, Bible women, agents of sanitary associations and others in encouraging the poor to alter their behaviour. For Dean and Bolton, the nurse was a 'regulator of health, habitation and family life'.²⁶ The rhetoric, certainly in the early reports of the nursing associations, gives emphasis to an educational, as well as a caring, role for the district nurses. Denny sees district nursing as fulfilling an important role by mediating between those 'wishing to influence the lives of the poor, and the poor themselves'.²⁷ To what extent district nurses had any influence over the lives of the poor is debateable, partly due to their small numbers. Health visiting was seen to be made up of

... uninvited intrusions on the privacy of the home, and offering high-minded advice on nutrition and personal hygiene which was absurdly irrelevant to the poverty of its recipients²⁸

It is not known if this is the case for nursing. As discussed earlier in this chapter, no records of the views of patients or of the interaction between the nurse and patient exist, so it is difficult to gauge what the nurse gave in the way of instructions, whether there

²⁵ J. Harris, *Private lives, public spirit: Britain 1870-1914* (London, 1993), p. 212.

²⁶ M. Dean and G. Bolton, 'The administration of poverty and the development of nursing practice in nineteenth-century England' in C. Davies (ed.) *Rewriting nursing history* (London, 1980), p. 98.

²⁷ E. Denny, 'The emergence of the occupation of district nursing in nineteenth-century England' (Unpublished PhD thesis, University of Nottingham, 1999), p.253.

²⁸ F. M. L. Thompson, *The rise of respectable society: a social history of Victorian Britain, 1830-1900* (London, 1988), p. 357.

was resistance to or acceptance of any information given or whether the nurse's intervention actually changed behaviour. What most of the urban poor required, particularly in places like Liverpool, was not instruction about health from district nurses, but better housing, wages and nutrition, something philanthropy could and would not supply.²⁹ This type of charity was not aimed at alleviating inequalities in society but at promoting the welfare of the deserving poor and thereby rewarding those with the required moral character and behaviour.³⁰ What is certain is that those people who supervised the nurses and who wrote the annual reports were confident that the nurses had a positive effect on the lives of the poor. The small numbers of district nurses would have had a limited effect in most towns and cities. Whether the motives, behind the training and employment of nurses, were based on an urge to exert control over the poor, or through Christian kindness to support them, is not clear.

In the case of nursing associations, social control could also be applied to the working-class nurses themselves. As outlined in Chapter 4, working-class nurses were subjected to a disciplinary regime in their training, their work and in their home life. Obedience to authority was instilled into them. Helmstadter and Godden maintain that the wards of early nineteenth-century London were disorderly places and that the nurses were feckless and unreliable. Reform based on training and strict discipline ensured that the nurse became a more reliable and conscientious attendant.³¹ Recruitment was aimed at the respectable working classes in order to replace the disreputable, lower class nurses of the old regime. This was the case in the new nursing associations of the 1860s. From a

²⁹ M. E. Baly, *A history of the Queen's Nursing Institute: 100 years 1887-1987* (London, 1987), p. 10.

³⁰ A. J. Kidd, 'Philanthropy and the "social history paradigm"', *Social History*, 21, 2 (1996), p. 187.

³¹ Helmstadter and Godden, *Nursing before Nightingale*, pp. 22-23.

structuralist or Marxist perspective, the issue of discipline could be explained simply in terms of middle-class hegemony, in that the more powerful middle-class superintendents and doctors imposed their will upon the less powerful working-class nurses. For Bourdieu, a person's position or standing within society depended upon the complete set of resources they possess, including economic, social, cultural and symbolic capital. Social learning in the form of cultural capital predisposes people to act towards others or in particular situations in certain ways.³² Women were significant in the transmission of values within the family but also as the 'pre-eminent bearers of class' within society.³³ According to Langton, middle-class women, possessing significant capital of all kinds, had developed knowledge in the ways of dealing with servants in the home which they were then able to reproduce elsewhere, for example, in their philanthropic work in a nursing association, in order to consolidate middle-class control over working-class women.³⁴ Nurses were disciplined and trained to act in certain ways by the officers of the associations, doctors and the paid and lay lady superintendents. In Foucauldian terms, nurses became useful and 'docile bodies' that were of value to the association as a corps of efficient and obedient workers.³⁵ However, this represents a one-sided process and Foucault failed in most of his writing to acknowledge 'personal agency as a historical force'.³⁶ The notion of nurses as 'docile bodies' represents quite a 'crude instrumentalist model of social control', and, as such, Foucault himself did admit that resistance to power

³² R. Jenkins, *Pierre Bourdieu* (London, 2002), pp. 74-91.

³³ S. Gunn, 'Translating Bourdieu: cultural capital and the English middle class in historical perspective', *The British Journal of Sociology*, 56, 1 (2005), p. 55.

³⁴ E. Langton, *Nobody's angel: middle-class women and domestic ideology in Victorian culture* (Ithaca, 1995), pp. 7-11.

³⁵ A. Bashford, *Purity and pollution: gender, embodiment and Victorian medicine* (Basingstoke, 1998), pp. 44-48. See Chapter 4 of this thesis for an explanation of Foucault's ideas as applied to these associations.

³⁶ C. Jones and R. Porter, 'Introduction' in C. Jones and R. Porter (eds.), *Reassessing Foucault: power, medicine and the body* (London, 1994), p. 8.

could occur.³⁷ Not only was there individual and group resistance in associations, but nurses were also able to exercise their freewill by resigning and taking a job elsewhere or by setting-up in business themselves. Others had religious and vocational motives for their choice of nursing as a career and thereby accepted the conditions that came with the job. It would appear that approaches that use Marx, Bourdieu and Foucault as explanatory frameworks for class relations rely too heavily on structural approaches to the makeup of society. They tend to ignore or downplay the role of agency.

One of the ways in which this study makes a contribution to the history of nursing is in its consideration of place as an important determinant in the establishment and form of the nursing associations in this study. The concept of structuration, a theory associated with the work of Anthony Giddens maybe a useful concept to consider at this point.³⁸

Structuration theory:

attempts to describe and understand the relations between the overarching structures that influence our lives (ranging from big structures such as capitalism and patriarchy to smaller scales [sic] structures such as national and local institutions) and our own ability to exercise agency in our everyday lives.³⁹

Thus, structures at a national, for instance, religion, class, gender, and those at a local level, for example local organisations, combined to produce conditions and circumstances for the creation of local nursing associations. The agency of influential local people was also important. The interplay of structure and agency resulted, first of all, in the establishment of nursing associations in specific towns and cities in provincial England

³⁷ F. Driver, 'Power, space and the body: a critical assessment of Foucault's Discipline and Punish' *Environment and Planning D: Society and Space*, 3 (1985), pp. 442-43.

³⁸ A. Giddens, *The constitution of society: outline of the theory of structuration* (Cambridge, 1984).

³⁹ T. Creswell, *Place: a short introduction* (Oxford, 2004), p. 35.

and, secondly, the differences in the actual form and structure of individual associations. The important factors at play in the towns and cities seem to have been the strong presence of religion within local life, prominent doctors with private practices and links to local voluntary hospitals and an urban elite committed to philanthropic activities. The towns in this study had the necessary resources and structures available to establish an association. For Giddens, structure has been overemphasised in some sociological theories and has masked the importance of agents.⁴⁰ Structuration theory gives equal emphasis to both. Agents in the urban areas in this study were people with sufficient capital, in all its manifestations, to influence others to act. Thus, in Liverpool, the resources and actions of William Rathbone almost single-handedly resulted in the city becoming the most important centre for innovation in nursing in provincial England. In Lincoln, Ann Bromhead fought against considerable opposition to the involvement of women in the Lincoln County Hospital to found the Lincoln institution. Even if sufficient resources were available, leaders were needed to ensure that associations were established and successful. Differences between the form and structure of associations occurred between towns. Thus, Derby became both a nursing and sanitary association, Birmingham had different institutions for private and district nursing and Stratford-upon-Avon based its nursing within a nursing home for women and children. As a result of this study, there seems to be a case to consider place as an important concept in the history of nursing.

⁴⁰ Giddens, *The constitution of society*, p. 2.

Philanthropy was an important element in the establishment and management of nursing associations. There are different ways in which the motives behind charitable involvement can be viewed. These include 'altruistic' and 'egoistic' reasons.⁴¹ The former includes acts of kindness without any necessary requirements upon the recipient whilst the latter indicates that the donor receives some form of reward for their act of giving. Altruistic acts may have been a result of religious or humanistic values that spurred individuals to act. In this study, urban elites were at the forefront of nursing associations. For them there may have been an element of self interest in that the position as a charity leader gave the individual esteem and status within the local and perhaps national arena. Nursing charities were more complex in that they not only rewarded individuals in terms of status, but they also provided material support to the rich in the form of a ready supply of nurses, when the need arose. Thus, self-interest may have been an important reason why nursing associations were established. There is undoubtedly no one single cause or explanation as to why people supported or became involved in these associations. The ideas behind the promotion of this form of charity probably included elements of social control, receiving esteem or status, fulfilling social aspiration, an obligation of wealth, offering Christian kindness to others or a way of legitimising groups on the margins of polite society.⁴² For the religiously active this type of charity enabled them to fulfil their Christian obligations and also probably gave unequalled opportunities for gaining contact with and converts from the working classes. As middle-class men, doctors would have had the same philanthropic motives as others of the same social standing. However, the involvement of elite doctors in nursing reform helped them to

⁴¹ Kidd, 'Philanthropy and the "social history paradigm"', p. 181.

⁴² K. Waddington, 'Subscribing to a democracy? Management and the voluntary ideology of the London hospitals, 1850-1900', *English Historical Review*, 118, 476 (2003), p. 362, note 20.

deliver a new form of medicine, but probably also contributed to securing their professional, social and economic status within society. The poor were at the receiving end of this form of charity but it was mediated by the nurses. For working-class nurses, these associations provided training, skills and knowledge, secure employment, social connections, the ability to accumulate capital for the future and the potential to earn a living or pursue a career independently. Alternatively nursing associations were, at times, accused of exploiting their nurses and imposing systems of unreasonable discipline. Thus the reasons behind the establishment and operation of these associations were complex and the involvement of different groups of people in the work of an association was a result of differing motives.

Conclusion

Place as a focus for the study of the history of medicine has developed within the United Kingdom over approximately three decades, scholars initially drawing out the importance of the provinces, not the nation's capital, for the study of hospitals and medical practice. This first began with work concentrating on locations such as Sheffield, Manchester and its region, Huddersfield and Wakefield and the midlands.⁴³ Within the last ten years, developments in the history of science and, in particular the work of David Livingstone, have promoted a 'spatial turn' in historical studies leading place to be considered as a factor in historical analysis deserving as much attention as the categories of race, gender

⁴³ I. Inkster 'Marginal men: aspects of the social role of the medical community in Sheffield 1790-1850' in J. Woodward and D. Richards *Health care and popular medicine in nineteenth-century England* (London, 1977), pp. 128-163; J. V. Pickstone, *Medicine and Industrial Society: a history of hospital development in Manchester and its region, 1752-1946* (Manchester, 1985); H. Marland, *Medicine and society in Wakefield and Huddersfield 1780-1870* (Cambridge, 1987); a summary of Joan Lane's work on medicine in the midlands can be found in J. Reinartz, 'Medicine and society in the midlands, 1750-1950: Introduction' in J. Reinartz (ed.), *Medicine and society in the midlands, 1750-1950* (Birmingham, 2007), pp. 3-4.

and class.⁴⁴ This thesis contributes to this emerging genre of work by identifying and recognising the importance of the provinces and particular towns and cities in the reform of nursing in mid-nineteenth-century England. What can be drawn from the work of Livingstone and others, and which has been brought to light in this study, is that nursing was not a ‘placeless’ or ‘universal’ phenomenon.⁴⁵ Nursing, like any other medical enterprise in these years, was not free from ‘the imprint of the local’.⁴⁶ This study emphasises the importance that place should be accorded in a historical analysis of nursing, in that local conditions and agents were important factors in the establishment and operation of nursing associations and thus in the reform of nursing. For instance, in the cases of the Lichfield diocese and in Lincoln, location clearly impacted on the establishment of nursing associations. Nursing reform in the Lichfield diocese was directly affected by religious controversy and in Lincoln it was significantly influenced by the issue of gender. In addition, the type of nurse produced by these organisations differed from place to place. For instance, it is possible to speak of Stratford-upon-Avon nurses being unique in terms of their ‘general tone and capacity’.⁴⁷ Overall, the historical geography of nursing needs to be considered when its history is being examined in order to draw out many other important features. Thus, the concept of place is an important aspect of historical analysis and as such is a significant component of this thesis.

⁴⁴ E. Dyck and C. Fletcher ‘Introduction: healthscapes: health and place among and between disciplines’ in E. Dyck and C. Fletcher, *Locating health: historical and anthropological investigations of health and place*, (London, 2011), p. 5.

⁴⁵ S. Naylor, ‘Introduction: historical geographies of science – places, contexts, cartographies’ *British Journal of the History of Science*, 38, 1 (2005), p. 2; J. Elliott, C. Toman and M. Stuart, ‘Introduction’, in J. Elliott, M. Stuart and C. Toman (eds.), *Place and practice in Canadian nursing history* (Vancouver, 2008), p. 1.

⁴⁶ D. N. Livingstone, *Putting Science in its place: geographies of scientific knowledge* (Chicago, 2003), p. 2.

⁴⁷ C. G. Gepp, *A Short Memoir of Emily Minet: For Twenty Years Lady Superintendent of the Nursing Home, Stratford-On-Avon*, (London, 1894), p. 34.

Recently, Helmstadter and Godden have put the reform of hospital nursing firmly down to advances in scientific medicine and the need for a trusted clinical assistant to implement new ways of treating patients in hospitals⁴⁸ Educated and skilled nurses were certainly demanded in the homes of the middle and upper classes but this was not the only stimulus for the reform of nursing in the provinces. The needs of the sick poor in their own homes were also recognised and this study demonstrates that charity, as a result of religious commitment and social concern for those in need, was an important reason why associations were founded from the 1860s onward. Thus, the history of nursing reform should not be viewed solely as a hospital based phenomenon or as a result of advances in scientific medicine. Philanthropy certainly played its part.

Why have the associations in this study been ignored or forgotten in the history of nursing? For Summers:

our reading of medical history takes the expansion of the hospital system for granted – together with the development of hospital ‘in-house’ nurse training schools – the origins of nursing reform in Britain have tended to be obscured.⁴⁹

Historians have emphasised the importance of the hospital over other sites in the history of nursing. This is an area where records are most easily located and on which most research still tends to be carried out. Local nursing associations have not been part of the progressive accounts of the history of nursing and, as they were not prominent in the development of the profession in the twentieth century, they have largely been forgotten. However, the story of the establishment and work of these associations is of value in the

⁴⁸ Helmstadter and Godden, *Nursing before Nightingale*, pp. 191-93.

