The Good Nurse

Discourse and power in nursing and nurse education 1945 -1955

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Abstract

Nursing and nurse education within Britain are influenced by the legacy of the development of hospital based adult general nursing in the 19th Century. Discourses that emerged at that time identify nurses as 'good women': respectable, hardworking, loyal and obedient. Currently, nurse education is criticised for being less able to produce nurses who are fit to undertake their role than in the past.

Taking the concept that discourse exerts a powerful influence on the way people behave, this thesis asserts that the 19th Century legacy is important and seeks to establish the discourses that shaped nurse education. The period 1945 -1955 is chosen as sufficiently distanced from early developments, but recent enough to be in living memory and prior to the relocation of British nursing from a hospital base into Higher Education.

Six overlapping discourses are identified though the literature. An interpretative approach is then taken to data collected in three stages: a life story 1932 -1973, semi-structured interviews with nurses who commenced their training 1945 -55 and documentary analysis of nursing journals for the same period.

The 'good nurse' is explored through discourses around the 'right kind of girl', the tension between vocation and profession and the transition from woman to nurse. Despite significant change of direction in educational theory and policy in the period 1945 -55 the thesis suggests that the power of the discourse meant that little changed in the practice of nursing or the conduct of nurse education.

Furthermore, it is argued that whilst discourses have changed and contemporary nursing is establishing its place in Higher Education as an applied academic discipline, the current discourses embracing caring, reflection and emotional labour are equally gendered and controlling. Now, as then, this discourse is not imposed by outside forces, but is generated and controlled from within the profession.

It therefore concludes that the pervasive influence of discourses surrounding the 'good nurse' and related discourses about control and care must be given full recognition when attempting to change nursing or to influence its policy and educational developments.

Key words:

Good nurse; Discourse; Gender; Nursing; Life story

ALICE BIRD 1915-2005

"In 1932 I was about 17, in my last year at the high school a woman came to talk to us about careers - there was a depression and colleges were shutting. She talked about teaching and then about nursing and somehow or other it just clicked with me and I thought that's what I want to do - - I told my Dad I'm not going to college, I'm going to nurse."

Acknowledgements

In memory of Alice Bird 1915 -2005.

I am indebted to both Alice, who sadly died before this project reached its conclusion and to all of the nurses who spent time sharing their memories, photographs and nursing records with me. I hope in this small way I have been able to memorialise them and their moment in nursing history.

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Chapter One: Introduction

1.1 Context

> *'The following qualifications are essential to the making of a good nurse:*
>
> 1. *a real love of attending to the sick and helpless*
> 2. *a strong constitution*
> 3. *an equitable temperament'*
>
> *(Ashdown: 1934:1)*

These are the opening words of Millicent Ashdown's 'A Complete System of Nursing' which in 1934 was in its eighth edition, having been in print since 1917. The book continues with two full pages of descriptors which expand on the strongly held view of the good nurse as a capable, respectable, vocationally oriented and even tempered woman. However a feature of nursing is that it is associated with powerful and often contradictory discourses. Ashdown continues in describing nursing as 'delicate' and 'refined' work , but this belies the core functions of nursing which entail close contact with the bodies of strangers, with bodily excretions, illness, pain and death - usually private acts and described by Lawler (1991) and others as 'dirty work'. The moral and physical ambiguity implicit in nursing work is a major factor in trying to determine what it is that good nursing entails.

Whilst the focus of this thesis is on the period 1945 -1955, nursing has a long and interesting history. This introductory chapter seeks to place the thesis within an historical context and to identify the contemporary challenges that led to the development of the aims and objectives of this thesis.

Early iconography within western cultures depicts women caring for the sick as one of the six acts of charity which constituted Christian duty, an image

which was exploited strongly in the Nightingale era of nursing reform in the late 19th century (Hudson –Jones 1988).

Without a religious or moral imperative, or a kin relationship, the acts performed for payment by nurses were close to those of domestic servants, or even prostitutes and conveyed with them low social status and esteem. Williams (1978: 40) offers an analysis of nursing ideology:

> 'conditions of helplessness and the tasks they require violate the normal relationships between adult men and women in our society. To deal with this situation as an act of charity, as a vocation, retrieves the status of the nurse performing the task as well as the status of the adult for whom they are performed. For to be 'called' to such work, to perform it sacrificially, is to sanctify and consecrate both task and person'

Being a good nurse thus implies a level of duty or conviction which elevates the acts of nursing into something of more significance and less basic. Florence Nightingale's 'lady with the lamp' image contrasts with the morally depraved nurse immortalised as Dickens's 'Sairy Gamp'. With no religious justification for her work, she is demonised as drunken and immoral.

Research by Kalisch and Kalisch (1987) and Hallam (2000) chart the development of nursing images through media, professional and personal accounts, arguing that the vision and place of nursing has been a source of constant scrutiny and has changed with the political and social influences of each historical period. Discourses around what it is to be a 'good nurse' permeate the literature and are a significant influence on the development and politics of the profession. Indeed nursing and its image are so publicly owned that it is inappropriate to examine the education system without acknowledging this.

As more nurses were employed in the growing Victorian hospital movement a system of education which elevated the work from its previous status as something akin to a particularly unsavoury form of domestic service was required. The apprenticeship model, of student nurses being contracted to a hospital training school and developing their expertise through a combination of learning at the bedside and school based lectures, commenced at that time

and continued until the 1980s. During this period the methods were a regular source of debate.

Promoting positive discourses around the respectability and value of nursing work was essential if sufficient numbers of appropriately educated women were to be attracted into the profession, but this was tempered by society's need for women's role to be one of service and obedience (Dingwall et al 1988).

Discussion following World War One, influenced by severe staff shortages in the hospitals and changes in women's working patterns, culminated in the Athlone Committee report of 1939, which drew together the arguments, calling for a move away from the largely apprenticeship - oriented model to one in which nurses in training were afforded full student status.

Despite continual incremental changes to nurse education and the development of several degree based programmes from the 1970s, this major change did not occur until the commencement of Project 2000 in 1986. The aim of Project 2000 was to change the orientation of nurse education (Le Var 1997). Student nurses were no longer apprenticed to a hospital, received a bursary rather than a salary and the education process moved from the hospital based training schools to institutions of higher education. It was argued that the National Health Service (NHS) needed nursing staff who were more flexible and able to respond to rapid and continuous change in the health service and that the new training would be better able to deliver such nurses.

Project 2000 was adopted and after the initial few years of experimentation became embedded as a pre - registration undergraduate diploma and the primary route to nurse qualification in the UK. However it was not considered to be a success by many and with the inception of the new Labour government in 1997, a further wave of reports and reforms was published (Lord 2002). For nursing the most significant of these were Fitness for Practice (UKCC 1999) and Making a Difference (DOH 1999).

Fitness for Practice suggested that the changes in the educational process had led to student nurses reaching qualification without having achieved the baseline level of competence necessary to perform as qualified nurses: better education did not make for better nurses.

In Making a Difference (DOH 1999:5) a new strategy for nurse education was proposed, which sought to emphasise the practice and competency oriented aspects of the curriculum, with the intention of making it more responsive to the needs of the health service. In the document it is claimed:

> 'We value the contribution of nurses…we want to improve their education, working conditions and their prospects of satisfying and rewarding careers. . we want above all to enable them to continue to provide the exceptional care they do to people'.

The language throughout the document is positive and forward looking, but by implication suggests that nursing education is failing to deliver nurses who are able to practise effectively. The discourse suggests that nursing has lost its way; in trying to modernise its training it has forfeited the core of what it is to be a good nurse.

As a nurse educator, I observed with puzzlement and frustration the changes that were taking place. The pace of change was so rapid that no sooner had one new idea been adopted the next had arrived.

I desperately wanted to believe that the way in which I was educating student nurses was effective in terms of their self esteem, their achievement and above all in terms of the quality of nursing care which they were able to offer.

The rapid changes in nurse education have been paralleled by the development of a research base. Whilst nursing remains a relative young academic discipline, there is a growing body of research exploring its nature. Earlier research, (mostly dating from the 1950s in the USA) tended to try to

look at what nursing was and what nurses do (for example much of the work in Fitzpatrick and Whall, 1989).

Others hoped through observation of practice to create a model which mirrored nursing practice and thus would be useful in teaching new nurses to nurse well [the most influential British research in this area was Roper Logan and Tierney (1980)]. The majority of this work drew on positivist traditions, mirroring contemporary research in medicine, the social sciences and education. Nursing, like other disciplines, must generate a body of knowledge if it is to justify its place in the Higher Education system, however there has been criticism of this early work in particular that it exists to promote the profession, rather than to improve nursing (Gruending 1985).

More recently there has been a growing interest in phenomenological research exploring the nature of nursing itself. Benner (1984) Benner et al (1996) and MacLeod (1996) all explore nursing practice, hoping to understand better the ways in which nurses use their experience and education in order to improve their practice. It is clear from their work that some nurses perform better than others and some are better able to benefit from their education and experience, but the full reasons for the differences have yet to be more fully explored.

What seems to emerge from this growing literature is that the link between what the profession might desire for itself, its educational programmes and their outcomes is neither clear nor easy to predict. The late 20th and early 21st centuries are characterised by increased interest in nurse education research and by growing collaboration with mainstream research into education and the social sciences. However, the implications of Fitness for Practice (UKCC 1999) are that in the very period that such research has taken place nurses have become less able to practice competently on qualification.

It became clear that investigating the relationship between education, the quality of nurses and nursing work was epistemologically and methodologically difficult. The methods of training adopted were changing

rapidly, such that in the period in which this study has been developing the curriculum has already changed twice.

The experimental courses designed to achieve the 'Making a Difference' agenda need adapting to accommodate the later raft of policy developments associated with the modernisation programme for the NHS (DOH 2000). Examples include the introduction of the Knowledge and Skills Framework (DOH 2004) and related new pay structure in Agenda for Change (DOH 2005). All of these changes are occurring within an NHS in crisis due to massive staff shortages. For all the rhetoric about improving training, it appears that quantity rather than quality remains the primary test of success and the discourses surrounding nursing are contradictory. In the light of these tensions aims and objectives have been identified which attempt to guide an investigation into these contradictions in a period of recent history.

1.2 Aim, guiding questions and focus

This thesis investigates the relationship between nursing policy, nurse education and nurse training aiming to *establish discourses that shaped nurse education during the period 1945 -1955*. Three guiding questions are formed in order to direct the data gathering and analysis:

1. *What did it appear nurse training was trying to achieve?*
2. *How was the experience of training/ learning to nurse expressed?*
3. *What are the connections with the discourse surrounding the good nurse?*

Rafferty (1996) argues that nursing knowledge is amongst other things a political issue and as such the introduction of new initiatives into nursing always bears close scrutiny. Thus, at a time when many changes are happening and when the public image of nursing appears to be at its least favourable in recent history, it is appropriate to examine the recent past. I postulated that if I could identify a period sufficiently in the past to be 'complete' and yet recent enough that there were people who I could talk to who trained then, I might begin to understand some of the issues currently facing nursing.

It is generally accepted that 'modern' nursing was developed in the 19th century, as a significant factor in the development of medicine and the rise of the hospitals (Abel - Smith 1960). Nursing was adopted by philanthropic middle class women who saw it as an opportunity to contribute to the improvement of the working class poor, reform nursing's unfortunate image and to create a female vocation (Brooks 2001). Despite the many social and demographic changes over the last 150 years there remain connections to this early vision.

Choosing a 'moment' from the 150 year period, which would be effective in addressing the study aims, was affected as much by serendipity and practical considerations as by scholarly analysis. It needed to be prior to the changes in the curriculum in the 1980s, but not much earlier than the Second World War as this would make finding people still alive to interview more difficult. A nurse whose career spanned from 1932 – 1973 provided the first stage of the research through a recording of her life history. Initial analysis led to the period 1945 -1955 becoming the main focus of the study. Such chance encounters are identified by Plummer (2001) as a frequent starting point for life story research.

It should also be stated at this stage that the focus of the thesis is on *hospital based general nursing.* Nursing is not a single occupational group; the title may be legally used by people registered to work with adults and children with physical and mental health problems and learning difficulties, in hospitals and community settings.

Within this thesis limiting the focus is not intended to suggest that hospital based general nursing is representative of the profession as a whole. Indeed, the development of community, child, learning disability and mental health nursing is just as complex and interesting (see for example Davies 1980). Nevertheless hospital - based general nursing has been a dominant force in terms of training methods and it has been argued (Maggs 1985) that it has influenced the whole of nursing development.

Thus I have intentionally excluded other types of nurses. The nurses in the interviews and life story were hospital based and looking after adult patients with physical illnesses and as I talk about 'nursing' it is these nurses that I have in mind. The nurse whose life story I have collected and the nurses who offered their memories for the interviews are closely matched in terms of age, social background and early nursing experience. Following from this, the analysis of journals deliberately seeks information that enhances my understanding of the discourses they recognised and used.

By choosing hospital based adult nursing I have attempted to get the most representative group possible, but recognise that there are discourses associated with other branches of nursing that may have been significant. The exploration of the alternative or extra discourses is not possible within the study and remains one of the limitations which will be discussed in greater detail in chapters three and nine.

Furthermore, throughout the text where appropriate to do so, the nurse is referred to as 'she'. This is unusual in contemporary academic writing about nursing. In an attempt to acknowledge that male and female people nurse, the convention is not to mention gender at all, instead to use the word 'nurse' and let it speak for itself. However, in the period of time studied adult general nursing was almost exclusively a female occupation, the discourses identified are strongly gendered and all of the participants involved in the life story and interviews are female. It would therefore seem at odds with the subject to write as if the sex of the nurses was irrelevant.

Whilst nursing is a very familiar occupational group, the discourses surrounding the profession are multiple and sometimes contradictory. For this reason the conceptual framework takes a postmodernist perspective, from the work of Foucault (1979).

1.3 Conceptual framework

Identifying a conceptual framework that captures all of the complex and often contradictory elements of nursing's educational development is not easy. Using a framework based on the work of Foucault (1979) allows the thesis to acknowledge the multiple discourses affecting nursing without assuming that one is dominant. In doing so it does not diminish the importance of the many differing perspectives which have been used to analyse nursing as discussed below:

Key research which has been referred to in this study includes frameworks based on social and health policy (Abel Smith 1960), socio-economic policy (Dingwall et al 1988), militaristation (Summers 1988, Starns 2000) and image (Hallam 2000). Each of these highlights different aspects of nursing development which can be used as a starting point for analysis.

Gender and class are acknowledged in all research into nursing as crucial to one's understanding, which might suggest that a feminist approach was more appropriate (Davies 1995). However the continuing ambivalent relationship nursing has had with feminism makes taking this approach problematic. Much of the history of (hospital based general) nursing reform is at odds with feminist ideology.

Nightingale strongly opposed attempts to align nursing with female suffrage, seeing its strength as a female vocation rather than employment, or a measure of equality. Throughout the last 150 years oppression and resistance to change have frequently come from within the profession, for example depressing wages and prolonging poor working conditions. (Abel – Smith 1960, Rafferty and Robinson 1997, Baly 1998)

Other potential frameworks which have some resonance include nursing as 'dirty work' (Lawler 1991). The metamorphosis of domestic cleaning into the 'science' of hygiene is clearly documented within the reform of nursing and nursing education. In addition motifs of cleanliness, tidiness and order as well as 'cleansing' of the sick poor are prevalent in the literature (Brooks 2001). Finally the doing of 'good works' and devotion to the well-being of other people within a tightly defined class and Christian structure has strong links particularly with the early reform of nursing (Maggs 1983, Dingwall et al 1988).

What this range of approaches illustrates is that the subject can be approached in a number of ways, none of which is fundamentally 'wrong', each though may overshadow some of the others. Foucault has developed the concept of discourse as a form of power; in proposing a concept around sexuality, rather than feminism, it may be argued that his position is more tenable within this study.

In the History of Sexuality (1979) he proposes a dominant, powerful discourse about sex and sexuality. Of particular relevance to the development of nursing is the focus on the concept of family. This discourse was initially a middle and upper classes preoccupation, but Foucault argues that from around the 1830s the middle class family model came to be seen as the

> 'indispensable instrument of political control, economic regulation for the subjugation of the urban proletariat' (p122)

Hospital based nursing with its emphasis on control and order can be placed comfortably within this discourse. The development of hospital routine, particularly in the voluntary sector, was a model of the middle-class family household, imported wholesale by the reforming new matrons. The physician or surgeon is in charge with a good strong woman in the role of matron. A strict hierarchy existed below this where each more junior grade of nurse was more suppressed by the grade above. Good nurses, like good women, knew their place within this model and strove at every level to maintain it.

In addition Cheek (2000:23) suggests that:

> 'Discourses create discursive frameworks which order reality in a certain way. They both enable and constrain the production of knowledge in that they allow for certain ways of thinking whilst excluding others'.

The rise of capitalism and the militaristation of the population would not have been possible without the control of the working population as a key component of the economy. Foucault's (1979) argument is that the family was the medium though which such powerful control was achieved.

Much of the literature presents the discourse on nursing reform as one in which middle class women impress their (superior) values on working class people for the good of the nation. Brooks (2001: 14) for example researches the role of the special probationer[1].

> 'these women (elite, middle class nurses) could inculcate the working class recruits without becoming polluted by them, in much the same way that middle class women could undertake 'rescue' work with prostitutes without becoming contaminated.'

However Foucault's notion is that discourse is not simply top down power, but is present at all levels of society (Hoy 1986). This allows for a more holistic view which acknowledges the much more complex class divisions, power relationships and disciplines within nursing.

A further element within Foucault's discourse is of 'bio power' that is the regulation and control of the body, power over the individual body and over sexuality, and thus ultimately power over life and death. This links well with the concept of cleansing and the science of hygiene. And finally Foucault acknowledges that the discourse on sexuality is embedded within a Christian ideology. This feature is crucial to the understanding of the rationale for many of the behaviours and decisions of nursing reform.

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[1] Special or lady probationers, were more wealthy women who could afford to pay for their training and were often coached from the outset to be ward sisters and matrons.

1.4 Structure

Following this first introductory chapter, **chapter two** is a review of the literature. Consistent with the conceptual framework six overlapping discourses are identified: Nursing as reform; the development of medicine and the rise of the hospitals; nursing as social control; nursing and the military; nursing as female vocation and the good nurse. Each discourse is analysed in the literature through five historically chronological sections. The 'early years of reform' is the largest section as this is where the discourses originate. The First World War, between the wars, the Second World War and the formation of the NHS all add to an understanding of the ways in which the discourses developed over time.

Chapter three outlines the methodological approach taken throughout the study. The principles of historical research are outlined and it is acknowledged that such research can be approached from different philosophical positions. For this research an interpretative approach is adopted so phenomenological method and analysis are discussed, along with the post-modern concepts underpinning the conceptual framework. As befits historical research, a number of methods of data gathering are employed. The use of life story, interviewing and documentary research is discussed and their use in this study is described and justified. Finally, the chapter addresses ethical considerations, reliability and validity and limitations.

Chapter four describes the conduct of the study. It outlines in detail the actual process of conducting the life story, interviews and documentary research and the management of the initial analysis and findings. Leading from this the conceptual framework is revisited and the structure for the discussion chapters is identified

Chapters five - eight all take different aspects of the discourse which emerge from the data: **Chapter five** focuses on the discourse specifically as it is represented in the voices from the life history and interviews.

Chapter six picks up one significant theme, which is the tension between nursing's development as a vocation or profession. **Chapter seven** explores the ways in which discourse is identified in the socialisation and education of the nurses. **Chapter eight** returns to the conceptual framework; deconstructing the ways the discourse manifests through family concepts, the use of language and of gaps in the discourse and ultimately the ways that this identifies and controls the discourses around what it meant to be a good nurse.

Chapter nine draws a number of conclusions regarding the power of discourse around being a 'good' nurse within nursing and nurse education. Further limitations and recommendations for nurse education and future research are made.

Chapter Two: Review of the Literature

2.1 Introduction

The aim of the thesis, to *establish discourses that shaped nurse education during the period 1945 -1955* is supported by the three questions guiding the research; *' what did it appear nurse training was trying to achieve', 'how was the experience of training/ learning to nurse expressed', and 'what are the connections with the discourse surrounding the good nurse'* . These are explored through three stages of empirical enquiry including a life story (1932- 1974), interviews and documentary analysis from the period 1945 -1955. In order to support this empirical investigation the review of the literature aims to place the data and findings within an historical context and to begin to explore the guiding questions.

Many authors state that little is recorded of nursing prior to the industrial revolution (see for example Verslvysen 1980, Hudson Jones 1988). The literature indicates that the foundations for the current development, education and training of nurses in England is located in the mid 19th century, thus 1850 is taken as the starting point for the review. For convenience this chapter is structured on an historically chronological basis, rather than the order in which the literature was written. Some of the literature is more difficult to place in this way, so there is a necessity for blurring of boundaries, however broadly the following sections are appropriate:

The early years of reform – 1850 -1914
World War One
The between the war years
World War Two
Conclusion and review of the discourses in 1950

The review is grounded in the conceptual framework of the multiple discourses relevant to nursing and nurse education. Six overlapping discourses have been identified through the literature. Firstly *nursing as reform;* this discourse is particularly strong in the late 19th century and is characterised by a perception that prior to the 1850s nurses were an ill bred, drunken and unreliable workforce whose reform not only transformed the hospitals, but epitomised the move of nursing from disorder into harmony, spiritual and physical hygiene and efficiency (see for example Abel Smith 1960, Maggs 1985).

Secondly *the development of medicine and the rise of the hospitals;* the growth of the modern hospital is well charted by Abel Smith (1964) and it is argued that this is the main development within which hospital based general nursing was able to emerge as it did as a key professional group within the changing health care setting (Dingwall et al 1988). A third discourse explored by Dingwall et al and others (for example Dean and Boulton 1980) is *nursing as social control;* the control of the sick and in particular the sick poor, was an important element of the development of political, health and social policy throughout most of the study period and nursing played an important part in its management.

A fourth discourse is *nursing and the military;* whilst this is not overtly explored in the same detail across the literature there is a strong military influence to much of the development of nursing and nurse education and some authors, (see for example Summers 1988, Starns 2000), argue that this is the defining discourse.

The fifth is part of a more general discourse on women and work but in this context is confined to *nursing as female vocation;* nursing offered opportunities to women which had previously not been available (Tilly and Scott 1987, Baly 1998). The sixth discourse is rather different in that it permeates not only all of the five discourses identified above, but is present in the writing about nursing from all periods, both prior to and since this study, this is the discourse of *the good nurse.*

Written into this discourse are a range of further sub discourses which merit individual attention, but here are taken to underwrite the notion of the good nurse, some of these include philanthropy, Christian notions of womanhood, the good woman, femininity, race and class.

2.2 The recording of nursing history

Hallam (2000) suggests that the image of nursing has been portrayed through the public, professional and personal imagination and each of the discourses above can be examined through these three fields. The public imagination features within the literature review through published research which draws on media representation of nursing in order to research nursing's image and identity (for example Kalish and Kalish 1987, Hudson –Jones 1988 and Hallam 2000). The personal imagination is thought to be of some value within the review, often filling gaps where historical analysis and research are limited and offering some connection to the first hand biographical accounts in the life story and interviews. Thus a number of biographical, autobiographical and published diaries are included (for example McManus 1956, Brittain 1981).

The majority of texts can be said to draw on the professional imagination, in that they chronicle, research and analyse the developments of hospital based general nursing within England. Very little of such literature exists prior to 1960, a notable exception being an American text: Nutting and Dock (1907). Included are histories, analysis and research; from Abel Smith's seminal work in 1960[2] to the present day. Whilst archive material has not been used extensively, original work for example from Florence Nightingale (1878) and Dickens (1852) as well as nursing text books are drawn on from earlier periods as appropriate.

Conventional history texts have been of remarkably limited use as they largely ignore women and domestic work (Rowbotham 1997). Tilly and Scott (1987) suggest that the 'uneconomic' nature of much of women's work has made their lives unimportant and thus invisible.

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[2] The major texts on nursing history from the last 40 years have been dominated by 5 people - Brian Abel Smith (the only non –nurse), Celia Davies, Christopher Maggs, Monica Baly and Anne-Marie Raffertey. Their work therefore features frequently in this review. In addition, the publication of the International History of Nursing Journal, and the growth of interest in nursing history internationally, has led to a considerable increase in the volume of, and publication of historical research in the past ten years.

Verslvysen (1980:176) states that statistically women through history have been the main healers but with the exception of nursing, almost no written records exist. In discussing women healers she acknowledges the difficulties in terms of sources from historical writing.

> 'History is not the past per se, but is predominately an intellectual operation which reconstructs the past through the interpretation of fragmentary written residues.'

She concludes that this selectivity has generally led to the exclusion of women from historical texts.

At the invitation of the International History of Nursing Society, a female historian (Simonton 2001: 43) writing about the location of nursing history within women's history states that:

> 'Nursing history is situated in a number of discourses, these include the structures that developed around professions as a whole and nursing in particular, but nursing is also couched in the discourses which colour approaches to women's history. In particular the discussion of gender, patriarchy and skill'

She suggests that as the skills women were perceived to be using in nursing were considered to be 'natural' or 'feminine' and thus did not require teaching in an organised or controlled way, they were devalued.

What is perhaps at first glance more surprising is that nursing, as an important female activity, as a major source of employment (paid and unpaid) for women and as a developing social phenomenon, is also largely ignored by mainstream texts on women's history. For example, Burman (1979) Tilly and Scott (1987) and Rowbotham (1997) barely mention nursing in any context. There are probably several reasons why this should be so. Nursing has, since the early reforms, created its own discourse which is often quite antagonistic to conventional feminist writing, setting itself out as a 'special' case. Baly (1998: 219) sums up this analysis well in her text on the Nightingale legacy:

> ' for better or worse (the Nightingale fund) succeeded in carving out an empire for nursing, the matron was supreme in nursing matters and nurses became accountable to nurses - -it gave career structure, status, and the hope of a reasonable salary within the sphere of women's work'

Baer (1997) argues that within the dichotomy between 'women as equal' v 'woman as special' Nightingale's strategy was to opt for the latter, arguing that this would give women the flexibility to develop careers outside of the social boundaries imposed in Victorian society.

Seeking to justify and maintain their position of relative power within a male dominated society nurses cultivated the image of themselves as middle class, white Christian philanthropists (Hallam 2000). The profession's apparent collusion with the image of nursing as the idealisation of femininity does not sit comfortably within the current interpretation of women's history which may explain its exclusion. Nursing, Baer (1997:256) suggests, may, with some justification, be seen to have distanced itself from woman's emancipation, often actively subverting feminist ideals[3]:

> 'nurses are the prototypically invisible women whose minds, hearts and hands have shaped a huge industry, yet who are ignored equally by traditional male power brokers and feminist status builders'

The majority of nursing history has therefore been written by nurses and a small number of social historians for an audience specifically interested in nursing. Dingwall and McIntosh (1978) draw parallels with the way in which official histories are written and tribal myths – suggesting that the 'story' will tend to develop and change depending on the context of the times. Davies (1980) suggests that most texts which predate her own have been written from the perspective of progressive, positive, linear reform.

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[3]The position of nursing within the feminist movement has always been an interesting and contradictory one. Many of the pioneer nurses within the late nineteenth century disagreed strongly about the direction nursing should take. The struggle for registration in England (Abel Smith 1960) and the development of the first professional associations (Dingwall et al 1988)) are two examples. Further afield, it has been argued that the fight for reasonable pay and conditions in Australia can be attributed to the contradictory influence of the early nursing reforms in which the vocational, philanthropic ideal upheld by the nurse leaders, meant that challenges to poor pay and conditions were considered disloyal and inappropriate to a nurses 'calling' (Godden 2001).

Nutting and Dock's (1907) epic two volume history of nursing from a USA perspective is perhaps the best example of this, although Abel Smith, first published in 1960, represents a more academic and analytical view.

Since 1980 there has been a significant increase in nursing writing and research generally, including historical analysis. These texts (for example; Maggs 1985, Dingwall et al 1988, Rafferty and Robinson 1997, Baly, 1998 Williamson 2001) offer a more contemporary analysis, which is none the less grounded in its own period of history and development.

Maggs (1985) acknowledges that nursing history is 'ideologically loaded' and needs to be contextualised. In many texts the discourse is clear, for example Abel Smith (1960) deals specifically with the organisation and structure of nursing and openly admits that the actual work of nursing is not within his remit. Bingham (1979) with the title 'Ministering Angels' is unsurprisingly a largely gentle and unchallenging text which glorifies nursing, Bendall and Raybould (1969) is an official history of the development of the General Nursing Council (and thus is much less critical of its development than others) and Holden and Littlewood (1991) through their discourse and arguments reveal a strongly feminist interpretation of nursing history that is closely concerned with gender roles and inequalities. The development of nursing and of nurse education is a constant theme within this body of literature.

The main focus of nursing historical texts has been the early period of reform and the life of Florence Nightingale. The literature suggests that the discourses identified were either generated, or refined during this time. As a consequence the section of the review relating to the 'early years of reform 1850 -1914' is significantly longer than the others. This imbalance is defended on two principles: firstly it is an accurate reflection of the importance of this period to the development of nursing's identity and thus its discourses; secondly this section of the review acts as a foundation upon which the remaining literature and the analysis of the findings are based.
Thus this first section seeks to ground each of the discourses in the historical setting and to chart the birth of hospital based general nursing in England.

The next section 'World War One' builds on the discourses and the development of nursing, particularly exploring the militaristation of nursing. The third section 'between the wars' draws all of the themes together again and the fourth section 'World War Two' identifies the specific ways in which this later war influenced the development of nurse education. A final section, drawing together the discourses brings the review to an end. These final two sections are most closely related to the study period, they are relatively brief. This reflects the specific but limited change that had occurred as well as the focus of scholarly activity to date.

2.3 The early years of reform – 1850 -1914

It is argued through the literature presented here that modern nursing was 'born' during these early years of reform. Consequently this section explores concepts which are important to the research, for example the strong alignment between womanhood and nursing, the development of hospital – based nursing as a distinct occupational group and the creation of an educational system. The importance of discourses around the development of the hospital system and of nursing as an important aspect of social control are key to understanding the links between nursing development and health policy.