⁴⁹ A. Summers, ‘The costs and benefits of caring: nursing charities, c.1830-c.1860’, in J. Barry and C. Jones (eds.), *Medicine and charity before the welfare state* (London, 1991), p. 145.

history of both nursing and philanthropy. They certainly have the potential to alter the way in which both subjects have to date been conceptualized by historians.

APPENDIX 1

Nurse Training Associations located that meet the criteria for this study

| Institution | Source | Date | Archive | Records |
|--|--|------|-------------------------------------|---|
| Bath Training Institute for Nurses | <i>Lancet</i> 1863 | 1862 | Bath & North East Somerset Archives | No records |
| | | | British Library | Annual Report 1863 |
| Birmingham and Midland Counties Training Institution for Nurses | Records of the General Hospital, Birmingham | 1869 | Birmingham City Archives | Annual Reports 1870-1909 House Committee Minutes 1885-1899 |
| Bristol Nurse Training Institution | <i>BMJ</i> 1870 | 1863 | Bristol Record Office | No records |
| | | | British Library | Annual report 1866 |
| Buckingham Nurses Home and Hospital | <i>BMJ</i> 1870 | 1869 | Buckinghamshire Archives | Annual Report 1877 |
| Cambridge home and Training School for Nurses | Rook A et al <i>The history of Addenbrooke's Hospital Cambridge</i> , (Cambridge, 1991) | 1873 | Cambridge Reference Library | Annual Reports 1878, 1880, 1886 & 1907 and Kenny A <i>The Cambridge District Nursing Association, 1873-1945</i> , (Cambridge, 1952) |
| Cheltenham Nursing Institution | National Archives A2A Database | 1867 | Gloucestershire Records Office | Minutes 1867-1872 |
| | | | | Annual Reports 1869, 1872 |
| Derby and Derbyshire Nursing and Sanitary Association | Bewick R, <i>History of a provincial hospital: Burton upon Trent</i> , (Burton-upon-Trent, 1974) | 1865 | Derbyshire Archives | House Committee Minutes 1892-1908; Board of Management. Minutes 1896-1914 |
| | | | Derby Local Studies Library | Annual Reports 1865-1901 (incomplete) |
| | | | Royal College of Physicians | Letters from Florence Nightingale to William Ogle (Physician) |
| | | | British Library | Prospectus 1864; Annual Report 1865; Practical hints on the formation of a Nursing Association (no date but after 1879); Annual Report 1889/90 |
| Kent and Canterbury Institute | <i>Lancet</i> 1877 | ? | Kent Archives | No records |
| | | | Canterbury Cathedral Archives | No records |
| | | | East Kent Archives | Annual Reports 1887-1908 |
| Institute of Trained Nurses for the Town and County of Leicester | National Archives A2A Database | 1866 | Leicestershire Archives | Annual Report 1878 |

| | | | | |
|--|--|-------|---|---|
| Nursing Association for the Diocese of Lichfield | National Archives A2A Database | 1865 | Staffordshire Record Office, Lichfield | Prospectus 1865 Annual reports 1866 & 1869 |
| | | | Wellcome Library | Edwards E J, <i>Nursing association for the Diocese of Lichfield</i> (London, 1865) |
| Lincoln Institution for Nurses | National Archives A2A Database | 1866 | Lincolnshire Archives | Minute Book of the Ladies Nursing Fund Minutes of the Nursing Institution 1886-1887 Annual Reports 1865-1907 Memoranda - case book of Cecilia Quincy, Nurse 1872 |
| Liverpool Training School and Home for Nurses | G. Hardy <i>William Rathbone and the early history of district nursing</i> , (Ormskirk, 1981). | 1862 | Liverpool Record Office | Annual reports 1862-1900. Other documents including training registers, minutes etc. |
| Manchester Nurse Training Institute / Manchester Sick Poor and Private Nursing Institution | Coyne et al <i>A guide to the records of health services in the Manchester region</i> (Manchester, 1981) | 1864 | Manchester Archives / Local History Library | Annual reports 1866-1881 & 1882-1950 Committee minutes 1890s |
| Newcastle Nurse Training Institute and Home | Hume G <i>History of the Newcastle Infirmary</i> (Newcastle, 1906) | 1872 | Tyne and Wear Archives | Newspaper cuttings of correspondence in the <i>Newcastle Daily Journal</i> 1872 |
| Institution for Training Nurses For the Diocese of Salisbury | <i>BMJ</i> 1874 | 1871 | Wiltshire and Swindon Record Office | Minutes 1871-1954 |
| Nursing Institute, Stratford upon Avon (later Nursing Home and Hospital) | Records of the General Hospital, Birmingham | 1872 | Shakespeare Birthplace Trust Records | Annual Reports 1873-1932 Entries in the <i>Stratford Herald</i> |
| Staffordshire Nursing Institution (Stoke upon Trent) | Records of the General Hospital, Birmingham | 1872 | Staffordshire Record Office, Stoke upon Trent | No records |
| | | | Staffordshire Record Office, Lichfield | <i>Church Calendar And Almanac For The Diocese Of Lichfield.</i> |
| Tunbridge Wells Nurses' Institution | Nightingale Collection | 1865 | London Metropolitan Archives | Annual Report, 1865 |
| West of England Institution for Training Nurses (Exeter) | <i>Lancet</i> 1869 | ?1866 | Devon Records (Exeter) | No records |
| | | | Plymouth and West Devon Archives | No records |

APPENDIX 2: Tracing Career Histories of Nurses

| Name | | Year of Birth | Institution or Association | Years of Employment | Place of Training | Census | | | | | | Will | |
|------------|-----------|---------------|----------------------------|---------------------|-------------------|--------|------|------|-----------|------|-----------|-----------|-------|
| | | | | | | 1841 | 1851 | 1861 | 1871 | 1881 | 1891 | | 1901 |
| Tunnington | Fanny | c1863 | Birmingham | 1891-? | ? | | | | ✓H | ✓Wk | ✓Wk | ✓Wk | Ø |
| Cryer | Jane | C1844 | Cheltenham | 1870-2 | Gloucester | | ✗ | ✗ | ✓Wk | ✗ | ✓Wk | ✓Wk | Ø |
| Morgan | Kate | C1844 | Cheltenham | 1869-72 | ? | | ✗ | ✗ | ✓Wk | ✗ | ✗ | ✗ | Ø |
| Field | Maria | c1835 | Bristol & Lichfield | 1865-9 | Bristol | | ✓H | ✓Wk | ✓Wk | ✓Wk | ✓Wk | ✗ | Ø |
| Hulme | Maria | C1843 | Lichfield | 1869-1887 | Kings Coll. H | | ✗ | ✓H | ✓Wk | ✓Wk | Died 1887 | | ✗ |
| Quinney | Cecilia | c1849 | Lincoln | 1872-? | Univ. Coll. H | | ✓H | ✓H | ✓Wk | ✓H | ✓H | ✓H | Ø |
| Brodrick | Ann | C1811 | Liverpool | 1865-1876 | untrained | ✗ | ✓H | ✓Wk | ✓H | ✗ | ✗ | ✗ | Ø |
| Leek | Eliza | c1833 | Manchester | 1866-73 | Kings Coll. H | ✓H | ✓H | ✓H | ✓H | ✓Wk | ✓Wk | Died 1900 | ✓1900 |
| Chambers | Agnes | c1840 | Liverpool & Manchester | 1862-6 1866-8 | Liverpool | ✓H | ✓H | ✓H | Died 1868 | | | | Ø |
| Chambers | Fanny | c1840 | Manchester | 1868-1889 | ? | ✓H | ✓H | ✓Wk | ✓Wk | ✓Wk | Died 1889 | | ✓1889 |
| Mackie | Mary | c1832 | Manchester | 1866 | St Thomas H | ✗ | ✗ | ✓H | ✓Wk | ✓Wk | # | ✓Wk | Ø |
| Case | Louisa | c1855 | Salisbury | 1879-1904 | Salisbury Inf | | | ✓H | ✓Wk | ✓Wk | ✓Wk | ✓Wk | Ø |
| Case | Charlotte | c1858 | Salisbury | 1881-? | Salisbury Inf | | | ✓H | ✓Wk | ✓Wk | ✓Wk | ✓Wk | Ø |

Key:

- ✓ Source checked, records found.
- ✗ Source checked, records NOT found.
- Ø Source not checked
- # Source checked, possible match, subject's identity not confirmed.

- ✓ H Traced in Census living at Home.
- ✓ Wk Traced in Census at Work.
- ? Not known

APPENDIX 3: Tracing Career Histories of Lady Superintendents

| Name | | Year of Birth | Institution or Association | Years of Employment | Place of Training | Census | | | | | | | Will |
|--------------|-----------|---------------|----------------------------|---------------------|-----------------------------|--------|------|------|------|-----------|-----------|-----------|------|
| | | | | | | 1841 | 1851 | 1861 | 1871 | 1881 | 1891 | 1901 | |
| Tindall | Julia | c1827 | Birmingham | 1870-75 | Kings Coll. H | ✘ | ✘ | ✓H | ✓Wk | ✓H | ✓H | Died 1901 | ∅ |
| Diamond | Elizabeth | c1828 | Birmingham | 1875-95 | ? | | ✘ | ✘ | ✓Wk | ✓Wk | ✓Wk | Died 1895 | ∅ |
| Brumwell | Mary | c1828 | Derby | 1868-84 | Mildmay Mission | | ✘ | ✓H | ✓Wk | ✓Wk | Died 1884 | | ✘ |
| Woodhead | Emily | c1849 | Derby | 1884-92 | ? | | | ✓H | ✘ | ✓Wk | ✓Wk | ✘ | ∅ |
| Marshall | Cora | c1845 | Lincoln | 1872-1907 | ? | | ✓H | ✓H | ✓Wk | ✓Wk | ✓Wk | ✓Wk | ∅ |
| Merryweather | Mary | c1820 | Liverpool | 1862-74 | Kings Coll. H & St Thomas H | | ✓Wk | ✓Wk | ✓Wk | Died 1880 | | | ∅ |
| Staines | Emmeline | c1839 | Liverpool | 1874- | St Thomas H | | | ✓H | ✓Wk | ✓Wk | ✓Wk | Died 1892 | ∅ |
| Alsop | Elizabeth | c1833 | Manchester | 1866-79 | Liverpool | | | ✓H | ✓Wk | ✓Wk | ✓H | ✘ | ∅ |
| Hussey | Anna | c1837 | Salisbury | 1876-96 | ? | ✓H | ✓H | ✓H | ✘ | ✓Wk | ✓Wk | ✓H | ∅ |
| Minet | Emily | c1835 | Stratford - on - Avon | 1873-92 | Walsall & Middlesex H | | ✓H | ✓Wk | ✓Wk | ✓Wk | ✓Wk | Died 1893 | ✓ |
| Moseley | Annie | c1867 | Stratford - on - Avon | 1892-1908 | Greenwich Seaman's H | | | | ✘ | ✓H | ✓Wk | ✓Wk | ∅ |

Key:

- ✓ Source checked, records found.
- ✘ Source checked, records NOT found.
- ∅ Source not checked
- # Source checked, possible match, subject's identity not confirmed.

- ✓ H Traced in Census living at Home.
- ✓ Wk Traced in Census at Work.
- ? Not known

APPENDIX 4 Population Growth of Towns Included In This Study¹

| | 1801 | 1811 | 1821 | 1831 | 1841 | 1851 | 1861 | 1871 | 1881 | 1891 | 1901 |
|--------------------|--------|---------|---------|---------|---------|---------|----------|---------|---------|---------|----------|
| Birmingham | 70,670 | 82,753 | 101,722 | 143,986 | 182,922 | 232,841 | 296,076 | 343,696 | 400,774 | 429,171 | 523,179* |
| % difference | | 17.1% | 22.9% | 41.5% | 27.0% | 27.3% | 27.2% | 16.1% | 16.6% | 7.1% | - |
| Cheltenham | 3076 | 8,325 | 13,396 | 22,942 | 31,411 | 35,051 | 36,693 | 44,519 | 50,727 | 49,775 | 49,439 |
| % difference | | 270.6% | 60.9% | 71.3% | 36.9% | 11.6% | 4.7% | 21.3% | 13.9% | -1.9% | -0.7% |
| Derby | 10,832 | 13,043 | 17,423 | 23,027 | 32,741 | 40,609 | 51,049 | 62,332 | 81,168 | 94,146 | 105,912 |
| % difference | | 20.4% | 33.6% | 32.2% | 42.2% | 24.0% | 12.6% | 12.2% | 13.2% | 16.0% | 12.5% |
| Lincoln | 7,197 | 8,599 | 9,995 | 11,217 | 13,896 | 17,533 | 20,999 | 26,762 | 37,313 | 41,491 | 48,784 |
| % difference | | 19.2% | 16.4% | 12.2% | 23.1% | 27.0% | 19.7% | 27.3% | 39.7% | 11.9% | 17.57% |
| Liverpool | 82,295 | 104,104 | 138,354 | 201,751 | 286,487 | 375,955 | 443,938 | 493,346 | 552,508 | 629,548 | 684,958* |
| % difference | | 26.5% | 32.9% | 45.8% | 42.0% | 31.2% | 18.1% | 11.1% | 11.9% | 13.9% | - |
| Manchester | 76,788 | 91,130 | 129,035 | 187,022 | 242,983 | 316,213 | 357,978 | 383,843 | 462,303 | 505,368 | 543,872 |
| % difference | | 18.7% | 41.6% | 44.9% | 29.9% | 30.1% | 13.2% | 7.2% | 20.4% | 9.3% | 7.6% |
| Salford | 13,611 | 19,114 | 22,772 | 40,786 | 53,200 | 63,423 | 101,752* | 124,801 | 176,233 | 198,139 | 220,957 |
| % difference | | 40.4% | 19.1% | 79.1% | 30.4% | 19.2% | - | 22.6% | 41.2% | 12.4% | 11.5% |
| Salisbury | 7,668 | 8,243 | 8,763 | 9,876 | 10,086 | 11,657* | 12,278 | 12,867 | 14,792 | 15,533 | 17,117* |
| % difference | | 7.5% | 6.3% | 12.7% | 2.1% | - | 10.4% | 4.8% | 14.9% | 8.0% | - |
| Stratford-on-Avon▪ | 2,418 | 2,842 | 3,069 | 3,483 | 3,321 | 3,372 | 3,672 | 3,863 | 4,079 | 3,869 | 3,897 |
| % difference | | 17.5% | 7.9% | 13.5% | -4.7% | 1.5% | 8.9% | 5.4% | 5.3% | -5.1% | 0.7% |

* Boundary changes ▪ Stratford township only

¹ Lichfield is not included as the diocesan nursing association was not based in the city but spread across Staffordshire, Shropshire and Derbyshire. Sources: Census of England and Wales 1861, *Volume III, General Report*, (London, 1863); Census of England and Wales 1871, *Preliminary Report*, (London, 1871); Census of England and Wales, 1891 *Preliminary Report*, (London, 1891); Census for England and Wales 1901, Volumes for the counties of Derby, Gloucestershire, Lancashire, Lincolnshire, Warwickshire and Wiltshire; Victoria County History, *A history of Warwickshire, Volume II*, (London, 1963), pp. 182-192; Victoria County History, *A history of Wiltshire, Volume II*, (London, 1959), pp. 315-361.