There is a long tradition of women acting as healers and carers, beyond the home and their own kin, as a craft (Davies 1980) and as a religious calling (Hudson Jones 1988). However for the vast majority of people even in the 19th century, the reality was that during periods of illness, whether rich or poor, the care they were likely to receive was in the home and provided by female relatives (Dingwall et al 1988). Nursing, as an occupational group, would not have been recognised.

By 1850 there was already considerable growth and development in nursing and hospital services, particularly in London and other large cities. The provision of hospitals in England can be dated back to the early Christian establishments in the 12th and 13th century, so hospitals were not a new concept, but the 'voluntary' hospitals had been increasing in number since the 18th century (Cartwright 1977). These hospitals were maintained by voluntary contributions and were often associated with a university, medical establishment or a professional guild.

The drive to develop the voluntary hospital sector was from physicians and surgeons wanting an establishment of 'beds' of their own and the social status for local businessmen and gentry of being governors. In consequence they catered for a small and selected minority of the population based on the interest of the case, the ability to pay, or patronage and thus were developed in a haphazard way[4] (Abel Smith1964).

A much larger, but far less prestigious and well documented sector was the workhouses. They had been created for the economic management of the poor and it was inevitable that the sick poor would need to be catered for in these establishments. There was no differentiation of types of illness, and most 'nursing' was undertaken by female inmates, who would have been barely stronger or more competent that the people they were caring for (White 1978). The 'less eligibility ' principle on which the poor laws rested, that the relief offered must always be worse than the worse case for an employed person, meant that these services were at best very basic (Abel Smith 1960).

Whilst the two sectors were different, there was a discourse in both around growth and improvement, an optimistic belief that through greater knowledge and the efficiencies associated with the industrial revolution, health could be improved and disease conquered. This improvement was predicated on the existence and development of a workforce that could control, care for and observe patients.

Nurses, in 1850, had no single identification and could not have been defined as a profession. Dingwall et al (1988) suggest three types of people were involved. Domestic servants would have done much of the nursing needed by people who could afford to pay them and in poorer and rural areas a 'handywoman' would often exist who could be called upon in times of illness, she would also help in childbirth and in laying out the dead.

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[4] There is a separate and detailed history of the development of the hospitals, which is drawn upon in this review but not fully explored. The growth of, and tensions between Surgeons, Physicians and General Practitioners along with the voluntary Hospitals, workhouse and local authority infirmary systems (Abel Smith 1964, Barker, 1984) all had significant influence on the development of nursing

In the voluntary hospitals much of the work that we now think of as nursing would have been done by the 'dressers', these would be young men who followed the surgeon 'carrying wooden trays filled with lint and surgical instruments' (Dickens 1852).

In the literature there is almost nothing positive to be said about the hospital-based nurse of the time. To what extent this is an accurate view is hard to discern, as it was in the best interests of the early philanthropic reformers to present the situation as badly as possible, in order to lobby for change and justify nurse training (Dingwall et al 1988, Baly 1998). The fictional view of the hospital nurse as the drunken 'Sairy Gamp' from Dickens has come to symbolise the dramatic transformation of nursing from 'drunkard and whore' to 'angel of mercy' (Kalisch and Kalisch 1987). Abel -Smith (1960:241) summarises hospital based nurses:

> 'mature women of the domestic service class hardened by their experience of life and often reinforced by gin, [they] were able to face the confusion and stench of the hospital wards.'

In contrast Dickens' (1852) in 'Household Words' records his visit to St. Georges Hospital in which he presents a positive view of the nurse;

> 'Carefully trained nurses are at hand day and night to ease his tired limb or sooth his wracking pain' [and]– 'at the end of each ward is a room for the nurse – see how she has contrived to make it home: a bit of carpet, a canary, pictures on the wall'

Clearly in this article Dickens wished to portray St Georges as a progressive institution, deserving of the voluntary contributions which kept it open, this is perhaps an early example of the way in which nursing discourses can differ significantly, even when describing the same period in history.

Prior to 1850 instruction for such nurses was likely to be very limited and to come from the Physician (Maggs 1983, Dingwall et al 1988): no formal training or recognition existed.

However there were notable exceptions to this, several religious orders providing nursing services to the poor had started to develop more structured nursing education; the most famous, the school of Lutheran Deaconesses in Kaiserworth, to which Florence Nightingale was later to go, was formed in 1836 (Cartwright 1977). Elizabeth Fry, also a pupil from Kaiserworth, funded an institute for nursing sisters from the 1840s (Huntsmann 2002) and Helmstadter (2002) makes reference to the Anglican sisters at St Johns House from 1848.

For these early nursing sisters nursing was a devout Christian duty. Williams (1978) talks of the vocation and sacrifice involved justifying the apparent violation of normal social roles and 'sanctifying the task'. Manton (1971:165) in her biography of Sister Dora describes her justification for offering physical care:

> 'as you touch each patient, think it is Christ himself you touch, then virtue will come out of the touch to you'

The work was dangerous and hard and the nurses were not always positively received. Sister Dora worked in the most difficult working class conditions in Walsall, and was even stoned on the street because the very sectarian local people thought she was Catholic.

From the 1850s the pace of change and reform created by the Industrial Revolution was massive, affecting every area of life in Britain and the developments in hospital based general nursing mirror this. Helmstadter (2002: 349) states that nursing reform was driven by the London hospital's need for better nursing care and that as a consequence nurse training became the 'cornerstone of hospital therapeutics'. Growth was continuous and rapid with a doubling of voluntary hospital beds in London from 1861 to1891 (Abel Smith 1964). The discourse is one of improvement and reform. Dickens (1852) describes St. Georges, a voluntary hospital in London as a 'beneficent institution' which is:

> 'fighting disease with education ' [and]' alleviating the terrible suffering of the respectable poor'

The workhouse infirmaries were also growing but as their role was essentially one of containment there is no discourse in the literature of cure or care. White (1978) suggests that due to the combined effects of the 1834 Poor Law Acts and the massive increase in industrialisation, by the mid 18th century about 70% of the paupers within the workhouse system were sick or elderly with no adequate care.

Following a public scandal over the appalling death of Timothy Daly in Holborn workhouse (Public Records Office (PRO) 2001) the Metropolitan Act of 1867 was passed which established separate workhouses for the insane, for those with infectious diseases and for the sick.

There is a strong line of argument in the literature that connects the growth of medicine, the economic role of the hospitals within a capitalist society and the need for a socially acceptable and philanthropic vocation for middle-class women (Abel Smith 1960, Abel Smith 1964, Davies 1980). Tilly and Scott (1987) suggest that nursing undertaken by people who were not kin had been for a long time the province of religious orders on the one hand and on the other 'charwomen'. Through a discourse which presents nursing as a vocation with social, moral and religious overtones, rather than a job roughly equating to a form of domestic service, nursing came to be seen as an acceptable form of employment for what Abel –Smith (1960) describes as the ' the growing pool of idle spinster labour'. Such women, because of their position in society were barred from most activities outside of the home (Maggs1983).

It is necessary at this stage to offer a limited analysis of the impact that Florence Nightingale's contribution had at the time and has continued to have on the discourses that surround nursing. In doing so this account makes no attempt to offer a detailed analysis of Nightingale. Maggs (1985:44) suggests:

> 'in history what people think is happening is often as important as what actually happened'

She is variously 'the lady with the lamp' (Woodman – Smith 1950), a tetchy but skilful tactician (Abel Smith 1960) and a flawed heroine (Baly 1998). She has become, as Whittacker and Olesen (1978:25) point out, a media icon:

> 'it is significant that Florence Nightingale, although widely accepted as a cultural heroine of the occupational subculture, was not the first recognised nurse, nor the founder of the first nursing school, not even the first trained nurse'

However despite this lack of factual accuracy she is never far away from a collective consciousness of what nursing is:

> 'She made nursing into a respectable profession which women could join without being taken for the drunken Sairy Gamp of Dickens novels. She also made nursing scientific. At a time when Doctors had very few drugs or anaesthetic, nursing was even more important for the patients' survival that it is now'
>
> (Kalisch and Klalisch 1987:20)

Perhaps what Nightingale was successful in doing was demonstrating that through vocation and training nursing could become secularised, without any loss of dignity and moral purity. Whilst spirituality was implicit in all of her nursing work and writings, she approaches the task not as a form of nun-like Christian devotion, but as a pragmatic, scientific problem to be solved. This view of her contribution is a sympathetic one and would probably have met with Nightingale's approval[5], but it is not without tensions.

Davies (1980) shows that the interpretative critique of the nursing literature is of nursing, under the influence of Nightingale moving from bad to good through education , whereas in the medical literature nursing moves from bad to better, but at the expense of the nurse becoming too theoretical.

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[5] There has been a great deal written about Florence Nightingale over the past 150 years, she is also explored in films and documentaries. In addition to what has been written about her there is a large archive of original letters, essays and other documents from the time which have been used in a range of research projects. It is not the intention in this text to explore her life in any detail, rather to accept her influence on the discourses identified, particularly those of *nursing as vocation*, and the *good nurse*.

Clearly an important factor relates to gender; Gamarnikow (1991) identifies that the issue of gender is a 'complex and problematic phenomenon' in that Nightingale used it to legitimise nursing as a woman's role but this meant that doctors could ensure nursing's subordination for the same reasons.

Thus, it may be argued that for all that a new, more educated nurse was needed to staff the hospitals the empire which the new Nightingale style matrons and nurses created for themselves (Baly 1998) was a threat to medicine. Indeed, it was only possible because the system of nursing education proposed was economically and ideologically attractive to the male dominated medical and hospital administration.

Despite the fact that there was much criticism of the Nightingale School of Nursing at St. Thomas's and that there is little historical evidence of its success (Maggs 1985) it became the gold standard for developing nurse education. The organisation of the voluntary hospitals was modelled on that of the Victorian middle-class household, and Nightingale –style training blended in with this:

> 'the process of moral training, which emphasised above all the quality of obedience, was largely an informal process, a code of behaviour that was learned in the same way as a child by making mistakes and being punished , by doing well and being rewarded – mirroring the middle-class construct of the family'
>
> (Maggs 1983: 13)

This construct places the doctor in the patriarchal role as head of the household in absolute control, with a matron in the position of 'wife', subordinate to him but superior in class to all others, managing a complex hierarchical household and ensuring the economic and moral health of all. Parallels with Foucault's (1979) discourse on the family are clear and put the hospital system in a strong position to exert social control, which will be discussed in greater detail below.

In order to develop this system the voluntary hospitals started to offer courses of instruction and respectable, safe accommodation in which probationers[6] were taught basic anatomy and physiology, nursing procedures and nursing ethics through a one to three year training period, at the end of which the nurse was awarded a certificate by the hospital. Bradshaw (2001) identifies this apprenticeship system as central to the Nightingale inspired model of a patient centred vocational preparation for nursing. Pupils 'lived the ideal' by being cloistered in the nurse's home and dedicating their whole lives to their work.

There have been a number of studies investigating the conditions in these early training schools. Maggs (1983) and Collins (2003) both identify the training period as typically involving 10 hour working days with a half day off duty per week and one day per month. Pupils were moved from each ward and from day duty to night duty without notice to meet the hospitals needs and lectures were attended during off duty periods, often entailing missed sleep when on night duty. These conditions were usual at the Middlesex hospital, with a standard 60 hour week (Baly and Skeet 2000).

Thus , despite Bradshaw's (2001) assertion that this apprenticeship model was a necessary and successful one, it set a pattern in the early nursing schools in which the nurses' education was always secondary to the economic needs of the hospital (Davies 1980) and where improvements were more concerned with managing the staffing crisis than with improving nursing *per se* (Wildman 1999). Probationers were paid a very low wage and although accommodation was provided and for many women it represented freedom from home, it remained a fairly basic privilege, and was accompanied by strict rules and regulations.

Nursing work included everything that the patient needed, from scrubbing floors, bedpans and toilets, through to procedures ordered by the doctor and

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[6] The terms 'probationer', or 'pro' and 'pupil' are usually used interchangeably to describe trainee nurses during this period. The term 'student' is rarely used until much later.

close medical observation[7]. A strict hierarchical model of task allocation meant that the most menial jobs were done by the most junior nurse. The hospital and its work were also influenced by the capitalist ideals of time and efficiency. Maggs (1983: 125) suggests that in the old system time had 'passed nurses by', in that they had in the main just watched over people who were ill. In the new system, nurses were:

> 'users of time. . . . the ward routine, determined by the clock and the hospital etiquette worked to produce order and method in an environment that was not itself ordered'

Initially as well as the paid probationers, 'lady pupils' could pay a fee for their training, which helped the hospital financially and ensured the pupils better treatment such as exemption from the more menial domestic duties, but this practice had largely ceased by 1900. In the larger teaching hospitals these pupils were often being coached for management positions, a practice which reinforced class distinctions (Weir 2000, Brooks 2001).

Although the elite, higher class women in nursing were a small minority of the actual workforce (Maggs 1985) through their power base in the voluntary hospitals they were able to influence the whole of nursing development[8]. Nursing emerged as a female vocation in which woman's 'natural' abilities were transformed into a profession. Two of the legacies from this are nursing's continued subordination to medicine and a work ethic which accepted low wages and poor working conditions as a privilege. Once established in the voluntary sector the system was disseminated to the new workhouse infirmaries, other fields of nursing and indeed all over the world (Godden 1997, Baer 1997).

A further factor in the discourses of nursing reform and of female vocation is the bitterly contested battle over professional registration, which was not

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[7] Verslvysen (1980) suggests that the phenomena of separating medical and nursing tasks, particularly along gender lines, is relatively modern. In creating this sexual division of labour within the hospital system the powerful and predominately male medical fraternity were able to control the input of women establishing power and financial differentials which are still apparent today.
[8] There is for example a well documented relationship between the Nightingale school and the workhouse infirmary at Brownlow Hill in Liverpool (Abel Smith 1960, White 1978)

resolved until 1919. Some nurse reformers, led by Mrs Bedford Fenwick, the founder of the British Nurses Association, campaigned for registration on the basis of protecting the public from unqualified practitioners and thus creating a closed professional group which required a nationally agreed standard of examinations (Abel Smith 1960).

Florence Nightingale and others opposed this view, believing that the art of nursing, acquired at the bedside was a more significant indicator of the nurses' quality and that 'book learning' and exams should not be the deciding factor. The Hospital Association, representing the interests of the main voluntary hospitals capitalised on these internal disagreements, seeing registration as a restricting factor in the free transfer of labour between hospitals. (Dingwall et al 1988, PRO 2001).

Nursing's preoccupation with itself is a recurring feature of its history, as is the tendency for the motivation to practise nursing to be presented by the profession as an unconditional and beneficent good. However, to portray nursing as a simple transfer of women's skills into an institutional setting is a limited analysis. Maggs (1985:176) suggests that:

> 'Too often, the history of nursing has failed to take account of the wider social events and contexts, and the development of nursing is often portrayed in isolation from the mainstream of society'

Clearly the period 1850 -1914 was one of massive social and political upheaval, and the changes to nursing need to be seen within this context. Literature commencing from a discourse focusing on socio-political change offers a different analysis on the reasons for the growth of the nursing. Dean and Bolton (1980: 77) suggest:

> 'It is our contention that a crucial key to understanding nursing practice…. and its transformation can only be established by locating it within the broad terrain given in the discussion about poverty and political and social organisation.'

Within the context of the industrial revolution, health and the management of hospitals for sick people can be seen as a form of 'industry' with the attendant concepts of organisation and control[9]. It may be argued that nurses played a significant role both as willing, cheap labour and as agents for this control. Many texts have discussed the importance of nursing reform in the management of the sick poor (Davies 1980, Dingwall et al 1988). The discourse of the time sees poverty in the working classes as a necessary aspect of capitalism. Their 'natural' inclination as a class was to deviance and poor physical and spiritual hygiene which made them dangerous to society. Thus the poor generally needed to be managed (Williamson 2001, Helmstadter 2002), and employing a better class of women to nurse them became a medium through which this was achieved.

> 'the patients, drawn from the working classes were put in the charge of young ladies who did not hesitate to impose their own culture upon them'
>
> (Abel Smith 1964:67)

Nursing work, often justified as being for the 'good of the patient' (Hawker 1985) played its part in imposing social and political order. Nursing development is inseparable from capitalist and colonialist ideology, as promoted and maintained by the white middle classes (Brooks 2001). Mitchell (2001) goes further to suggest that it was the perceived 'pliability' of nurses as a collective group which led to them being viewed so positively as agents for change and reform. Whilst Mitchell's research specifically looks at Learning Disabilities nursing, the parallels can be clearly seen in hospital based general nursing.

Despite there being much rhetoric within nursing discourses about holism and the centrality of the patient, the discourse around social control and the disease oriented hospital system leaves little space for this.

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[9]Health of course was not alone in this matter, other areas of medicine, for example midwifery, and non medical areas such as education and the police force could be analysed in a similar way. Perhaps most importantly the established Christian Church reiterated the dominant ideology that social stratification and unequal distribution of wealth were morally right and necessary and that this social order should be reinforced at every opportunity

Boschma (1997) suggests that the more patient centred aspects of nursing were systematically marginalized; for example Keleher (2003:50) shows that public health nursing is practically invisible in the historical records of nursing development within Australia:

> 'In order to serve the needs of hospital medicine training and education for nurses was limited to learning about illness and disease'

Interestingly, Keleher goes on to state that public health nursing in Australia was referred to as 'civilian nursing' which identifies a further, 'hidden' discourse (Hallam 2000). This receives scant attention in the majority of texts but is explored by Summers (1988) whose research covers the period leading to the First World War and Starns (2000) the period of World War Two. Both argue that the development of nursing cannot be understood without reference to the influence of the military.

Summers (1988), argues that there was an increase in the awareness of and involvement in military behaviour amongst the general public in Europe throughout the 19th century. The culture of volunteerism and the potential excitement for women being involved on a 'world stage' created an idealised and romantic view of military nursing. The Crimea, and the way it was portrayed, through popular literature and Florence Nightingale's own efforts, inspired women to want to war nurse. Despite this nursing was still very much on the periphery of military action and a regular nursing force was not established until later in the Boer war (Starns 2000).

In 1883 Queen Victoria created the Royal Red Cross medal in recognition of nurses' bravery, the first such award to be given to women. (Summers 1988: 178)

> 'the idea that women might not only distinguish themselves in the public sphere, but might do so in much the same was as men , was growing'

The cloistered, 'military imagery' in nursing (Baly 1998) can be seen in the discourses about obedience, patriotism and duty; the uniforms, the obsession with rank, the language and the culture.

It may be argued that the military discourse was particularly useful in nursing to help suppress, or control the aspects of femininity deemed dangerous or uncontrollable. Savage (1987) for example suggest that the uniform served to suppress identity and individual sexuality and Stein (1978:115) that the military flavour was created through petty chores and rigid rules. She further suggests:

> 'To inculcate subservice and inhibit deviancy nursing schools for the most part were tightly run, disciplined institutions [creating] fear of independent action'

It can be seen that the literature does not offer a single explanation for the reasons that nursing developed as it did, or a unifying discourse on what nursing became. The changes brought about by the industrial revolution, including the ways in which society in general and women in particular were to behave, the development of medicine and the hospital system and increased military activity are all significant. What emerges is an overarching, contradictory discourse about what it meant to be a 'good nurse'. It may be argued that the review of the literature to this point has identified at least five different aspects of this discourse.

The first aspect Kalisch and Kalisch (1987) describe the reformed image of the nurse from the 1850s as that of 'angel of mercy'. Hallam (2000) relates this to the discourse on white femininity; the good and great Englishwoman transporting the 'Angel in the House' to the hospital. The image that is portrayed is of a person who is impossibly good: 'consistent' pure' 'truthful' 'unselfish' ' courageous' ' intelligent' 'warm' ' compassionate' ' steadfast in a crisis' (Kalisch and Kalisch 1987) . Maggs (1980) researches the advertisements for nurses as 'educated Christian Ladies' and later (1985) as having the virtues of a good woman – obedience, truthfulness and kind-heartedness. Whilst there has been a degree of secularisation of nursing – no-one by the turn of the 19th century assumes that nurses should take holy orders - there remains a strong discourse around vocation and calling, that minimises the sense that nursing is a job and promotes the concepts of service, long working hours and poor pay (Godden, 1997) .

The second aspect of the discourse of the good nurse suggests that women must manage to achieve this image without appearing to be too clever and to be ambitious only for service (in or out of marriage) rather than esteem. Nightingale (1878) makes it clear that character is more important that intelligence or class and Lorentzon (2001) shows that in the records of nurse probationers in the late Victorian era to be judged 'good, kind and reliable' was better than 'clever'. Lorentzon's later research (2003) into nursing within a workhouse infirmary reiterates the expectation that suitable candidates for nursing were 'good' rather than 'bright', but that with training and dedication they could use nursing as a means to better themselves.

Whilst much of what the nurses did was domestic work, they were separate and superior in rank, behaviour and treatment from servants. These attributes all relate closely to the contemporary discourse of the good woman and good wife. Many authors (for example Maggs 1983, in relation to nursing recruitment and Kalisch and Kalisch 1987 in popular fiction) show through their research that nursing was portrayed as an ideal preparation for marriage and a worthy 'second best' if marriage was not possible.

A third aspect of the good nurse discourse relates to the extent to which good nursing is innate or can be learned through training. For example in Williamson's (2001) research the good nurse is identified as the good Christian woman – meaning that the middle class woman, purely through breeding and education has all the skill and aptitude necessary to both nurse and instruct women of lower classes in the art of nursing and family improvement. Nightingale did not hold this view, believing that women with a good temperament and upbringing through education and discipline could become good nurses, but that this was not a 'natural' state (Nightingale 1878, Van der Peet 1995).

It may be argued that the fourth and fifth aspects of the good nurse discourse are in direct contradiction to each other. They seem to require physical and moral strength in combination with gentle femininity and despite an innate

tendency for the ill disciplined female character to be volatile and untrustworthy.

McManus (1956: 34) reinforces the good nurse/ good woman discourse when she describes the nursing ethics taught to her at Guys in the early years of 1900:

> 'courtesy, consideration and an understanding of other people's feelings. Utter accuracy in performance and utter honesty if mistakes were made. A sense of responsibility in our own work and a readiness to take full responsibility on our shoulders if the need arose. The creation of an atmosphere of peace and confidence; to be careful in everything and afraid of nothing'

This description suggests women needed great ethical and moral strength and yet the training served to reinforce their subservience and weakness within the hospital system. Abel Smith (1960) identified the Matron as pivotal to the success of the new hospitals, she had the contradictory role of taking on a huge responsibility for herself and expecting hard work and responsibility from the nurses, at the same time as imposing strict discipline because the 'volatile' female nature of her trainee nurses was not to be trusted (Kalisch and Kalisch 1987). In addition she must never question her own subordination to the physicians. Gamarnikow (1991) suggests that nurses used 'the traditional power base' available to women, using manipulation and feminine wiles to influence their more powerful male colleagues and gain some control.

The ambivalent role nurses undertook, both as women and workers is prevalent in the imagery throughout the literature on Victorian and Edwardian nursing reform and it may be argued it mirrors the confusion and double standards within society. Ruskin (1895) presents a portrait of respectable femininity where the women is all things; delicate, feminine and soft, but also strong enough to manage a household, please a husband, bring up a family correctly and do good works for those of lower classes, without being corrupted.

Having explored the multiple discourses surrounding the early reforms on nursing and the relationship between policy, practice and experience it is hard to articulate what the actual experience of nursing was, who nurses were and what their education achieved. It may be argued that nursing presents a particularly confused group of discourses because, having drawn on the concept of femininity to justify its development, close examination of the emerging occupational group challenges this same concept. Two examples may be helpful:

The first challenge is that despite the discourse on (white) middle-class femininity, nurses came from a wide range of backgrounds and classes. The number of nurses needed to staff the new hospital system meant that the idealised image of the wealthy lady seeking her redemption through good works and naturally able to nurse because of her breeding and education could never fully supply the growing employment needs of the sector (Maggs 1983).

Beyond a basic education it was considered inappropriate to appear too bright (Weir 2000)] also obedience, physical health and the willingness to work hard were important factors, but class was not. High drop out rates (Baly 1998, Lorentzon 2001) testify to a tough training in terms of the work, the hours and the discipline. They also may be related to the increasing competitive opportunities for 'white blouse' work within English society.

The Second challenge is that nursing, even allowing for the cultural and social norms of the day, was a difficult and dangerous job. The image that had been fostered led to an expectation that an English trained nurse could turn her hand to any situation. McManus' (1956: 65) autobiographical account of her life offers a rare insight into the actual practices of nursing[10]. She recounts one of her first nursing tasks following qualification a few years prior to the First World War. She is travelling to Egypt to take up a post there but when people hear that there is an English Nurse available, they ask her to care at

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[10] In the many texts on nursing few people talk about what nurses actually **do -** perhaps reinforcing the analysis of Foucault (1979) regarding hidden discourses and gaps.

night for an Army Officer who has smallpox. Thus she finds herself in a foreign country, it is cold and she has no heating, no help, no laundry facilities and no change of uniform:

> 'my patient was in a bad state, I was ordered to cleanse his skin constantly with disinfectant lotion and olive oil to soften the crusts. He was a heavy powerful man and unused to female attentions, so he was awkward to nurse. He could not drink lying down; I had no help at night and could not possibly hold him up. So as he became more helpless I used to kneel up on the bed behind him, prop him up against my chest, put my arms around him and feed him that way'

By whatever standards one judges this is not a description of the work of a woman who is weak or afraid and does not fit the espoused image of femininity.

Despite these confusions by 1914 a considerable change to hospital based adult general nursing had taken place. It was no longer an occupation for older women and had become a more systematic form of education and employment for young women. Wildman's (1999) documentary research from the Birmingham General Hospital is illustrative of this showing that the average age of recruits had dropped from 42 years old in 1842 to 27 years old in 1891.

The demand for trained nurses was strong and the sector, including both voluntary and municipal hospitals, were now running nursing schools and building nurses homes to attract suitable candidates.

Whilst the system of apprenticeship was universal, there remained considerable debate regarding the length and content of nurse training. A departmental committee had been formed in 1902 to look at the education in the poor law infirmaries, which had recommended a one year national syllabus for nurses and extended three year training for nurse managers (Dingwall et al 1988). There was however no resolution over either a national system of education or professional registration and although Maggs (1983)

states that nursing was now defined as a professional group, education was still a consideration secondary to the economic needs of the hospitals.

2.4 World War One

The period of the First World War is acknowledged to have transformed many aspects of society. This review cannot begin to do justice to the changes the war brought to everyone and thus limits its focus to the key concepts of the research; namely nursing and the identified discourses. Understandably, the strongest discourse relates to the military development of nursing, but all were affected by the profound social and cultural effects of the war.

The need to manage war casualties brought the inadequacies of unsystematic hospital growth into focus, forcing a more Government led and united discourse. The traditional spirit of volunteerism which had supported the development of the voluntary hospitals (Barker 1984) was no longer sufficient to finance the hospital sector and Lloyd George had introduced the first health insurance scheme in 1912. Hospital reform was swift: the number of hospital beds available, the organisation of the hospitals and the strategy for managing health were all revealed to be inadequate for the task of managing the war effort. Abel Smith (1964: 284) states;

> 'The case for an integrated approach to the nation's health which had been canvassed by a minority before the war became widely accepted in the national crisis.'

Thus not only did the number of beds increase dramatically to accommodate the war wounded, the system became more efficiently managed and developed. As a consequence the demand for nurses continued to outstrip the supply leading to chronic shortages such that regular services were supplemented by a massive voluntary effort.

Due to the increased military awareness and the threat of invasion, volunteer forces had been growing since 1900. Quasi military organisations for children, such as the Boy Scouts and Girl Guides and the Red Cross Brigade for girls taught first aid and encouraged a spirit of everyone supporting the war effort.

The territorial force and the Voluntary Aid Detachment (VAD) were both gathering recruits around the country and by 1914 the VAD alone had 50,000 volunteers, mostly women, ready to work in hospitals in Britain and to go out to the war zones, to staff clearing stations, drive ambulances and manage rest stations (Summers 1988).

Tylee (1990) suggests that this was an explosive time, for both the working class and for women. For women this was a time of liberation, despite the losses it was an opportunity to enter the 'danger zone' of previously forbidden occupations and of sexual freedom. Brittain (1981) shows the contrast in her diary; within the space of a few months she moves from being chaperoned, to having intimate physical contact with war wounded and the opportunity to make friendships without her parents' knowledge or control.

Trodd (1998) however argues that this freedom very much relates to middle rather than working class women – whilst middle class women were discovering new freedoms most working class women were struggling to survive the war within a system which gave them little support or reward in the absence of a male breadwinner.

The volunteers forces were met with ambivalence: for the development of hospital services and the maintenance of the war effort they were essential and a clear success story, however for those wishing to control the development of nursing they were a threat. The discourse of nursing as a reforming female vocation had been strongly associated with the long training, discipline and hierarchy imposed within the general hospital system. The VAD arrived armed with nothing more than elementary first aid and a spirit of adventure and was deeply resented by the established profession (Dingwall et al 1988, Lorenzton 2001). This conflict is presented within literature as a fairly straightforward two sided dispute, however it may be argued that it is more complex and far reaching, illustrating the most fundamental of conflicts within the discourses of what it really meant to be a 'good' nurse.

Taking Hallam's (2000) three images – the public, professional and autobiographical imagination, in the early years of reform, whilst there was some divergence, for instance regarding the extent to which women were 'naturally' able to nurse, or needed training, there was a fair amount of congruence between these images. This changed in World War One, as what it meant to be a good nurse became less clear: the public image of nursing needed to support the war effort and the discourse promoted by the media reflected this. The good nurse was still associated with the 'angel', but was now a more modern, plucky and courageous woman.

> 'In these World War One media portrayals another model of an angel of mercy with new values was depicted. The nursing identification provided an effective way to mask the novelty of female independence with traditional nursing values'
>
> (Kalisch and Kalisch 1987:54)

Women in every sphere of life needed to be seen to be patriotic, to support the nation at war. Nursing was no exception. Training to nurse, or signing up as a volunteer were two ways that women could engage in active duty.

The professional discourse was supportive of the war, indeed nursing appears to have been keen to embrace a military image, mimicking military processes in organisation, dress and behaviour. Military and civilian nurses excelled themselves in Britain and abroad in makeshift army hospitals. However Summers (1988) suggests that military nursing thrived as an auxiliary function, in which women were co-opted into the war without undermining the traditional gender roles or hierarchy; they were 'in' the army but not 'of' it, and were not afforded officer status.

One factor in this separation was the presence of volunteers. The emerging profession wished strongly to distinguish trained nurses from volunteers and untrained people and to portray an image which suggested that the former were by far superior, this can be seen in the trivialisation of Brittain's (1981) volunteer work by some regular nurses.

Nursing had by this time established itself as an indispensable part of the health service. It was a predominately female occupation, managed by middle-class women, within the dominant patriarchal system. Trodd (1998) suggests that the concept of 'profession' as male and 'amateur' as female is used as a way of devaluing women's work and experience. If VADs could, with a uniform and a few weeks training do the job of a trained nurse, then the premise on which nursing had based its development for over 50 years was destroyed.

The autobiographical discourse parallels this difference between voluntary and regular nurses. Two texts which can be contrasted are McManus (1956) who had several years experience as a trained nurse before the war and served both in London and on the continent throughout the fighting, and Brittain whose diary (1981) chronicles her experience as a VAD. Both were the daughters of respectable middle class families, but McManus, from a medical family, expected to have a career in nursing from a young age. Her account of the war is factual and unromantic. She volunteers for military service and spends some time in mobile and makeshift hospital settings in Europe, close to the Front. She has already travelled and nursed in Egypt and Europe nevertheless the war stretches her skills and is an exhausting experience.

Brittain, prior to 1914 is bright and modern, looking forward to life at Oxford and the possibilities of a literary career. The war changes everything and in many ways she typifies the VAD movement. Despite her diary conveying the desperate sadness and waste of the war, it cannot disguise the romance and adventure she experiences through it. Where 60 years earlier Sister Dora (Manton 1971) urges her nurses to think of Jesus when they nurse to preserve their piety, in 1914 -18 a generation of middle class women thought of the men they loved and hoped that some other nurse would care for them too. Brittain (1981:173) decides to give up her studies as an act of sacrifice:

> 'if he dies I shall sign on as a Red Cross nurse, say I am 23 and do really hard dirty work[11]'

In fact she found it impossible to study and started nursing some months before his death; one diary entry (pp 220) catalogues a particularly hard shift when she has only a few months nursing experience:

> 'besides the incidental and continual occupation of fetching basins, cleaning away cups and filling hot water bottles I had to rub a new patient's chest, rub Hopkins back and bandage it, paint and bandage Hibbart's foot, paint & bandage Hill's ankles and legs, put Johnson to bed and bandage him to his splint, collect and wash the cups & rub the chest of the man I always go to last thing at night'

The war allowed Brittain to move into a totally new social situation, which would have been unthinkable in peace time and she seems to have little if any embarrassment at the physical closeness she is expected to manage, with just the symbolic barrier of her Red Cross uniform. It seems from other entries that her job as a VAD was mainly to undertake domestic duties, and to 'fetch and carry' but in some settings (as above) she was clearly completing a range of duties which a qualified nurse would have been doing if available. The line between volunteer and nursing work was a movable one, this illustrates the difficult position the regular, qualified nurses were in – if the work needed doing and an able VAD was available then there was no choice but to let her do it, however this then undermined the mystique and authority of the image nursing wished to portray.

The two characters (Brittain and McManus) also match the female stereotypes which Trodd (1998) identifies for working women, of the single young female – working as an adventure and preparation prior to marriage and the celibate female – who has chosen a career as an alternative to the 'normal' female role in marriage[12].

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[11] 23 was the age of entry to the VAD – Vera Brittain was only 21 at the time and lied about her age.

[12] Brittain returns to England after the War and eventually marries, using her war experience as the material for her literary publications and campaign for peace. McManus returns to Guy's Hospital in London, to become the matron, and later leads the Hospital's work in World War Two.

In consequence of the pressure upon nursing during the war the discourse of the good nurse is a confusing one. The VAD movement caught the popular imagination and it may be argued that this obscured the regular development and growth of nursing as an occupational group both at the time and since.

The war meant that many women had been admitted to new jobs (Lorenzton 2001) which changed their expectations and further established work outside the home as a respectable preparation for, or alternative to marriage. This, in addition to the threat to professional identity posed by the volunteer forces, shifted the discourse on nursing reform to arguments regarding the status and protection of the qualified nurse, what nurses should do and how the systems of education and practice should be managed to attract enough women to join.

The profession had been unable to agree on registration prior to the war and various different competing registers of qualified nurses had existed since 1887. Parallel debates were happening in other sections of nursing, for example the asylum workers (Arton 2003). A pre war select committee on registration had met in 1904-5 and each year from 1908 to 1914 there had been attempts to take a Nurses Act through parliament. These had all been successfully blocked, in the main by the powerful lobby from the London teaching hospitals[13] .

There had been an agreement to stop working on the Act throughout the war, however the influx of volunteers threatened the power base of the elite voluntary hospital nurses, making agreements on what the term 'nurse' denoted more urgent. Thus in 1916 a 'college of nursing' was formed as a limited company (later to become the Royal College of Nursing) which started its own Register (Bendall and Raybould 1969).

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[13] The pro registration nurses, led by Mrs. Bedford Fenwick had a feminists ideal of an all female, exclusive profession, with limited numbers and a fairly narrow entry gate, but they were consistently outvoted by the hospital association which was keen to ensure sufficient staff at a competitive cost for the growing hospital sector. The Hospital Association, led by the London hospitals, was supported not only by the medical profession, but also by a significant number of influential nurses. (Bendall and Raybould 1969).

Bradshaw (2001) suggests that this formed a paradox; attempts to improve pay, conditions and status could have been promoted through unionisation but this would have challenged the strongly held discourse of nursing as a vocation. But the threat that vocation could be seen as the same as volunteering, might encourage a view amongst both the general public and the hospital authorities that nursing was an amateur occupation, rather than a profession; the anxiety this generated shifted the balance of power allowing the registration movement to overcome the main disagreements within the profession.

This involvement in politics was notable, as nurse historians (see for example Lorenzton and Bryant 2001) generally comment on the lack of political involvement of nurses. For example, despite the growing movement for suffrage and the potential for women's involvement in the war effort to be evidence of the right to citizenship and thus the vote, this features little in nursing discourse. Indeed Summers (1988) shows that the Red Cross nursing movement was strongly opposed to nurses campaigning for the vote and she further suggests (p275) that,

> 'VADs longed less for the vote than for the outbreak of war, when they would be reassured that their work was of real use and of central importance to the great national enterprise'

Bradshaw (2001), discussing the debate regarding registration, states that in addition to arguments about the inability of a register to distinguish a 'good' nurse from a 'bad' one, there was no agreement on what standard training should include as the threshold for registration.   Courses still varied greatly between large and small hospitals and between the voluntary hospital and poor law infirmary sectors. Despite the professional discourse on reform and the espoused value of employing qualified nurses, in reality the vast majority of the actual hospital work was done by unqualified probationers or VADs and there was no agreement regarding where domestic work ended and nursing began. The influx of the volunteer forces were necessary to staff the wards, but their presence added to the confusion (Dingwall et al 1988, White 1978)

Although nurses may have been reluctant collaborators with the process of change, at this time as in many others, social and political forces affected them anyway. Firstly, Tilly and Scott (1987) identify that the combination of compulsory education, increased industrialisation and government involvement in health care meant a large increase in the type and volume of women's work. Within this nursing was a small but growing sector. Secondly, the fight for female suffrage was won, faced with a growing vote carrying female lobby a Nurses Act was finally passed in 1919 and so the General Nursing Council (GNC) got off to a stormy start (Bendall and Raybould 1969). Finally Dingwall et al (1988) suggest that the breaking down of class barriers through the collective war experience, alongside the increased treatments available meant that middle class people were now accustomed to thinking of hospitals as a safer, more appropriate place to go when ill.

2.5 The between the war years

If the First World War revolutionised British society it may be said for nursing that the between the war years were more a matter of evolution: major changes did not take place, rather incremental development both of nursing and of women and their work was gradual. These incremental changes brought about subtle changes to the discourses which are significant to the key concepts of the research, in particular the tension between discourses of profession and vocation.

The multiple discourses around nursing continue in this period to be set against the backdrop of hospital reform. There was massive growth in hospital beds, more hospitals were built and more treatments were available (Abel Smith 1964). Numerous and continuous medical breakthroughs for example in the treatment of Tuberculosis and the discovery of Penicillin (Le Fanu 1999) meant more and more people sought help from medical sources. However the legacies of the pre war period remained, with uncoordinated administration and problems for nursing over autonomy, pay and control.

The two tier system of voluntary and local authority medical provision was strengthened through the increase of private beds and paying patients in the voluntary hospitals, where richer people could jump the queue for treatments. The literature from this period, right up to the formation of the NHS in 1948 identifies a two way fight (Abel Smith 1964, Barker 1984).

On the one hand the government, needing, in the face of a population in poor health, to use its power to regularise the service such that it could genuinely improve the health of the nation and on the other the hospitals and the various medical lobbies, concerned respectively with economics and status. Despite nurses being the largest single workforce, they are barely mentioned.

The apparent apathy of individual nurses and their leaders to policy development which was identified throughout the suffragette movement is mirrored in the development of the hospitals. Despite this lack of interest the development of the hospitals remained centrally important to the reform of nursing, as their major employer, the location of their training and the focus of disputes over status and recognition (Abel Smith 1960, White 1978, Dingwall et al 1988).

Instead, focus was on the newly formed GNC, which started the task of creating central regulations for the profession, but there were frequent disagreements over what this might entail. A final practical and theoretical examination, plus viva voce were designed, but initially no formal syllabus to prepare candidates was published (Bradshaw 2001).

There was uneven representation on the GNC, leading to biases that mirrored the power differentials within the profession. For example, of the sixteen nurses on the Council fourteen were from the voluntary sector and ten of these were medical school hospitals. One of the few areas of agreement was the desire to exclude VADs from the register at all costs, a reflection of the bias towards the more prestigious hospitals who could afford to set more stringent entry gates.

One of the main functions of the GNC was to commence the nursing register, which opened in 1921, but was slow to take off, causing a financial crisis. The first national examinations in 1924 were voluntary; but from 1925 they were compulsory, although the syllabus remained advisory. By 1927 the system was accepted, although there remained considerable debate around the extent to which the passing of an exam denoted a 'good' nurse (Bendall and Raybould 1969, Bradshaw 2001). The major hospitals continued to subvert the system, treating the state exams as 'irrelevant' for example the Middlesex (a typical London Teaching hospital) had no trouble in recruiting probationers, and qualified nurses with their prestigious name and hospital badge had no difficulty in finding work(Baly and Skeet 2000).

These developments affected the ways in which the discourses around nursing reform and female vocation progressed. The way that general nurses were trained, including the working conditions and social expectations, were a source of debate and policy development. The 1920s saw major problems in terms of recruitment. The reason for and management of this crisis is subject to differing analyses. On the face of it, there were insufficient women coming into nursing. It is suggested by Davies (1980) that nursing blamed itself for this problem, rather than tackling the poor conditions of service, for example the student labour system, which went largely unchallenged until World War Two. The 'servant-less home' (Trodd 1998) was a post war phenomenon, leaving fewer opportunities for domestic work and thus a potential pool of aspiring recruits.

However other social changes and improved overall education meant that nursing was just one of many employment options available. Indeed, Dingwall et al (1988) show that the numbers of women seeking employment and the number of nurses were increasing all the time, but as the number of hospitals beds and the range of potential occupations was also increasing the supply and demand were not well matched.

The period is characterised by a growing tension between the expectations of recruits, nursing's self image as a vocation and the practical economics of staffing the hospitals. Despite the apparent regularisation of the profession through registration and state examinations, the unmet demand for sufficient staff meant that there was a wide difference in experience of training. The 'best' hospitals could attract good, secondary school educated candidates and were richer. By the 1930s some in London were offering a 54 hour working week with 2 hours study time and a three week Pre Training School (PTS) (Abel Smith 1960). Indeed the Middlesex, was offering an 8 week PTS from 1926 (Baly and Skeet 2000) and the Birmingham General Hospital from 1923 (Wildman 2003). On the other hand many of the smaller hospitals took candidates as cheap labour, with little expectations that they could pass the more stringent exams. The typical failure rate of 40% in 1932 (Abel Smith 1960) is illustrative of this.

It may be argued that up to this time the discourse of nursing as a female vocation was fairly consistent, but the literature suggests an increasing use of the word 'profession'. It is difficult to judge the extent to which the change of semantics represents a real shift in emphasis. When nursing was first being developed as a recognisable occupation for women in the latter half of the 19th century the concept of vocation was used to align nursing work with religious calling and thus to make it more acceptable to the growing number of middle-class women who were considered suitable for the task (Abel Smith 1960, Dingwall et al 1988).

To have a vocation is defined by the 1952 edition of the Oxford dictionary[14] as a person's: 'sense of being called to a particular occupation or task'. Ideologically the concept of vocation is an important one to nursing, rooted in the 'sanctifying' (Williams 1978) of nursing work which legitimates bodily contact between respectable women and people who are not their kin.

The 1952 Oxford Dictionary definition of profession is not that dissimilar from vocation suggesting that it too is a calling, but specifically to something learned or scientific, such as divinity, law and medicine.

It would seem that the secularisation of nursing and the move from a holistic to a more technical, medically oriented occupation (Williamson 2001) may have meant that vocation was no longer needed to make the nurses work respectable. Williams (1978) suggestion that 'vocation' was necessary for nurse's respectability may have been usurped by the discourse around medical advancement.

As the tasks involved in nursing became more sophisticated, involving technical equipment and fewer bedside skills and as social change made women caring for men less morally dubious, it's possible that the expression 'profession' was more sympathetic with popular notions of nursing.

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[14] In using this old edition I am attempting to find a definition which is closer to the study period. The new Penguin dictionary (2001) has definitions which are different and less closely aligned, suggesting that contemporary usage of these words has changed.

It would seem however that in most instances the two words are used interchangeably and that this discourse is worthy of closer scrutiny.

Certainly in both training and regulation the profession sought to portray an image of the nurse as a young 'professional', dedicated to the good of her patients and her 'vocation' but strong, confident and intelligent enough to earn her place in the essentially female hospital hierarchy. It also continued to promote nursing as exclusively female.

Although the inclusion of more men would have helped with recruitment, the discourse of nursing as an exclusively female occupation led the GNC fiercely to protect the profession from men, excluding them from the register, such that only 100 men were employed as nurses in the voluntary hospitals by 1937 (Abel Smith 1960).

The gradual move of emphasis away from vocation to profession within the discourse did not change the training, espoused by the Nightingale school, which had the nurse taking personal responsibility for all aspects of the patient's care, thus not only making dressings and taking detailed observations but also scrubbing floors and emptying bedpans.

However, as pay for qualified nurses had marginally improved and recruitment and retention was problematic practice was changing. For example domestic staff were employed to do the heavier cleaning duties in some instances, in others a hierarchical system of task allocation gave nurses the promise that their work would become less menial and their conditions of service better over time. The Middlesex is typical:

> 'all nursing on the wards was task oriented by seniority, with juniors responsible for many domestic tasks'
>
> (Baly and Skeet 2000: 53)

What nurses were taught was variable, as the GNC did not initially set a syllabus, but contemporary nursing texts give some insight into the expectations of the nurse in training. For example Ashdown (1934) was first published in 1917 and was in print continuously for at least 20 years and Houghton (1945) was first published in 1938, as one of the 'Aids to Practical Nursing' series. In both texts the overtly Christian role, that is found for example in Notes on Nursing (Nightingale 1878) is absent. There is no longer a suggestion that an appropriate activity for a nurse is to read the scriptures to her patient but Christianity is implicit in the moral philosophy of loyalty, reliability and personal integrity espoused in 'nursing ethics'.

Great emphasis is also placed on the 'science' of nursing, relating to cleanliness and hygiene.

> 'In nursing cleanliness is not merely a matter of taste – the natural outcome of good breeding and good manners - but a duty involving a very real and very important professional obligation . . . . . the hygiene of the nurse is as important as the hygiene of the sick room'
> (Ashdown 1934: 3)

It is worth noting the 'nursing ethics', in conjunction with 'professional obligation' are referred to rather than 'nursing vocation'. Each text commences with an outline on nursing ethics and then covers a full range of duties, including domestic chores, sickroom cookery, medical, surgical and children's nursing, bandaging and first aid. Interestingly Ashdown (1934) includes a chapter on massage, but this receives no mention in Houghton (1945), perhaps showing the growth of physiotherapy as a discipline during that time.

State exams included questions on domestic work and nursing ethics, as well as all other areas (Houghton 1945). These texts maintain a discourse in which the nurse is still required to have an impeccable character in order to control and guide her patients and also to have a very comprehensive knowledge of all patient conditions.

During the earlier years of reform the role of nursing in social control was very overt. Whilst there is little reference to it in later literature, the reference above from Ashdown regarding the nurse's image as embodiment of hygiene may be seen to represent a more covert means of influencing social change. The First World War had emphasised how poor the overall health of working class people was, and mothers were seen as the medium through which this could be improved Trodd (1998:10)

> 'the focus on the mother as a potential saviour of the race, but sorely in need of education, continued after the war'

Not only could training to nurse be seen as the development of excellent life skills for women, but the conduct of the profession itself could continue to exert an influence through the education of patients. Nurses were expected both on and off duty to present an image sympathetic to these social expectations.

Lorenzton and Bryant (2001) reiterate the developing discourse emphasising the professional rather than vocational element of nursing[15]. This is supported by Abel Smith's (1960) suggestion that the GNC created an examination system which favoured girls with secondary school education because they wanted nursing to be seen as a career for educated women. However contemporary texts continue to place more emphasis on character and dedication than on intellect. The concept of the 'good' and 'bad' nurse is evident, for example in Ashdown (1934:2)

> 'Nurses should recognise that is it characteristic of nursing work to either bring out all that is great, noble, and self sacrificing or to tend to deterioration by affording opportunities for selfishness , liberty of action and thought, and frivolous amusement'

And McManus (1956:20) states, almost paraphrasing Nightingale's earlier work;

> 'but what kind of nurse? That can never be defined by paper qualifications'

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[15] In reality, all but a very small number of recruits entering nursing at this time needed to earn a living, unlike the lady probationers in earlier times who may have been self supporting

Biographical and autobiographical accounts from this period (for example Arthur (2001a, 2001b, and Thomas 2002) indicate little change in actual experience from much earlier accounts. They experienced a training which was very 'traditional' with a highly structured task oriented hierarchy and the expectation of unquestioning obedience, punctuality and loyalty. Whilst no generalisation can be made from such biographical accounts, they support Bradshaw's (2001) research which shows how the apprenticeship model of nurse education was effective in perpetuating a very strong set of nursing behaviours.

Popular images of nursing drew on all of these factors. Whilst it may be argued that the discourse created through fiction is superficial, in presenting a continuous conflict between duty and service on the one hand and pleasure and freedom on the other, fictional images of nursing shape the conceptualisation of nursing and reflect images which are recognisable and plausible.

Kalisch and Kalisch (1987) suggest that in the 1920s increased sexual freedom and wealth meant that nursing offered a good story line from which a heroine found romance and marriage. Nurses are seen as having exciting opportunities to meet men, possibly of a higher class. Rather than sacrificing this opportunity for the sake of their vocation, the 'angel' image of duty and devotion was thus underplayed during this period. The 'good' woman is now too emotional, too alive, to submit to the overly rigorous and harsh duties of the nurse, so the twin images of good woman and good nurse are no longer sympathetic[16].

The pre war necessity for women to sacrifice their more feminine side for the sake of the nation (Summers 1988) was no longer an issue. Indeed, unemployment was a major problem with increased poverty and political unrest (Morris 1976), so women were encouraged to stay at home.

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[16] Trodd (1998) suggests that spinsterhood and celibacy were seen to be dysfunctional, and that marriage was promoted as the only normal, healthy way for women to have a fulfilled life

The new professional emphasis on nursing as a career for educated strong, women may also have alienated it from dominant popular images of womanhood.

Hallam (2000) suggests that there was a shift away from this image as the 1930s drew on. In the face of a further war there was a need to reinforce, or perhaps re-establish a dominant ideology in which women are prepared to sacrifice their own needs. Thus the heroine who might in the 20s have given up nursing for a wealthy husband is now more likely to give up romance for duty – to be poor but happy. The release of 'White Angel' in 1936 offered a timely Hollywood version of Florence Nightingale's life, a reminder of the value of female nurses in times of war.

By the outbreak of World War Two, nursing was maintaining a discourse of reform through professionalisation and increased recognition of status, whilst being under pressure to staff an increasingly large, badly organised and complex service. Politicians had been attempting to create an integrated health system since Lloyd George's reconstruction committee in 1917, with little success. Pressure for change was huge, as hospitals within the same geographical location continued to operate as separate institutions, with poor flow of information and resources between them and hospital outpatient departments competed with General Practitioner services for trade.

Some cities, for example Liverpool and Birmingham, attempted to manage this by creating their own united hospitals administration in 1939. The Stanley report for the British Hospital Association (BHA) in 1937 set out plans for better organisation, improvements in pay and conditions for doctors and changes in nursing training (Abel Smith 1964, Barker 1984, PRO 2001).

In the light of the increasing problems with nurse recruitment, the Athlone Committee was formed. Dingwall et al (1988) suggest that its interim report in 1937 showed a better analysis of nursing than previous papers, for example highlighting that the mismatch between supply and demand was the main problem, rather than recruitment per se.

Statistically it would have been impossible for the number of school leavers available to staff the wards even if they all chose a career in nursing. Also, although nursing was not exceptional at the time in expecting women to leave once they married; the pay and conditions, including the obligation to live 'on the job' in a tightly controlled, matriarchal establishment was acknowledged as a factor.

Once published in 1939 the Athlone Report suggested changes to pay and conditions and reiterated points which had been being debated for some time: that training should be separate financially from the economics of running the hospitals and that it could be successfully completed in two years, if the work was more differentiated such that probationer nurses did not spend a large amount of time undertaking repetitive menial and domestic tasks. These suggestions, challenging as they did strongly held beliefs regarding nursing practice, were not positively received by the profession and the outbreak of war conveniently delayed further debate.

2.6 World War Two

In addition to the continuation of the established discourses a new discourse was developing in the period leading up to the War, in which nursing as an educational phenomenon was growing. It would appear the 6 year period of conflict exerted a disproportionate delay in the growth and acceptance of this discourse.

Tylee (1990) argues that women during the Second World War, as in the First, were given many new opportunities, but despite the different character of the wars were presented with the same tensions between supporting the war effort and campaigning for peace. Nursing, along with the rest of the health services generally accepted the military influence with enthusiasm. The espoused ideals of duty, self sacrifice, discipline and respect for authority suited the image the established profession aspired to. Starns (2000) says that military nursing was by this time well established and the war increased its influence on civilian practice.

In an attempt to avoid the staff shortages and chaos of the previous war, the whole of the hospital service was reorganised around the war effort. Beds were cleared of civilian patients in readiness for casualties, extra facilities were acquired and many experienced nurses volunteered for active service (McManus 1956). The government formed a civilian nursing reserve, much like the VADs, these people served in both military and civilian settings, easing the staffing problems.

Nursing was subject to greater control than in 1914, although most hospitals were still independent, nurse training and registration was nationally regulated through the GNC. The GNC however supported the Government and did little to resist change. Indeed, Starns (2000: 34) argues that

> 'Policies emanating from the Ministry of Health from 1939 onwards
> established a pattern that continued for decades'

This can be demonstrated through the tightening of government control over nursing issues. The Ministry of Health had a vested interest in promoting policies that were economically driven rather than professionally or educationally motivated. Firstly, despite the apparent power of the GNC to close poor nursing schools, this rarely happened and secondly the 1943 Nurses Act introduced legislation for the appointment of less academically able 'associate nurses' with a two year training, which the professional generally saw as an erosion of their status. As a consequence the standard of qualified nurses continued to be quite variable and the number of people who could legitimately claim to be doing nursing work, but who were not registered as nurses, grew.

Nursing pay continued to be an issue, but despite the Ministry of Health guaranteeing student nurse salaries in 1941 and the Rushcliffe Committee regularising wages across the sector in 1943 (PRO 2001) a qualified nurse could still receive better pay by leaving the profession to work in a munitions factory (Starns 2000).

As material rewards could not be cited as an incentive and educational development was variable, the discourse of nursing as vocation regained strength. The public image returned to that of heroine: nurses were 'brave', 'rational', 'dedicated', 'decisive', 'humanistic' and 'autonomous' (Kalisch and Kalisch 1987) and there was a move away from using the nursing role as just a romantic device in novels and films to presenting more complex characters. This, along with reverential film biographies of Florence Nightingale and Edith Cavell, depicted women with the right characteristics as being able to 'make a difference'.

Nursing's profession leaders were strongly supportive of the war and for the first time military nurses achieved the status of commissioned officers, which they were proud of (Lorenzton and Bryant 2001). Starns (2000) shows that the military image was exploited through devices such as the uniform and through the promotion of 'masculine' values such as punctuality, consciousness of rank and lack of emotion.

However military nursing highlighted many anomalies of rank and privilege, for example as only female nurses could register, male nurses could not be afforded officer status (Abel Smith 1960). The War challenged this situation and again undermined the power of the GNC. Thus despite apparent gains in terms of military status, hospital based general nursing, linked as it was so strongly to hospital care, was forced to be subordinate to the military needs of the war and to Ministry of Heath imperatives.

Autobiographical accounts (for example Williams 1983) suggest that many of the tensions within the voluntary forces were similar to World War One. Again the presence of 'amateurs' threatened the authority of registered nurses and Williams recounts many instances of problems, not just between the qualified and volunteer force, but between military and civilian registered nurses.

A further illustration of the challenge the war represented to the discourses around hospital based general nursing was the situation regarding refugee nurses. Stewart (2003: 166) identifies that a significant number were either nurses in their own country and wished to work in England, or once in England sought the opportunity to train:

> 'it was almost certainly the case that for female refugees without prior training the opportunity to enter the nursing profession in itself offered the possibility of an acceptable career'

These women presented a dilemma to both Nursing and the hospitals' management. The GNC ruling meant that foreign qualifications could not be recognised so further training was needed. Quota systems were brought in and many Matrons and hospitals welcomed the nurses, but mainly on the basis that England would train them with the expectation that they would not require jobs as registered nurses once qualified, but would be returning to their own countries.

What is not discussed in Stewart's article is that the majority of these nurses were refugees because they were Jewish. Bradshaw (2001) has described nursing in England as a 'Christian job for Christian women' and much of the training and culture was based on this shared understanding. Multicultural and multi faith discourses did not exist within English nursing at the time.

Despite the delays and the competing needs of the war effort, this period did see a continuation of the debate surrounding the modernisation of nursing education and the emergence of this as a new discourse. Whilst Abel Smith (1960) argues that the need for well qualified staff forced incremental improvements in the education system, Starns (2000) suggests that in reality little had changed since Nightingale. The apprenticeship system, poor pay and conditions and the cloistered military – style training were a part of this. In addition the military influence encouraged the continuation of what Starns calls an 'anti education bias'. Character remained more important than intellect; the training aimed to mould the nurse's character and perpetuate the culture of the profession, rather than encourage educational and intellectual growth. Starns may be overstating the case in order to support her thesis, however the continued high wastage rates reported by Abel Smith (1960)[17], do suggest that the training, or perhaps the match between the training, the quality of candidates and the expectations of the GNC, remained problematic.

The now Royal College of Nursing produced the Horder report, which appeared in sections from 1941, looking at training and in particular the role of the assistant nurse. The Wood Report, published by the government in 1946 also looked at training, and reiterated previous suggestions of full student status, a two year training and separation of training and hospital budgets. These reports suggest the emergence of a new discourse despite the war, in which nursing is primarily an educational endeavour. In this discourse the nurse is a student first and employee second.

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[17] The wastage rates for voluntary and municipal hospitals respectively for 1937, 1938 and 1942 were 37%/52%; 33%/35%; 41%/47% (Abel Smith 1960)

By moving the focus from nurturing the innate nursing qualities within women, it also creates the possibility of a discourse which is less gendered. Despite the fact that many of the recommendations from both reports supported the Athlone Committee report from 1939 offering realistic, progressive solutions to nursing problems, few were approved by either nursing or the powerful BHA lobby. The main points around reducing the training and improving student status were a threat to the hospitals in terms of staffing costs and to nursing's espoused ideal of a long, bedside based apprenticeship (Bradshaw 2001)

Thus, as the war finished and the nursing profession looked ahead to change and development within the NHS, it may be argued that many opportunities for change were missed. The evidence for this is found in the Nurse's Act of 1949. Despite the Athlone, Horder and Wood Reports (1939, 1941-3 and 1946-7 respectively) all making similar recommendations, few of these were agreed. Area Nurse Training Committees were formed, but had few of the powers Wood recommended. The opportunity for experimental courses which differed from the traditional model was approved, but the State Registration qualification remained at 3 Years, despite significant evidence that more focused 2 year training would be both professionally and economically effective. This limited the amount of change that could be made to the training (Watkin, 1978).

2.7: Alternative discourse:

Whilst Maggs (1985) says that the history of nursing is dominated by hospital based adult nursing it may be argued that the discourses as expressed in this review still only present a partial view of nursing's development, leaving unexplored areas of hospital based adult nursing that are not well represented in the majority of nursing history texts. The development of nursing is presented by Maggs and others (Abel Smith 1960, Dingwall et al 1988) as having been nurtured through the voluntary hospital sector and then cascaded to the other areas, such as workhouses, Poor Law and Municipal hospitals. The only 'alternative' type of nurses discussed in detail in a number of texts is the VADs; the analysis of the tensions caused by their presence during wartime is used to illustrate the insular nature of nursing's development and its resistance to change.