APPENDIX 5: Origins and Career Progression of Nurses, 1862-1901

Social Class

| Employed | I | II | III | IV | V | No Data | Total |
|----------|---|----|-----|----|---|---------|-------|
| 1862-71 | 0 | 6 | 19 | 12 | 1 | 13 | 51 |
| 1872-81 | 0 | 8 | 14 | 29 | 3 | 10 | 64 |
| 1882-91 | 1 | 18 | 26 | 21 | 3 | 2 | 71 |
| 1892-01 | 0 | 22 | 22 | 15 | 3 | 4 | 66 |

Occupation Before Employment By A Nursing Institution

| Employed | Not occupied | Servant | Nurse | Tx | Dr | Te | Sh | Oth | No Data | Total |
|----------|--------------|---------|-------|----|----|----|----|-----|---------|-------|
| 1862-71 | 4 | 13 | 0 | 4 | 1 | 2 | 2 | 3 | 22 | 51 |
| 1872-81 | 0 | 29 | 2 | 1 | 2 | 0 | 0 | 4 | 26 | 64 |
| 1882-91 | 10 | 26 | 3 | 3 | 5 | 2 | 1 | 5 | 16 | 71 |
| 1892-01 | 6 | 18 | 11 | 1 | 3 | 2 | 3 | 1 | 21 | 66 |

Reason for leaving / Subsequent Career Progression

| Employed | M | R | Di | Ds | Private Nurse | District Nurse | Institutional Nurse | Dom. Servant | Other | No Data | Total |
|----------|---|---|----|----|---------------|----------------|---------------------|--------------|-------|---------|-------|
| 1862-71 | 3 | 3 | 8 | 2 | 8 | 2 | 9 | 4 | 2 | 10 | 51 |
| 1872-81 | 6 | 4 | 3 | 1 | 18 | 2 | 5 | 0 | 4 | 21 | 64 |
| 1882-91 | 5 | 4 | 1 | 2 | 18 | 6 | 4 | 1 | 0 | 30 | 71 |
| 1892-01 | 0 | 0 | 0 | 0 | 10 | 4 | 7 | 0 | 1 | 44 | 66 |
| | | | | | | | | | | Total | 252 |

Tx = Textiles Dr = Dressmaker Te = Teacher Sh = Shop worker Oth = Other
M = Married R = Retired Di = Died Ds = Dismissed

APPENDIX 6: Origins and Career Progression of Lady Superintendents and Matrons, 1862-1901

Social Class

| | I | | II | | III | | IV | | V | | No Data | | Total | |
|----------|----------|-------|-----------|-------|------------|-------|-----------|-------|----------|-------|----------------|-------|--------------|-------|
| | Head | Asst. | Head | Asst. | Head | Asst. | Head | Asst. | Head | Asst. | Head | Asst. | Head | Asst. |
| Employed | 2 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 6 | 0 |
| 1862-71 | 2 | 0 | 2 | 1 | 0 | 2 | 0 | 0 | 0 | 0 | 3 | 1 | 7 | 4 |
| 1872-81 | 1 | 1 | 2 | 6 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 4 | 8 |
| 1882-91 | 1 | 1 | 3 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 3 | 2 | 7 | 6 |
| 1892-01 | | | | | | | | | | | | | | |

Occupation Before Taking Up An Appointment

| | Not occupied | | Matron or LS elsewhere | | Trained Nurse | | Religious or social work | | Other | | No Data | | Total | |
|----------|---------------------|-------|-------------------------------|-------|----------------------|-------|---------------------------------|-------|--------------|-------|----------------|-------|--------------|-------|
| | Head | Asst. | Head | Asst. | Head | Asst. | Head | Asst. | Head | Asst. | Head | Asst. | Head | Asst. |
| Employed | 0 | 0 | 1 | 0 | 1 | 0 | 2 | 0 | 0 | 0 | 2 | 0 | 6 | 0 |
| 1862-71 | 1 | 2 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 4 | 1 | 7 | 4 |
| 1872-81 | 0 | 1 | 1 | 0 | 1 | 6 | 1 | 0 | 0 | 1 | 1 | 0 | 4 | 8 |
| 1882-91 | 0 | 1 | 1 | 0 | 3 | 1 | 0 | 0 | 0 | 1 | 3 | 3 | 7 | 6 |
| 1892-01 | | | | | | | | | | | | | | |

Reason for Leaving / Subsequent Career Progression

| | Married | | Retired | | Died | | Matron or LS elsewhere | | Other employment | | No Data | | Total | | |
|----------|----------------|-------|----------------|-------|-------------|-------|-------------------------------|-------|-------------------------|-------|----------------|-------|--------------|-----------|-----------|
| | Head | Asst. | Head | Asst. | Head | Asst. | Head | Asst. | Head | Asst. | Head | Asst. | Head | Asst. | |
| Employed | 0 | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 1 | 0 | 2 | 0 | 6 | 0 | |
| 1862-71 | 1 | 0 | 1 | 1 | 2 | 1 | 0 | 1 | 0 | 0 | 3 | 1 | 7 | 4 | |
| 1872-81 | 1 | 1 | 0 | 1 | 1 | 1 | 1 | 1 | 0 | 0 | 1 | 4 | 4 | 8 | |
| 1882-91 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 6 | 6 | 7 | 6 | |
| 1892-01 | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | Total | 24 | 18 |

Head = In charge of the entire institution either as Lady Superintendent or Matron

Asst = Assistant responsible for part of the work e.g. as Matron or Superintendent of District Nurses

APPENDIX 7: Biographies of Selected Nurses

There is little detailed information regarding the lives and careers of the nurses employed by the institutions in this study. Many of these working women cannot be traced within the surviving documents and it is difficult to track those that are named. The census returns from 1841 to 1901 have been utilised, but nurses located in one census are, more often than not, untraceable in a previous or subsequent census. Most nurses appear to have moved on, married or died between censuses. As a result only an isolated entry in a record or a single census entry remains to tell of the lives of many women who belonged to the first few generations of trained nurses.

BIRMINGHAM AND MIDLAND COUNTIES TRAINED NURSES INSTITUTION

Fanny Tunnington, born c1863, Aston, Warwickshire

In 1871, Fanny was living in Duddeston, Birmingham the eldest of six children. Her father was a sheet maker. In 1881, she was employed as a domestic nurse for the three children of a farmer at Baxterley, Warwickshire. Sometime in the 1880s she trained as a nurse and was employed by the Birmingham and Midland Counties Trained Nurses' Institution. The census return for 1891 shows Fanny to be nursing Lady Alexandra Leveson-Gower, the daughter of the third Duke of Sutherland. Lady Alexandra had rheumatic fever and had moved from her Staffordshire home to Argyll Lodge, her uncle's house in London. Fanny was with Lady Alexandra when she died on April 16 1891, and is named as present at death, on the death certificate - her address being 12, The Crescent, Birmingham – that of the Birmingham and Midland Counties Trained Nurses' Institution. This particular career illustrates the fact that nurses from institutions with a good reputation could be employed at distance from their home base and by clients of the highest social standing. Fanny continued to nurse private clients and in 1901 is described as a 'sick nurse' at Enville Hall, Staffordshire.

CHELTENHAM NURSING INSTITUTION

Jane Cryer, born c1844 Lechlade, Gloucestershire

In 1851 Jane was living with her family in Lechlade. Her father was employed as a gardener and her brothers were agricultural labourers. In the 1861 census Jane was employed as a house servant in Bisley, Gloucestershire. It is possible that she gained some experience in nursing before June 1870 when she was sent to the Gloucestershire Infirmary to be trained as a nurse at the cost of 10/- per week.¹ Here she “absented herself from the Infirmary without leave, did not confine her attention to any particular ward and excited hopes of higher wages in the Nurses”.² This complaint from the matron resulted in a letter to Dr E T Wilson, the Secretary of the Cheltenham Nursing Institution. In his reply Dr Wilson apologised and reiterated that the Nurses are “instructed to conform to all rules of your Institution” and that

Our terms [wages] are undoubtedly high but we still find it difficult to secure nurses of the class we require. Numbers of applicants have to be refused as not possessing the requisite qualifications. In giving special training to an otherwise formed and capable nurse your Infirmary will confer a very great boon on our Institution and on the public.³

Thus it would seem that Jane had been recruited having already undertaken some nursing work and that the two months in the Infirmary was intended to give her enough experience for home nursing. In spite of her behaviour at the Infirmary she was taken on as a trained nurse by the Institution. During the rest of 1870 she was engaged for all 24 weeks of her employment and earned £25-4s-0d for the Institution and was paid £11-6s-6d in wages and board.⁴ In 1871 she was employed for the entire year and in the census returns was described as a trained nurse in the household of a retired druggist, in Cheltenham. She continued with her employment for the first six months of the following year but gave notice in July “to enter the family she is now attending, as a servant”.⁵ In

¹ Gloucestershire Record Office (hereafter GRO), Gloucestershire Infirmary Minutes 1870-1878, June 30 1870 (HO19/1/20)

² Ibid, September 15, 1870

³ Ibid, September 29, 1870

⁴ GRO, Cheltenham Nursing Institution, Minutes 1867-72: November 11, 1870 (D2465 3/1).

⁵ Ibid, July 16, 1872

the 1891 and 1901 censuses she is described as a housemaid and housekeeper respectively, in the employ of the same person. Like many other nurses at this time it appears that Jane was willing to change occupation for both security and possibly better terms and conditions. Thus her nursing career lasted just under two years.

Kate Morgan, born c1844, Bristol

In 1861, Kate was living in Bristol with her family, her father being a labourer. She joined the institution in 1869 as a trained nurse and was employed as private nurse in which capacity she was described as “much listed for her skill and gentleness”.⁶ In the 1871 census Kate is identified as a trained nurse in the house of a Church of England Chaplain in Weston Supermare and later in the year she was nursing the children of Dr E T Wilson – the Institution’s secretary:

On July 6. The children caught scarlet fever – Lily, Bernard and Nell. Pollie was supposed to have had a slight attack but it was doubtful. Their nurse Kate Morgan was a noisy party and sang Shalibala at the top of her voice from morning to night, to keep her patients quiet!⁷

This gives one of the very few instances of a comment regarding the nurse in the course of her duties. Kate continued with the Institution until it closed in 1872. There are no further traces of her as a nurse, and it is possible that she married in 1880.

NURSING ASSOCIATION FOR THE DIOCESE OF LICHFIELD

Maria Field, born c1835, Kelling, Norfolk

Maria was the daughter of a Norfolk farmer. In 1861 she was working as a domestic nurse (child care) in Twickenham, Middlesex. At sometime in the early 1860s she joined the Bristol Training Institution and would have received hospital experience in either the Bristol Royal Infirmary or the General Hospital. Following this she was employed as a fever nurse for the poor in St Jude’s parish. She did house to house visiting in some of the ‘most miserable streets and courts of that district’ Afterwards she became one of the head

⁶ Ibid, January 4, 1870.

⁷ Cheltenham Art Gallery & Museum, Wilson Collection.: E.T. Wilson *My life. Volume I: 1832-1888*, (Manuscript Ref 1995.550.35A), p137

nurses of the temporary fever hospital.⁸ She was then recruited by the Lichfield Diocesan Nursing Association to begin district or parochial nursing in Longton, Staffordshire and became its first trained nurse in June 1865.⁹ She remained there until 1868 or 1869 when she “left from failure of health and strength”.¹⁰ This did not mean the end of her nursing career as the 1871, 1881 and 1891 censuses indicate she was employed by the Cazalet family of Capel, Surrey. In 1871 she was attending a water cure establishment in Great Malvern with Mrs Emmeline Cazalet and in the two subsequent censuses she was located at the family home – Greenhurst at Capel. In all instances she is identified as a nurse, one servant amongst many in a very large household. There is no other record of her life after 1891 but her career shows two things. The first, that mobility was important in order to maintain a career as a nurse and secondly that some nurses were inclined to seek secure employment as household servants rather than continue as a nurse for the sick poor in a charitable institution.

Maria Hulme, born c1843, Stoke on Trent, Staffordshire, died 1887.

Maria was the daughter of a pottery worker and in 1861 was working as a milliner. Sometime in 1868, at the recommendation of the Reverend Sir L T Stamer, vicar of Stoke On Trent, she was taken on by the Lichfield Diocesan Association and was sent to Kings College Hospital for training.¹¹ She returned to Staffordshire in December 1869, when she was appointed to the North Staffordshire Infirmary as a nurse. She remained in post, within the hospital, until her death in 1887. There are no traces of Maria within the surviving Hospital records but her career illustrates that some nurses were appointed to fulfill the Association’s original aims to provide nurses for hospitals as well as for nursing the rich and poor in their homes. Ironically, Maria’s career lasted much longer than the ill fated association.

⁸ British Library Cup Bristol Nurses’ Training Institution and Home, Annual Report for 1866 (401c10 (7))

⁹ Staffordshire Archives, Lichfield (hereafter, SAL), Second Annual Report of the Nursing Association for the Diocese of Lichfield, 1866 (D30/11/118)

¹⁰ SAL, Fifth Annual Report of the Nursing Association for the Diocese of Lichfield, 1869 (B/A/19/2/106)

¹¹ Ibid.

LIVERPOOL TRAINING SCHOOL AND HOME

Ann Brodrick, born c1811 Asby, Westmorland

In 1851, Ann was a widow with two children and working in Liverpool as a laundress. Ten years later she is described as a matron in a house, in Chatham Street with three patients, two servants and her children. There is no trace of the nature of this institution. In 1862, Ann was employed by the Liverpool Training School and Home as a nurse in District 10 and then District 17 from 1865.¹² In 1876 the Nursing Committee decided to dismiss Ann and a Mrs Edwards and replace them both with trained nurses. In lieu of Ann Brodrick's service she was given £25.¹³ This seems quite a low reward for a woman who had given service over a fourteen year period, as each district nurse was paid at least £52 in "money and board" not including rent and coal, per year, during the early 1870's.¹⁴ After her dismissal there is no further trace of Ann in either the records or the census returns.

LINCOLN NURSES INSTITUTION

Cecilia Quinney, born c1849 Marylebone, London. married Breconshire, Wales, March 1876

Cecilia was born and lived in Marylebone, London. Her father was an unskilled worker being a cowkeeper in 1851 and a bell toller in 1861. Cecilia was in training at University College Hospital, London in 1871 and in 1872 was a private nurse working for the Lincoln Nurses' Institution. It is possible that she was recruited to Lincoln through the offices of the Society for the Promotion of the Employment of Women (SPEW), which was founded and run by Jessie Boucherett a subscriber to the Lincoln Institution and sister to Louisa who was one of the women who ran the organisation. Although there are no direct references to Cecilia in the Society's records, SPEW kept a register of women

¹² Liverpool Record Office (hereafter, LRO), District Nurses in Liverpool 1862-1900 by Gwen Hardy, 1973 & 1985 (Hq 610.730922 HAR)

¹³ LRO, Nursing Committee Minutes 1874-1938, February 20 1876 (LRI 614INF/4).

¹⁴ Correspondence from Mary Merryweather, *Englishwoman's Review*, July 1, 1873, p. 245.

seeking employment and directed a small number every year to nursing institutions.¹⁵ In addition the Lincoln institution placed many women for training with the All Saints sisterhood which managed the nursing of University College Hospital. In 1872 Cecilia was employed by the Lincoln Institution for Nurses. The case book she kept whilst nursing a Mrs Dixon during her final illness between 27th April and the 6th May 1872 has, unusually, survived.¹⁶ In it she details the care given to her patient over eight days and nights, this consisted, mainly of giving the treatment prescribed by the family doctor which included medicines but also champagne, sherry, egg and brandy and a chocolate breakfast. She concluded her service to the family by laying out the patient and attending the funeral. This is the only record, in this study, of an account of nursing practice by a nurse. There are no further records of her career at Lincoln and she was married in 1876 to John Batemen a railway guard in Breconshire, Wales. After a further six or seven years residence in Wales the family moved to Cucklington in Somerset, John Bateman's home village where he was employed as a farm labourer in 1891 and in 1901 he was an independent carrier. Cecilia had eight children between 1879 and 1899.

MANCHESTER NURSE TRAINING INSTITUTION

Eliza Leek, Born c1833 Atherstone, Warwickshire. Died Bradford, Yorkshire, July 1900

At the age of eighteen, Eliza was employed as a silk weaver in Bedworth, Warwickshire but was recorded as a reel packer in Little Bolton, Lancashire in 1861. This move was probably initiated by a general depression in the English silk industry with many workers relocating to Lancashire at this time. In 1865 she was trained by St. John's House sisterhood at Kings College Hospital, London. On her return to Lancashire, nurse Leek worked in the Adelphi Street District of Salford and in 1866 the Lady Superintendent of the district wrote:

¹⁵ Girton College Cambridge, Society for the Employment of Women, Annual Reports 1860-81 (GCIP 2/1/1)

¹⁶ Lincolnshire Archives, Lincoln Institution for Nurses' Memoranda: Details of Mrs J G Dixon's last illness by Cecilia Quinney, nurse, 1872 (DIXON 22/11/20)

she has not only proved herself a skilful and well trained nurse, but also, by her judicious exertions, been of great advantage to the poor by teaching them many useful lessons, such as the value of cleanliness, the proper way of preparing food etc.¹⁷

This was followed by five years' exemplary work as a district nurse in which she was said to be 'upright, zealous, and good' and "much loved by the poor".¹⁸ The house in which she lived was stocked with a small number of medicines, blankets and other equipment which was loaned to the poor. In January 1870, she had 23 cases on her books, eleven of which were medical, five fever and seven cases that required dressings or bandages. In addition she was said to be a skilled midwife, something she more than likely acquired at Kings College Hospital.¹⁹ In 1871 she was appointed as the matron of the Bradford Eye and Ear Hospital, Yorkshire.²⁰ She stayed in post until retirement in 1893, where she was given an illuminated testimonial and £100 in "deep appreciation of her labours".²¹ She died in July 1900 and left an estate of £173-1s-5d. Eliza's career illustrates that working-class women with the necessary skills could make nursing a worthwhile career and accumulate capital for retirement.

Mary Mackie (McKie), born c1832, Scotland

In 1861 Mary Mackie was working as housekeeper to her uncle in Chorlton upon Medlock, Manchester. In 1865 she was recruited by the Manchester Trained Nurses' Institution and sent to St. Thomas's Hospital in London to be trained. Here she was described as "of ordinary capabilities, excited and nervous"²². She returned to the Institution in January 1866 where she was employed at the Salford Hospital but her behaviour proved to be a cause of concern. A flurry of correspondence about her resulted in Mrs Wardroper, the matron of St. Thomas's Hospital reporting that:

¹⁷ Manchester Archives and Local Studies (hereafter MALS) Manchester Nurse Training Institution Annual Report, 1866, p17 (362.1 M85)

¹⁸ Ibid., Annual Reports, 1867 p12 & 1868 p13

¹⁹ 'Our lesser charities, No8. The Nurse Training Institution' *Manchester Guardian* January 13 1870.

²⁰ West Yorkshire Archives, Bradford Eye & Ear Hospital, *Annual Report*, 1871, p13, (70D95/1b).

²¹ Ibid, *Annual Report*, 1893, p11, (70D95/3).

²² London Metropolitan Archives (hereafter, LMA), Nightingale Training School, Probationer Record Books 1860-1871, (H1/ST/NTS/C/4/02/001)

Mackie is so exceedingly uncertain that I think it is unwise to prolong her stay. Her temper is also violent and although she has been quieter of late still I could not trust her to the care of female patients.²³

Dr Morgan wrote from Manchester:

When she came to us Mrs Wardroper spoke of her as somewhat eccentric in her manners I am very sorry to say we have found her not only eccentric but likewise sadly deficient in her temper and consideration toward the patients entrusted to her care.²⁴

As a result she was dismissed but this did not prevent her earning a living from nursing female patients. In 1871 she was employed as a nursemaid, in the house of a cotton spinner, employing 800 people, in Ashton Under Lyne. In 1881 she was living in Toxteth Park, Liverpool and was described as a ladies nurse. In 1891 it is probable that she was an in-patient in St Mary's Paddington, London. In 1901 she was back in Liverpool being employed as a ladies nurse. Thus 35 years after her dismissal she was still earning a living as an independent private nurse attending women and new born children.

Agnes and Fanny (Frances) Chambers, born c1840, Sheffield, Yorkshire. Died 1868 & 1889.

Agnes and Fanny were twins. In 1841 their father was a railway guard. In 1851 he was widowed and lived in Wakefield as a cattle dealer, by 1861 he had moved to Liverpool and was a dairyman. Agnes was living with him and is described as a sewing machinist whilst Fanny was employed elsewhere in the city as a general domestic servant to a book-keeper. In August 1862 Agnes entered the Liverpool Training School and Home as a probationer, where she was described by Miss Merryweather, the lady superintendent as “more suitable in men’s than women’s wards. Requiring much supervision tho’ decidedly interested in her patients and nursing generally”.²⁵ Agnes remained in Liverpool until she resigned in July 1866 and then she moved to Manchester to take up district nursing. Here she was appointed to the Oldham Road district and was said to be “thoroughly interested in her work; is clever as a Nurse – especially clever in surgical cases, and we believe

²³ LMA, Mrs Wardroper to Henry Bonham-Carter, November 2 1866, (H01/ST/NC/18/007/020)

²⁴ LMA, Dr Morgan, Hon Sec, Manchester Trained Nurses’ Institution, to Henry Bonham-Carter, October 29 1866, (H01/ST/NC/18/007/021)

²⁵ LRO, 614 INF/26/2/1 Register of Trainee Nurses 1862- 1876

thoroughly sober and honest”.²⁶ She died in February 1868²⁷ probably from typhus.²⁸ Agnes was succeeded in her district by her sister Fanny, who was described as “intelligently and warmly interested in her work, and is much valued in the neighbourhood”.²⁹ Fanny continued in district nursing, becoming the district matron in 1877.³⁰ In 1879 she was appointed district nurse to the Eccles and Patricroft Dispensary, where she remained until her death in 1889.³¹ She left an estate of £138-12s-5d to family, friends and the district nurses’ home. The careers of Agnes and Fanny show that district nursing could be a dangerous but rewarding career.

SALISBURY DIOCESAN INSTITUTION FOR TRAINED NURSES

Louisa Case, born c1855, Upton Lovell, Wiltshire & Charlotte Matilda Case, born c1858, Bradford, Wiltshire

Louisa and Charlotte (also referred to as Matilda) were daughters of a farm worker. Their careers show that an institution such as that at Salisbury could supply private nurses to a wide geographical area as well as serving the population in and around its home city. In addition, nursing provided the two sisters, who came from a humble background, a satisfactory living over the last two decades of the nineteenth century.

Both Louisa and Charlotte were trained at the Salisbury Infirmary and joined the Diocesan Institution in 1879 and 1881 respectively. In 1881, Louisa was a ‘sick nurse’ at Fremington House, Devon whilst Charlotte was employed as a nurse in the household of a builder, in Salisbury. On census night 1891, Charlotte was resident in the Institution’s nurses’ home in Salisbury, presumably between engagements, whilst her sister was employed in Hanover Square, London. In 1901 both sisters were working together at Houston House, Renfrewshire, Scotland. In 1904, Louisa resigned, after 26 year’s service, to work for Lady Ann Speirs, the builder of Houston House and the widow of

²⁶ MALS 362.1 M85 Manchester Nurse Training Institution Annual Report, 1866, p15

²⁷ MALS, Philips Park Cemetery, Burial Registers 1867-1876, (microfilm copy) (MFPR 687).

²⁸ MALS, Manchester Nurse Training Institution Annual Report, 1870, p. 6, (362.1 M85).

²⁹ Ibid.

³⁰ Slater’s Directory of Manchester & Salford 1877-8, p.146 and 1879, p.71.

³¹ MALS, Manchester Nurse Training Institution Annual Report, 1880, (362.1 M85).

Alexander Speirs, a descendent of Glasgow tobacco merchants and holder of the Barony of Fulwood.³² On leaving Louisa's earnings were £76 and she received £35 in bonuses and had a pension fund of £40-7s-0d.³³ There is no record of Charlotte's subsequent career.

³² The barony of Fulwood at [www.baronyof fulwood.com](http://www.baronyoffulwood.com) accessed on 1/12/09

³³ Wiltshire & Swindon Record Office, Salisbury Diocesan Institution for Trained Nurses, Minute Book 1879-1907, August 5 1904, (J8/109/3).

APPENDIX 8: Biographies of Selected Lady Superintendents

The same issues in tracing working-class nurses as outlined in Appendix 4 have been encountered for these women

BIRMINGHAM AND MIDLAND COUNTIES TRAINED NURSES INSTITUTION

Julia Tindall (née Williams), born c1827, Selby, Yorkshire. Died in Devon 1901.

Mrs Tindall was married to an ironmonger and ironfounder in 1849 and had at least two children. The circumstances surrounding her marriage are not known, and in censuses from 1871 onwards she is described as married, but her husband, Lorenzo, was never present. He seemed to be a successful businessman and was accredited with patenting improvements to churns¹ and also developing an improved version of the domestic mangle.² During the 1860s she trained as a lady nurse in Kings College and Charing Cross hospitals.³ Both hospitals were under the control of the St. John's House sisterhood at this time. After this she established a nurse training institution in Exeter in 1866 and was appointed lady superintendent to the Birmingham and Midland Counties Training Institution for Nurses in 1869. She managed the Institution but also took control of the nursing of the Birmingham Children's Hospital as its lady superintendent, was honorary lady superintendent for the Women's Hospital and also offered to manage the nursing of the Queen's Hospital.⁴ The training institution received excellent feedback from the hospitals, about the probationers who were learning to be nurses, and also regarding the managerial capabilities of Mrs Tindall. In regard to her role in supervising the private nurses they were said to be under her constant supervision and that she constantly

¹ 'Patents filed at the office for the Commissioner of Patents', *London Gazette* (21532), 17 March 1854, p. 883.

² www.ourmansfieldandarea.org.uk (accessed February 21 2010).

³ Birmingham Archives and Heritage (hereafter BAH), Birmingham & Midland Counties Training Institution for Nurses, Annual Report 1870, p. 10 (L46.6 12811)

⁴ BAH Birmingham & Midland Counties Free Hospital for Sick Children: Management Committee, Minute Book, October 27 1869 (HC/BCH/1/2/1); Birmingham and Midland Hospital for Women: Annual Report 1871-2, p12 (HC/WH/1/10/1); Queen's Hospital Birmingham: House Committee, Minute Book, February 7 1871 (HC/QU/1/2/3)

observed and tested their capabilities.⁵ In 1875 she resigned her post and retired. In the 1881 and 1891 censuses she was found to be a visitor in the house of Thomas Blackall, a retired physician, in Exeter. Blackall was associated with hospitals in Exeter and she may have known him from her time at the nursing institution in the town.⁶ Julia Tindall died in 1901.

Elizabeth Diamond (née), born c1828, Brenchley, Kent. Died August 11 1898, Birmingham.

In 1871 Mrs Diamond was a widow and was acting for the lady superintendent at the Evelina Children's Hospital in London. She was appointed as the Lady Superintendent of the Birmingham and Midland Counties Training Institution for Nurses in 1875. She remained in post until her death in August 1898.⁷ During this period the number of nurses and probationers more than doubled and she was involved in negotiating places in hospitals for the probationers to train as well as the management of the nurses' home. For this she was given credit for her 'economical management'.⁸ Little else is left in documents concerning her work.

DERBY AND DERBYSHIRE SANITARY AND NURSING ASSOCIATION

Mary Brumwell, born c1828, Monkwearmouth, Durham. Died in Derby, 1884.