By contrast two aspects of discourse have not featured in this review, nor do they appear in the data, but they were present through this period of history. In parallel with the development of nursing in the voluntary sector were the development of the Poor Law nurses and the 'assistant' nurses, the latter were re-named as 'enrolled' nurses through the 1943 Nurse's Act. The invention of enrolled nurses in 1943 is presented in the literature (see for example Dingwall et al 1988), as a Government expedient for managing the crisis in the war with little critique of their origins, their importance or their role in the development of nursing and nurse education.

Carpenter (1988:12) in charting the development of the Confederation of Health Service Employees (COHSE) states that:

> 'in place of the celebrated 'angels' - contented, submissive and self-effacing - we will find discontented assertive and even on occasions militant individuals , who rather than giving in to circumstances believed it was possible to change them.'

In Carpenter's history of COHSE a different discourse for nursing is presented. Growing out of the workhouse system and the 19th Century Poor Laws is a parallel nursing profession. As poor people who were sick and mentally ill became separated from general paupers in the workhouses a system of asylums and Poor Law establishments were created which later became the Municipal and Local Government hospitals and along with the voluntary hospitals joined the NHS in 1948. Whilst the conventional history is to see these developments as the origins of mental health nursing, both White (1978) and Carpenter (1988) show that a great deal of general hospital based adult nursing was undertaken by these institutions.

The Voluntary hospitals, supported by sponsorship of wealthy people and industries in the locality and led by eminent surgeons and physicians, chose carefully the patients they wished to treat and were concerned with cure, medical advance and a positive reputation. There was little space for the chronically sick, the incurable and the elderly. Thus policy tended to focus on containment, both in terms of the patient population and costs of care. Whilst White (1978) asserts that nurses were not offering a second class service, the lack of prestige offered by the work meant that the profile of nurses was working class, rather than aspiring to being middle class and any sense of vocation or 'calling' was mediated by the nurses need to earn a living wage.

A particular feature of this different discourse can be seen in the development of unionisation in the Poor Law establishments. Many unions were formed in the workhouse sector from around the First World War until they merged to form COHSE in 1946. The names of the various unions reveal the ways in which workers in this sector changed their identification over time (a non – exhaustive list includes the *National Asylum Workers Union*, the *Poor Law Worker's Trade Union*, the *National Union of County Officers* and the *Hospital and Welfare Services Union*) People caring for the mentally ill and chronically sick moved over the period of the review from being 'keepers' to 'attendants' to 'nurses'.

As in the voluntary hospital sector the 'nurses' by whatever name made up a significant number of the workforce and were valued by the trade union movement which was keen to increase membership and fight for recognition, pay and conditions. For example in 1919 25% of the members of the Poor Law Worker's Trade Union were nurses and in 1937 the Trades Union Congress (TUC) launched a 'nurses charter' (Carpenter 1988). This alternative discourse pivots around the conceptualisation of nursing as either a 'calling' or a 'trade'.

The between the war years involved considerable union activity around the agreement of an 8 hour working day and nursing became involved with this through unionisation. The College of Nursing opposed both the call for an 8 hour day and the use of strike action (the standard bargaining tool of the unions). White (1978) suggests that this was seen as 'undignified' by the College and by nursing leaders. For nursing to align itself with this artisan aspiration eroded the 'special' status that nursing had created for itself and challenged the discourse of nursing as vocation.

Even though there were more nurses in the Municipal and Poor Law hospitals than in the voluntary sector, their power and influence was marginalised within the nursing establishment. The GNC, with membership dominated by nurses from the voluntary sector in the London hospitals (Abel Smith 1960), created a registration examination which was difficult for the less well educated nurses to pass and thus attempted to narrow the entry gate. Despite this, by 1926 40% of all of those registered were from the Poor Law infirmaries. White (1978) suggests that this is indicative of the hidden high standards of nursing in the Poor Law sector. Further, the Poor Law sector employed a second grade of 'assistant 'nurse which goes virtually unexplored within the history of nursing in the UK.

Having identified this different and largely hidden nursing group it must be acknowledged that they did not exist in total isolation. Their nursing schools had to be approved by the GNC and there is a great deal of evidence (both White 1978 and Carpenter 1988 state this and it is clear in more general texts such as Dingwall et al 1988) that the majority of senior nurses in the Poor Law hospitals were in fact voluntary hospital – trained nurses who were drafted in to run the nursing and nurse education services within the general nursing wards areas of the institutions (see footnote 8).

In conclusion, there is evidence of a discourse within nursing that is much more closely aligned with a discourse of nursing as work and with a more unionised pragmatic approach to caring for the chronically sick. The fact that they were disempowered and remain largely invisible in historical analysis reflects the power of the dominant discourse in directing our understanding of nursing development. Despite being marginalised by the professional voice of nursing the nurses in the non – voluntary hospitals were significant in policy developments as can be seen in the Athlone Report (1939), the Horder Report (1943) and the Wood Report (1946), the creation of enrolled nurse status in 1943 and in the acknowledgement that pay and conditions did need to improve if sufficient people were to be recruited into nursing.

2.8 Review of the discourses in 1950

The aim of the thesis is to *investigate the relationship between nursing policy, nurse education and the experience of training.* The review of the literature has explored six discourses that contribute to an understanding of these relationships and the development of nursing through the period reviewed. In the hundred years from 1850 -1950 these discourses remain relevant; some, for example the influence of the military, are largely unchanged; others, for example female vocation, have been moderated through time. In addition, it has been argued that a further discourse, relating to nurse education has begun to emerge.

Nursing as reform had particular significance in the first 50 years from 1850, when the identification of nursing as a female occupational group was being established and the image of the incompetent, drunken and immoral woman needed to be purged. The campaign for nursing to be recognised as a distinct profession led to the formation of the GNC and state registration in 1919. By 1950, rather than needing to justify a reforming role, hospital based general nursing was well established and recognised, with a clear role within the health system.

Within the reformed profession there remained much variation between training schools and limited development in terms of pay and conditions. By regularising the administration of the hospitals, the formation of the NHS had helped to bring uniformity, but the very conservative behaviour of the nursing elite made change slow. Abel Smith (1960) states that by the 1950s salaries and conditions had improved, with for example a nationally agreed 88 hour fortnight by 1959.
However nursing did not compare favourably with other professions, such as teaching. In addition, unlike less skilled hospital workers nursing had rejected strong union representation, thus with no special duty payments registered nurses earned less than untrained hospital orderlies.

There is strong evidence that the discourse of *nursing as a female vocation* is significant and pervasive throughout the period examined. However 'vocation' seems to change and may be interchangeable with professionalism. Both concepts are used to elevate the role of nursing above domestic work, Doctor's assistant, or 'just' women's work.

However by identifying nursing as special and an exclusively female occupation, the profession frequently seems to have limited its own progress (Dingwall et al 1988). As a consequence whilst the 1949 Nurses Act did allow for more experimental training programmes the GNC, fearing that new ideas would challenge the vocational nature of nursing, blocked many opportunities for change.

The slow and reluctant reform of nurse education included the avoidance of married, part time and male nurses, the continuation of a cloistered and strictly imposed moral code on and off duty and the rejection of a more independent, educationally oriented training. These all reinforced the discourse that nursing was a serious, full time vocation, in which the good nurse could make a significant and worthy difference to society. By implication education and the promotion of intelligence was viewed with suspicion.

A further element of nursing as vocation is the continuation of a strongly gendered identification and the consequent attempts to exclude men from the profession. Having 'invented' hospital based general nursing as an extension of the natural talents and temperament of women, the presence of men was incongruous. By 1950 there were a small number of men trained, in the main working with sexually transmitted diseases, on male urology wards (i.e. exclusively with male patients) or in more gender neutral areas such as casualty, but they remained a marginalized minority[18].

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[18] The development of male general nursing is a large subject worthy of separate consideration. The powerful female imagery associated with general nursing makes their presence interesting. They are frequently simply ignored in the literature, or faced with challenges to their identity, motivation and sexuality.

The discourse surrounding *nursing as social control* changed significantly through the period identified. The overt use of educated middle-class women to influence working-class health and behaviour (Holden and Littlewood 1991) became less evident as the spiritual and moral aspects of nursing decreased and educational and health standards of the population improved. By 1950, the management and control of ill health and the increased emphasis on public health and health promotion, all supported a powerful, pervasive ideology [embraced by the NHS concerned with cleanliness and the 'fight' against disease] that the responsibility of the individual citizen, within a developing welfare state, is to maximise their own health. Whilst the relevance of class may be less prominent, nurses were expected to be role models for this ideal and were centrally important in promoting this view through their own education and their influence on the patient.[19].

The *military* discourse permeates the reform of nursing and its ideal as a vocation. Four major conflicts, the Crimea, the Boer and two World Wars punctuate the period reviewed and it is not surprising that of all the nurse reformers the two who are most famous are Florence Nightingale and Edith Cavell - both remembered for their role in war. The powerful images they created of women in what might be described as a 'defence' role: protecting their men from an enemy, representing their country and fighting disease were still strong in the post war period. This translated into a practice culture of a strict code of obedience within the hierarchical structure which was maintained through tactics such as bullying and purposeful fault finding, thus ensuring that the majority of the nursing recruits who remained to qualify supported this regime (Starns 2000)[20].

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[19] Hawker's (1985) research suggested that in earlier periods the notion of 'the good of the patient' had been used to legitimise practices that where more focused on the hospitals needs and on keeping order – it can be argued that much of the routine practiced within the NHS is similarly about maintaining control, rather that optimising the fulfilment of patients needs.
[20] It would be wrong to suggest that the military only influence nursing discourses; it is in fact prevalent throughout medicine and health –'fighting' disease, 'battling' with ill health and poverty and permeating policy development.

The *development of medicine and the rise of the hospitals* reached a landmark moment in the formation of the NHS. Debate, which had been continuous for many decades over the best management of the service, was brought to a conclusion by the war[21]. Abel Smith (1964:499) argues that this was the final significant factor:

> 'The virtual elimination in one day of the historic voluntary hospitals would have been regarded as politically impossible by virtually all sections before the war'.

However the extent to which the NHS made a major difference to nursing is unclear. Watkins (1978) suggests that the sense in which the NHS 'created' a health system is debatable – the infrastructure, staff and hospital beds were already in place, so it was more related to a new administrative structure. Baly and Skeet (2000:86) recall of the Middlesex;

> 'on the wards, there were some changes for the better. New specially designed lockers arrived, black beds were painted cream and many patients began to sport spectacles or dentures - -meanwhile the sisters found themselves having to account for all items of equipment. Inventories of laundry were especially disliked'

The NHS did not change much of significance in the daily running of the hospitals, perhaps more significant for nursing practice were the changes in medical practice, for example the development of antibiotics and improved surgical techniques like plastic surgery, which were pioneered through the necessity of war casualty injuries   (Measor et al 1998).

It has been argued that the discourses surrounding the notion of the *good nurse* and the good woman are particularly strong throughout the whole century. In the post war period the media discourse moves to one of nurse (as well as many other women whose labour was gratefully receive during the war years, and no longer required in peace) as wife and mother.

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[21] The Beveridge report in 1942 had been followed by a white paper in 1944. With the defeat of the Conservative government Aneurin Bevan as minister of health produced his white paper in 1946. He faced major disputes between various sections of the medical profession, and also the voluntary hospitals, but through negotiation and compromise brought the NHS into being (Abel Smith 1964).

Kalisch and Kalisch (1987: 142) show that the portrayal of nursing as a vehicle for romance and marriage at this time was even stronger than in previous periods.

> 'During the 50s and early 60s romantic novels about nurses and nursing constituted the largest occupationally linked category of mass market paperback fiction'

Hallam (2000) also shows that medical and nursing settings increased in popularity in films of the same period. The women in these images are 'humane' and 'compassionate' managing to be both strong and competent, but also to redeem others and bring out the best in them.

A counter to the warm images above is that of the 'ice maiden' (Kalisch and Kalisch 1987). This gives a strong message that nursing can lead to a loss of femininity, through the rejection of opportunities for love and marriage. Maggs (1985) observation that the early reform nurses fostered a non –sexual image in order to legitimise their role is developed further in this suggesting that nurses, who reject their destiny as women, are in some way asexual, or dysfunctional.

2.9 Conclusion

The three guiding questions of the research: *' what did it appear nurse training was trying to achieve', 'how was the experience of training/ learning to nurse expressed', and 'what are the connections with the discourse surrounding the good nurse'* have been used to direct the analysis of the literature. Through the period identified there is a shift from the home to the hospital as the focus for the management of ill health across both the working and middle-classes. To a large extent the relationship between nursing policy, nurse education and the experience of training has been shown to be closely related to the need to staff and manage a very large and complex health care system. In doing this it may be argued that both the media and the profession exploited the discourses surrounding womanhood and nursing in order to legitimise and control the direction in which the profession developed.

The review of the literature has confirmed that discourse is indeed important to an understanding of the development of nursing and nurse education. The six discourses identified at the beginning remain relevant and a further discourse appears to be emerging around the education of nurses. It seems clear that the period of apprenticeship for nurses both moulded their professional identity and set the standard for the culture within hospital wards: however there remain a number of key areas where further investigation is necessary for greater understanding of the study aims.

Firstly a number of ambiguities are identified within the literature. Discourses around professionalism and vocation appear to be important, but it is unclear exactly what is meant by these terms within nursing and the extent to which they are significant to an understanding of nursing's development over time.

Does 'vocation' represent a different discourse from 'profession', in which case it may be an element of the way in which nursing developed over time?

The literature offers a confused discourse where nursing, womanhood and motherhood are interlinked: however although gender is clearly of great importance nursing is not an exclusively female occupation. Thus polarised male/female, doctor/nurse discourses need to be explored as they offer too simple an explanation of many of the phenomena involved.

Secondly throughout the latter half of the historical period reviewed in the literature a further discourse around nurse education begins to emerge. Pupil, or probationary nurses start to be referred to as students and their role and rights as people to be educated become more prominent. This seems to be of importance to the aims of the study as it may evidence the beginning of a change in nursing discourse.

But perhaps most importantly the majority of texts reviewed are written about nursing and healthcare in the abstract and are thus once removed from the actual business of nursing. The discourses are mediated through a professional and academic voice and thus may be more representative of nursing's espoused image, than of actual nurses and so cannot represent the discourse as nurses themselves would recognise it.

I set out to try to gain a better understanding of the forces that affected nursing and nurse education and reviewing the literature added greatly to my knowledge base. Through exploring the discourses as they are spoken by nurses who trained in the study period and as they appeared in the nursing journals at that time, I hope that the thesis may offer an opportunity to scrutinise the content and authenticity of the discourses in greater depth.

Chapter Three: Methodology

3.1 Introduction

The literature review has sought to identify and analyse the discourses relating to nursing and nurse education over the one hundred year period from 1850 -1950, in order to set the study within its historical context and refine the research question. In the following chapter the methodological approach to the study is outlined and justified. The philosophical position taken is interpretative and it is acknowledged that this is influenced in turn by the post-modern stance taken in the conceptual framework. Both phenomenological and historical methods are used to guide the gathering of data. This is achieved through three stages: life history, interviews and documentary analysis. The process of analysis includes a narrative analysis of the life history and thematic analysis of all data. In conclusion ethics, reliability, validity and limitations are considered.

The choice of oral history, in both the life story and the interviews imposes a particular construction on the thesis the limitations of which are discussed in detail in sections 4.2 and 4.3 of the next chapter. The authenticity of oral histories is grounded in the experience of the person whose life is being recorded, and is subject to distortions of memory, as well as deliberate decisions on the part of historians and their collaborators to include or exclude certain information (Miller 2000, Plummer 2001).

Additionally, in asking the nurses to recall their experience of training and of being nurses, the histories are affected by popular memory. Nursing's image is publicly owned (Hallam 2000) with many stories in the media and in the nurses own lives being told and retold over the years.   There is therefore a need to accept that the life story and the memories of training in the interviews must be accepted as the version of events remembered and recorded by the nurses.

The research attempts to faithfully reproduce their authentic contribution, but does not claim this should be universally accepted as a single nursing voice.

However, this thesis can claim to make a valuable contribution to nursing knowledge. The aim of the research is to explore the discourses used to describe nursing and their role in the way that the training moulded and controlled the participant's metamorphosis from women into nurses. The discourse does not seek a 'truth' nor does the methodology seek to find out if the memories are an accurate representation of nursing. Rather they seek to identify the voice/ voices of nursing at that time

3.2 Philosophical position

Education and health research draw upon several disciplines, including social and biomedical science and history. It is generally agreed that both interpretative and positivist ontological perspectives can be used by these disciplines (Cohen and Manion 1998). The two approaches differ in their beliefs about the nature of reality and thus the potential limitations of investigation. This thesis takes an interpretative approach, so it is necessary to explore the key premises involved in some detail and justify this decision.

Rather than starting from the assumption that the world is 'real' the interpretativist believes that we each have our own subjective reality which we agree collectively to name in various ways. Thus within a positivist approach concepts such as 'nursing' or 'training' can have some measurable objective reality, whereas in an interpretativist approach their meaning is open to interpretation by each individual. Phillips (1987:105) suggests that this approach is closely aligned with philosophy:

> 'people act because they are swayed by reason, or because they decide to follow rules, not because their actions are causally determined by forces'

Phillips is well supported by Edwards (1998) who further suggests that there are two elements which make the study of people through positivist, scientific methods problematic. The first is the concept of free will: whereas inanimate objects can be put into a controlled situation and shown in given circumstances to behave in a particular way, humans will have the capacity to behave differently. The second is mental state: regardless of how closely a researcher may attempt to create exactly similar circumstances, by controlling variables and carefully choosing research subjects, it is impossible to control the individual's experience of the event. Indeed, not only is it impossible, but the researcher can have no way of knowing exactly what the person has experienced. The statements made, or the behaviours observed, may not be a true representation of the phenomena.

The understanding of the world that leads to an interpretative approach acknowledges that the best we can do is make value judgements about the named phenomena, which are known to be personal and subjective. Each nursing student, whilst being socialised into a recognisable occupational group and sharing many common features, experiences their training in a unique way. Cohen and Manion (1998) suggest that this concern with the individual is characteristic of the interpretative approach and may be considered to be a defining feature.

Researching education, in this case for nurses, is further characterised by having difficult, unpredictable and multiple variables. Some aspects may be measurable, for example attainment in examinations, or direct observation of behaviour. However these are affected by a number of factors; for example age, gender, psychological state and culture, which makes the isolation of any single relevant variable problematic (Field and Morse 1985). The formation and testing of a hypothesis, characteristic of scientific methods (Black 1993), is therefore unhelpful. In order to address this problem Flick (1998:5) suggests that one should start from the subject area and work towards method, choosing the most appropriate way or ways to increase understanding:

> 'the goal of research is less to test the already well known than to discover the new and develop empirically grounded theories'

Whilst there is no attempt in this thesis to develop theory, the analysis of the discourses about nursing and the ways in which they have originated and developed may add to an understanding of the relationship between practice and education.

Interpretative approaches focus on respondents, as the object of the research is people and their social reality. Bulmer (1988) therefore suggests that data must come from the people themselves and their experience. The perceptions and memories of nurses are the principal means through which I can gain an understanding of their training, so I must try to 'get inside' their experience.

Interpretivism acknowledges that the researcher is not and cannot be an objective observer. May (1997) states that as the subject matter in social science research is society, it may be neither possible nor desirable for the researcher to suspend his/her sense of belonging.

This is also true for educational research. The researcher is 'in communication' with the field and is an acknowledged element of the research. In many methodologies associated with Interpretivism this involvement is used as an advantage, for example in participant observation and action research. Here reflexive techniques may be used. In this research I cannot 'un-know' my own experience of nursing and nursing training and need to acknowledge this influence within the context of the data.

Reflection is a concept which has gained considerable interest within health, education and social science over the past 20 years. It has many definitions (see for example Schon 1983, Boud et al 1985). Within the context of an interpretative approach to research the idea that the researcher is reflexive is widespread. Steier (1991) suggests that this means that one acts contemplatively, taking time to think about the meaning of the data and to question and challenge both ones own and others interpretations.

There is also an element of evolution within each stage of interpretative research. Progress and results of the study may not be predictable, and the process of gathering and interpreting data may itself lead to changes in the direction of the study. For this reason Bulmer (1988) suggests that flexibility and a lack of structure may be important elements in research design. Within my research at several key points reflection on the data has led to a change of direction, which could not have been predicted at the outset. The final work is richer and more meaningful for this ability to develop the methodology along with the gathering of data.

It can be seen that the interpretative approach is a cluster of complementary concepts, sharing the same ontological premise. The complexity of nursing and nursing education's development in which no single or absolute truth is sought lends itself to such an epistemology, which allows for multiple interpretations of the world.

3.3 Post modernism

Whilst interpretative approaches are not necessarily post-modern, the nature of this study draws upon the cluster of concepts which are generally associated with this movement and thus it requires some explanation.

Postmodernism rejects the 'modernist' beliefs that such things as social cohesion exist and that there may be some grand, overarching theory to be discovered. In consequence in many disciplines, from the social sciences to architecture it represents a challenge to the accepted discourses (Usher and Edwards 1994). As this thesis seeks to better understand and perhaps challenge the discourses within nursing and nurse education, the post-modern approach seems appropriate. However, this approach is not common within educational research.

Papkewitz and Fendler (1999) state that education theory has not engaged readily with postmodernism and that the discipline is grounded in modernity. The central premise, that through education and knowledge people may improve, means that any critique tends to reside *within* the discourse and to focus on internal logic, rather than challenging the overall ideas. As a consequence educational research tends to sit within its own discourse, rather than standing back and examining the discourses themselves. Despite this Usher and Edwards (1994:28) argue that it is important that post-modern approaches are taken to critiquing education, but they warn that the progress they can make is limited:

> 'all that we may reasonably hope for is that it might suggest a way of looking differently at education as a social practice , at education processes such as learning and teaching and at bodies of knowledge and the way they are organised and transmitted'

It may be argued that medicine and the NHS are equally grounded in a powerful and long standing discourse of modernity. The main aim of research and development is clinical effectiveness, which draws almost exclusively on the range of positivist research traditions[22].

Through the latter half of the 20th century nursing, prompted by the development of University –based courses in the USA, has followed this tradition by seeking to professionalise itself through positivist research. Many overarching grand theories of what nursing is, for example Orem, Roy and Neuman (Fitzpatrick and Whall 1989) were produced which claimed to offer cohesion and a unified discourse[23].

Post modernism challenges this position, rejecting the conceptualisation of reality that can be represented in this way. Rather than looking at how nursing education functions, it asks questions about how it came to function as it does.

By looking at discourse it is possible to explore the ways in which nursing formed as a recognisable occupational group. Within this development Usher et al 1997: 204) assert that language is not 'a mirror held up to the world', rather it is through language that the nurse's autobiographical accounts and the journal articles make their world known: the discourse is a further take on reality, which can be explored and contested.

In discussing post-modernism, Cheek (2000:6) poses a question which appears to closely match the desired outcomes of this study:

> 'what are the assumptions and understandings of health care practice that are taken for granted which have shaped the way practice settings operate? Whose assumptions and understandings are they? And why are other views excluded and marginalized'.

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[22] Examples would include the National Institute for Clinical Effectiveness and the Cochrain centre, both of which conduct research into evidence based practice.

[23] Nurse education in England has, since the early 1980s been dominated by an epistemology centred on the premise that nursing is essentially a problem solving process. This originated from research in the USA (Yura and Walsh 1978). The dominant ideology remains one in which nursing (along with other health care roles including medicine) can be directed through this approach and that the best way to nurse can be discovered through predominately positivist research based methods.

In choosing a conceptual framework which uses Foucault (1979) as a guide to looking at multiple discourses, this thesis accepts that the questions posed in the quote above are central to the successful completion of this work.

3.4 Phenomenology

Beneath the broad umbrella of interpretative methods there are a range of approaches which could be used. Within the field of nursing research these may include for example ethnography, grounded theory and action research. The advice in the literature (Streubert and Carpenter 1999, Morse 1991, Silverman 2000) is to select a method which is based on what you want to find out. In order to address my guiding questions I needed to understand nurses' perceptions of how it felt to be learning to nurse and to explore how they would talk about this, so the approach taken was phenomenological.

Phenomenology is not a single or easily defined concept. It shares its common characteristics with most interpretative research methods, in that it has a commitment to multiple realities and the discovery of the 'phenomenon' to be studied through the understanding of the participant's viewpoint (Streubert and Carpenter 1999).

This method is often associated with the idea of discovering the 'lived experience' of the participants' and is well defined by Bergum (1991:55) as:

> '… a research method that explores the humanness of being in the world as a drama, an iterative involvement of both the 'researcher' and the 'researched' trying to interpret and understand …'

These associations seem to offer a good 'fit' with exploring the life story and discourses around nursing. Whilst postmodernism rejects dichotomies in research methods such as objective/ subjective the concept that the research is trying to capture the 'drama' is consistent with trying to understand and 'tell the story' of the factors that influence the development of nursing and nurse education (Usher et al 1997).

The phenomenological movement has its origins in the early 20th Century, in the works of Franz Brentano (1838 -1917), Husserl (1857 -1938) and later, Heidegger(1889 – 1976) and Jean –Paul Sartre (1905 -1980).

Anderson (1991) suggests that its development through the 20th century includes many tensions. One of these is the extent to which researchers can separate their own ideas out from the research when undertaking the analysis of the data. The ability to perform this activity, called 'bracketing' was believed by Heidegger and others, to be incongruent with the acceptance that the researcher is fully involved in the research.

Heidegger built on the work of other phenomenologists and existentialists in the early 20th century, in particular Husserl. He asserted the need to remain 'authentic', meaning not taking things for granted. This however is within the context of the need to maintain awareness of factors, such as previous knowledge and social setting which influence our understanding of the world (Heidegger 1962).

Heidegger's philosophical astonishment at the nature of being is described by Steiner (1978:32) as a question of,

> ' what it is that is, of what it is that dwells in all extant things, of what it is that constitutes beingness'

He goes on to suggest that one should try to suspend 'fore knowledge', that is to try to gain an understanding of the world which is not influenced by ones own preconceptions. This is a difficult position to attempt to take, as my own experience and professional identity are close to the research aims. However I take this to mean the need to constantly remember the influences my own knowledge and experience may have on my interpretation of the findings, the shared understanding between myself and the nurses in the study and the need to allow each section of the data to be of equal value.

Steiner's interpretation suggests that Heidegger challenges the scientific and technological stance of philosophers such as Aristotle and Descartes because they take for granted the central existential mystery of 'Being' itself.

For Heidegger the existence of 'Being' is that which makes it possible for all things to 'be'. This is a difficult concept, taking one beyond the normal bounds of assumptions about the nature of the world. Steiner offers the analogy of music, which humans would have a collective understanding of, but which defies in its essence categorisation in terms of notes, pitch and rhythm.

It would seem from this analysis that choosing Heidegger's interpretation of phenomenology is appropriate for this study, whilst accepting the difficulties posed by his notion of 'fore knowledge'. Thus my own experience of being a student nurse and of teaching within the nurse education system means that I need to be aware of my 'fore knowledge' and its influence on my interpretation of the phenomena.

In addition, the review of the literature suggests that nursing, both for people who nurse and in terms of cultural expectations, is more than just an occupation. The discourse tends to be embedded in nurses' conceptualisation of themselves as people (and in the case of myself and the research participants, women). Phenomenology acknowledges this connectedness, and so may be effective in enabling the research.

3.5 Historical research

Whilst this thesis does not claim to be predominately historical in philosophy or method, it has drawn heavily on both of these and thus they require some discussion. The potential value of taking an historical approach to educational research is well argued by Cohen and Manion (1998).

Studying a former period offers insights into the present. The relationship between nursing and nurse education is complex, as can be seen in the introduction and review of the literature. Health policy and subsequent nursing curricula have undergone many developments: attempting to investigate them in a contemporary setting would need to accept that many of the factors identified at the outset of the work would have changed by the end. By situating the research in the recent past, it was possible to identify a period of nursing's development which was over, or could be said to have some level of completeness.

Streubert and Carpenter (1999) suggest that historical research may be useful in two instances. Firstly, when it is possible that something from the past will help with the understanding of something in the present or the future; this is very relevant as the connections between nursing and nurse education are now seen as crucial in managing the new 'modernised' NHS.

 Secondly where there is conflict about what has been written about the past. This too is relevant; there is a belief within nursing that there was a period in the past when 'nursing got it right'[24], which influences the discourses about nursing and subsequent policy development.

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[24]Nursing maintains a powerful discourse about a 'golden age' when the training and conduct of nursing was 'right' this can be seen in the discourses within the data. Bradshaw's (2001) text on the nurse apprentice is a researched example of the same phenomenon, arguing that the demise of the apprenticeship system is at least in part responsible for a shift in the strength and value of the nurses role and training.

However an historical approach does not offer a clear and unambiguous guide to progressing with the research, in fact it offers yet another set of questions. Kaestle (1997: 75) suggests that:

> 'The history of education shares the methodological problems of the field of history in general. There is no single definable method of enquiry. They are the result of an interaction between fragmentary evidence and the values and experience of the historian'

By choosing a period in the recent past the 'fragmentary' nature of the evidence is less problematic than it might be. Documentary evidence from 1945 -55 is more plentiful and complete than from, for example 1845 -55.

In addition, the opportunity to draw extensively on living memory adds a significant dimension: it supports the phenomenological requirement for first hand information and the post modern acceptance that the way the 'story' is constructed through language and discourse is important.