Miss Brumwell was an unmarried woman of independent means from a middle class background. She was a devout Christian, undoubtedly of an evangelical nature. Sometime in the 1860s she attended the Mildmay Mission where she worked for a year with the poor in the east end of London. She was described as 'preferring a life of active usefulness; having a decided taste for nursing; and specially for work amongst the poor; of good judgement; of inexpensive habits; with special powers of administration in giving relief, and in helping the poor themselves'.⁹ In 1869 Miss Brumwell was appointed as

⁵ BAH Birmingham & Midland Counties Training Institution for Nurses: Annual Report 1870, p10 (L46.6 12811)

⁶ P. Russell, *A history of the Exeter hospitals, 1170-1948*, (Exeter, 1975).

⁷ *The Nursing Record & Hospital World*, August 20 1898, p. 152.

⁸ BAH Birmingham & Midland Counties Training Institution for Nurses: House Committee, Minute Book, October 13 1885. (MS807/6/6).

⁹ Derby Local Studies Library (hereafter DLSL): Derby and Derbyshire Nursing and Sanitary Association; Twentieth Annual Report 1884-5, p5 (A610.73).

Lady Superintendent at Derby. Here she had control of the private nurses, ran the nurses' home and also acted as supervisor to the district nurses. She visited all of the district nurses' patients once a week, and allocated the nurses their daily cases, which were cared for according to the directions given by her.¹⁰ Newspaper reports following the annual general meetings invariably praised her for her judgement and for setting high standards.¹¹ Miss Brumwell worked tirelessly for 15 years for the Association but died suddenly in December 1884. The committee saw her death as "deeply lamented" and felt 'By her force of character, powers of discernment, and truly Christian spirit she has raised the institution to its present high state of efficiency. She inspired her nurses with a deep devotion to their work, and has made the Institution valued far and wide.... and hundreds of families both poor and rich will gratefully remember her'.¹² When she took up her post there were six nurses and at the time of her death there were approximately sixty.

Emily Alice Woodhead, born 1849 Oswaldkirk, Yorkshire; Adelaide Mary Atthill, born c1859 Ireland; Agnes E Atthill born Ireland 1864

These three women were the successors of Miss Brumwell. They all seemed to have come from a religious background and are proof that the organisation whilst not sectarian, expected its superintendents and nurses to be protestants and to have a religious vocation in their work. Emily Woodhead was the daughter of a captain in the Madras Militia. In the 1881 census, she was recorded as the Lady Superintendent of a medical mission in Shadwell, London. She was appointed lady superintendent at Derby in 1884 and resigned in 1892. In the 1901 census she was listed as the head of a secretarial mission in Leytonstone, London.

Nothing is known of Adelaide Atthill before she was a hospital sister at St Mary's Hospital, Paddington, London. She had been there for five years and was the sister in charge of the training of probationers for four of those years, before her appointment to

¹⁰ National Association for Providing Trained Nurses for the Sick Poor, *Report of the sub-committee of reference and enquiry* (London, 1875), pp. 36-40.

¹¹ 'Derby and Derbyshire Nursing Association', *Derby Mercury*, April 7 1875; 'The Derby and Derbyshire Nursing Association', *Derby Mercury*, April 11 1877

¹² 'The Late Miss Brumwell', *The Derby Mercury*, 24 December, 1884.

the post of Lady Superintendent at Derby in 1892.¹³ She resigned in May 1894 and married a local clergyman. In 1901 she is recorded as still living in Derby with her husband and three young children. Adelaide was succeeded by Agnes E Atthill, probably her sister. She too was a trained nurse and was also at St Mary's Paddington in 1891, being recorded as a hospital nurse. It was known that she had been connected with the Young Women's Christian Association prior to her training as a nurse.¹⁴ In 1901 her sister Matilda Atthill was the Superintendent of district nurses in Derby, having previously been the outdoor midwife at City Road, Lying-in hospital, London in 1891 and a private nurse in Essex in 1881. This dynasty of nurses was complemented by Lavinia, probably another sister, who was a hospital nurse at the Mildmay Mission Hospital in 1891. The Atthill sisters illustrate the change within nursing organisations from lay women being appointed as superintendents to those who had undertaken nurse training by the end of the century.

LINCOLN NURSES INSTITUTION

Cora Marshall, born c1845, Lincoln, Lincolnshire.

Cora Marshall was born in Lincoln. Her father was a brewer and maltster employing a number of men. In 1872 Miss Marshall was appointed as the resident matron or lady in charge of the nurses' home in Greetstone Place, Lincoln. It is not known whether she obtained any nursing experience or a qualification to equip her for the post. She was not, like many of her contemporaries in charge of the entire Institution. This position was undertaken by Mrs Bromhead the founder of the institution, who was succeeded by her daughter in 1886. It would seem likely that Miss Marshall supervised the nurses' home, maintaining discipline and managing the day to day affairs of the home. This would have been a task she was well used to in her parent's home as there were always servants

¹³ DLSL, Derby and Derbyshire Nursing and Sanitary Association; Annual Report 1891-2, p. 8. (A610.73)

¹⁴ Derbyshire Record Office, Derby and Derbyshire Nursing and Sanitary Association, House and Management Committees minute book, 13 July 1894. (D4566/2/1)

employed to undertake the domestic tasks. In 1907 Miss Marshall resigned as Lady-in-Charge after 35 years of ‘most loyal, devoted, and faithful service’.¹⁵

LIVERPOOL TRAINING SCHOOL AND HOME

Mary Merryweather, born c1818, Hampreston, Dorset. Died May 5 1880, London.

Mary Merryweather was a Quaker, deeply religious and concerned about the rights of women. In this respect she was acquainted with a number of people who fought for women’s rights, in particular Bessie Rayner Parkes, with whom she had a long friendship and correspondence.¹⁶ In 1869, she was one of the first subscribers and member of the committee of the Ladies National Association for the Repeal of the Contagious Diseases Acts.¹⁷ In addition, she supported women’s suffrage as ‘justice and morality can never rule the country where half the population, even when qualified otherwise, is, by the accident of sex, excluded from the representation’.¹⁸

Running alongside active support for women’s rights was a practical career that spanned 33 years in three different organizations. In 1847 she was appointed by Samuel Courtauld to run evening classes for the female factory workers at his silk factory in Halstead, Essex. Her curriculum, as well as teaching the young women to read and write, included lessons on physiology, health and hygiene. She established a hostel for the women, a day nursery and attempted to set up a factory wash house.¹⁹ All of these ventures had limited success. She did, however, visit sick workers in their own homes and was instrumental in instructing the female members of the factory sick club regarding caring for the sick and preventing illness. In this respect she was a sanitarian and in both the 1851 and 1861 censuses she is described as a moral missionary. She published an account of her life at Halstead in: *Experiences of Factory Life* in 1862. Bessie Rayner Parkes provided the preface.

¹⁵ Lincolnshire Archives (hereafter LA), The Institution for Nurses, Lincoln: Annual Report 1907 (Bromhead 4/2).

¹⁶ Girton College Cambridge, Letters from Bessie Raynor Parkes to Mary Merryweather 1856-1877 (GCPP Parkes 6E) and Letters from Mary Merryweather to BRP (Parkes 6F)

¹⁷ Obituary: Miss Mary Merryweather, *The Shield*, 15 May 1880, p. 76.

¹⁸ Central Committee of the National Society for Women’s Suffrage, *Opinions of women on women’s suffrage* (London, 1879), p. 54.

¹⁹ J. Lown *Women and Industrialization*, (Oxford, 1990).

In 1861 William Rathbone developed a scheme for the Liverpool Training School and Home which would train nurses for hospital, private and district nursing. He recruited Mary Meryweather to become the first Lady Superintendent and her sister Elizabeth became her deputy. Both of them went to St Thomas's and Kings College hospitals to familiarize themselves with the work, for a few months, before taking up their appointments. Mary had little to do with the running of the Liverpool Royal Infirmary and concentrated on making the training school a 'refined Christian Home'.²⁰ It was recognized by the committee that her efforts largely contributed its success²¹. Nightingale was of another opinion having met with Mary in 1874 and asked 'Does she know anything at all about nursing?'²² Nightingale's opinion, based partly on the testimony of Agnes Jones, was that discipline and training were lax resulting in immorality and drunkenness and that the district nurses were worse than those in the Royal Infirmary. In summary Nightingale said 'I believe her to be a very good woman, in a post for which she was wholly unfit'.²³ Mary remained in Liverpool until 1874 when she left, with her sister, to establish a training school at the Westminster Hospital, London,. Her time at the Westminster was controversial with disputes between the doctors and the management committee over the authority of the lady superintendent and her sister. There was also no systematic plan of training – a similar criticism of her time at Liverpool.²⁴ Amidst the controversy she fell ill and died of apoplexy. To a certain extent her work in nursing was an extension of her work at Halstead with much of her efforts being concerned with the supervision and disciplining of the mainly working-class nurses. It would seem that the art and science of nursing was of less concern to her.

²⁰ 'Art.II. - Miss Merryweather', *The Englishwoman's Review*, 15 June 1880, p. 244.

²¹ Liverpool Record Office (hereafter LRO), Nursing Committee Minutes, August 10 1874 (LRI 614INF/4).

²² British Library, Notes from Florence Nightingale to Henry Bonham Carter, 23 July 1874 (Add Mss 47719 ff68-69), reprinted in L MacDonald, *Florence Nightingale: extending nursing*, Collected works of Florence Nightingale, Volume 13 (Waterloo, 2009), p. 266.

²³ *Ibid.*, 27 July 1874, pp. 267-8.

²⁴ M. E. Baly *Florence Nightingale and the nursing legacy*, 2nd ed. (London, 1997), p. 166.

Emmeline Stains, born c1839, St Marylebone, London. Died 1892, Liverpool.

Emmeline was the daughter of a brewer. Her career in nursing started in 1867 at the Herbert Military Hospital in Woolwich, London.²⁵ She is recorded as a ward nurse at the same hospital in the 1871 census and she is reported to have trained at St Thomas's Hospital in the same year. In 1873 she was described as "the only good surgical sister" in St Thomas's Hospital by Nightingale.²⁶ In 1876 she was expected to go to the Herbert Hospital as the acting superintendent but because of prevarication by the War Office she declined the appointment and applied to the Wolverhampton General Hospital to be the lady superintendent.²⁷ She was appointed in May 1877 and stayed until 1881. There are no reports about her work at Wolverhampton in the surviving records, other than her appointment and resignation in the annual reports.²⁸ However, she did have three meetings with Nightingale prior to her appointment in order to discuss sanitary matters and the costs of staffing the hospital.²⁹ She left Wolverhampton in 1881 for the Liverpool Royal Infirmary to take charge of the hospital, the training school and the nurses' home, including private and district nursing within the city. She remained in Liverpool until her death in December 1892. Nightingale described her as 'a woman of a mighty spirit – *she* built the new Liverpool Infirmary'.³⁰ Emmeline Stains was one of a generation of middle class women who trained as nurses in the middle to late nineteenth-century and who devoted their lives to improving the nursing of the poor.

²⁵ LRO, Liverpool Royal Infirmary, *Annual Report of the Training School and Home for Nurses*, 1892, (614 INF/ 17/8)

²⁶ Letter from Florence Nightingale to Henry Bonham Carter, early 1873, (BL Add Mss 47717 ff195-204) reprinted in L MacDonald, *Florence Nightingale: The Nightingale School*, Collected works of Florence Nightingale, Volume 12 (Waterloo, 2009), pp. 254.

²⁷ Baly, *Florence Nightingale and the nursing legacy* pp. 113-14.

²⁸ Wolverhampton Records Office, Wolverhampton General Hospital, *Annual Report*, 1877 and 1881 (NHS-RH/3/2/3)

²⁹ L. MacDonald, *Florence Nightingale: Extending nursing*, Collected works of Florence Nightingale, Volume 13 (Waterloo, 2009), pp. 300-01.

³⁰ *Ibid.*, p.271

MANCHESTER NURSE TRAINING INSTITUTION

Elizabeth Alsop, born c1833, Bolsover, Derbyshire.

In 1861, Elizabeth Alsop was a widow and shopkeeper living in Chesterfield with three children. Nothing is known of her before this time. In March 1865 she secured a position to train as a nurse at the Liverpool Training School and Home on the recommendation of the Rev. Grey of Bolsover. She served three months in the wards, and then acted as housekeeper in the Home, until December 1865 when she was appointed as Matron of the Manchester Nurse Training Institution. At the end of her training she was described as having ‘Undoubted Sobriety, honesty and truthfulness.’³¹

In Manchester, she took control of the nurses’ home and supervised the private nurses, receiving reports about them and reporting to the management committee regarding the running of the home, the nurses and their work. The district nurses lived in their own homes and were supervised by a ladies committee and individual lady superintendents for each district. Elizabeth fulfilled her role satisfactorily until 1879, when a house committee was set up to review why the income from private nursing had not covered its expenses for the previous two years. This committee found that there were problems and that it would be impossible to introduce any changes under the existing management and as such Mrs Alsop was dismissed.³² The 1881 census records her being the Head of a medical and surgical home in Chorlton-on-Medlock, Manchester and she was still there in 1883.³³ This, no doubt, was a private organisation but no records remain today. In 1891, Elizabeth was recorded as lodging house keeper, in St Leonards-on-Sea and this census entry is the last record of her career and life.

³¹ LRO, Register of Trainee Nurses 1862- 1876, p. 47 (614 INF/26/2/1)

³² Manchester Archives and Local Studies, Manchester Nurse Training Institution Annual Report, 1879, pp. 5-6 (362.1 M85)

³³ I. Slater, *Slater’s Royal National Commercial Directory of Manchester & Salford 1883* (Manchester, 1883).

SALISBURY DIOCESAN INSTITUTION FOR TRAINED NURSES

Anna Hussey, born c1836, Hayes, Kent.

Miss Hussey was the daughter of the Rector of Hayes in Kent, a well known amateur astronomer.³⁴ He died in 1851 and Anna's uncle became rector. What happened to her is not clear as there is no record of her having been trained as a nurse or indeed having any paid employment until her appointment as lady superintendent in April 1876. In the previous four years there had been two superintendents. Miss Michell was appointed in 1872 but seriously, for an organisation of the established church intent on avoiding religious extremes, she had been arranging for some members of the institution to take confession. She was warned by the bishop and subsequently resigned in June 1873.³⁵ Her successor, Miss Noyes left in 1876 after complaints by the nurses regarding her disciplinarian stance and lack of attention to their comforts in the home.³⁶ Miss Hussey was a different character, an adherent of the Church of England, an able administrator and she remained in post until October 1896 having given 'twenty years of invaluable service'.³⁷ Throughout her time as lady superintendent she was praised for her 'judgement with which she decided which nurse to send, the way in which she kept them together and refined them' and also the nurses 'devotion to the poor; they were always as ready and willing and as devoted to the poor as to the rich'.³⁸ Following retirement she lived in Oxford.

³⁴ G. D. Rochester, 'The history of astronomy in the University of Durham from 1835 to 1939', *Quarterly Journal of the Royal Astronomical Society*, 21 (1980), pp. 369-378.

³⁵ Wiltshire and Swindon Record Office (hereafter WRSO), Salisbury Diocesan Institution for Trained Nurses: Minute Book, 1871-1876, 26 June 1873 (J8/109/1).

³⁶ *Ibid.*, 28 February 1876

³⁷ WRSO Salisbury Diocesan Institution for Trained Nurses: Minute Book July 1879-1907, 5 October 1896 (J8/109/3)

³⁸ *Ibid.*, Speech by Mr Coates, surgeon to the Salisbury Infirmary in a newspaper cutting, 28 February 1884

STRATFORD-ON-AVON NURSING INSTITUTION

Emily Minet, born January 27 1835, Funchal, Madeira. Died August 8 1892, Stratford-upon-Avon.³⁹

Emily Minet was a deeply religious woman from a fairly wealthy background. Her father, descended from Huguenots, was a wine merchant when she was born in Madeira. On return to England she was educated at home and at the age of 17 she became a companion governess for the Paull family at Blundeston, Suffolk. Here she practiced district visiting, Sunday school teaching and developed an interest in nursing and administering to the sick poor. In 1861 she went to Barrow in Furnace to establish a middle-class school on the invitation of the vicar. She continued with her district visiting activities and helped with nursing in the local cottage hospital. In 1870 she went to Walsall, where she trained to be a nurse under the supervision of ‘Sister Dora’ Pattison. There are no surviving records of this time in her life and none in Walsall itself, but Gepp reprints a letter from a dying Sister Dora, in 1878, regretting the fact that Miss Minet would not take on her work at Walsall.⁴⁰ At the end of 1870 she went to the Middlesex hospital as the night superintendent but could only stay a few months because of ill health. The hospital would not grant her a certificate because of the shortness of her stay. Then in October 1871 she was invited to become the superintendent of the nursing institution in Stratford-on-Avon. Here she remained in post until her death in 1892. She managed the institution through its development into a ‘Nursing Home for Convalescent Women and Sick Children’ as well as maintaining its staff of private nurses and offering free nursing for the sick poor. She, assisted by one nurse visited the sick poor in their own homes deciding upon what type of nursing they required and what they should be taught about health and care of the sick. The institution gained a good reputation and private nurses were sent long distances. She kept in touch with them by letter. In 1891 she became ill, which turned out to be cancer and in spite of an operation died in August 1892. In May 1893, as a result of public subscriptions, a memorial window featuring St Elizabeth of Hungary working amongst the poor was unveiled in the parish church. Her life had been dedicated to the care of others and according to her biographer ‘she was deeply, earnestly, intensely Christian.

³⁹ Much of this account comes from: C. G. Gepp *A short memoir of Emily Minet* (London, 1894)

⁴⁰ *Ibid.*, pp. 17-18

Her Christianity spoke for itself. She looked, she spoke, she lived it'.⁴¹ Like so many women who took on the management of nursing, she was guided by her religion.

Annie Moseley, born c1867 Framlingham, Suffolk.

Annie Moseley was the daughter of a solicitor. In approximately 1885⁴² she became a nurse and in the 1891 census was working at the Seaman's Hospital, Greenwich, London. She had been in temporary charge of the Stratford-Upon-Avon Infirmary during the summer of 1892 and was appointed Lady Superintendent of the 'Nursing Home for Convalescent Women and Sick Children' following Miss Minet's death.⁴³ She was said to have run the home very well and was Lady superintendent until 1908.⁴⁴ Her appointment illustrates the trend for nursing associations to employ qualified nurses as superintendents by the end of the century.

⁴¹ Ibid., p. 83.

⁴² *Stratford Herald* October 7 1892

⁴³ Shakespeare Birthplace Trust Archives, Stratford-Upon-Avon, Nursing Home for Convalescent Women and Sick Children *Annual Report*, 1893.

⁴⁴ P. Spinks 'The Stratford-upon-Avon convalescent home' *Warwickshire History*, (Winter 2005/6), p. 100

APPENDIX 9: Subscribers and Donors to Nursing Associations and Local Voluntary Hospitals: A Comparison of Clergy, Male and Female patterns of involvement

Birmingham and Midland Counties Nurses' Training Institution: Subscriptions & Donations

| | 1870 | 1880 | 1890 | 1900 |
|--|-------------|-------------|-------------|-------------|
| Numbers of Individual Subscribers & Donors and as a percentage of the total | | | | |
| Clergy | 5 (1.8%) | 6 (2.3%) | 4 (1.9%) | 0 |
| Other Men | 98 (35.0%) | 96 (37.2%) | 94 (43.7%) | 72 (52.2%) |
| Women | 177 (63.2%) | 156 (60.5%) | 117 (54.4%) | 66 (47.8%) |
| Value of subscriptions & donations as a percentage of the total | | | | |
| Clergy | 1.04% | 2.65% | 1.41% | 0 |
| Other men | 58.95% | 44.54% | 45.82% | 53.07% |
| Women | 39.05% | 49.75% | 49.53% | 44.05% |
| Corporate | 0.87% | 2.04% | 2.40% | 1.44% |
| Offerings & Collections | 0 | 0 | 0 | 0 |
| Miscellaneous | 0.08% | 1.02% | 0.84% | 1.44% |

Birmingham District Nursing Society: Subscriptions & Donations

| | 1870 | 1878¹ | 1890 | 1900 |
|--|-------------|-------------------------|---------------------|---------------------|
| Numbers of Individual Subscribers & Donors and as a percentage of the total | | | | |
| Clergy | No Data | 1 (0.8%) | 4 (1.4%) | 5 (1.5%) |
| Other Men | No Data | 20 (15.5%) | 77 (27.2%) | 125 (37.4%) |
| Women | No Data | 108 (83.7%) | 202 (71.4%) | 204 (61.1%) |
| Value of subscriptions & donations as a percentage of the total | | | | |
| Clergy | No Data | 0.52% | 0.87% | 0.34% |
| Other men | No Data | 23.15% | 24.88% | 19.97% |
| Women | No Data | 76.33% | 37.29% | 15.88% |
| Corporate | No Data | 0 | 4.79% | 18.54% ² |
| Offerings & Collections | No Data | 0 | 0.46% | 1.15% |
| Miscellaneous | No Data | 0 | 31.72% ³ | 44.12% ⁴ |

¹ Records are incomplete and this is the nearest report to 1880

² Corporate subscriptions include businesses, boards of guardians, the dispensary, and benevolent societies

³ This includes donations from the Nurse Training Institute, The Hospital Sunday Collection and Hospital Saturday Collection.

⁴ This includes donations from the Nurse Training Institute, The Hospital Saturday Collection and The Muntz Trust (charity).

Female Subscribers & Donors: A comparison of the Nursing Training Institution and some of the Birmingham hospitals⁵

| | 1870 | 1880 | 1890 | 1900 |
|--|---------|--------------------|---------|---------|
| Numbers of Individual Subscribers & Donors and as a percentage of the total | | | | |
| Training Inst. | 63.2% | 60.5% | 54.4% | 47.8% |
| DN Society | No Data | 83.7% ⁶ | 71.4% | 61.1% |
| General Hosp | 8.8% | No Data | 9.9% | 10.2% |
| Children's H | 19.5% | 18.8% | 19.6% | 19.2% |
| Queen's Hosp | No Data | 7.3% | 7.5% | 8.3% |
| Women's H | No Data | 49.6% | 46.7% | 47.0% |
| Value of subscriptions & donations as a percentage of the total | | | | |
| Training Inst. | 39.05% | 49.75% | 49.53% | 44.05% |
| DN Society | No Data | 76.33% | 37.29% | 15.88% |
| Hospitals | No Data | No Data | No Data | No Data |

Derby & Derbyshire Nursing & Sanitary Association: Subscriptions & Donations

| | 1865 | 1870/1 | 1882/3 | 1889/90 | 1900 |
|--|------------|------------|-------------|-------------|-------------|
| Numbers of Individual Subscribers & Donors and as a percentage of the total | | | | | |
| Clergy | 24 (23.1%) | 33 (16.8%) | 33 (12.1%) | 23 (10.4%) | 20 (9.3%) |
| Other Men | 50 (48.1%) | 69 (35.0%) | 99 (36.3%) | 71 (32.3%) | 86 (40.0%) |
| Women | 30 (28.8%) | 95 (48.2%) | 141 (51.6%) | 126 (57.3%) | 109 (50.7%) |
| Value of subscriptions & donations as a percentage of the total | | | | | |
| Clergy | 9.40% | 14.86% | 5.10% | 6.02% | 8.04% |
| Other men | 75.21% | 35.59% | 20.96% | 38.26% | 43.03% |
| Women | 15.38% | 37.78% | 31.24% | 28.60% | 27.36% |
| Corporate | 0 | 1.15% | 1.20% | 3.14% | 3.37% |
| Offerings & Collections | 0 | 9.94% | 3.94% | 2.28% | 9.15% |
| Miscellaneous | 0 | 0.69% | 37.57% | 21.69% | 9.05% |

⁵ Data on Birmingham hospitals from J. Reinartz 'Charitable bodies: the funding of Birmingham's voluntary hospitals in the nineteenth century'. In M. Gorsky and S. Sheard (eds) *Financing Medicine: The British experience since 1870*. (London, 2006) p. 43.

⁶ Data from 1878

Female Subscribers & Donors: A comparison of the Nursing Association and the Derbyshire General (Royal) Infirmary⁷

| | 1865-66/7 ⁸ | 1870/1 | 1882/3 | 1889/90 | 1900 |
|---|------------------------|------------|-------------|-------------|-------------|
| Female Subscribers & Donors and as a percentage of the total | | | | | |
| Nurse Assoc. | 30 (28.8%) | 95 (48.2%) | 141 (51.6%) | 126 (57.3%) | 109 (50.7%) |
| Infirmary | 65 (15.2%) | 87 (15.1%) | 101 (16.9%) | 89 (14.8%) | 237 (15.3%) |
| Value of subscriptions & donations from women as a percentage of the total | | | | | |
| Nurse Assoc. | 15.38% | 37.78% | 31.24% | 28.60% | 27.36% |
| Infirmary | 10.96% | 11.60% | 12.85% | 10.74% | 14.44% |

Lincoln Institution for Nurses: Donations and Subscriptions⁹

| | 1867 | 1870 | 1880 | 1890 | 1900 |
|---|-------------|-------------|------------|------------|------------|
| Numbers of Individual Subscribers and as a percentage of the total | | | | | |
| Clergy | 24 (13.8%) | 27 (15.6%) | 27 (16.8%) | 20 (11.6%) | 12 (10.6%) |
| Other men | 27 (15.5%) | 31 (17.9%) | 36 (22.4%) | 47 (27.3%) | 33 (29.2%) |
| Women | 123 (70.7%) | 115 (66.4%) | 98 (60.9%) | 105 (61%) | 68 (60.2%) |
| Value of subscriptions as a percentage of the total | | | | | |
| Clergy | 15.3% | 14.2% | 15.7% | 8.7% | 6.2% |
| Other men | 19.4% | 17.8% | 25.7% | 28.5% | 32.7% |
| Women | 56.4% | 54.3% | 55.6% | 52.9% | 45.9% |
| Corporate | 0.2% | 0 | 0 | 4.8% | 1.5% |
| Offerings & Collections | 7.5% | 12.6% | 3.0% | 4.6% | 5.5% |
| Miscellaneous | 1.2% | 1.2% | 0 | 0.45% | 8.2% |

Liverpool Training School and Home for Nurses: Subscriptions and Donations:

| | 1862 | 1870 | 1880 | 1890 | 1900 |
|---|-------------|----------------------|-------------|-------------|--------------|
| Numbers of Individual Subscribers and as a percentage of the total | | | | | |
| Clergy | 6 (2.0%) | 7 (2.4%) | 10 (3.3%) | 4 (1.3%) | 1 (0.41%) |
| Other Men | 261 (86.7%) | 221 (77.3%) | 230 (75.2%) | 238 (78.8%) | 184 (75.10%) |
| Women | 34 (11.3%) | 58 (20.3%) | 66 (21.6%) | 60 (19.9%) | 60 (24.49%) |
| Value of subscriptions as a percentage of the total | | | | | |
| Clergy | 1.60% | 1.74% | 1.48% | 1.13% | 0.24% |
| Other men | 81.00% | 62.16% | 71.89% | 72.02% | 72.56% |
| Women | 8.85% | 12.53% | 14.16% | 16.97% | 18.16% |
| Corporate | 8.15% | 23.57% ¹⁰ | 9.22% | 9.65% | 9.04% |
| Miscellaneous | 0.40% | 0 | 3.25% | 0.23% | 0 |

⁷ Sources: Derby Local Studies Library Annual Reports of the Derby and Derbyshire Nursing and Sanitary Association 1865 – 1900 (A610.73); Derbyshire Royal Infirmary, Annual Reports 1843-1900 (BA362). These records are incomplete and therefore the nearest dates to 1870, 1880 and 1890, where a report exists for both organisations, have been utilised.

⁸ The nearest surviving report to 1865 for the Infirmary is 1866/7

⁹ No annual reports have survived for the Lincoln County Infirmary so that a comparison cannot be made.

¹⁰ This includes a £100 donation from the Liverpool Corporation - over 16% of all subscriptions and donations.