Thus gaining sufficient materials to study nursing education is not a problem, but 'values and experience' are very significant in choosing what and how to progress. There is in the end no real control over the data available, and 'elasticity' over what might count (Rafferty 1997). In addition it has been extensively argued that research is essentially fiction (Maggs 1996, Plummer 2001), and that historical research is particularly creative:

> 'We create the past, design and people the landscape with whatever forms and structures fit, but are ready to recreate where they do not' (Maggs 1996: 630)

One of the most valuable concepts for this research may be Magg's final point, that historical research is creative. Streubert and Carpenter (1999: 211) further suggest that:

> 'historians weave together historical facts, research findings and interpretation, influenced by the conceptual framework into a coherent story'

This research does tell a 'story' of how nurse training was for this group of people, drawn together from their memories, and from contemporary literature. From this the many discourses are able to be examined and analysed. It makes no claims to be 'true' or 'untrue' but acknowledges that it represents a cohesive version of the story (Usher et al 1997), which is not necessarily the only one that might have been written.

3.6 The research structure

Having explored the philosophical approach to the research question, the aim and guiding questions led to a thematic and textual analysis of the discourses of the 'good nurse'. This was based on listening to the memories of nurses who trained in the period and accessing contemporary literature.

The guiding questions gave a structure to the development of the research and the conceptual framework relating to discourse, particularly with regard to the 'good nurse' remained. However there was an attempt to 'bracket' this knowledge and to reflect at each stage on the meaning of the data and the specific direction that the research should take next. The final achievement is 6 stages of research which progressed developmentally over a three year period:

Stage one: a first review of the literature which created an historical context from which to search for appropriate data.

Stage two: data gathering for and initial analysis of the life story. This spans the nursing career of Alice[25] from 1932- 1976. A period of reflection ran concurrently with gathering the life story data. The original intention, which had been to study the whole of the period, was re-examined in the light of the findings and initial analysis.

The emerging life story showed that studying the whole of her career span would not lend itself to addressing the aim and guiding questions in any depth. The breadth of experience over more than 4 decades could be seen to cover:

- seven separate periods of her working career , overlapped with achieving six qualifications
- Pre World War Two, the war years, post war

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[25] Alice is her real name, as this is her preference. A discussion regarding confidentiality is included within the section on ethical considerations.

- Training, clinical work, teaching work and education management

Taking the phenomenological approach of purposive sampling in order to gain information rich cases (Streubert and Carpenter 1999), it became clear that the life story was leading the research to the period 1945 -55. The reasons for this were:

- At this stage of her life Alice was closely involved with one particular nursing school, running the initial Pre Training School (PTS) stage of nurse training. This meant that she had continued sustained 'hands on' contact with the nursing syllabus.
- Through Alice it was possible to contact people who had trained at that nursing school in the same period
- Sufficient of these people were reachable geographically to make face to face interviews a possibility
- Their expected age – between 64 and 74 years old meant they were likely to be retired, but still in reasonable health- thus possible participants in an interview

Stage three: nine respondents agreed to semi structured face to face interviews, focusing on their early experience of training in the period 1945-55. Six of them trained at the school of nursing where Alice worked[26], all trained in the same period and all had a long and close association with the hospital attached to the nursing school, through membership of the Nurses League. Interviews were audio taped and initial analysis identifying themes was conducted.

Stage four: the original research plan had been to use contemporary literature to support the life story findings, this remained a consistent plan so the RCN archives of Nursing Times and Nursing Mirror journals were accessed from the period 1945 -55. Initial analysis identified a number of themes related to the life story stage and interview stage preliminary findings.

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[26] However they were unaware of Alice's involvement in the research

Stage five: revisit and further review of the literature which consolidated the historical context in relation to the conceptual framework

Stage six: in depth analysis of the three sets of data, using the guiding questions and the conceptual framework to identify new and continuing discourses.

In addition to this data analysis a number of contemporary documents have been useful in identifying the emergent discourses. These include the transcript of the Horder Report (1943) and the 1952 GNC syllabus for state registration Training (which is included as appendix V).

3.7 Method for first stage of data gathering - Life story

The lives of people that appear in historical texts have tended to be predominately those of 'great men', whereas using life stories may be useful in revealing aspects of history which are 'hidden from view' (Maggs 1996). It may be argued that nurse's experience of training is an example of this.

Towards the end of the 19th century and through the 20th century the use of 'ordinary lives' in humanist and social science research generally has grown, and is particularly associated with the 'Chicago School'. Seminal texts, such as the work done with Polish immigrant peasants[27] forged the way forward for what was a new and radical departure from mainstream social science research. From this the use of ordinary life stories in research across a number of fields has grown in popularity and acceptability.

Justification for this approach tends to come from a rejection of positivism, in that it is looking for subjective meaning, rather than looking to discover or prove theory, it therefore fits well within the approach adopted by this research. Plummer (2001) argues that life stories are useful to counter the imposition of order and rationality which social science research often strives for. Life is chaotic and messy and the real world does not fit neatly into categories for analysis.

Life story research is not without its critics however and Goodstone (1995) suggests that by concentrating on the person attention is deflected away from critical social and political analysis. There are a great variety of analyses of the life story method, in terms of what should be done, the reasons for doing it and how best to collect data. These are aptly summarised by Plummer (2001) but include many other authors, (Fry and Keith 1986, Polkinghorne 1995, Blumenfeld - Jones 1995, Miller 2000).

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[27] W I Thomas and F Znaniecki first published their work using life stories of Polish peasant immigrants in 1918 -21. this work is cited in most texts on life history, (see for example Plummer 2001, Miller 2000) as the seminal text that defines the Chicago School and the start of this particular epistemological tradition

Life stories are used by many researchers for different reasons, but a predominant theme is the use of the medium to reach, explore, celebrate and reveal those who are marginalized and hidden. This may include for example women, ethnic and social minorities and persecuted people (Blumenfeld - Jones 1995, Polkinghorne 1995). As both women and nursing are generally underrepresented in mainstream research and nurses are underrepresented in research looking specifically at women's history, a life story would seem to be an appropriate and helpful starting point.

Plummer (2001) suggests that choosing the person may be through a purposeful search, but may also be through a chance encounter. The latter was the case for this research. My life story - Alice - is my second cousin, who I met through happenstance for the first time whilst undertaking the first year of this Doctor of Education programme. My mother and she had last met in London in the early moments of World War Two, when Alice was a young nurse and my mother a 10 year old child about to be evacuated from the city.

Plummer further advises on the type of people to use for life history research and their necessary characteristics. He suggests that there are three types of people: the 'marginalized' person, the 'great' person and the 'common man'. Ones choice depends on the object of the research. Alice fits into the category of 'common man' in that she would be judged by her own contemporaries and by current nurses as a typical and easily recognisable [although nonetheless remarkable and unique] example of a 'career nurse' of her generation. In addition her career was predominately centred in nurse education, so I postulated that an in depth investigation of her life may shed some light on my guiding questions.

Hitchcock and Hughes (1989), Miller (2000) and Plummer (2001) suggest processes for gathering data. There is clearly no single method, and the choice is related to the aims of the research.

Using Plummer (2001) as the guide, and taking to heart his assertion that there is no absolute protocol, the life story in this study, falls somewhere between 'long' and 'short'. It is not an attempt to record the whole of Alice's life from birth to the present, but having been collected through many hours of interviewing and discussion, neither is it the briefer sketch that might have been gleaned from a single interview. It has been quite deliberately researched, although some of the anecdotes recounted in the subsequent narrative may well be recounted in conversation generally, the story as it is told here has been sought out deliberately as a tool for research. However, it is not particularly 'probing' there has been no attempt to cover everything, or to push Alice into discussing areas which did not naturally arise[28].

Polkinghorne (1993) refers to Dollard's (1935) seven criteria for judging a life story as still being relevant, the life story should:

1. include a description of the cultural context
2. attend to the embodiment of the person – factors such as age and health affect the life history
3. show awareness of significant others in the person's life – but -
4. be focused on the person, *their* meaning and interpretation
5. be biographical, taking into account social and historical factors, relating to both the person and their social world
6. have an outcome – that is have a distinct beginning , middle and end.
7. be plausible and understandable.

In both collecting and narrating the life story all seven of Dollard's (1935) criteria were met. Frank and Vanderburgh (1986) describe life history research as an act of personal collaboration and say that the giving of a story is a precious gift to society, which should be respected. The sense of collaboration was strong in the conduct of this research and the story which has emerged is a powerful and truly valuable insight into the experience of a nurse from what Plummer (2001) would describe as the 'great war' generation.

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[28] An example of this is her almost total lack of memory of the birth of the NHS, or its impact on nursing work or nursing education.

Data was gathered over a period of time through discussion, taped interviews and through analysis of personal documents. Where appropriate Initial validation of the chronology and basic accuracy has been obtained through cross referencing with personal documents (for example certificates) and returning in subsequent meetings to check for clarity. Absolute accuracy in dating related historical events has not been pursued so for example whilst the evacuation of Dunkirk clearly dates a period of her nursing practice the exact date of the bombing of the Middlesex Hospital is not relevant and therefore has not been investigated.

Initial analysis of the emerging life story showed that studying the whole of her career span would not lend itself to addressing the research questions in any depth. In a desire to meet the aim: *establish discourses that shaped nurse education* a purposeful approach was taken to identifying the most fruitful source of information to progress the research.

3.8 Method for second stage of data gathering – interviews

Face to face interviews are seen as valuable techniques for generating qualitative data. They give the participant the opportunity to talk in depth about the phenomena and for clarification of meaning to be established and explored (Burns and Groves 1995, Streubert and Carpenter 1999).

Cohen and Manion (1998) suggest that there are three uses for the interview. The principal one is as a means of gathering information. The second may be to test hypotheses or to suggest new theory; the third may be as a follow up to other data gathering techniques, where clarification and more depth are required. The interviews in this study both develop themes from the life story and generate new information and understanding of their own.

Interviews may vary from being highly structured, where the questions are tightly controlled allowing for limited answers, through to completely unstructured where the respondent talks freely about the given subject. Polit and Hungler (1997: 254) suggest that unstructured interviews:

> 'encourage respondents to define the important dimensions of the phenomenon and to elaborate on what is relevant to them, rather than being guided by the investigators' a priori notions of relevance'

The interviews in this research are intended to expand on the themes emerging from the life story, which suggests that a completely unstructured interview process might be problematic.
Respondents were being asked to remember events which had happened over 50 years ago and as such some focusing of the questions seems appropriate. Offering a limited amount of structure created some direction through a set of broad questions, but allowed for 'purposeful conversation' and for probing.

The potential population for the interviews includes all members of the hospital League of Friends[29] who started their training between 1945 -1955. The League keeps a record of all members, including details of their place and dates of registration, so it was clear from this documentation that a number of nurses within the League fitted into the period of interest. It was also clear from the league membership that a sample could be chosen from information available in several ways.

The most rigorous sample would be random and stratified (Polit and Hungler 1997) this could be achieved by extracting the names from the list and taking an equal number randomly from each year in the study period. However there were two important reasons for not choosing this method:

- The list revealed that a significant number of the people registered with the league did not live within the close geographical area – many lived as far away as Canada -this is fairly typical of emigration patterns soon after the Second World War. These people could not be expected to be available for a face to face interview.

- More importantly my access to the list of names was through the loan of the documentation from Alice - I had no permission to use the names on the list and would have been considered to have acted unprofessionally in contacting the league members from what was clearly a private source of names and addresses.

The sample therefore needed to be self selecting – I wrote to the League president, explaining my research and seeking permission to contact the league members. There were two possible courses of action – to either include a request for help in the next newsletter, which would have gone to all league members on the list, or to have flyers available at the next league AGM, which members attending could pick up and respond to if they wished.

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[29] Many nursing schools maintain a league of friends which includes all nurses who trained at the school and 'associate members' who have worked at the hospital and requested admission to the league. It serves a similar function to university Alumni associations, keeping people in touch, arranging reunions and annual meetings etc.

Her decision was to make available flyers at the next AGM. This restricted my access to a very specific sample, of people in the League who happened to attend the AGM and trained within the study period. This limitation was taken into consideration when interpreting the data.

Although this did restrict the sample it was reasonable to assume it contained a significant percentage of the people who were likely to want to be interviewed. It also excluded all league members who lived too far away for me to travel to, or were too infirm to undertake the interview. It also meant that the people who did respond had had a recent conversation about this particular period of their lives, which brought valuable memories to the surface and encouraged them to prepare for the interview by thinking further about the past.

This tactic led to nine League members contacting me to offer to be interviewed. Six had started SRN training at the Infirmary[30], between 1944 - 1952; three had trained elsewhere during the period and became associate league members at a later date. All nine were included for interview as it was postulated that the nurses from other hospital training schools would offer some contrasts and different perspective.

Interviews took place in the respondent's homes at their convenience. Each interview lasted 45-60 minutes and was audiotaped. Several respondents also made available documents and artefacts from their training -these were often referred to in the interviews and in many cases the respondents gave permission for them to be photocopied.

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[30] Throughout the thesis 'the Infirmary' refers to the hospital where the Pre Training School that Alice managed and six of the nurses attended was based

3.9 Method for third stage of data gathering – documentary research

The majority of the literature on research methods in education, social science and nursing is limited in its coverage of documentary research. Indeed Scott (1990) in his preface states:

> 'Questionnaires and participant observation feature centrally in texts and courses on research methods but documentary sources are considered only in a fragmentary way'

Nevertheless documents can provide a valuable source of information and can validate, or triangulate the findings from the life story and interview stages of the research. Contemporary literature is seen to be an essential counterbalance to the limitations of memory and an alternative discourse to the accounts from these data sources.

The use of multiple sources and methods of data gathering, defined by Hammersley (1993) as 'theoretical eclecticism' can, as with life story research, be dated back to the Chicago school, who combined methods in unique ways to better investigate sociological issues. He further states that these experimental methods became less acceptable as the 20th century progressed and that it is only in recent decades that there has been a challenge to the dominance of positivist methods in analysis. Platt (1981), Scott (1990) and Hammersley (1993) all argue that documentary sources are valuable in both positivist and interpretative epistemologies.

Scott (1990) acknowledges the limitations, in that documents may not tell you the whole story; however the story you get is interesting in its own right. Hammersley (1993) supports this by suggesting that the reasons why something was written, what words were used and who the document was written for, are all significant. This matches to the post-modern view of the cultural significance given to language and text (Usher et al 1997).

For this research the documents chosen for analysis were two popular journals which catered for both student and qualified nurses: the Nursing Times and Nursing Mirror. During the period 1945 -1955 both these journals were produced weekly (with the exception of a small number of weeks in the immediate post war period where printing deemed non essential by the Government was stopped to save resources).

Lorenzton and Bryant (2001) use the Nursing Times in their research, noting that journals are a valuable, but underused source of data. Journals cover issues that were topical and through editorial debate offer an insight into contemporary thinking. In addition both they and Soothill (1996) suggest that the inevitable bias reflects contemporary interests, which is usually missing from books, retrospective analysis and policy documents.

Cohen and Manion (1998) suggest that external and internal criticism of documents is necessary to evaluate their worth. Scott (1990) expands this further into four factors – authenticity, credibility, representativeness and meaning.

Authenticity relates to the genuineness of the documents: are they what they say they are, could they be fakes for example, or poorly made copies. Whilst this is clearly a major consideration in documentary research, it is unproblematic with the Times and Mirror.

The journals are not available in an electronic form, so are original documents archived by the Royal College of Nursing (RCN). The majority of the journals are in their original form as published. Some however have been bound and indexed. In these cases although the documents clearly remain authentic, the advertisements have been removed and there is a possibility in doing this that other material that might have been useful is missing.

Credibility relates to how selective or distorted the contents might be (Platt 1981 a+b). The Times and Mirror are clearly *nursing* journals and thus are written for an audience with a collective professional identity. As such any distortions would seem to be appropriate. As an example both journals include regular articles about the nursing management of medical conditions. Clearly these would be framed differently for a lay, or a medical reading public. In addition where the journals are campaigning for improved pay and conditions, it is reasonable to assume that they will be presenting a view biased in favour of nurses' interests.

The two journals are a little different in their distortions; both were conservative in their approach, but with slightly different political agendas. The Times was the official journal for the RCN and thus dedicates more space to reporting RCN activities. This is appropriate as it was the main method of communicating RCN matters to the nursing population. The Nursing Mirror is more parochial, covering national events in less detail, including a regular religious element and more opportunity for individual nurses to express their opinions. Both journals attempt to reach a wide audience, including articles about all branches of nursing and specific material for students. However, as is the case throughout the development of nursing, the dominant group remains hospital based adult general nursing. As this is the focus of the research it works to its advantage.

Representativeness relates to the place of these journals in the totality of relevant documents that might be available. Firstly the RCN archive has complete copies of *all* the Times and Mirror from the period, so the collection is complete. It is reasonable to assume that nursing issues would also at times have been reported in the news and in hospital publications, however searching and analysing these documents is beyond the scope of this study both in terms of volume and balancing the data from the three phases. There are also a number of policy documents, for example the RCN Horder report on Nurse Education and GNC syllabi from the same period which could have been included.

Whilst these documents are clearly relevant, their use is considered to be more valuable in the discussion of the findings, as a source of triangulation and validation. The Times and Mirror are chosen as the source most likely to be close to the actual experience and thinking of nursing in the period.

Meaning relates to the ease or difficulty of gleaning understanding from the documents. For example a document may have been partially destroyed, or may be written in a language for which a full translation is not available. These issues are of minor consideration in the context of the Times and Mirror. Although some of the journals have been poorly stored over the years and are fragile, the text is complete and clear. The issue are sufficiently contemporary for lack of clarity to be checked from other sources and my shared understanding of nursing issues helps me to engage with the text. However it is acknowledged that my own biases may mean that I do interpret meaning in ways which are not necessarily originally intended[31].

Having established the appropriateness of the journals for analysis choosing a sample was important. Platt (1981) suggests that sampling can be tricky if you do not know the scope of available material. Having narrowed the source down to Times and Mirror, 1945 -1955 and knowing that the archive was complete, this was not a major problem. Lorenzton and Bryant (2001) sampled on the basis of both content and pragmatism in terms of scope, a process which I shared.

The archive yielded a potential of 1040 journals. The journals were not available in electronic form, so needed to be accessed as originals on site in the RCN nursing history archives. Some, but not all of the years were in a single binding, by year. Others, from the war years had never been bound but were in a loose leaf folder by year in their original form. These were very delicate to handle.

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[31] An example of this is my amusement with the knitting competition in the Mirror, which is one of the features which makes me describe this journal as parochial – this may be an unfair interpretation if viewed contemporarily.

Those that were fully bound by year did have an index at the front listing in alphabetical order the titles of all the main articles published in the year. It would therefore have been possible in part to scan the journal's contents list and identify all of the titles which seemed relevant. This would have given me the opportunity to analyse elements of all of the journals, but would have excluded all of the letters, editorials and smaller contributions, thus not capturing effectively all of the areas of interest.

It would also have been possible to choose one per month from both journals from each year; this would have given a random sample and yielded 360 journals. The disadvantage of this method is that the number is still large to manage and the opportunity to track through correspondence and running issues would be lost. A weekly journal has the advantage of capturing the moment.

In consequence I decided to take two consecutive months from each year. This allowed for a manageable sample of 160, maintained continuity and contrasted the ways contemporary issues were dealt with in the two journals. The months chosen were as follows:

1945 January –February
1946 February –March
1947 March –April
1948 April –May
1949 May –June
1950 June –July
1951 July –August
1952 August –September
1953 September -October
1955 October –November

The method used was to review the contents of each journal in the blocks of eight, taking notes on the general issues that were being reported and focusing specifically on the guiding questions and the cluster of themes identified within the first two stages of the data analysis for further triangulation. These included:

- articles describing changes in the structure of nurse education and its development over the period of study

- any materials that shed light on the experience of being a student nurse in the period

- opinion, in letters and editorials on the direction that nursing education was taking

- any material which sheds light on the 'good nurse' concept, and the image that the journals wished to portray of nursing.

On a number of occasions a particular theme or issue was being covered over a period of some weeks. In these cases further journals were reviewed beyond the two month per year sample.

3.10 Process of analysis

In keeping with the philosophical approach outlined above, analysis is interpretative and acknowledges the involvement of the researcher. The aim of the research in trying to gain a greater understanding of the relationship between nursing education and practice seeks to understand the experience of nurses. Phenomenology accepts that it is difficult to conceptualise 'experience' and that interpretation of the data is problematic. A Heideggarian 'hermeneutic' approach would seem to be appropriate. Ricoeur (1978) describes hermeneutics as a theoretical structure which can be used in order to interpret text.

In dialogue he suggests that the usual techniques of question and answer can be applied to ensure that the researcher has clearly understood the meaning of the speaker's words, however in written text there is always a risk that the researcher's own knowledge and subjective beliefs will influence their interpretation. (Gadamer In: Murray 1978:164) suggests that the hermeneutic cycle helps to avoid the researcher's preconceptions - fore knowledge - getting in the way of understanding the thing itself which is being studied. He is however realistic in saying that the researcher cannot forget all that he or she knows, rather;

> 'All that is asked is that we remain open to the meaning of the other person or the text, but this openness always includes our placing the other meaning in relation with the whole of our own meanings'

Within this philosophical frame, the analysis was conducted in four stages, as they are represented in the text. Data gathering for stages one –three that is the life story, interviews and journals were conducted separately, but the process of analysis overlapped in that the interviews had commenced before the life story was complete and the archival research was undertaken in parallel with transcribing the interviews. The final stage, analysing the emerging thematic discourses across all three sets of data was undertaken separately after a period of reflection and revisiting the literature.

Bearing in mind the conceptual framework's focus on discourse, the potential for using both narrative analysis and analysis of narrative was explored. Polkinghorne (1995) defines narrative analysis as using a range of data to construct a story. On reflection this seemed to be a legitimate way of representing the initial analysis of the life story stage of data gathering. In undertaking narrative analysis Blumenfeld -Jones (1995) identifies 'fidelity' as a major criterion. This being 'keeping faith' between the story teller and the researcher.

There is a balance to be achieved which requires a degree of artistic creativity, but also in the decoding and recoding of the interview data and other relevant documents, believability is important. Plummer (2001) states that part of the analysis is deciding whose voice the story is to be written in and the need to capture the experience, plots and 'epiphanies' within the story.

Analysis of narrative, that is the deconstructing of the text to identify themes, (Polkinghorne 1995) was considered to be a more appropriate form of analysis for the interview stage of the research. The possibility of continuing to analyse using a narrative framework was explored, but was rejected on the grounds that my inexperience in this method would raise doubts regarding the legitimacy of the method and findings. Each interview was audio taped and transcribed. Text was then analysed manually and themes identified. The themes were placed within related clusters and verbatim quotes were used to clarify the various concepts. A software programme for analysis was not used as I wanted to read and understand the text myself and felt more distanced from it in electronic form. The need to remain close to the hermeneutic cycle was easier for me this way, as I felt closer to the data and its analysis and less inclined to 'objectify' the findings.

Scott (1990) argues that in documentary analysis what is really interesting is the purpose of the document: why was it written, and in this particular way and why has it been kept. Holmes (1997:33) goes further is saying:

'the historians task is to offer plausible, imaginative interesting (some
might add useful) interpretation of the facts so that they assume
meaning'

Each sample of text was analysed in order to identify the main themes
present in the journals of relevance to the research. Themes relating to who
was writing, the kind of language used and why were also identified. No
attempt at numerical statistical analysis of the text was attempted, as this was
considered to be unhelpful to the research aims.

In all three stages there was an intention to remain true to the data and to
record themes as they appeared. There was also a deliberate attempt to put
aside the 'fore knowledge' related to the identified discourses and to look at
the data with fresh eyes. Thus the analysis used the guiding questions to
explore what good nursing was perceived to be and what nursing and nurse
education consisted of, rather than attempting to find a 'match' between the
discourses identified in the literature review and the data.

Following this initial analysis the emerging themes and the original texts were
returned to for clarification of the discourses that were revealed. By
deconstructing the three data stages and then reconstructing and revisiting
them the discourses from the research were shown to both reinforce, but also
challenge the discourses identified in the literature. The meaning of this to the
research aim was then discussed.

3.11 Ethical considerations

The principles relating to ethical research can be taken from Beauchamp and Childress (2001) as being: Autonomy; Beneficence; Non-maleficence and Justice. In conducting the research I was particularly mindful of the participants' age and their potential vulnerability. A number of considerations have arisen in this research with regard to these principles.

The normal 'rules' emanating from these principles are to respect autonomy through ensuring genuinely informed consent and protecting the participants' identity. This would usually be assured through confidentiality during interviews and anonymity in the text, but in this case has presented an unusual dilemma. All of the participants would be quite happy, indeed proud, to be named in the script. Alice is quite clearly happy to be herself, it seems a little odd to her *not* to want to own and celebrate the life she has enjoyed. However I do not think she appreciated, (nor did I encourage discussion in this area), that the interview participants might reveal things about her, or that her commentary was an analysis of the hospitals and people with whom she has worked. In addition almost without exception one of the first questions the interview participants asked what who else I had seen. As they received the flyers together at the League AGM, many of them had discussed contacting me and had been egging each other on, so complete anonymity was beyond my control.

In order to resolve this dilemma the following actions were taken:

- I explained the need for anonymity in the thesis, and so did not discuss participants with each other, or reveal that Alice (whom they all knew) was also involved in the research.
- I resolved not to ask any questions in the interviews which would directly lead to discussion about Alice, and not to use any data which inadvertently identified her.

- I decided to keep Alice's name, as it was her preference, but to anonymise all other details in order to disguise the location of the nursing school. Whilst with some detective work it might be identified, the similarity with other city –based voluntary hospital schools makes it difficult to distinguish.
- I agreed to write a light hearted 'memories of PTS 'article for the League magazine, once my thesis is finished, which all parties will have editorial rights to.

In addition to these measures I followed normal protocols for not identifying places or people who have not given consent.

In taking these measures it is hoped that all aspects of autonomy have been respected. With all participants extra time has been given to discuss nursing and their stories beyond the run of the tape, ensuring an enjoyable social event and further contact is being maintained through an article for the league magazine. These measures should ensure that the research is beneficent. Through anonymising the nursing school no harm should come to either the hospital or other parties (non-maleficence).

With regard to justice, the research has been conducted fairly. All participants have had the opportunity to own a copy of the taped interview (two people took up this offer) and to comment on its accuracy. Alice has validated the full script of the narrative analysis and all documents which were lent to me were carefully copied and either returned by hand or recorded delivery.

3.12 Reliability and validity

Validity may be defined as the ability of a given method to measure the intended outcomes or results and reliability the consistency with which this is achieved (Polit and Hungler 1997). A major criticism of interpretative approaches is that the subjective nature of the data limits the achievement of both of these factors. However, this causes a dilemma, as the area of interest only lends itself to exploration from this particular epistemological position.

Interpretative methods may only be valid within the individual piece of research and data cannot easily be replicated thus the researcher may be seen to be starting from the beginning again with each study. For this reason Hammersley (1993) suggests it may be difficult to produce accounts which one can be sure correspond with social reality.

However Edwards (1998:101) in discussing health care research states that subjective meaning is essential:

> 'factors accessible, it appears *only* from the first person perspective . . . . seem so essential to our understanding of illness that any research into health care would need to take such factors into account' (his emphasis)

Whilst Edwards is referring to illness, the concepts 'education' or 'nursing' could equally be applied to this quote. I would argue that the first person perspective is needed across all of social research, to balance the fundamental tension between producing results which are meaningful and useful and the need to capture experience as related by the participants. Taken further Field and Morse (1985:20) state that;

> 'life events are not predictable and controllable and cannot be studied if such parameters can be applied'

Although the research was concerned with understanding the experience of learning to nurse in this period and was not seeking to prove or disprove an hypothesis, there was a desire to understand better the links between nursing education and policy in the recent past and to offer a more informed and useful critique of the current situation.

Quantitative approaches tend to offer more certainty about what they can produce. For example Charles (1988:15) suggests that the information from research should be useful as an aid to making 'sound educational decisions' which is of course desirable, thus representing a powerful and plausible body of experts who see the role of research to deliver measurable answers.

However, the argument that quantitative methods can offer greater objectivity is questionable. The necessity for the researcher to be involved and for individual interpretation of the data (Douglas 1976, May 1997) means that the results of any research cannot be fully and unquestionably 'true'. Field and Morse (1985) argue that where little is known about a subject, qualitative methods have greater validity and further that the differences and discrepancies which occur when gathering qualitative data are an important part of the process.

For example when two or more people offer a different account of the same event (which is 'true' for them) the shared understanding and misunderstanding is part of the context. This supports Usher et al's (1997) suggestion that constant vigilance is needed to ensure that assumptions of truth are avoided.

Validity within the study is ensured through the thoughtful and conscientious use of three well known and previously used techniques [life story, interviews and documentary analysis]. As a relatively inexperienced researcher working in isolation, I have not attempted to use more radical approaches either to data gathering or analysis. Thus for example the narrative analysis is limited to the life history stage, rather than being extended to the interviews and familiar sampling and analysis conventions have been used throughout.

For the documentary phase Nursing Times and Mirror publications have been purposefully chosen as this collection of documents is complete and clearly authentic. In addition, the use of original documents, such as the 1952 GNC Syllabus and the Horder Report (1943), support the results.

Results of this research, in accord with the methodology are acknowledged to be subjective and grounded within the time and space of the actual study (Cohen and Manion 1994). The results are viewed as provisional, and part of a wider and continually emerging picture. Whilst this view may be frustrating from a policy perspective, it is the only honest position that can be held. Hammersley (1993) warns against research findings being misused in developing policy which has no reasonable grounding. This warning is not necessarily limited to qualitative approaches, Eisenburg (1995) critiques the scientific approach to education research, suggesting that the knowledge gained and subsequent influence on policy is not always as valuable as the positivist methodology would aspire to.

3.13 Limitations

The limitations to the research fall into four categories. These relate to the epistemological position, scope, sampling and personal bias.

Firstly the limitations in terms of methodology have been discussed in depth within this chapter. It is acknowledged that the focus on interpretative methods and the conceptual framework limit the generalisability of the results and their consequent value in terms of informing the development of nurse education policy.

In choosing for the scope of the research to concentrate solely on adult hospital based general nursing a further limitation is apparent. Nursing is far more than just this. An exploration of nursing in other settings, both the kind of patients (for instance children) cared for in hospital based nursing and in other settings (for example the community) would have been fruitful in informing the research aim. It may further be argued that the concentration on adult general nursing emphasises the bias already acknowledged within the profession, towards this particular nursing group being seen as dominant and representative of nursing as a whole. The discourses identified may be those for hospital based adult general nursing, rather than nursing in a broader sense.

Whilst the choice of population and sampling of participants for interview was purposive and positive, the choice of nursing school and the fact that the actual people were self selecting are inevitable limitations. Nursing schools had very specific reputations and criteria for admission, which means the pupil nurses accepted are not a cross sectional representation of all people in nursing at the time.

Furthermore the people available and willing to be interviewed are a specific subset of all the nurses who trained in that school. One very obvious factor is that there are no male participants in this study.

The nursing school was slow to accept male nursing students and of the limited number that might have been available and are members of the League, either none attended the AGM or none chose to contact me. Male adult general nurses were at the time such a small minority that had data from one or more of them been available it could be argued that the study aims would need to be adjusted, however the assumption that their absence is a limitation must be maintained. The obvious gender bias is taken into account in the analysis.

Finally my own biases must be acknowledged as a limitation. In choosing a qualitative approach I have attempted to engage in research where my obvious connections, as a nurse and nurse teacher, as well as a woman are capable of being synthesised in to the process. My own preferences and interests will have affected both the conscious and unconscious ways in which the research has progressed, the areas I have explored, the occasions in which I have probed, or moved away from exploring an area in the interviews and life story.

Having identified and justified the methodological basis of the thesis, chapter four will outline the way in which the research was conducted.

Chapter Four: Conducting the Study

4.1 Introduction

The conduct of the empirical stages of the study involved a number of data gathering phases, overlapping with reflection and early data analysis. As a researcher using qualitative methods, May (1997) says that one stands in the centre of the research process and this is very much how it felt for me to proceed. Whilst there are specific time periods and phases there is also a sense of the research having a momentum of its own, developing at a pace which could not be neatly mapped to a chronological pattern.

A major factor through the process was consideration of the way in which the final paper would be written. It became clear that a single, simple analysis was not emerging from the data and I wanted to convey this, whilst writing in a clear and unambiguous way. Emihovich (1995) states that we communicate our intellect through our writing and Atkinson (1991:165) that the text we create contains a force beyond just being a correct or accurate account:

> 'all texts are constructed in accordance with socially shared conventions'

Thus it is acknowledged that this text; the conduct of the research, life story, interviews and documents, including reflection on the ways in which the data and analysis have developed itself becomes a part of the discourse on nursing and nurse education.

4.2 Life Story

Alice, in her mid 80s, is a small and slight. Despite some physical difficulties which make walking slow and painful she gives the impression of still being full of vitality and strength. She has a remarkable memory for people and places, and continues to take an interest in current affairs generally, as well as nursing. At the time of recording the life story Alice shared a bungalow with her nursing companion (M) of some 50 years. They have a good support network through their Church and though not at all wealthy live in relative comfort. Despite the obvious constraints on her lifestyle and the reality of getting older and frailer, Alice is cheerful, humorous and sharp witted.

My chance encounter with Alice, which became the springboard for the research led to a series of 5 meetings over a 12 month period in which Alice recounted her life story. The pattern for data gathering was close to that described by Plummer (2001); we would meet for an afternoon which started and finished with social discussion, at some point on three occasions (1, 2 and 4) there was an agreement to turn on the tape recorder and 45 -90 minutes of transcript was collected. Some notes were also taken in the time together and others composed immediately afterwards.

On the second visit Alice recounted many of the same things she had talked about in the first meeting. Initially I was disappointed and wondered at the value of these overlapping, repetitive sessions.
However it soon became apparent that the opportunity to revisit the memories added depth and richness to the data and that I was able to record a much fuller life story than would have been possible with a single interview. Many authors (for example Nespor and Barber 1995, Coffey 1996, Plummer 2001) identify that the story told is not the person's life and the way that it develops will depend on the audience for whom it has been written.

Alice's story began to emerge much more as 'her life as a nurse' rather than 'her life as a woman'. This was in part due to the influence of my interest, but also an inability on Alice's part to separate 'self'' from 'nurse'. Plummer (2001:262) suggests that life story research:

> 'is not about an individual 'self' but [this human being] is an embedded , dialogic, contingent, embodied universal self'

Alice's fusion of self and nurse is a powerful illustration of this, in that both she and I would see her 'self' as a paradigm case of a career nurse of her generation – unique in her personal experiences, but part of a collective memory of how nursing used to be.

On meeting 3 Alice was upset at her friend's illness and we did not record, we went over some of the information from earlier transcripts and I took notes.

Polkinghorne 1995:15 suggest that narrative analysis:

> 'is the procedure through which the researcher organises the data elements into a coherent developmental account'

Between meetings 4 and 5 I attempted to write my narrative of the life story I had collected, using the tape transcripts along with written information and artefacts that Alice had given me. These included qualification certificates, an information leaflet regarding one of the nursing schools she worked in and the original transcript, written by Alice in 1956, of her year at Teachers College in New York. I took this history with me to meeting 5, intending to leave it for Alice to read and annotate, however she suggested that I read it to her. With the tape recorder running I read the script, pausing for her comments and annotating as I went along. The redraft of the narrative analysis following this meeting in included as Appendix I.

Frank and Vanderburgh (1986) describe a life story as an act of 'personal collaboration' and this is how it felt to me. I tried through discussion and cross checking to maintain 'fidelity' (see Blumenfeld – Jones 1995), thus staying close to her story and incorporating her words where possible.

This was particularly evident in the read through of my first draft of the life story. Alice listened very attentively to this and frequently interjected to check and discuss elements of the paper. For example she was surprised at the content of her visit to Teachers College, as she did not believe that she would have remembered it so clearly. I explained that some of the detail had come from her account written in 1956, and thus the narrative analysis drew on more than the interview transcripts.

This illustrates that although the narrative attempts to capture the experience as hers, not mine (Plummer 2001) it is acknowledged to be crafted in a particular form and is thus essentially a fiction (Hutton -Jarvis 1999, Plummer 2001). The narrative included in the appendix is the composite of the original narrative and the alterations and additions from meeting five. I continued to meet her regularly up to her death in January 2005, but have treated this narrative as a complete section of data and have not altered it.

On reflection, the data and subsequent narrative contain a number of biases, from Alice, myself and our interaction (Plummer 2001). Alice wanted to talk about some things and not others so she simply avoided or ignored areas that were of no interest to her. Alice avoided some subjects when M was present, and I did not push sensitive areas like illness & death, out of respect for Alice and M's current health status. Goodstone (1995) suggests that life stories become histories through contextualisation, but in the narrative this was limited – for example Alice had almost nothing to say about the NHS, despite its development running parallel with her career and the far reaching influence it has had on nurse education.

She has a script or set of scripts (as we all do) which does not always allow for introspection and critical analysis. I include in these her 'war stories' which I suspect have been told and retold over the years to the point that they have a 'truth' which has been mediated by time and telling and could not readily be challenged or changed.

Some things were not relevant to her and unless I searched for them they were difficult to find. For example there is a very evocative photograph in a promotional booklet for the Nursing School where she led the Pre Training School, of nurses kneeling around the ward table whilst Sister took morning prayers, so I particularly probed her about the role of Christianity, or more specifically the Church of England.

Alice seemed vague about this, but then, casually talked about taking prayers each morning in the nursing school - which would have been every morning up to her retirement in 1976! A further anecdote, told with wry amusement of the occasion when two Roman Catholic nurses accepted her invitation to remain for morning prayers, only to be scolded by their priest and told not to, illustrated to me how much social norms related to Christianity have changed in less than 30 years, and thus that I need to be aware of this when conducting my analysis.

The role of Christianity in nurses' socialisation is clearly of importance to me in view of the research question, Alice's lack of awareness of this as a significant factor is as interesting as the phenomena itself. Having probed a little in this area and been rewarded with some interesting insights, I am aware the there are other areas which could have been usefully explored which will have been missed.

The narrative analysis formed one part of the analysis of this stage of the research. It was recorded in no particular order, but for clarity is structured around the chronological periods she spent in each job and 'epiphanies' (Denzin 1989) such as her year at Teacher's College. It can be analysed as a series of stories (Plummer 2001): firstly including those that he describes as '*habitually told'* this covers many anecdotes, the best example is probably her interview for 'Barts'*.* Secondly *'collective memory',*   some of the Pre Training School memories are like this - particularly where she and M taught together - this is a major part of their shared careers. And finally *'memorialisation'*, Plummer suggests major events such as the holocaust as examples of this.

There are no such dramatic memories for Alice, although the evacuation of Dunkirk during the early stages of World War Two in 1940 is close.

Mandelbaum (1972) Nespor and Barber (1995) and Polkinghorne (1995) all state that in order to conduct analysis the research needs to be clear about why the life story has been collected. I wished to explore the discourses used in nursing, particularly relating to nurses in training and the conceptualisation of the 'good' nurse. I was also searching for a coherent direction through which to continue to explore this subject. Writing the narrative analysis helped me to find a voice which was congruent with the discourses identified in the literature. It also helped me to identify Pre Training School as exerting a powerful influence on the experience of nursing and nurse education and thus directed me to this area for the next stage of my data gathering.

In addition to completing the narrative analysis, the interview transcripts and other documents were analysed. I decided not to use a computer package for analysis. Instead I used a manual technique of typing up transcripts of the tapes and clustering the data into themes. This was achievable with the volume of data and allowed me, as a relatively inexperienced researcher to gain the maximum benefit and understanding from the transcripts (Webb 1999).

Although my 'foreknowledge' relating to nursing and nurse education remained, I attempted to identify themes without trying to create a 'fit' with my preconceived expectations. These are listed in Appendix II.

4.3 Interviews

Nine semi-structured interviews were conducted as per the methodology. Cohen and Manion (1998) suggest that interviewing can be conceptualised in three different ways: where there is a skilled interviewer, or a set of interviewers working together, it can be a fairly impartial exchange; it can be a transaction; or it can be seen as simply an extension of every day life exchanges.

For me the interviews were clearly a transaction. With the exception of one respondent who due to a domestic crisis had forgotten that I was coming, they all treated the interview as a fun social exchange. They had anticipated my visit, prepared food, spent time thinking about the past and searching for artefacts such as photographs and documents from their training. My role in turn was to listen, to be empathetic and be genuinely interested in their experience of training.

Nine interviews were completed. Each took between 45 -60 minutes. Interviews were semi structured; the interview schedule consisted of the following four broad questions which were chosen to attempt to gain insights into the guiding questions and to explore further the emerging discourses:

1. Why nursing? Memories of why you applied, what the interview was like and why you chose this particular nursing school.
2. What did you learn to do in Pre Training School?
3. How were you expected to behave – dress, speech, religion, manners
4. What did being a good nurse entail – did you start to learn the skills etc you needed to do this in Pre Training School?

It is clear that nursing for many people is more than just a job, so the reasons for joining and choosing a particular school were relevant. This question was first as it gave a safe and easy starting point and made an attempt to locate the interview within the Pre Training School period of training. The other questions were not introduced in any particular order, but were returned to as a check to ensure they had been covered. In each interview the only strong steer was through always at some point using the words 'good nurse'. This was important in ensuring that data specifically relating to their perceptions of the good nurse and the language and discourse which they associated with it was included.

Streubert and Carpenter (1999) say that the interview gives you a way in to the other person's world, but for Silverman (2000) the transcript is still a narrative and as such is 'actively constructed'. Thus the extent to which the interview transcript contains an agreed and shared understanding of the person's experience is open to analysis and interpretation.

Although they were completed as nine single interviews, the cue questions required the nurses to look back on their careers and talk about the past, this meant that there was considerable overlap in technique and content with the life story methods in stage one. Indeed Miller (2000) suggests that short life histories can be obtained in single interviews, particularly where you are interested in researching a particular aspect of people's lives and it may be argued that this is what I was attempting to achieve.

The element of life story was evident in the way the interviews progressed. Nurse training and in particular Pre Training School were significant moments in all of the nurses lives so they had no difficulty in remembering many aspects of this time, however each of them spent time locating this in a broader 'story' of their lives. For some, nursing was something that only happened to them for a few years, prior to marriage and so being a student constituted the majority of their nursing experience. For others, a long career in nursing followed and thus their memories of Pre Training School were mediated by their later experiences as trained nurses.

The need to contextualise their experience of learning to nurse, with other experiences, for example as young women living away from home and later as wives, mothers and workers is congruent with life story narratives (Goodstone 1995, Plummer 2001). A consequence was that a great deal of extra data was generated, beyond the scope of the guiding questions which became a source of reflection when completing the analysis.

A further aspect of the data generated from the interview transcripts was the need to reflect on the accuracy of the nurses' memories. Whilst this is a potential bias in any interview data (Cohen and Manion 1998) it is particularly relevant where interviewees are asked to recall events from 50 years ago (Miller 2000, Plummer 2001). Interview 7 illustrated this particularly well because the nurse (who did not train at the Infirmary but moved there later) had kept her 'nurse time book' which was a daily log of all of her shifts, holidays etc for the duration of her training. In the interview we fluctuated between her reminiscing about her training and reading from the log, which was well matched to the general spirit of her memories, but revealed a number of inaccuracies in her recall.

On reflection this has made me very careful in drawing sweeping conclusions from the data, where I could not verify particular aspects from documentary evidence the nurses presented. However, although there were inaccuracies in recall of detail, the spirit of the memories was congruent with the written evidence and there was a degree of consensus between the nurses which suggested that I could have some confidence in the data.

Furthermore, I was interested in how they spoke about what they did as much as the actual work. The analysis is attempting to identify the discourses presented by the nurses, thus there is a consistency of language embedded in the text which is independent of chronological and technical facts.

As with the life story transcripts, each interview was audio-taped, transcribed and manually analysed line by line, to identify the themes (Webb 1999). Although I had completed the life story transcripts and worked on the narrative analysis prior to the interviews, I again attempted to keep my knowledge and reflection from these activities distanced from the analysis of the interviews; allowing a separate set of themes to develop, rather than seeking themes which matched those already identified (Gadamer In: Murray 1978).

Many of the 28 themes that emerged can be clustered around the four cue questions. However three further clusters emerged relating to the contextualisation of the interviews around the nurse's broader life experiences. These relate to the 'profile' of the interviewees, 'how they felt about nursing' and 'experiences of nursing'.

Faced with this broad array of information I reflected on where the data was taking me, trying to look at what the nurses had talked about and how they had talked in an attempt to impose some order on the growing and disparate information which I had gathered. At this stage I drafted a number of chapters and sections of chapters, searching for a way of expressing the findings. Webb (1999) suggests that this is a legitimate and necessary stage for analysis and that much of this writing may be discarded. This has indeed been the case.

The 28 themes and 7 clusters are detailed in appendix III

4.4 Documentary analysis

Although the Nursing Times and Mirror journals were chosen to cover the same historical period as the interviews, they offered a significant contrast and challenge to the gathering of data and its analysis from both these and the life story. Firstly the journals were more representative of the public and professional image of nursing, rather than the autobiographical image in the interviews and life history (Hallam 2000).

Although some of the extracts are letters or personal opinion, which could be said to be autobiographical, they were written for publication. I am therefore postulating in the analysis that these writings reveal a spectrum of 'voices' from nursing which have been selected to be representative by the journals' editors.

Secondly I had to choose how to manage the vast amount of potential information differently from the life story and interview stages. By choosing which questions to ask and avenues to explore and pragmatically by restricting the amount of time spent listening to and recording the nurses, the amount of data gathered in stages one and two is limited. I may speculate on what additional information I could have gleaned, with the value of hindsight by asking different questions, but I cannot go back and revisit this; even if I did I might not find what I was looking for.

With the Journals the process of exclusion had to be more overt and deliberate, as the data was there and was only excluded by my conscious act. All four of Scott's (1990) factors; authenticity, credibility, representativeness and meaning were present, as the archive included all volumes of both journals in full for the study period. I was very aware of the responsibility this gave me, as I had to rely on my own judgement to narrow the material down.

Platt (1981b) suggests that there is an element of trust in all research, that is the reader has to trust the researcher to have represented the findings fairly and truthfully, but this trust is particularly important where documents are being used. The researcher must choose the elements of the documents wisely and honestly. I have tried to demonstrate the authenticity of the findings by describing the process by which the data has been collected and sifted prior to analysis.

I kept fairly rigidly to the sampling plan (outlined in the methodology chapter) I had made prior to visiting the archives, thus only looking at the Times and Mirror and only looking at the pre chosen months, (with the exception of following up one set of letters, which ran for several weeks concurrently). Even having narrowed down the search for data from the journals in this way, the volume of material was massive. I am conscious that I continued to filter the information I read and chose to copy. I knew that in deciding what to copy I was making very clear choices about the further restrictions I was imposing on the data. I attempted to look for evidence that related to the guiding questions with fresh eyes and to copy materials which shed light on these, rather than focusing very specifically on the themes which were already emerging. I also resisted chasing themes which had been significant in the literature search but had not emerged as significant in the life history and interviews.

For example the lack of analysis of men in adult nursing was significant in the literature review. Dingwall (1979) offers one of only a small number of research papers on the subject, in which he acknowledges that the position of men in adult nursing is anomalous. Studying the unusual, or non – standard often sheds light on a subject (Cohen and Manion 1998): in particular the gendered discourses surrounding hospital based adult general nursing are challenged by the presence of men in a nursing role, so in consequence I would have been interested in pursuing this in the life story and interviews.

However no male nurses volunteered to be interviewed and the data generated suggested that men featured little in Pre Training School and nurse training in general during the period studied. It seemed that my interest in this risked biasing the data and that this avenue of enquiry was not going to be fruitful. By contrast the journals did include a significant amount of material about male nurses, including articles, features and letters. In excluding this area from the analysis I acknowledge that a potentially interesting area of discourse has been missed. Had I started from the documentary analysis, rather than the life story I may well have pursued different avenues for analysis and I acknowledge that this would have affected my results.

As with the interview transcripts and life story, although I could not dismiss my 'fore knowledge', I attempted to identify themes as they emerged from the journals, rather than looking for matches to the other analysis or my own experience.

Platt (1981 a) states that documentary research is not a separate method; the important factor is how you decide to use it. Many research texts (see for example Scott (1990) and Jupp and Noris (1993)) suggest that documents can be treated as any other 'data' for analysis. I followed the same method as for the interviews, reading the text and looking for themes. These fell into 11 groups which are detailed in appendix IV.

Despite the claim above from Platt that documents should be treated as similar to all other data, she identifies two biases which are specific to documentary research. The first (Platt 1981a) is that the inferences of what is written are significant. The researcher needs to be aware of the reason for the text to have been written in the particular way:

- What was the audience?
- Is the text representative of 'normal' affairs at the time?
- How deliberate and conscious of its audience is the text?

The second (Platt 1981b) is that just because the documents are published does not mean the people of the time assented to the views represented. In the same way that the present reader has to appraise how trustworthy the interpretation of the researcher is, the researcher must appraise the meaning behind the choices made to publish in the original papers.

The example given by Platt is of propaganda published during a war, but there are more subtle influences, such as which letters are chosen to be published. On reflection, both journals are intended for a nursing audience and as they survived through subscription it seems likely that they were representative of a popular view of nursing, at least amongst nurses. This makes it plausible that the discourses identified are representative of the professional voice of nursing. What might be less accessible through the journals is the public discourse, for example the tension between 'professionalism' and 'vocation'.

What might also be of significance during analysis is to be aware of the 'gaps' that is to say themes that appear in only some of the data. These may be relevant in understanding some of the tensions within the discourses used.

Having undertaken an initial analysis of all three sets of data the results far exceed the aim, guiding questions and scope of the research. Whilst it was possible when scanning the Nursing Times and Mirror journals to exclude some material that did not relate to the guiding questions it still exceeds my brief. In addition the range of material in the nine interviews is much broader and richer than just the 12 week Pre Training School experience and it could further be argued that the life history is worthy of comprehensive development as a separate study.

Thus it is acknowledged that whilst this thesis represents a unique analysis of discourses related to adult hospital based general nursing, as they have emerged from the data, it is not the only interpretation. It is however argued that the authenticity of this thesis is not diminished by the potential for further alternative interpretation.

4.5 Conceptual framework revisited

Through analysis it became clear that whilst the discourses identified in the review of the literature(Figure 4.1) were still evident they were no longer the most congruent mechanism for analysing nursing in the 1945 -55 period.

- Nursing as reform
- The development of medicine and the rise of the hospitals
- Nursing as social control
- Nursing and the military
- Nursing as female vocation
- The Good Nurse

Figure 4.1 Discourses identified in the review of the literature

In addressing the guiding questions of *'what did it appear nurse training was trying to achieve', 'how was the experience of training/ learning to nurse expressed', and 'what are the connections with the discourse surrounding the good nurse'* the data leant itself to an integration of several core discourses which for the purposes of analysis and discussion can be clustered into three groups. In addition, it is argued through the discussion that the conceptualisation of what nursing and being a good nurse means is directed, controlled and restricted by more dominant discourses about the health service, gender and power. These are represented diagrammatically in Figure 4.2

Discourse as power -control of health, illness and sexuality

Discourse: maintaining the status quo in the health service –

controlling nurses and patients: money, medicine and power

Nursing discourse:
The right kind of
girl

Nursing
discourse:
The transition from
woman to nurse

Nursing
discourse:
Vocation or
profession?
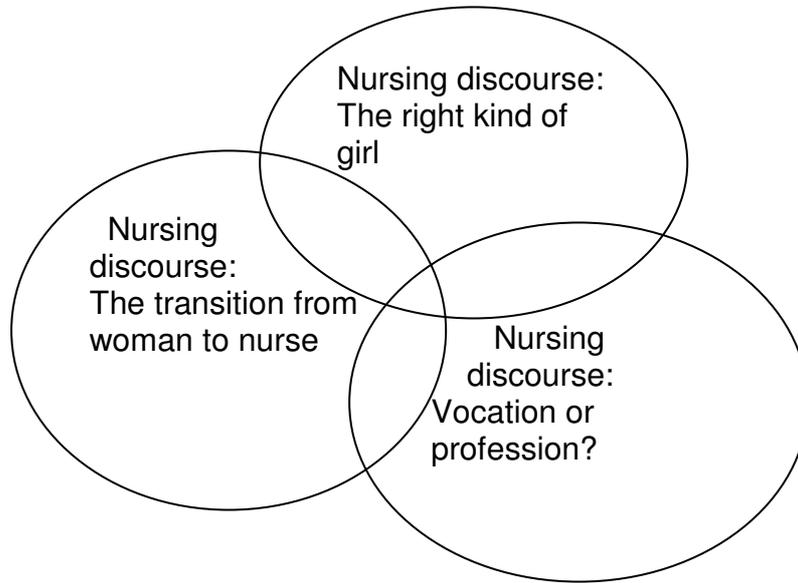
Figure 4.2 Conceptual Framework

Usher and Edwards (1994) state that it is acceptable for discourse to have multiple meanings and that they remain incomplete and only partially known. Taking this as a starting point, Chapter Five explores the discourses around the 'right kind of girl' which emerge from Alice and the nurses' narratives, and Chapters Six and Seven extend this into broader professional discourses around professionalism, vocation and education evident in the journals. Chapter Eight locates the discourses within the conceptual framework, and Chapter Nine attempts to draw some conclusions from the findings.

Journals are referred to by their title (NM or NT) and date of publication. The nurses interviewed are identified by number (1-9). Interviewees 4 and 5 were friends and were interviewed together, thus on occasions the text involved both of them speaking and is identified as '4+5'. Quotations from Alice's transcript refer to her by name. All direct quotations from interviews and Times and Mirror are recorded in Comic Sans MS script size 10 to distinguish them from the rest of the text. As in other sections of the thesis, 'the Infirmary' refers to the hospital were the majority of the nurses interviewed trained and where Alice was in charge of Pre Training School in the 1945 -1955 period.

Chapter Five: The Right Kind of Girl

5.1 Introduction

It has already been suggested in the review of the literature that Hallam's (2000) identification of nursing's image as being about the 'popular', 'professional' and 'personal' imagination is useful in analysing the discourses around the 'good nurse'. These three voices remain helpful when looking at the data. However the life story, interviews and documentary sources are biased towards the professional and personal imagination, with the popular imagination less audible as it is mediated through the editorial control of the contents of the journals.

This chapter will offer an exploration of nursing discourse primarily through the medium of the nurses' and Alice's voices. This discourse, around the experience of nursing and nurse education and the concept of what it meant to be a good nurse will be structured around three parts of the discourse which are evident in the data:

The *'right kind of girl'* is both a recognisable discourse within the text and can be seen as a general descriptor for the whole discourse. It contains the sub – sets of class and femininity, innocence and cleanliness. '*Control of self (and others)'* is the second cluster; it consists of uniform, rank, discipline, both emotional and behavioural and religion.
The voice of the nurses in the third cluster, *'vocation or profession?'* is arguably the least audible, but it is nevertheless important to identify how this discourse manifests itself through the ways in which the nurses talked about themselves and their experiences, in contrast to the more politically motivated views in the subsequent chapters.

5.2 The right kind of girl

Above all else, the data identifies that to be a good nurse you had to be 'the right kind of girl' this is seen through discourses around class and femininity, innocence and cleanliness.

5.2.1 Class and femininity

Alice and all of the nurses interviewed conform to an intensely gendered view of nursing (Davies 1995) and fitted into the image identified by Hallam (2000) as the embodiment of white, middle class femininity. The way they talked about the recruitment process illustrates the expectations in terms of class. Firstly Alice's 1936 interview for St Bartholomew's Hospital:

She [matron] said could my father give me an allowance? So I said well - he had four children - and he just couldn't. So she said what does he work at? And I said he is an engineer for London Passenger Transport. She was not happy with that; you see he ought to have been a Bishop, or a Headmaster or something of that sort. (Alice)

Whilst the Infirmary did not have quite the reputation of the London hospitals it could nevertheless afford to be very selective and this was well understood by the nurses:

The Infirmary would only take you a) if your parents were married, b) a decent education   -they were very hot on where you had been educated (2)

It was teaching or nursing if you were grammar school (5)

Schooling and family background were powerful denominators in the selection process and were clearly evident to the nurses as they made friends with other new recruits in Pre Training School.   By their own, sometimes wry admission, the nurses selected for the Infirmary knew that they were the 'right type'.

You may have hit on something there I mean some of us were wild!! (Laughter) but I think we probably all came from lets say more or less the right background so we would not have got tarted up I mean when we went out we might have worn a bit of lipstick but eye shadow just wasn't (trails off to silence) - -but then that was like you say more or less coming from the same background (4)

The 'wildness' as identified by this nurse is clearly mediated by an upbringing which sets this within socially acceptable limits. The distinction between lipstick and eye shadow is one of many in the discourses where Alice and the nurses identify the subtle social divisions between acceptable and unacceptable manifestations of femininity.

It is not clear however that class was a defining feature of entry to nursing. Hospitals in London and major provincial former voluntary hospitals such as the Infirmary could afford to restrict entry on the basis of class or at least grammar school education, but in general Abel Smith (1960) identified that poor recruitment and a lack of suitable candidates had brought both the educational standard and age of recruits down. Despite this the image of nursing as a suitable occupation for respectable middle class girls was a powerful and useful one for the profession and was thus perpetuated.

 It would seem that across the profession the middle-class nature of nursing was *aspirational* rather than a pre –requisite. Thus it was not necessary to be middle-class to gain a place in nursing, but once accepted the discourse endowed nurses with characteristics associated with class and respectability. A girl with the right schooling or family could choose a nursing school, like the Infirmary, which matched their social expectations and guaranteed that the majority of recruits who they would be sharing accommodation with were from similar background.

Girls from a lower social class may not reach the Infirmary's standards but through being accepted into training at other schools they automatically improved their social position, with the potential to engage in a lifetime career as Alice did, or to meet a wider range of eligible men with a view to marriage. An NT article, entitled 'the art and profession of nursing' sums up the possibilities as they were presented:

Parents who oppose their daughters who choose nursing as a profession often have in mind that marriage is the most desirable career for those whose happiness we have at heart. Could there be any better training for marriage and motherhood than this? - - nursing both as an art and as a profession is above all else a woman's job - - -what is the art of nursing ? The art of nursing lies latent in many women, in and out of hospital, and in most mothers. (NT 16.3.46)

Both Kalish and Kalish (1987) and Hallam (2000) identify the post war period as one where nurses image in popular fiction and cinema was strongly associated with romantic depictions of wife and mother. In the 50s-60s the largest occupationally linked category in romantic novels was nurses (Kalish and Kalish (1987) and in cinema Hallam(2000) notes that there were no depictions of working class women in nursing roles (all were either middle or upper class) in the 40s and early 50s. Thus the collective discourse of the nurses themselves, the profession and public expectation were that nursing either carried with it, or created through the medium of becoming a nurse an expectation about class and the kind of woman you were.

5.2.2 Innocence

To be a respectable young female also meant to be innocent and a most striking aspect from the nurses interviewed is their recollection at the commencement of their training of how young and naïve they all were:

March 1948, my mother took me in a taxi and left me at the door and I was absolutely an innocent abroad, I had never worn make up, never left home straight from school (8)

I think I was so innocent in those days in PTS it was not true (2)

I am amazed because I realise what a child I was really - still in ankle socks (3)

I was only a child (4)

The similarity of language and attitude as they recalled this factor were notable -a shake of the head, a little chuckle of remembrance - almost a sense of disbelief that they could have embarked on such a difficult career from such a state of innocence.

Alice confirms this situation describing each new batch of recruits affectionately as 'wet behind the ears'. In the earlier years of nursing reform (see for example Maggs 1985) 23 years old was considered to be a reasonable age of maturity for entry to nursing, but the necessity to bring in more recruits, and changes in the educational experience of women had brought the age of entry down to 17 years by 1945. All of the nurses interviewed were 17 – 19 years old at the commencement of their training.