Liverpool: Subscriptions for District Nursing

| | 1862 | 1870 | 1880 | 1890 | 1900 ¹¹ |
|--|-------------|------------|----------|------------|--------------------|
| Numbers of Individual Subscribers & Donors and as a percentage of the total | | | | | |
| Clergy | 9 (5.3%) | 6 (4.8%) | 6 (6%) | 4 (4.3%) | 1 (0.8%) |
| Other Men | 133 (79.2%) | 89 (71.8%) | 62 (62%) | 67 (72.0%) | 87 (69.6%) |
| Women | 26 (15.5%) | 29 (23.4%) | 32 (32%) | 22 (23.7%) | 37 (29.6%) |
| Value of subscriptions as a percentage of the total | | | | | |
| Clergy | 1.78% | 1.93% | 1.26% | 1.90% | 0.30% |
| Other men | 65.92% | 52.10% | 46.57% | 45.88% | 46.75% |
| Women | 7.73% | 18.24% | 18.40% | 12.11% | 16.68% |
| Corporate | 5.53% | 5.82% | 6.87% | 6.89% | 5.92% |
| Miscellaneous | 19.05% | 21.91% | 26.91% | 33.23% | 30.35% |

Liverpool: Subscriptions and Donations for District Nursing given directly to the districts¹²

| | 1862 | 1870 | 1880 | 1890 | 1900 ¹³ |
|--|------|-------------|-------------|-------------|--------------------|
| Numbers of Individual Subscribers & Donors and as a percentage of the total | | | | | |
| Clergy | 0 | 8 (2.7%) | 3 (1.2%) | 1 (0.6%) | 7 (2.2%) |
| Other Men | 0 | 144 (49.0%) | 86 (34.4%) | 69 (39.2%) | 86 (27.6%) |
| Women | 0 | 142 (48.3%) | 161 (64.4%) | 106 (60.2%) | 219 (70.2%) |
| Value of subscriptions & donations as a percentage of the total | | | | | |
| Clergy | 0 | 1.19% | 0.37% | 0.11% | 0.37% |
| Other men | 0 | 35.44% | 25.28% | 19.43% | 13.71% |
| Women | 0 | 29.07% | 16.02% | 12.71% | 20.56% |
| Corporate | 0 | 12.64% | 5.85% | 5.51% | 3.26% |
| Offerings & Collections | 0 | 11.77% | 44.33% | 52.20% | 54.34% |
| Miscellaneous | 0 | 9.89% | 8.17% | 10.04% | 7.76% |

Female Subscribers & Donors: A comparison with the Liverpool Royal Infirmary

| | 1862 | 1870 | 1880 | 1890 | 1900 |
|--|------------|-------------|-------------|-------------|--------------|
| Female Subscribers & Donors and as a percentage of the total of individuals | | | | | |
| General fund | 34 (11.3%) | 58 (20.3%) | 66 (21.6%) | 60 (19.9%) | 60 (24.49%) |
| District Nurse | 26 (15.5%) | 29 (23.4%) | 32 (32.0%) | 22 (23.7%) | 37 (29.60%) |
| Direct to dist. | 0 | 142 (48.3%) | 161 (64.4%) | 106 (60.2%) | 219 (70.20%) |
| Infirmary | 195 (7.9%) | 174 (7.9%) | 182 (9.4%) | 167 (11.6%) | 271 (16.41%) |
| Value of subscriptions & donations from women as a percentage of the total | | | | | |
| Private nurse | 8.85% | 12.53% | 14.16% | 16.97% | 18.16% |
| District Nurse | 7.73% | 18.24% | 18.40% | 12.11% | 16.68% |
| Direct to dist. | 0 | 29.07% | 16.02% | 12.71% | 20.56% |
| Infirmary | 6.70% | 6.61% | 7.77% | 9.57% | 14.26% |

¹¹ District nursing data from Liverpool record Office, Annual Report of the Liverpool District Nursing Association, 1901. (LRO 610.73DIS)

¹² Collections include the Hospital Sunday collections in 1880 (£480) and 1890 (£513). In 1900 the Hospital Saturday & Sunday collections donated £780. These account for more than 50% of all donations and subscriptions given directly to the districts.

¹³ District nursing data from LRO, Liverpool District Nursing Association, Annual Report, 1901. (LRO 610.73DIS)

Manchester Nurse-Training Institution: Subscriptions & Donations

Subscriptions and Donations for the Private Institution

| | 1866 | 1870 | 1880 | 1890 | 1900 |
|--|-------------|-------------|------------|------------|------------|
| Numbers of Individual Subscribers and as a percentage of the total | | | | | |
| Clergy | 6 (4.0%) | 6 (2.8%) | 7 (8.2%) | 5 (3.5%) | 2 (1.9%) |
| Other Men | 104 (69.8%) | 145 (67.8%) | 49 (57.7%) | 93 (65.0%) | 88 (84.6%) |
| Women | 39 (26.2%) | 63 (29.4%) | 29 (34.1%) | 45 (31.5%) | 14 (13.5%) |
| Value of subscriptions & donations as a percentage of the total | | | | | |
| Clergy | 1.82% | 0.88% | 2.38% | 1.56% | 1.07% |
| Other men | 59.75% | 37.29% | 32.14% | 32.68% | 62.42% |
| Women | 17.66% | 10.90% | 11.91% | 13.39% | 8.72% |
| Corporate | 12.54% | 13.10% | 16.88% | 21.63% | 26.93% |
| Offerings & Collections | 0 | 16.76% | 31.76% | 29.63% | 0 |
| Miscellaneous | 8.23% | 21.10% | 4.92% | 1.11% | 0.86% |

Subscriptions and Donations for District Nursing

| | 1866 | 1870 | 1880 | 1890 | 1900 |
|--|------------|------------|------------|-------------|-------------|
| Numbers of Individual Subscribers & Donors and as a percentage of the total | | | | | |
| Clergy | 0 | 0 | 5 (3.7%) | 12 (4.0%) | 13 (1.4%) |
| Other Men | 13 (18.3%) | 64 (41.3%) | 50 (37.3%) | 107 (35.4%) | 466 (35.7%) |
| Women | 58 (81.7%) | 91 (58.7%) | 79 (59.0%) | 183 (60.6%) | 821 (62.9%) |
| Value of subscriptions & donations as a percentage of the total | | | | | |
| Clergy | | | 1.96% | 1.55% | 0.50% |
| Other men | 17.78% | 27.82% | 26.76% | 50.29% | 31.24% |
| Women | 73.73% | 62.10% | 50.70% | 26.19% | 28.09% |
| Corporate | 0 | 0.68% | 11.78% | 5.98% | 14.77% |
| Offerings & Collections | 7.12% | 9.40% | 3.24% | 2.78% | 9.41% |
| Miscellaneous | 1.36% | 0 | 5.55% | 13.21% | 15.99% |

Female Subscribers & Donors: A comparison of the Nursing Training Institution and the Manchester Royal Infirmary

| | 1866 | 1870 | 1880 | 1890 | 1900 |
|---|------------|------------|------------|-------------|-------------|
| Female Subscribers & Donors and as a percentage of the total | | | | | |
| Private nurse | 39 (26.2%) | 63 (29.4%) | 29 (34.1%) | 45 (31.5%) | 14 (13.5%) |
| District Nurse | 58 (81.7%) | 91 (58.7%) | 79 (59.0%) | 183 (60.6%) | 821 (62.9%) |
| Infirmary | 59 | 59 | 41 | 74 | 65 |
| Value of subscriptions & donations from women as a percentage of the total | | | | | |
| Private nurse | 17.66% | 10.90% | 11.91% | 13.39% | 8.72% |
| District Nurse | 73.73% | 62.10% | 50.70% | 26.19% | 28.09% |
| Infirmary | 2.63% | 2.11% | 1.60% | 2.68% | 2.35% |

**Stratford upon Avon Nursing Home for Convalescent Women and Sick Children:
Donations and Subscriptions**

| | 1871/2 | 1880 | 1890 | 1900 |
|--|---------------------|------------|------------|---------------------|
| Subscribers & Donors (%) | | | | |
| Clergy | 18 (16.7%) | 13 (9.0%) | 18 (13.5%) | 8 (10.4%) |
| Other men | 23 (21.3%) | 55 (38.2%) | 45 (33.8%) | 27 (35.1%) |
| Women | 67 (62.0%) | 76 (52.8%) | 70 (52.6%) | 42 (54.5%) |
| Subscriptions and Donations (%) | | | | |
| Clergy | 12.5% | 7.7% | 12.2% | 5.2% |
| Other men | 21.5% | 42% | 30.1% | 12.7% |
| Women | 37% | 47.6% | 45.2% | 41.8% |
| Corporate | 0 | 0 | 4.1% | 4.2% |
| Offerings & Collections | 1.8% | 0.7% | 5.5% | 12.8% |
| Miscellaneous | 27.2% ¹⁴ | 2% | 2.9% | 23.3% ¹⁵ |

**Female Subscribers & Donors: A comparison of the Nursing Home and the
Stratford upon Avon Infirmary**

| | 1870/1 | 1880 | 1890 | 1900 |
|---|----------|------------|------------|------------|
| Female Subscribers & Donors and as a percentage of the total | | | | |
| Nurse Assoc. | 67 (62%) | 76 (52.8%) | 70 (52.6%) | 42 (54.5%) |
| Infirmary | No Data | No Data | 57 (36.5%) | 49 (32.0%) |
| Value of subscriptions & donations from women as a percentage of the total | | | | |
| Nurse Assoc. | 37% | 47.6% | 45.20% | 41.80% |
| Infirmary | No Data | No Data | 21.84% | 17.30% |

¹⁴ Includes one donation from 'Friend' of £78

¹⁵ Includes £33 from the Hospital Saturday Fund

APPENDIX 10: Birmingham Institution: Income

| | 1870 | | 1880 | | 1890 | | 1900 | |
|----------------------------|-----------|------|------------|------|------------|------|------------|------|
| | £-s-d | % | £-s-d | % | £-s-d | % | £-s-d | % |
| Donations | 285-03-00 | 34.8 | 5-05-06 | 0.2 | 4-13-06 | 0.1 | 9-06-00 | 0.2 |
| Subscriptions | 304-02-00 | 37.1 | 299-08-00 | 11.3 | 198-10-00 | 5.3 | 118-08-06 | 3.2 |
| Dividends, interest etc | 9-01-06 | 1.1 | 1-19-02 | 0.1 | 72-03-07 | 1.9 | 56-01-06 | 1.5 |
| Fees for Nursing | 210-05-00 | 25.6 | 2333-19-00 | 88.2 | 3478-12-06 | 92.1 | 3494-03-00 | 94.6 |
| Collections | | | | | | | | |
| Other income | 11-09-00 | 1.4 | 5-00-00 | 0.2 | 21-00-00 | 0.6 | 16-10-00 | 0.5 |
| Total | 820-00-06 | | 2645-11-08 | | 3774-18-07 | | 3694-080-0 | |

Birmingham Institution: Expenditure

| | 1870 | | 1880 | | 1890 | | 1900 | |
|--------------------------------------|-----------|-------|------------|-------|------------|-------|------------|------|
| | £-s-d | % | £-s-d | % | £-s-d | % | £-s-d | % |
| Household expenses | 320-10-06 | 33.76 | 580-12-00 | 23.42 | 573-14-02 | 18.47 | 760-03-02 | 24.3 |
| Salaries & wages | 456-14-03 | 48.12 | 1636-05-06 | 66.02 | 2184-09-06 | 70.32 | 1963-13-08 | 62.8 |
| Grant to District Nursing Society | | | | | 56-00-00 | 1.80 | 150-00-00 | 4.8 |
| Nursing expenses, & uniform | 53-06-01 | 5.62 | 177-17-04 | 7.18 | 237-03-07 | 7.63 | 205-18-04 | 6.6 |
| Adverts, printing post etc. | 52-19-09 | 5.59 | 20-06-05 | 0.82 | 44-16-11 | 1.44 | 24-16-11 | 0.8 |
| Miscellaneous | 65-12-01 | 6.91 | 63-10-06 | 2.56 | 10-09-06 | 0.34 | 22-18-03 | 0.7 |
| Total | 949-02-08 | | 2478-10-09 | | 3106-13-08 | | 3129-10-04 | |

APPENDIX 10: Derby and Derbyshire Nursing and Sanitary Association: Income

| | 1870 | | 1882/3 | | 1889/90 | | 1900 | |
|----------------------------|-----------|-------|------------|-------|------------|-------|------------|-------|
| | £-s-d | % | £-s-d | % | £-s-d | % | £-s-d | % |
| Donations | 64-07-08 | 10.31 | 302-00-11 | 9.96 | 234-03-08 | 9.05 | 73-09-04 | 2.00 |
| Subscriptions | 178-05-06 | 28.54 | | | | | 166-10-00 | 4.54 |
| Dividends, interest etc | 0 | | 67-15-10 | 2.24 | 138-11-05 | 5.35 | 99-13-00 | 2.72 |
| Fees for Nursing | 352-00-06 | 56.35 | 2258-16-10 | 74.53 | 2010-12-00 | 77.67 | 3210-02-09 | 87.50 |
| Other income | 30-00-00 | 4.80 | 402-06-00 | 13.27 | 205-04-08 | 7.93 | 82-09-11 | 2.54 |
| Collections | | | | | | | 36-13-00 | 1.00 |
| Total | 644-13-08 | | 3030-19-07 | | 2588-11-09 | | 4074-10-06 | |

Derby and Derbyshire Nursing and Sanitary Association: Expenditure

| | 1870 | | 1882/3 | | 1889/90 | | 1900/1 | |
|-----------------------------------|-----------------------------|------------------|-------------------------------|------------------|------------------------------|--------------------|-------------------------------|--------------------|
| | £-s-d | % | £-s-d | % | £-s-d | % | £-s-d | % |
| Private Nurses & Home | 458-18-00 [w- 208-00-00] | 64.70 [29.33] | 1957-10-05 [w- 1686-13-06] | 70.56 [60.80] | 1885-09-08 [w-1484-11-07] | 74.81 [w-58.90] | 2457-19-09 [w- 1720-04-01] | 71.64 [w-50.14] |
| Probationer's training & costs | 118-15-10 [w- 62-17-06] | 16.74 [8.87] | 140-07-08 [w- 85-00-00] | 5.06 [3.06] | 169-19-09 [w- 46-00-00] | 6.74 [w-1.82] | 232-19-11 [w- 109-01-09] | 6.79 [w-3.18] |
| District Nursing Work | 114-18-09 [w- 46-12-06] | 16.21 [6.57] | 648-06-00 [w- 275-10-00] | 23.37 [9.93] | 429-16-09 [w- 180-12-06] | 17.05 [w-7.17] | 681-09-07 [w- 446-08-00] | 19.86 [w-13.01] |
| Adverts, printing post etc. | 16-13-02 | 2.35 | 28-01-02 | 1.01 | 35-04-01 | 1.40 | 58-09-10 | 1.71 |
| | | | | | | | | |
| Total | 709-05-09 | | 2773-05-03 | | 2520-10-03 | | 3375-19-01 | |