For parents of girls from this 'right' sort of upbringing to be persuaded to allow such young, innocent women to live away from home the hospitals needed to be convincing that they could offer a setting that inculcated the values of a respectable middle class home. The Infirmary seems to have been very successful in achieving this. In a Nursing Times round up of self reported news from around the country the Infirmary's contribution includes tennis, swimming, a 'riotous' Halloween party and the weekly gramophone evening:

Records of concert music are borrowed and the more knowledgeable amongst us supply introductions to each item. It is a peaceful pleasant gathering at which the proceedings are helped along by tea and at which dressing gowns are not frowned upon (NT 6.1.45)

The image created from the language in the nurses' quotations ('still in ankle socks', 'never worn makeup, 'only a child') and the gramophone evening above work together to suggest a discourse in which nursing offers the safest and most cloistered of lives. It would appear that the discourse directed the nurses' behaviour and thus ensured that they would perpetuate it through the traditions they created. All of the nurses interviewed, including the three who trained elsewhere, remembered Pre Training School as full of innocent girlish fun:

There was no question of boyfriends, we never ever thought about men we used to create our own fun; one girl could play the piano and we used to sing all the pop songs but there was no (trails off to a pause) – no-one went out, we had no money. On the first payday in PTS and subsequent two pay days we went to Betties in - - - for a cup of tea and a cream cake for 1 and sixpence and that was our treat there was no (trails off to a pause), nobody ever went (trails off to a pause), you could come in a 10 o'clock, that was the curfew, no-one wanted to go out after that, no-one asked for a late pass, no-one went dancing, we did not drink (2)

5.2.3 Cleanliness

Discourses related to cleaning and cleanliness can be seen throughout the interviews and Alice's story and operate on a number of levels. The moral cleanliness evident in their youthful innocence as illustrated above underpins the requirement for physical cleanliness of themselves and their environment. Since Nightingale's 1893 assertion that hygiene is a fundamental component of the science of nursing (Hampton 1949), a key aspect of nursing has been the transformation of normal household routines, generally identified as women's work into the 'science of hygiene' (Maggs1996).

This nurse's discourse underpins writing about practice in the journals where cleaning and being clean are cited as important components of the aesthetics of nursing:

The most fundamental of all skills – the ritual of cleanliness, asepsis and antisepsis (NM 16.2.46)

The expectation that nurses were responsible for cleaning and the cleanliness of their environment was evident throughout the data and started from the first day of Pre Training School:

 (Shared exchange, with much laughter) and what else did we do in PTS, cleaning the stairs with sawdust - we were at the nurses home, attached to the Infirmary - that was one of the jobs we had to do - we got to do the cleaning before the start of lectures, it changed each week . . . And what else did we do - we cleaned the loos of course we did (4 +5)

It was a hard slog [on the wards], and we used to mop the floors and everything like that . . . . and the sterilisers and that were either brass or copper and they would have to be perfect, and it had to be spotless, all the urinals were glass and had to be without stains (7)

Words like 'spotless and 'stain free' occur regularly within the data, visible 'dirt' indicating contamination, and lack of control over a hostile and threatening environment. Despite engaging in this cleaning work, nurses were expected to always look clean themselves. The meticulous detail of this was captured in one nurse's recollection of the ritual of apron changes:

and of course we went on the ward at 7.30 and at 9.15 and 10.15 had two apron breaks where you went for a cup of tea and changed your apron from the dirty work so you came back on again with a clean apron so your dress was never actually in contact with the patient- [they] had a big bib and came right round and were starched (3)

There is reference in both Alice's narrative and in the interviews to the employment of 'maids' who undertook some of the heavier cleaning duties (e.g. setting and cleaning of fireplaces), but it is clear that the nurses believed it to be their responsibility to ensure that all of the work was done, and on a strictly hierarchical basis to engage in cleaning tasks themselves. These routine procedures split the working day into 'clean' and 'dirty' periods thus adding a further dimension to the discourse of control.

The implication is that the expectations of a good nurse are that she will know how to transfer the skills for good household management to good ward management. Whilst the actual work of cleaning may be learned in Pre Training School and the wards, the principle of its importance and the unspoken acceptance that this is one of the hallmarks of an appropriately brought up female, relates as much to pre training expectations in terms of class and gender as to the actual training itself.

The role women play in managing families and homes is well documented in the feminist literature (Oakley 1976) and Lawler (1991) explore the role of 'dirty work' in nursing. What is revealed in the nurse's discourses is the unquestioning and seamless link between their identification as respectable, 'clean' women and the expectations in terms of their appearance and work as nurses.

An unclean environment or a dirty uniform is an indictment against a nurse's ability to maintain control: the 'right sort of girl' will be able to remain cool, clean and in command. If she cannot control these physical manifestations of dirt, then how is she to control the more fundamental issues of health and disease, and avoid her latent sexuality either being contaminated by or contaminating the hospital environment? This leads to a second group of discourses regarding control of self and others.

5.3 Control of self and others

As I have engaged in the process of data gathering and analysis I have been frequently struck by the seeming gulf between the innocence and youth of the nurses and the awful reality of hospital based adult nursing. The nurses' self image as innocent and naïve young women contrasts with the difficult, intimate and at time dangerous activities I know they were expected to engage in.

Firstly nursing was a hazard to their health: treatments for TB and other infections were in their infancy and so contamination from bacterial and viral sources was a real worry. Secondly an important part of patient management was immobilisation: thus patients needed assistance with the most intimate of bodily functions, requiring the nurse to be both observant and physically close.

Finally much that patients came into hospital for was incurable and medical etiquette meant that nurses were not expected to discuss diagnosis and treatment with patients, or to become emotionally involved. There was therefore a need to convey through the close physical work sympathy with the patients' situation, without being drawn into a more engaging relationship where conventions of behaviour and decorum could be threatened.

Hallam (2000) discusses the ambiguity between the required image of nurses to be angelic and virtuous, whilst having knowledge of and exposure to what she calls the 'hidden physical'. The discourses surrounding dress and behaviour identified here show some of the means through which this ambiguity was managed.

The parallels between nursing and the military (Summers 1988, Starns 2000) and religious imagery (Hudson-Jones 1988) have already been made in the review of the literature. Both can be seen in the discourses around uniform, etiquette and behavioural control.

5.3.1 Uniform: badge and shield

The function of the nurse's uniform was threefold. Firstly the detachable cuffs and apron were a practical way of maintaining a clean appearance at a time before disposable aprons and more easily laundered fabrics were available. The cap to a lesser degree also acted as an aid to hygiene as hair could be firmly secured underneath it. However the function of the cap and the uniform were equally related to rank and prestige, with each grade of nurse wearing a different one and various hospitals identifying their status through the design. Finally the uniform served to remove all traces of individuality from the nurses, including as it did the requirement for the hair to be hidden under the cap and for no makeup or jewellery, thus minimising the presence of their physical and sexual selves.

There was a taken –for –grantedness for both Alice and the nurses about the importance of the uniform. They show that it was frequently uncomfortable, poorly designed and impractical: however as a badge to be proud of and a shield to hide behind its significance outweighed these difficulties. It was both a measure of rank and had a clear value as protection from physical, emotional and sexual closeness to the patients they were nursing. All could describe in detail the precise requirements for the uniform from their training, down to the shop from which the exact pair of shoes had to be purchased.

The discourses within the interviews and Alice's transcript show how these functions of the uniform were embedded into the everyday expectations of the nurses. One quote serves to illustrate the extent to which the uniform changed totally the nurses self perception and thus help to minimise the potential role confusion between innocent girl and nurse:

and of course we had no contact with men until we were on the wards and that was a completely different thing (in role - -in uniform) but you would never have dreamed of [trails off into silence] - - (2)

The uniform for this nurse is the means through which a clear distinction between acceptable and unacceptable physical closeness to men could be managed. It's almost as if she can see herself as two different people: a girl who has no contact with men and a nurse who can have very intimate contact with men when they are patients within a defined set of circumstances which both he and she will understand.
Savage (1987) says that the uniform serves to suppress individual sexuality and create a 'disembodied sexuality' thus the 'girl' becomes 'nurse'.

The extent to which the uniform functioned as it would in a military setting to render the individual person invisible is illustrated in the lack of any use of names. The most important thing in a hospital setting was not who an individual nurse was but the position occupied within the hierarchy. This uniform governed your work, level of responsibility and social behaviour, down to who you could speak to and where you were permitted to sit and eat.

no-one was called by their first name , and you really did think you had arrived when sister called you by your second name (9)

The uniform also acted as a device to bond students to their particular nursing school. The Infirmary housed one of two nursing schools within a large city, where the other school was attached to a former municipal hospital and workhouse. In consequence the Infirmary students were encouraged to see themselves as far superior to the other training school[32].

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[32] This situation is typical of a number of Cities within England where fierce rivalry existed between nursing schools.

I can remember going on a visit to _____and the nurses wore earrings and we were horrified, absolutely horrified!! And we came back and the sister tutor said 'you will have noticed that some of the nurses were not properly dressed I do hope that you will never ever do that' (2)

The significance of their 'horror', reinforced by the tutor conveys the certainty that their superior discipline in terms of their physical appearance was a measure of the better class of their nursing school.

The extent to which the wearing of the uniform transformed you into a nurse, and for the Infirmary into the sort of nurse they wanted to be associated with is revealed in two extracts from the data where nurses retold stories where a sanction was applied for wearing the uniform inappropriately. The first, told with warmth and humour demonstrates how quickly and effectively unsuitable recruits were identified and removed:

Women were being called up, she was an actress , or she would have liked to have been, so she was sent to a munitions factory , but she decided she would like to do nursing - she 'heard the call' (laughter) very dramatic! we all arrived at PTS we all had our hats on well her hat was a particularly soggy one she arrives like this with all her makeup on - very glamorous, and was promptly sent to get washed and when she came back - every eyebrow, everything went - this pale completely naked face - she did not last long! (Laughs) (4/5)

This woman, on day one of Pre Training School, failed the test, which was that she had to quite literally wash off her individuality and become the image if she wanted to be accepted. Her inability to see this or her defiance at the convention sets her apart. As with the reference to nurses at the 'other' hospital wearing earrings, this also reinforces the discourse amongst the nurses that they were superior to nurses who trained elsewhere.

The second story is very different and relates to a particular shift:

I will never forget that once during my training I twisted my ankle and I had a pot on - - you never thought of going off sick so I went on duty with a pot on and one black shoe and stocking and Matron remonstrated me I'd no right to be walking round like that and I said but Matron I have a pot on - it does not matter you should be wearing black shoes and stockings! (2)

I have reflected a lot on the significance of this memory, re-examining it in context with the rest of the interview and the themes from the analysis. On one level this illustrates the invisibility of the individual as discussed above and the attitude of senior people to junior staff. The 'purposeful bullying' that occurs here, (as identified by Starns (2000)), is a recurrent theme evident in many of the interviews and in the Journal extracts.

However I think its significance at this point is in highlighting the point at which two equally important requirements clash: to always be available for duty and to always be correctly dressed. The expectation as shown here that you simply did not take time off sick unless you were incapable of getting to the ward is repeated in many of the interviews. It is also a recurring theme in the journals. These include numerous letters on health and sickness and an article (NM 24.2.45) suggesting that poor health and a worrying incidence of TB amongst nurses is due to both 'foolish heroism' on the part of nurses who do not recognise their symptoms and report sick and nursing administration which sees the nurses as 'pairs of hands 'having no concern for their individual welfare.

So the nurse has a dilemma -to go on duty inappropriately dressed, or to call in sick. She chooses the former as this seems to match the expectations of her. This then gives the Matron a dilemma - which she resolves by ignoring the nurse's injury and telling her off for being incorrectly dressed (an *Infirmary* nurse never wears her uniform improperly!).
Clearly there are issues of recall, and the Matron may well remember the same incident differently, but the discourse feels like a true representation. The nurse has sustained an injury, thus demonstrating poor judgement and commitment to duty, subsequently this has put her in a position where she cannot comply with the uniform regulations. It is congruent with the discourse that she would be told off on both counts.

5.3.2 Behavioural control

The final illustration above indicates that the uniform was just one of a number of ways of controlling nurses and their behavior. The initial stages of training reinforced control of behavior through hierarchies in obedience, communication and task allocation:

We learned that in PTS you were very much the junior nurse you were made to feel this, you did not speak out of turn and got all the rotten jobs to do, and of course the nurse the set above you had a halo. . . . . I don't think it was difficult- because our upbringing was such that you obeyed people, you really did take anything that was said, and you did not question (1)

We were taught unquestioning obedience, no-one ever asked why we did that, we knew we did it and it could have been dangerous, but we didn't really know, we were taught you did it without question and this lasted throughout training, we rarely questioned why we were doing it we automatically though it was right (2)

The combination of careful selection and early inculcation into the rules of the hospital ensured that obedience and discipline were automatic. Indeed, a number of the nurses including Alice when asked cited this as one of the hallmarks of a good nurse.

Much of the discourse discussed so far has related to the control of physical behaviour and appearance. Just as significant is the ways in which the nurses' emotional behaviour was moulded and sanctions imposed when it was deemed inappropriate. One memory is particularly interesting:

and I remember the first ward I was on, the sister was a very regimental sergeant major - she was a miserable dour Scottish lady, and I was a happy person, and I used to sing on the ward, and it was a young ward - a lot of motorbike accidents and she used to have me out in the middle of the ward and she used to tell me off she used to try to make me cry but I wouldn't, and she sent me to Matron because I was rebellious because I would not cry (2)

An analysis of this story, identifying military influences and the ways in which junior nurses could be bullied and humiliated into conformity is plausible and supportive of the conceptual framework. However, I do not believe it is an accurate analysis of the discourse which is revealed here.

My interpretation of this story, mediated by my own experience as a student nurse is that the type of ward (male orthopaedic) the nurse describes had at that time a very specific atmosphere. The treatment for the classic leg injuries sustained in motorbike accidents was up to 3 months in traction on complete bed rest. It is impossible to put on pyjama bottoms when in leg traction so the patients become accustomed to being semi –naked. After the initial trauma and pain of the accident patients are generally well, but traction is a difficult position in which to read or write and television, radio and other electronic devices would not have been available. Boredom was one of the main difficulties so it's inevitable that the arrival of a new junior nurse was a source of interest, entertainment and sexual tension.

The sister may well have been dour but it seems reasonable to assume that the control exerted here was intended as much to protect the young nurse from potential harm and to manage a sexually charged atmosphere as to sanction the nurse's behaviour. Everything within the interview transcript suggests that she was committed to nursing and fitted into the expected image but her feisty response to the sister clearly earned her some careful surveillance from Matron, just in case she was not, after all, the 'right sort'.

Where this nurse exposed her true self and missed, or misunderstood the cues in terms of keeping an emotional distance others articulated it as can be seen in the following exchange between nurses 4 and 5:

there was a distance wasn't there -   don't get too close it could end up (silence) - -I don't think we were ever told that (silence) - -I mean you didn't sit on the bed, and if you had a few spare minutes you did not go and chat to a patient, no matter how much they may have appreciated it, or needed it - you went and cleaned the sluice or something (5)

- you weren't seen talking to patients the only time as you got more senior was going round once per day to ask if they had had their bowels opened! (4)

The silences in the quote were accompanied by eye contact between both nurses and myself and imply a shared understanding of unwritten codes from our training that 'getting too close' is a) dangerous for the nurse's emotional security and b) foolish professionally. Working in the sluice and thus busy with cleaning activities is an acceptable way for the nurse to spend time where talking and listening to patients anxieties is not. Equally the more senior nurse can approach the patient and seek information, but only about aspects of the patients' condition which fall within her ability to measure and control. Chapman's (1983) research identified the use of ritual and routine as a way of nurses distancing themselves from anxiety. It may thus be argued that the combination of exact rules in terms of clothing and appearance, combined with detailed and ritualised forms of etiquette and communication distanced the nurses emotionally and physically from patients and made the process of transition from girl to nurse more possible. The discourses which demonstrate this trend emphasise the danger, morally and emotionally of making an error of judgement and the permission nurses had to ignore a whole range of patient needs rather than expose themselves and their professional image to this risk.

5.3.3 Religion

A further discourse which appears in all of the interviews, in Alice's transcripts and life story and in the Journals relates to religion. This is so pervasive that it is difficult to identify where it fits into the pattern. Most of the nurses felt it was not absolutely essential to be Church of England or even a practising Christian to get into nursing, so it was not a prerequisite to being the right kind of girl. It does however seem to have been part of the bedrock in terms of behavioural control.

At the Infirmary at least, it would seem that the hospital acted as an extended Church of England parish. This can be seen in two activities which were discussed by several nurses.

Attendance at the Friday evening service 'Compline'[33] was compulsory in the 1940s. Nurses who were Catholic could opt out but were given tasks (bandage rolling) to complete during the service, so it was not seen as free time. One nurse had trained with some Jewish women but had no recall of how this was managed for them.

The change came for the later nurses – this one from 1951:

> and we were told - and this rankled - - that we had to go to church on Friday evening to Compline, now I was brought up in the C of E and I had gone to church all of my life, all of my life but I did not want to be told to go to Church, now Compline is a lovely service it brings the day to a close but we were 18 and we were feeling our feet and we did not want to go to Compline on a Friday evening and we said so – we said we would go, but only if it was without ordering, and it was not very well received . . . . and after that they were asked if they wanted to go (6)

The second aspect which numerous nurses and Alice discussed was morning prayers:

> Did prayers every morning: at 8 when sister appeared at the door. We came on at 7.30 to do the beds and when sister and her full time staff appeared - around this lovely long table we had a prayer for the day and the Lord's Prayer and the patients joined in and it was a lovely start to the day, and I have never heard any one say anything against it. Never prayed for any one in particular just a general prayer to prepare you for the day – we liked it. (6)

Although the nurse's rebellion against being required to attend Church suggests a less obedient attitude, the later quote shows that compliance with Christian behaviour was expected. Indeed, the morning prayers ritual seems to be part of the Sister's duty, which would imply that a post as Sister at the Infirmary required a certain level of Christian commitment.

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[33] Compline is a Church of England devotional service which occurs at the end of the day

The post war period was one of intense change within health care and society. Many of the voluntary hospitals, such as the Infirmary, had been maintained by subscription and thus had a close link with local establishments, including the Church. The creation of the NHS in 1948 shifted the balance of power. In addition, demographic change, reduction in active Church membership and immigration changed the profile of British society, such that it was no longer possible to assume that staff or patients had a shared Christian identity and nursing became more secular (Williamson 2001). For the nurses interviewed who trained elsewhere ward based prayers and Compline had not been part of their experience, so I would postulate that the Infirmary was maintaining some traditional practices that had already faded out in other nursing schools.

It would seem that Christian ethics were an important denominator within British society at the time, so it is not surprising that they underpin the respectable middle-class values identified in the discourses. It may also be the case that the Infirmary, as a competitor to the London hospitals, saw the promotion of traditional values as a way of maintaining its quality.

The discourses identified from the nurses and Alice clearly show that control over behaviour and appearance was an important aspect of socialisation into nursing. The transformation from woman to nurse was however more profound and not limited to time spent on duty. The final section of this chapter explores the ways in which nurse's discourse reveal how their occupational identity was understood.

5.4 Vocation or profession?

It is evident from the interviews and life history that the nurses and Alice understood that they were embarking on a serious and difficult career, which endowed them with rank and privilege. A discourse identified within the review of the literature was nursing vocation. This was evident thought the literature, but was also challenged by concepts of professionalism, such that by the study period there was some disagreement regarding the extent to which nursing was a profession or vocation.

The initial analysis of both the life history and the interviews did not include thematic groups around vocation or profession. In fact the word 'profession' is used infrequently and 'vocation', never. By contrast this was a major theme in the analysis of the journal articles. I reflected on the differences and looked again at the transcripts when trying to find a coherent way of expressing the discourses. What I found was that despite differences in semantics, much that is said by the nurses resonates with the discourse *nursing as female vocation* in the review of the literature.

When asked what she looked for in a potential nurse at interview Alice replied:

….. a reasonable level of intelligence and common sense . . . but also wanted to know about their feelings, why they wanted to nurse and we were quite interested in their general approach and how they spoke (the Queen's English). . . We felt character and motivation were almost as important as education you know . . . . not a job but a profession (Alice)

For Alice *profession* raises the status of nursing from just a *job* to something internalised though attitude and state of mind. The sense of importance and gravity placed on the role of the nurse is evident in the discourses within the interviews. The nurses did not talk about themselves in terms of profession or vocation, but of privilege and power:

In those days the general public thought that nurses knew every thing, it did not matter that you were first day on the ward, it was blind faith, that whatever you were told to do in hospital was right for you. (6)

A very privileged position to be a nurse - people feel safe to be with you. (3)

These statements seem to be in striking contrast to the identification of themselves as very innocent inexperienced young girls, their experience in the early stages of their training of being at the bottom of a very strict hierarchy and the expectation that they perform the most menial of cleaning tasks. What is also interesting is that although the nurses may have been a little afraid of this responsibility, it clearly matched their expectations when they joined. The following extract was one of several:

I came into nursing because I lived in a small village and I lived next to the district nurse, who appeared to me to have the most glamorous interesting job. . . .. She knew everything about everybody and cared about everybody and all this business of bandaging up people and dripping blood on the doorstep like you did with your dolls - her influence on me was enormous. I saw something I could do (4)

The nurses' position, on the one hand seemingly powerless as women and junior members of staff, whilst simultaneously having huge power over the well being of patients is illustrative of the ambiguous nature of nursing work identified by Littlewood (1991).

The power of the discourse is in making possible the apparent dissonance between the two positions. This can be explored further through the nurse's articulation of what being a good nurse had meant to them:

- - well I think the tender loving care came into it but you had to be hard working, you had to be observant and say this person's pulse is not what it should be , just being all things to all patients   (7)

one of the things I remember that matron said is that a good nurse is one who can anticipate what the patients needs before they needed to ask. I used to feel very chuffed if I could say to someone 'you're not very comfortable 'and they said 'no' (9)

I believe that the discourse reveals the role that nurses play in the sociological phenomenon Talcot Parsons was in the process of identifying as the 'sick role' (Parsons 1951). People whose sickness meant that they were hospitalised accepted that their normal rights to self determination were curtailed. The effect of being bed bound in a hospital ward was to remove all control over when you ate, drank, washed and went to the toilet.

A transaction occurred whereby the patient accepted their lack of power on the understanding that the nurse would be aware of, respect and provide for all their physical needs.

An article in the Nursing Mirror, entitled 'a new patient makes suggestions' written as an open letter to the profession by a lay person who had recently been hospitalised for the first time, reinforces this discourse:

[The patient] -' he puts every trust in his nurse, do not therefore upset his confidence'
[The sisters] 'The ward is your Kingdom and all the patients your subjects and your responsibility'
NM 13.1.45

A key feature of the discourse seems to be that no matter how junior or new they were, by being accepted into a training school and acquiring the appearance and behaviour identified by the general public as 'nurse', they had undergone a life changing transformation. They did not describe this as a vocation or profession but the discourse around service, privilege and responsibility shows they did not see nursing as merely an occupation.

5.5 Conclusion

This chapter has attempted to articulate the discourses around nursing as identified by Alice and the nurses. The transition from girl and to nurse seems to be an amalgam of the 'raw materials' implicit in their gender and class and the controls imposed through the uniform, training and hospital system.

The right kind of girl is reasonably well educated, innocent, young and either is or aspires to be middle-class. Against this background and expectations the control of appearance and behaviour creates a powerful image of capable safe womanhood.

The extent to which these factors constitute a vocation or profession is not articulated in the interview transcripts, but concepts such as dedication, diligence and obedience are explored along with the privileged and powerful position nursing occupied. The discourse as presented by the nurses seems to accommodate the huge gap between what the girls coming into nursing were, and the role they were expected to undertake. In doing so, it provided a medium through which the transformation to 'nurse' could be made.

Chapter Six: Profession or Vocation?

6.1 Introduction

The discourses identified in the life history and interviews with nurses examined in the previous chapter conform to Cheek's (2000) assertion that discourse presents as incoherent and multiple voices, rather than a single concept.

Despite this, the data suggests a shared understanding of what it meant to them as individuals to go through the process of becoming a nurse and to mature as women. This is manifested in a strongly gendered discourse around character; moulded through morality, duty and service. By contrast, the professional voice in the journals and other policy papers reveals significant differences of opinion and a lack of shared agreement about what good nursing is and should be.

I am curious to explore this, as it seems to represent a gap, or inconsistency in the discourse. Thus this chapter seeks to explore these differences in more depth, analysing the discourse on nursing and nurse education as it polarised around the question of whether nursing should progress as a profession or a vocation. Data is drawn from the contemporary documents identified in the methodology: the analysis of Nursing Times and Mirror, the RCN Horder Report of 1943, and the GNC Nursing Syllabus of 1952.

6.2 The debate

Three reports on nurse education were published in the period just preceding and during World War Two, the Athlone Report (1939) the Horder Report (1943) and the Wood Report (1946). All three were responding to a perceived need to reform the nurse education system in the light of staffing shortages in general hospitals and changes in the educational and professional aspirations of women. The Horder Report, commissioned and written for the RCN by a committee of nurses, represents the public declaration of the profession's aspirations and intentions for nursing, rather than the government's view. I therefore consider it to be an important document that articulates the professional voice at that time. Two extracts serve to identify the aims of the report:

'As the committee proceeded in its work it became more and more convinced that, given a liberal outlook and a carefully planned curriculum, the training of nurses in this country could be developed into one of the great national education movements for women' (p5)

'in the committee's view, nursing is not merely an item in the nation's medical service, but a profession parallel to that of medicine occupying an appointed, and increasingly important place in the national plan for health' (p11)

To suggest that the outlook should be 'liberal' indicates a discourse which is new and challenging. A liberal education, according to the 1942 edition of the Oxford Dictionary (Fowler and Fowler 1952) is 'of a general and literary, rather than technical kind', implying that nurse education should do more than just teach nurses how to perform their job effectively
.
The report focuses on the curriculum, on the effect this could have on the women involved, rather than hospitals and the effect on service provision. The greater good is not improved patient care, but a positive contribution to the education of women. Nursing is described clearly as a profession; a point reinforced by suggesting it is 'parallel to medicine'. The use of the words 'important' and 'not merely' implies that nursing is to take a primary rather than secondary role in developing the health service.

A contrasting discourse is demonstrated in the following extract from the Nursing Mirror, criticising the content of the GNC syllabus in use in 1947, which it claimed was too academic:

'leading nurse educationalists are coming to believe that there is too much in the present syllabus, or at least that the balance is too heavily weighted towards the theoretical side, leaving the practical art of nursing panting to catch up with the preoccupied mind of the student nurse - - - - the higher flights of treatment, requiring knowledge of abstruse diseases [if the nursing of them ever does require it] are not the first consideration with the mainly chronic patients. Acutely ill patients require more understanding and more knowledgeable care but they also need this basic bedside attention which is *nursing* - - - - the nursing which the young potential recruit visualises in those days when she wears the coveted nurse's uniform only in her dreams. If when she has the uniform on she finds she is not required or allowed to give the attention which for her is *nursing* she becomes disillusioned and her interest flags' NM 12.4.47

The use of the phrase 'leading nurse educationalist' suggests the author is speaking for an established and respectable opinion and implies knowledge and authority. Nursing emphasised in italics by the author is then describe through an emotive visualisation of a basic bedside, rather than complex disease oriented, role.

Theoretical education is described negatively with the nurse 'panting' to keep up with the knowledge of 'abstruse diseases'. The nurse's mind is 'preoccupied' implying that her attention is being deflected from the important task of bedside caring, in order to cope with unnecessary educational input. This represents a discourse which runs continually through the Journals in the period studied. A further extract from an article written 6 years later entitled 'service and satisfaction' illustrates this:

In previous weeks we have stressed our belief that nursing is basically a relationship between two people, a relationship of a special kind that demands not only continuous remembrance of its essential human relationship but the nurse's peculiar responsibility to maintain the human touch. Whether this is called a vocation, or a profession matters little but those who enter it, or rather continue in it, should feel they are ideally suited to it and be willing to accept its inherent responsibilities. . . . real nursing is a spiritual business, and as such is demanding . . . we have made this mistake over nursing – for in our recruitment appeals we have tended to stress the material aspects – the salaries, the conditions, the training and what not – to make nursing sound like an easy profession offering conventional rewards. Nursing is not an easy profession it is probably the most exacting work any man or woman could take up (NM 2.10.53)

There is a great deal written into the detailed discourse in this extract. The 'special' and 'peculiar' relationship it claims for nursing, plus the reference to 'remembrance' and 'spirituality' evoke the discourse of female vocation identified in the review of the literature. There is an overt challenge to the practice, detailed by Abel Smith (1960), of emphasising the perks involved with training and offering incentives in terms of accommodation and improved pay. The passage concentrates on what sort of person the nurse must be, rather than what they might know and the reference to 'those who enter it, or rather continue in it' hints at the fact that many people who commence nursing are in some way not suitable and do not stay.

There is a suggestion that the title profession or vocation is not relevant, but I would argue that the discourse is clearly one of vocation. To have a vocation is defined by the 1942 edition of the Oxford dictionary (Fowler and Fowler 1952), as a person's 'sense of being called to a particular occupation or task' and the language in both Nursing Mirror passages is suggestive of this calling.

A further observation is that both journal extracts suggest the writers are confident in nursing having a shared and absolute meaning. 'Nursing' in italics in the first extract and 'real nursing' in the second appeal to the reader to agree with their analysis and imply that any vision of nursing which does not conform to their ideas is false. By contrast the Horder Report asserts that through education, nursing has the potential to change; to grow into something different and better.

I would like to suggest that these passages identify a dissonance *within* the professional voice of nursing during the study period which is additional to the contrast with discourses identified through Alice and the nurses. Further insight can be gained by looking at nursing as a profession for women, the role of theory, and the importance of vocation.

6.3 A profession for women

To be a professional, it is argued (see for example Davies 1995, Trodd 1998, Simonton 2001) is a masculine state. It involves being in a public, rather than a private domain, not amateur and autonomous. There is therefore a dissonance between the concept of 'nurse' and the concept of 'profession'. Good nursing is associated with a gendered view of caring and the attributes of being professional are masculine. Hence it could be argued that the notion of a professional woman, or professional nurse, is inevitably an oxymoron.