APPENDIX 10: Lincoln Institution for Nurses: Income

| | 1867 | | 1870 | | 1880 | | 1890 | | 1900 | |
|----------------------------|-----------|-------|------------|-------|-------------------------|-------|------------|-------|------------|-------|
| | £-s-d | % | £-s-d | % | £-s-d | % | £-s-d | % | £-s-d | % |
| Donations | 83-09-06 | 16.26 | 92-14-06 | 8.24 | 41-06-00 | 1.13 | 81-10-04 | 4.38 | 50-19-04 | 1.52 |
| Subscriptions | 164-17-06 | 32.11 | 221-12-06 | 19.69 | 205-12-00 | 5.61 | 175-19-00 | 9.47 | 212-09-00 | 6.33 |
| Dividends, interest etc | 2-16-11 | 0.55 | 4-18-10 | 0.44 | 51-16-11 | 1.43 | 1-06-06 | 0.07 | 226-16-10 | 6.76 |
| Fees for Nursing | 209-13-07 | 40.83 | 780-02-06 | 69.32 | 2210-15-08 | 60.29 | 1490-08-06 | 80.02 | 2603-8-11 | 77.54 |
| Other income | 52-12-01 | 10.24 | 25-18-06 | 2.3 | 1157-04-07 ¹ | 31.56 | 109-11-07 | 5.9 | 263-13-02 | 7.85 |
| Total | 513-09-07 | | 1125-06-10 | | 3666-15-02 | | 1858-15-11 | | 3357-07-03 | |

Lincoln Institution for Nurses: Expenditure

| | 1867 | | 1870 | | 1880 | | 1890 | | 1900 | |
|----------------------------------|-----------|-------|------------|-------|-------------------------|-------|------------|-------|------------|-------|
| | £-s-d | % | £-s-d | % | £-s-d | % | £-s-d | % | £-s-d | % |
| Nurses' Home & Institute | 221-14-09 | 34.05 | 364-18-07 | 36.03 | 684-02-05 | 19.64 | 433-08-06 | 22.65 | 776-13-08 | 23.42 |
| Nurses' wages | 304-03-03 | 46.70 | 500-09-00 | 49.41 | 1284-19-10 | 36.90 | 1155-18-01 | 60.41 | 1817-00-10 | 54.80 |
| Nurse Training | 87-02-00 | 13.37 | 92-11-00 | 9.14 | 127-14-00 | 3.67 | 147-08-08 | 7.71 | 206-10-00 | 6.23 |
| Nurse's Uniform | - | - | - | - | 235-18-06 | 6.77 | 86-01-02 | 4.50 | 288-01-06 | 8.69 |
| Drugs & articles lent to poor | 21-06-09 | 3.28 | 22-15-10 | 2.25 | 109-19-01 | 3.16 | 33-14-10 | 1.76 | 73-12-07 | 2.22 |
| Adverts, printing post etc. | 17-01-02 | 2.62 | 32-00-07 | 3.16 | 33-07-04 | 0.96 | 30-04-10 | 1.58 | 25-06-03 | 0.76 |
| Miscellaneous | | | | | 1006-11-00 ² | 28.9 | 26-09-10 | 1.38 | 128-14-00 | 1.38 |
| Total | 651-07-11 | | 1012-15-00 | | 3482-12-02 | | 1913-05-11 | | 3315-18-10 | |

¹ Includes sale of stock and interest on other stocks

² Includes purchase of land

APPENDIX 10: Liverpool Training School and Home: Income

| | 1862 | | 1870 | | 1880 | | 1890 | | 1900 | |
|---------------------------|-------------------------|-------|------------|-------|------------------------|-------|------------|-------|------------|-------|
| | £-s-d | % | £-s-d | % | £-s-d | % | £-s-d | % | £-s-d | % |
| Donations | 4461-13-06 ³ | 78.89 | 210-18-06 | 5.14 | 2753-08-09 | 33.93 | 119-16-00 | 2.15 | 51-18-00 | 0.99 |
| Subscriptions | 990-05-00 | 17.51 | 1019-02-06 | 24.85 | 783-09-06 | 9.65 | 607-17-06 | 10.91 | 250-10-00 | 4.77 |
| Dividends, interest etc | 33-16-01 | 0.59 | 189-03-11 | 4.61 | 158-02-10 | 1.95 | 269-02-07 | 4.86 | 128-06-06 | 2.44 |
| Fees for Private Nursing | | | 1242-17-06 | 30.31 | 2171-13-06 | 26.76 | 2646-00-00 | 47.47 | 2428-13-07 | 46.25 |
| Fees from Royal Infirmary | 170-06-05 | 3.01 | 1250-00-00 | 30.49 | 1500-00-00 | 18.48 | 1500-00-00 | 26.91 | 2200-00-00 | 41.89 |
| Training fees | | | 128-15-00 | 3.14 | 181-00-00 | 2.23 | | | 192-02-00 | 3.66 |
| Collections | | | 60-00-00 | 1.46 | 167-10-00 ⁴ | 2.06 | 229-00-00 | 4.11 | | |
| Miscellaneous | | | | | 400-14-00 | 4.94 | 200-01-10 | 3.59 | | |
| Total | 5656-01-00 | | 4100-17-05 | | 8115-18-07 | | 5571-16-11 | | 5251-10-01 | |

Liverpool Training School and Home: Expenditure

| | 1862 | | 1870 | | 1880 | | 1890 | | 1900 | |
|-----------------------|---------------------------------|-------|---------------------------------|------------------|-------------------------------|------------------|-------------------------------|------------------|--|------------------|
| | £-s-d | % | £-s-d | % | £-s-d | % | £-s-d | % | £-s-d | % |
| District Nursing Work | 340-04-00 [wages -340-04-00] | 6.68 | 763-07-08 [wages -763-07-08] | 19.34 | 992-14-02 [w -672-18-11] | 11.93 [8.09] | 1046-16-00 [w -708-02-08] | 19.83 [13.41] | District nursing transferred to new organisation | |
| Private Nurses & Home | 628-15-00 | 12.35 | 3014-10-07 [w -1348-01-08] | 76.37 [34.15] | 4364-02-10 [w -2067-00-11] | 52.43 [24.83] | 4068-06-08 [w -1793-10-06] | 77.06 [33.97] | 4528-07-01 [w -3192-19-00] | 95.83 [67.57] |
| Adverts, printing | 224-09-04 | 4.42 | | | | | | | 76-05-07 | 1.61 |
| Miscellaneous | 3896-09-04 | 76.55 | 169-10-06 | 4.29 | 2966-05-03 | 35.64 | 164-01-01 | 3.11 | 120-17-07 | 2.56 |
| Total | 5089-17-08 | | 3947-08-09 | | 8323-02-03 | | 5277-03-09 | | 4725-09-03 | |

³ Donations and miscellaneous costs in 1862 and 1880 are associated with the building and extending of the Training School and Home.

⁴ This income and the collection for 1890 comes from the Hospital Sunday collections in the city.

APPENDIX 10: Manchester Nurse Training Institution: Income

| | 1867 | | 1870 | | 1880 | | 1890 | | 1900 | |
|----------------------------|------------|-------|------------|-------|------------|-------|------------|-------|------------------------|-------|
| | £-s-d | % | £-s-d | % | £-s-d | % | £-s-d | % | £-s-d | % |
| Donations | 110-16-06 | 10.23 | 137-00-00 | 8.36 | 102-11-00 | 6.18 | 22-00-00 | 1.17 | 390-00-00 | 12.23 |
| Subscriptions | 413-12-06 | 38.23 | 431-15-00 | 26.34 | 319-10-00 | 19.27 | 339-03-06 | 18.13 | 397-18-06 | 12.48 |
| Dividends, interest etc | 0 | | 0 | | 8-09-08 | 0.51 | 59-09-02 | 3.18 | 46-12-04 | 1.46 |
| Fees for Nursing | 557-13-04 | 51.54 | 941-11-06 | 57.45 | 1063-12-00 | 64.15 | 1310-13-01 | 70.05 | 938-11-01 | 29.44 |
| Hospital Sunday | | | 128-15-00 | 7.85 | 163-18-11 | 9.89 | 139-17-00 | 7.47 | 734-09-02 ⁵ | 23.04 |
| Bequests | | | | | | | | | 680-11-03 | 21.35 |
| Total | 1082-01-04 | | 1639-01-06 | | 1658-01-07 | | 1871-02-09 | | 3188-02-04 | |

Manchester Nurse Training Institution: Expenditure

| | 1867 | | 1870 | | 1880 | | 1890 | | 1900 | |
|-----------------------------------|-------------------------------------|------------------|-------------------------------------|------------------|--------------------------------------|------------------|--------------------------------------|------------------|--|-------|
| | £-s-d | % | £-s-d | % | £-s-d | % | £-s-d | % | £-s-d | % |
| Private Nurses & Home | 746-13-03 [wages -256-17- 11] | 68.62 [23.61] | 851-15-03 [wages- 349-11- 03] | 60.79 [24.95] | 1212-03-06 [wages- 565-04- 01] | 55.77 [26.00] | 1044-07-04 [wages- 582-03- 01] | 53.92 [30.06] | 1070-14-05 [wages not specified] | 36.97 |
| Probationer's training & costs | 33-01-00 | 3.05 | 75-05-06 | 5.37 | 31-06-07 | 1.44 | | | | |
| District Nursing Work | 268-10-11 | 24.68 | 440-14-06 | 31.45 | 813-05-02 | 37.42 | 767-17-08 | 39.65 | 1659-03-04 | 57.28 |
| Adverts, printing post etc. | 39-13-07 | 3.65 | 33-08-10 | 2.38 | 71-10-11 | 3.29 | 69-11-09 | 3.59 | 97-11-00 | 3.37 |
| Miscellaneous | | | | | 45-05-00 | 2.08 | 55-00-00 | 2.84 | 69-02-02 | 2.38 |
| Total | 1087-18-09 | | 1361-04-01 | | 2173-09-02 | | 1936-15-09 | | 2896-10-11 | |

⁵ From both Hospital Sunday and Saturday Collections

APPENDIX 10: Salisbury Institution: Income

| | 1872 | | 1880 | | 1890 | | 1900 | |
|----------------------------|-----------|------|-----------|-------|------------|-------|------------|-------|
| | £-s-d | % | £-s-d | % | £-s-d | % | £-s-d | % |
| Donations | 794-00-10 | 80.5 | 42-05-06 | 4.32 | 19-19-00 | 1.32 | 5-00-00 | 0.27 |
| Subscriptions | 172-11-00 | 17.5 | 253-05-00 | 25.91 | 242-16-00 | 16.01 | 150-08-00 | 8.12 |
| Dividends, interest etc | 19-16-05 | 2.0 | 12-07-01 | 1.26 | 5-08-04 | 0.36 | | |
| Fees for Nursing | | | 658-09-06 | 67.26 | 1248-09-05 | 82.22 | 1665-02-00 | 89.90 |
| Collections | | | 10-15-09 | 1.10 | 1-08-05 | 0.09 | | |
| Other income | | | 0-09-04 | 0.05 | | | 31-12-00 | 1.71 |
| Total | 986-04-03 | | 977-12-02 | | 1521-03-02 | | 1852-02-00 | |

Salisbury Institution: Expenditure

| | 1872 | | 1880 | | 1890 | | 1900 | |
|--------------------------------|-----------|------|-----------|-------|-----------|-------|------------|-------|
| | £-s-d | % | £-s-d | % | £-s-d | % | £-s-d | % |
| Household expenses | 299-19-08 | 33.9 | 362-04-01 | 36.51 | 394-10-08 | 24.78 | 338-10-07 | 18.40 |
| Salaries & wages | 19-09-05 | 2.2 | 426-15-04 | 43.02 | 859-17-00 | 54.01 | 961-14-09 | 52.27 |
| Nurse Training | | | 36-18-00 | 3.72 | 18-00-00 | 1.14 | | |
| Nursing expenses, & uniform | 16-15-03 | 1.9 | 125-06-03 | 12.63 | 213-10-11 | 13.41 | 205-11-13 | 11.17 |
| Drugs and equipment | | | 15-05-06 | 1.54 | 44-16-06 | 2.81 | 17-13-10 | 0.96 |
| Adverts, printing post etc. | 20-04-05 | 2.3 | 20-01-11 | 2.03 | 29-09-05 | 1.82 | 34-05-09 | 1.86 |
| Miscellaneous | 527-16-11 | 59.7 | 5-08-00 | 0.55 | 32-07-05 | 2.03 | 282-07-03 | 15.34 |
| Total | 886-05-08 | | 991-19-01 | | 1592-9-11 | | 1840-04-03 | |

APPENDIX 10: Stratford Institution: Income

| | 1871 | | 1880 | | 1890 | | 1900 | |
|----------------------------|-----------|-------|-----------|-------|-----------|-------|-----------|-------|
| | £-s-d | % | £-s-d | % | £-s-d | % | £-s-d | % |
| Donations | 143-01-00 | 35.40 | 18-19-00 | 2.78 | 49-19-09 | 5.70 | 3-09-06 | 0.4 |
| Subscriptions | 160-15-06 | 39.79 | 144-05-06 | 21.16 | 146-10-04 | 16.70 | 113-09-06 | 13.02 |
| Dividends, interest etc | | | 72-13-01 | 10.66 | 78-06-06 | 8.93 | 142-00-02 | 16.29 |
| Fees for Nursing | 45-11-00 | 11.27 | 271-12-00 | 39.84 | 425-02-00 | 48.46 | 399-12-09 | 45.85 |
| Inpatients | | | 173-00-06 | 25.38 | 163-04-00 | 18.61 | 150-12-03 | 17.28 |
| Other income | 54-14-05 | 13.54 | 1-04-02 | 0.18 | 14-00-00 | 1.60 | 62-06-10 | 7.15 |
| Total | 404-01-11 | | 681-06-03 | | 877-02-07 | | 871-11-00 | |

Stratford Institution: Expenditure

| | 1871 | | 1880 | | 1890 | | 1900 | |
|--------------------------------------|-----------|-------|-----------|-------|-----------|-------|-----------|-------|
| | £-s-d | % | £-s-d | % | £-s-d | % | £-s-d | % |
| Household expenses | 167-02-10 | 63.33 | 363-03-11 | 49.52 | 368-09-09 | 42.83 | 398-06-05 | 44.79 |
| Salaries & wages | 69-05-00 | 26.24 | 284-08-08 | 38.78 | 393-14-04 | 45.77 | 419-05-05 | 47.15 |
| Nurse Training | 12-00-00 | 4.55 | - | - | 13-13-00 | 1.59 | - | - |
| Nursing expenses, linen & uniform | 6-09-11 | 2.46 | 48-03-10 | 6.57 | 52-14-04 | 6.13 | 44-02-00 | 4.96 |
| Drugs & Instruments | - | - | 23-04-10 | 3.17 | 8-15-06 | 1.02 | 11-05-01 | 1.27 |
| Adverts, printing post etc. | 9-00-05 | 3.42 | 13-05-00 | 1.81 | 19-14-08 | 2.29 | 11-09-06 | 1.29 |
| Miscellaneous | - | - | 1-01-07 | 0.15 | 3-04-00 | 0.37 | 4-16-11 | 0.54 |
| Total | 263-18-02 | | 733-07-10 | | 860-05-07 | | 889-05-04 | |

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