A theoretical position which is congruent with the professional discourse in the journals, the autobiographical accounts in the interviews and life history and the review of the literature is that nurses could be permitted to take on a role which conformed to the expectations of a profession lifestyle as long as they abdicated many of the culturally defined female expectations and duties. The organisation of nurse training and practice enabled this to happen. Thus to become a nurse you had to move away from your family and live in the nurses home in a setting not dissimilar to a military or religious order. This meant that the 'normal' female duties of household management, marriage (and its related sexual awareness) and childbearing were removed and the nurse was free, in the same way as a man would be, to pursue her career. To do this she gave up her individuality through adopting the uniform, behaviour and lifestyle dictated by the profession.

I would like to argue that the power associated with being a nurse is greater than that which most professions available to women in the study period would have allowed. As a consequence the nurse accepts the erosion of some of the culturally normal expectations for her gender. The discourse in Chapter Five suggests that for the nurses this was the implicit, expected transaction which they undertook in order to achieve the privileged and powerful position it afforded them.

The restriction, which Horder does not examine but was true for most female occupations at the time, was that this parallel female career could only be enjoyed by women who chose not to marry. Whereas for men a profession occurred in conjunction with being a part of a household, for women it was instead of. Therefore nursing is seen as an alternative career to or a preparation for the 'natural' career for women of marriage and motherhood.

This split is supported by the nurses involved in the research. Eight of the nurses interviewed married within a short time of registering and as a consequence either did not nurse again, or did not return to nursing until later in the 1950s or the 1960s, when changes in employment practices made this possible. One married quite late in her nursing career and continued to work.

Alice, it may be argued was the career nurse of the group, achieving higher academic qualifications, rank and pay than any of the others. The opportunities she had, to live in with the job, to have unrestricted study time to pursue her qualifications on top of a full working week and to take a sabbatical in the USA were only possible because she did not have the responsibilities or privileges of household management, marriage and parenthood.

It is also argued in the literature that educational achievement is a significant denominator of professionalism. Indeed, Davies (1995:59) claims that:

> 'expertise derived from formalised training based on science lies at the heart of a claim to professionalism'

By suggesting that Nursing could be 'one of the great national education movements for women' Horder is offering a challenge to the male dominated medical establishment within British healthcare[34]. Group and Roberts (2001) suggest that education is a benchmark which can be used to enhance women's development, or to exclude them.

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[34] It could be argued that this situation remains today.

The Horder Report appears to be using education in this way to attempt to raise the educational standard for nursing and thus close the gap between the status of nurses and doctors. I would argue however that Horder's views remain aspirational within the period studied. Indeed the only place were such achievement is evident is in Alice's year at Teachers College in New York.

Here the curriculum is liberal, emancipatory and based on contemporary educational theory, for example espousing student centred learning and a broad liberal education to develop the student's mind as well as their basic capacity to do a job. It is notable that this opportunity was only open to Alice because she was single, working full time in nurse education and won a Red Cross scholarship[35].

The discourse identified from the nurse's interviews does not support Horder's aspiration to a 'liberal outlook and a carefully planned curriculum'. They had lectures in anatomy and physiology, hygiene and other aspects of nursing care and learned about patient conditions from more experienced nurses and doctors at the bedside. They did not identify any learning, either formal, ward based or by example, that was not directly related to either care giving or developing the right manner and appearance for nursing. Thus the interview data supports the 'basic bedside attention' referred to in the nursing Mirror article (NM 12.4.47) as being more focused on learning practical tasks and developing the correct attitude. In addition I would argue that the requirement for 'unquestioning obedience' (2) as identified in chapter five meant that their individual and educational needs were always secondary to the requirements of service delivery.

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[35] In addition Teachers College was the only institution in the world where this level of undergraduate education was available to nurse teachers. Had she been able to remain in the United States for a few months longer, she would have been able to take a final module and graduate, making her one of only a handful of British nurses with such qualifications.

6.4 Too much theory

In the interviews and life story the nurses' focus in terms of learning was almost exclusively practical. During Pre Training School it may be argued that there were some liberal studies in that they visited local housing developments and environmental institutions such as water and sewage management. However these were intended to aid the students to put their nursing practice into context, rather than to give them a broader education.

Two extracts are typical of the ways in which the nurses talked about their training:

really looking after the patients with supervision because there was only the ward sister and a staff nurse - they were the only qualified people on the ward the rest did the work - so there were 3rd and 2nd and 1st year nurses, there were perhaps 4 of you - 2 from the same PTS went on a ward and you did things together but when you first went on you were in the sluice - -you were good for bed bathing - you were taught to be reasonably competent, you enjoyed it because you were reasonably competent and liked making the patient comfortable (2)

I think about PTS I learned how to handle things how to make a bed and turn the mattress, I learned how to handle instruments and handle a syringe. I developed my manual dexterity with the bandaging and we were shown how to give injections I think this is the thing that I learned most. (9)

In both cases the nurse's discourse is intensely practical, they talk about how to 'handle' things and the mechanics of getting through the days work. The description of the staffing pattern also belies any suggestion that there was time for students to engage in theory. Time was filled with jobs to be done the nurse was 'good for bed bathing' and defaulted to working in the sluice Implying that the work was a series of tasks of varying degrees of complexity that the student was matched to according to rank and ability.

The discourse identified by the nurses would seem to be at odds with the Nursing Mirror assertions that nursing had become too theoretical, and the policy recommendations from the Horder Report for a broader educational curriculum.

This dissonance is supported by an analysis of the actual content of the nursing syllabus at the time. As the 1952 syllabus was produced in the wake of the Horder and other reports and in the same time period as the Times and Mirror analysis, the assertions regarding excessive theory appear to be untrue:

Taking the 1952 syllabus (Appendix V) in its entirety, there is a recommended 232 hours of lectures over the whole of the three year period, inclusive of the hours spent in the Pre Training School. The advice regarding content for the 232 hours includes for example 14 hours each for medical and surgical nursing, 6 hours of paediatrics and nursing sick children and just 2 hours on mental disorders. A later GNC circular 73/7/16 (appendix VI) suggests that with revision and coaching classes this should equate to 20 weeks worth of study days through the course however the circular states that 'many training schools did not achieve this objective for many years'.

Statistically 20 weeks over 3 years equals seven weeks per year, or14%. However the Pre Training School was included in this recommendation accounted for 8 -12 weeks of study time and was included as a block to be completed prior to the students gaining a contract with the hospital and commencing their training.

Consequently even in the schools which strove to achieve the GNC standard the periods of study were minimal. In addition the descriptions of the new training methods in the Times and Mirror suggest that where a system of full week 'blocks' of study time was established during such study periods students spent a percentage of the day on bedside nursing, for example bed making between 07.30 and 09.00 prior to lectures until 17.00.

Such emancipatory schemes were not compulsory and the nurses interviewed confirm that the Infirmary did not move to this system until the late 1940s. Lectures were staggered through the year and students were expected to attend, regardless of whether they fell in an 'on' or 'off' duty period including time that they might otherwise have been sleeping between night shifts

This analysis confirms that the amount of theory in the syllabus is clearly disproportionate to the degree of alarm caused. Had this been a discourse wholly originating within medicine, or the hospital authorities, in might have been reasonable to construct an argument regarding the potential threat to the medical, male dominated health service that would be created by a powerful politically and educationally astute female dominated nursing body. However this view was also strongly supported in the journals by both leaders and rank and file nurses. From this I conclude that a simple gender or 'nursing v medicine' division is not a robust enough explanation. The strong anti – intellectual bias in nursing as discussed by Rafferty (1996) and others appears to be supported by the data.

Foucault (1980) suggests that the nature of discourse is that it is owned and controlled at all levels Thus it follows that nursing discourses are self perpetuating and do not need to be to be maintained by medicine or the hospital managers.

It would be wrong to present this as a simple dichotomy between the nursing policy and the journal publications. Both Times and Mirror do publish letters articles and editorials that support the academic development of nursing. In particular the period following the formation of the National Health Service in 1948 and the Nurses Bill of 1949 saw a number of new experimental nursing programmes and the development of the 'block ' system described above. Many nursing schools were featured and favourable reports of the modernisation of nursing were printed. In addition each week both journals ran a series of educational articles featuring anatomy and physiology and a wide range of nursing practices, indicating strong support for education and education reform from subscribers.

There is some evidence from the data sample that the Times favoured the changes in nurse education more than the Mirror. This would be consistent with the Time's position as an official voice for the RCN however this is a tentative assertion which would need further research to be fully supported.

What is clear is that despite policy which is supportive of educational development a discourse which remains conservative and distrustful of theoretical developments in nursing remains strong and consistent in the professional discourse within the journals throughout the period studied.

6.5 The role of vocation

In Chapter Five it was identified that the nurses did not use the word 'vocation' to describe their role in nursing. However the language they used implied an affiliation with this concept and their identification of nursing as vocational. By contrast the discourses examined at the commencement of this chapter demonstrate a tension between profession and vocation which exists through the study period.

In order to examine this further I identified words and phrases which are evocative of the vocational discourse. The examples below are indicative of the discourse embedded in the texts and are by no means exhaustive:

compassion, without out which the nurse might just as well pack up and go home, is not an easy virtue. NM 9.3.46

. . . . a relationship, not unlike that between mother and child.' NM 29.3.47

devotion to patients is the keystone to the plan' NM16.2.46

The art of nursing lies latent in many women, in and out of hospital, and in most mothers' NT 16.3.46

good hands and a good temper NM 29.3.47

There are no material glittering prizes . . . . . . Reward will come at the sight of a child breathing easily after a tortured night, and of old people dying happy because a nurse they love is beside them. We need a crusade. 'If any man come after me let him take up his cross' NM 11.6.49

Virtue features strongly in this discourse – 'compassion' 'devotion' and a latent natural goodness are identified. The abilities to become a nurse are innate, coming not from education, or from professional accomplishment, but from the positive outcomes in patient care. Whilst not all words relate to women, the discourse is as always strongly gendered, with frequent explicit reference to the natural links between nursing and motherhood.

I also include here a reference to religious devotion. Whilst this is not prevalent in all of the texts it does feature frequently, particularly in the discourses within the Nursing Mirror and thus remains symbolic of the sort of dedication that nursing continues to aspire to. These findings support Bradshaw's (2001) research into nurse training where she states that good nursing was at that time predicated on enhancing and developing the cardinal virtues.

I would argue that such attempts to maintain nursing as a female vocation or 'calling' in the study period can be seen as a continuation of the discourse identified through the review of the literature in the 19th century. The divergent views over the direction nursing was taking mirror the tensions within nursing, dating back to Nightingale's early reforms and the battle undertaken in the early 20th century over registration[36].

The data from both written texts and interviews supports the view that nursing as a privileged vocation, 'natural' extension of women's caring and nurturing instincts, continued to be promoted within nursing as a way of legitimising the intimate physical work involved and the working conditions. Simonton (2001:44) suggests nursing is an idealised form of extended feminine caring, and a craft passed on from woman to woman:

> 'this emphasis on caring rather than the knowledge and skill required for nursing, often from nurses themselves, has contributed significantly to the public perception and standing of nursing and nurses'

Thus nursing is portrayed as a tactile, practical occupation, carried out in such a way as to nurture and dignify the sick person and legitimise the nurse's role.

However, it may be argued that whilst virtuous attributes are a prerequisite for many professions, they are not a viable benchmark for measuring achievement nor sufficient to permit membership.

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[36] Clearly, in the wider context of female emancipation nursing does not sit in isolation. Woman's role in society was changing; they could now graduate and engage in many careers which would have been impossible earlier in the century. Despite this, the discourse presenting nursing as different or special in some way continues to pervade the study.

For example a Doctor of Divinity or Medicine would be required to develop a virtuous disposition, but would also require evidence of significant educational achievement. Thus the argument that the 'goodness' required for a vocational occupation in some way eroded by intellectual ability is indefensible.

In conclusion I would suggest that the educationalists that produced the Horder Report recognised that without aspiring to a strong educational base none of the other reforms would be possible. Nursing could not be judged as equal to medicine without distancing itself from its vocational image and having a comparable academic preparation. However, whilst the authors of the Horder Report may have understood that education alone did not make the nurse 'good' they significantly misjudged the conservative and anti intellectual bias towards a vocational discourse prevalent within nursing, which made such reforms all but impossible to implement.

Whether the discourse promotes a professional or vocational theme, all agree that the training is central to the development of nursing and socialisation of nurses. Thus the education system and the discourses related to this form the focus of analysis in the next chapter.

Chapter Seven: From Woman to Nurse

7.1 Introduction

The review of the literature identified that nurse training was the process whereby people, predominately young females, were received into this occupational group through engaging in a hospital based apprenticeship. It also suggests that a new discourse around nurse education was emerging in the middle of the 20th century, which challenged some of the established discourses around training to nurse.

A further important factor, evident from the autobiographical accounts in the interviews and life history and the contemporary journals, is that a significant majority of the people 'nursing' were not in fact registered, but were students in training. Thus I would suggest that the period of training was not just a means to becoming a registered nurse; indeed it could be argued that student nurses were a separate and important occupational group, providing as they did a substantial portion of hospital care. The education infrastructure therefore served to both train a future, qualified workforce and regulate the majority of the staff caring for hospitalised patients.

It is also clear from the interview findings that the student nurses spent the majority of their time in one of three interconnected environments. These were Pre Training School (and later in their training the nursing school), the nurses' home and the hospital wards. Together these created an almost closed society, accounting for 24 hours 7 days per week in most weeks of the year. In conducting this research I came to the conclusion that the Pre Training School period was particularly significant, as it appeared to be specifically designed to inculcate the students into nursing. Whilst the data covers a much wider period than just Pre Training School this significance is supported by the analysis.

Furthermore, the GNC syllabus (1952) states that the main purpose of the Pre Training School, in addition to introducing elementary anatomy and physiology, first aid, hygiene, invalid cookery and basic nursing, is to socialise students into the nursing role.

This chapter seeks to explore the ways in which discourse features during initial training: a very formative period in the nurse's lives and careers. It argues that the training acted as a filter to ensure that undesirable people did not gain access to registration, a buffer between often wildly contradictory elements and a means to inculcate the values and behaviours of obedience, loyalty and service that were considered appropriate for a good nurse.

7.2 She did not last long!

In Chapter Five it was identified that the discourse presented the nurse as the 'right kind of girl' with a shared understanding of behaviour related to class and gender. The fact that in all but the most elite nursing schools these may have been aspirational made the role of Pre Training School in filtering out women who could not or would not conform all the more important.

I would argue that the Infirmary [which is central to the life story and interviews] played a particular role as one of the 'best' provincial schools. In order to maintain its reputation as being on a par with the London teaching hospitals it presents itself as a prestigious alternative for recruits and a beacon for other schools in the region. Thus I believe the data offers a particularly rich example of the discourse, which may have been less evident had the nurses whom I interviewed trained elsewhere.

For example both Alice and the nurses talked about the application process in which the expectation was that girls accepted for the Infirmary were from respectable homes and well educated. Once accepted to train, the nurse's remembrance of Pre Training School and their early experience of ward work identify the ways in which the filtering system continued through this period.

Clearly Pre Training School gave students an opportunity to practice at perfecting the uniform appearance which was expected of them. The 'coveted nurse's uniform' (NM 12.4.47) referred to in Chapter Six is not just a matter of clothing. Uniformity included dress, appearance, hair style and makeup. It also, on a very practical level was the first 'test' that the nurse could understand and was prepared to obey rules. Amongst the nurses there was a great deal of pride in the uniform:

I liked the uniform I never stopped being proud of my uniform. (5)

The word 'pride' occurs in other transcripts, and is also implied in many other exchanges. I have argued in Chapter Five that the uniform served to remove the individuality from the person. In doing so it conveyed a universal image 'nurse' which the nurses appear to have been pleased to acquire. The use of different types of hats and of colour gave an incentive for the nurses to progress and the Infirmary a way of identifying itself as elite.

The importance of the uniform was explored in Chapter Five where the aspiring actress is required to remove her makeup in order to be correctly dressed. This is a good example of the way this discourse works:

. . . and when she came back - every eyebrow, everything went - this pale completely naked face - she did not last long! (Laughs) (4/5)

The uniform in its entirety is the embodiment of the woman as an Infirmary nurse, not only to herself but more significantly to the other new recruits. Savage (1987), Summers (1988) and Starns (200) all identify the uniform as a significant element in nurses identity so it is not surprising that this incident is still remembered as an important lesson 50 years later. If she does not look the part then she cannot be an Infirmary nurse, and if the Infirmary allows her to progress, wearing her uniform incorrectly, then it will lose credibility. Furthermore, her decision to dress this way in the first place suggests a measure of deviance, which will not be tolerated. The importance of these details is illustrative of the power invested in such discipline as described by Foucault (1991:136)

> 'For the disciplined man . . . no detail is unimportant, but not so much for the meaning it conceals within it, as for the hold it provides for the power that wishes to serve it'

Whilst my own experience of nursing makes me aware of the importance placed on obedience I had not realised how deeply embedded this is in the nursing discourse. The discourses around control have already been explored in Chapter Five but the links to obedience bear further scrutiny here. A number of quotes remembering Pre Training School activities are illustrative of the activities that reinforced the discourse. In particular this is one of many describing taught skills sessions:

we were taught how to do them [injections] with oranges and then to inject ourselves and then each other with sterile water –this would not be allowed now - we used to have to pass Ryles[37] tubes! We used to have to pass them on each other - if you think about health and safety - (2)

The experiential learning involved in Pre Training School was clearly quite dangerous. Doing an injection and passing a Ryles tube both take a steady hand and a fair degree of self confidence and both techniques if done incorrectly can cause quite serious damage. Thus the new recruits were 'tested' in the safe environment of the nursing school, passing this stage before they signed a hospital contact and were allowed to practise on patients. Also both activities require the nurse to inflict pain and discomfort on the patient, therefore run counter to any romantic images of nursing which the new recruits may have arrived with.

Clearly students who had not the courage to perform these activities in the safety of the classroom were unlikely to succeed in practice and so this was an important practical exercise. I would argue however that exposing the student to such procedures was equally important as another effective filtering process. Agreeing to perform these tasks on a fellow student and allowing an inexperienced person to do it to you would only happen in a situation where there was an absolute obligation to obedience and no opportunity to refuse. If a recruit was unable to both do and experience such procedures it would, like the example of the incorrect uniform above, signal either weakness or deviance.

A further important factor related to Pre Training School was that it provided opportunities to establish the shared experience of living in the nurses' home. All of the nurses said how important the nursing home was to personal support and survival, so fitting in socially was essential.

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[37] A 'Ryles' tube is a thin plastic tube passed through the nose into the stomach, in order to drain the stomach contents, and to 'rest' the gastro –intestinal tract. Having one passed is very uncomfortable, and carries the danger of aspiration pneumonia if the tube is inadvertently passed into the lung by mistake.

Reflecting on their daughters' experience of training a generation later the two nurses who were interviewed together were very clear that the nurses' home had been a special and significant part of nursing:

-what XXXX and I maintain is that our girls training had not got the rapport - -had not got the memories - they were not together, they were living out. - -did not have the closeness, the intenseness (4+5)

The interviews indicate that this intensity was deliberately created by the way that Pre Training School was managed. The students were excluded from other students in training through having separate bedrooms and dining area and later at the Infirmary living in a separate geographical location. They wore a different uniform which singled them out. They followed a strict routine, including mealtimes and bedtimes, they also quickly learned that further codes around dress and behaviour were expected of them when they were in the town which effectively regimented their week wherever they happened to be. I believe that an important effect of this socialisation was to buffer them against the transition to the ward environment. Whilst they were excited about going out into the ward areas, this was a source of anxiety – one quote is indicative of many more:

I think I mean we were all apprehensive. Much more than apprehensive actually I mean you would open those glass doors with the brass handles when you were going on to a new ward – (6)

Having somewhere safe to return to and learned set of behaviours appears to have offered some protection from the emotional and physical contrast between Pre Training School and the rest of their training.

The reference in Chapter Five to them being from 'more or less the right background' (4) reinforces the importance, in such a close and intense environment, of fitting in socially. From the interview transcripts language appears to be an interesting aspect of this. The way the nurses spoke identified them as the right type and by default singled out and chastised inappropriate people.

Alice refers to recruits needing to speak 'the Queens English', but this appears to be more than just correct grammar. I was interested in one memory from the nurse in interview 8 of her first days in Pre Training School which I did not at first understand:

And the particular memory I had that afternoon we were sitting around and she got up and said 'I'll go for a wee' and I was horrified (8)

Looking at this in the context of the transcript and her eye contact with me at the time, its clear that the 'horror' she felt was that she was unaccustomed to being in the company of people who would use such a graphic expression for going to the toilet. Learning acceptable boundaries of language and behaviour was part of the process of socialisation. Within nursing the body's functions and fluids are associated with the 'dirty work' (Lawler 1991) that nurses undertake and thus become both more prominent in the nurses understanding and yet more in need of controlling and hiding.

It would appear that the Pre Training School period was an opportunity to get a feel for what being a nurse was going to entail and to moderate behaviour and attitudes which did not conform; it also gave both the hospital and the potential recruit a period of grace in which either could withdraw with minimal difficulty.

Despite the indication explored in Chapter Five that there was an atmosphere of innocent fun, all of the nurses remembered that a small number of people had left during Pre Training School. This seems not to have been talked about very much, in particular where one student may have been pregnant:

we were 28 of us all together, 3 dropped out during PTS one, we did not know why she just disappeared overnight, I feel she might have been pregnant, because she just disappeared. Two did not like it. (2)

I could not get a feel from the interviews of whether this has been a big event; rather, having failed to pass through the initial filtering system, the lost recruits ceased to have any relevance for the nurses, reinforcing their special bond. The discourse suggests that they felt that they were the chosen ones, who in all aspects were good enough to progress to the next stage.

The subtleties in the discourse: knowing the correct way to refer to the need to urinate, the correct amount of makeup to appear appropriately feminine but not 'tarted up' (4) and the confident assumption that a young woman who disappears is probably pregnant were clearly not acquired overnight, but can be seen to be related to class, upbringing and education. The recruits were already familiar with the popular image. In addition the recruitment process which favoured a middle-class background and the role modelling provided by the tutors were used to effect in the Pre Training School in order to quickly identified people who did not fit in.

7.3 Bound together

Although my own experience of training and the review of the literature left me with no doubts about the reality of nursing practice I still found the numerous contrasting discourses between the safety of the nurses' home and the stress of the wards striking. Both of the incidents below happened after Pre Training School but whilst the nurses were still quite junior. In this first extract it is half an hour after she should have been dismissed at the end of a 12 hour night shift.

I was once in such a panic that I set fire to the curtains round the bed! (Laughter) I had to give morphia[38] I did this sort of - -it comes on a tray and you had to melt the morphia tablet on a spoon, and this was my last job before I went off duty and I was very, very tired and very well - -it was ½ past by this time and I had this job to do and there I was behind the screens and the screen went onto the Bunsen burner and it lit, and I knocked it and the mess went on the floor - the flame went on the floor sister - - -was sat at her desk & looked at me - & all this was happening and she looked at me and I put it out she did not come and help me nobody came to help me they just looked at me (4)

The second is an observation of another nurse;

we had one nurse who got herself into such a state about the sister that she could not think what she was doing she got up in the middle of the night and took all her rollers out and went to work - got dressed and went to work - she thought it was time to go to work. She was so frantic and worked up - there was no counselling (4+5)

In both cases they describe nurses who are under extreme duress. This is made so for a number of reasons:

The work is difficult and mistakes have serious consequences for their patients; the work is carried out in an atmosphere of distrust and hostility; this bullying atmosphere is made possible because of the clear power differentials; and the nurses are chronically sleep deprived.

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[38] Morphia was supplied as powder form which needed to be mixed with a warmed fluid before it could be drawn into a syringe and injected, hence the Bunsen burner. Screens were not permanently around each bed, but were mounted on wheels and placed round patients to offer some privacy. The distance between beds was small, making the space available once the screens and treatment trolley were in place very limited.

Both this evidence from the data and the literature review have shown that hospital based health care took place in wards which were managed by a very small number of registered nurses supported by a team of students. Thus I would argue that the environment created was one in which the student nurses had to be able to cope with ambiguous and stressful situations, for long periods of time with minimal supervision. Whilst the interviews also record examples where they were well supported the sense that the ward environment was hostile is present in almost all of the exchanges. Amongst all of the stories about practice that Alice and the nurses told me the Bunsen burner story offers such a powerful image of the way in which this woman became a nurse that I will return to it later in this chapter.

By contrast the nurses' home and the community it contained were presented by the nurses as safe; somewhere where you could be emotional in a secure environment and in which you could revert to being young and admit your vulnerability. Almost without exception when asked who they would go to in times of trouble they said each other. One quote is illustrative of the responses:

we congregated in one another's room I think w e did our own (pause) - now everyone goes for counselling and all this business I think we did our own counselling and our own (pause) – we dealt with it all ourselves very well (8)

The nurse's home was the one place where they talked about letting go and allowing their emotional exhaustion to show;

I think you will find nurses of my generation do not find crying easy we were taught not to show your emotions it was not the nurse's job. . . . . . . but I do remember spending many afternoons in my room crying I presume it was the stress and all this & I do not know why I was crying (3)

The data leads me to believe that the Pre Training School performed an essential function in reinforcing the discourse which led the students to accept this contrast and the way they were treated as normal. It gave them time to get to know each other and bond together as a group, for the cultural norms to be embedded and for them to develop a level of compliance.

I'm never sure that what they did with us in PTS was meant to be practical it was meant to bind us together to the hospital and give us a sense of discipline (4)

Furthermore the nurses' home gave them a geographical location which reinforced this. The nurses' home seems to have been a haven to which the nurse could return and to have acted as a buffer to soften the impact of entering this difficult and dangerous world in which people suffered pain and illness which they could not control and in which the sexual ambiguity of their intimate relationship with patients was not fully understood and could not be articulated.

In Chapter Five the discourse showed how the nurses learned that talking to patients about their personal needs was not acceptable and that keeping busy, or concentrating on measurable physical signs was a way of being seen to behave appropriately and cope with this. Equally it would appear that nurses managed their own distress by distancing themselves from the wards and people in authority and caring for each other. Several nurses said that they would have gone to the sister or one of their tutors if they were in trouble, but only as a last resort.

I could detect no sense of confusion in the telling of these stories. The discourse does not seem to allow for any dissonance between on the one hand espousing the virtues of care and their sense of privilege at being nurses and on the other colluding with a system that treated them so poorly.

It would appear that the harsh reality of ward life is compensated for by the protective environment they created for themselves in the nurses' home. I would argue that this and the image of themselves as privileged and valued people is as much part and parcel of the discourse around what education was trying to achieve as the more overt classroom and ward based activities. Alice and many of the nurses were very clear that learning to nurse had been a wonderful experience:

there were a lot of compensations you know we used to go to the pictures for nothing saw all the films before the public saw them and we could go to one of the theatres for 4pence halfpenny - - and go in the gods, and we used to get free tickets for the grand theatre it was the golden days of nurses you know the public thought you were wonderful and you know we may have worked really, really hard and we did – your feet nearly killed you when you came off duty – but you were looked after (8)

7.4 Becoming a nurse

Through exploring the discourses around the process of education and socialisation into the nursing role the research findings contribute to a more critical analysis of what exactly they were being socialised into. For example Bradshaw (2001) undertook an analysis of nursing textbooks from the 1930s to the 1970s. From this she suggests that there were four principles to nurse training: the development of moral character; the teaching of technical knowledge and skills; perpetuating the apprenticeship method; and encouraging professional etiquette.

Whilst not overtly Christian, the texts are underwritten by the cardinal virtues of prudence, justice, temperance and fortitude. Furthermore they present a single view of nursing as if the patient (in isolation from family and hospital environment) is the centre of attention, with the nurse in absolute control. Her research suggests that one of the key functions of nurse training, and Pre Training School in particular was socialisation into the norms and etiquette of the profession.

For all the rhetoric in both the nurses' accounts and the literature about the privileged and important role that nurses played, both Alice and the nurses' experiences suggest that the life of a student nurse whilst conforming in part to Bradshaw's view consisted of long days of hard physical work, repetitive domestic chores and petty rules.

The 'morphia' and Bunsen burner story related earlier in this chapter contains many elements of the discourse which is seen throughout the interviews. Firstly the acceptance of the fact that this was *her* work – she could not leave the ward until she had finished the tasks assigned to her, even though it was now some time beyond the point at which she should have been relieved from her spell of duty.

Secondly the sister appears to make a decision that the nurse can cope: she expects the nurse to finish her task and to sort out the mess she is causing, without expecting others to leave their assigned tasks. And thirdly no other nursing staff on the ward will dare go to the student's assistance because the sister has not moved. The sister is demonstrating the level of power she has over each individual nurse and over the organisation of the ward.

This model of nursing work supports the disciplinary concepts of Foucault (1991) and was analysed by Maggs (1983) where he makes the connections between the development of nursing's role in hospital organisation in the late 19th century with the development of the modern factory in the industrial revolution: the business of looking after people who are hospitalised becomes the 'work' of the nurse and is fragmented into packages of tasks 'delegated by rank and ordered by time'.

The obsession with routine and ritual is repeated in autobiographical accounts from the 1930s-40s (Arthur 2001a, 2001b) here training to nurse is described as a 'race against the clock' in a task oriented, highly ordered hierarchical organisation. Had there been a serious risk of the ward burning down, presumably the sister would have intervened. As it was, the incident at a practical level was probably a minor inconvenience, but at the level of discourse I would argue that it perpetuated a model of nursing created over 70 years earlier.

I would suggest from the data that the discourse created at that time prevailed, thus a key aim of nurse education in the 1940s and 50s had to be to nurture a workforce which could function in such organisations. This, along with the filtering system of recruitment and Pre Training School meant that the 'good' candidates were socialised into seeing loyalty, obedience and service as essential to becoming good nurses.

Although the nurses did talk about the changes to the training, in for example the development of the 'block' system of teaching and the inclusion of male nurses, what was not evident was the educational discourse identified

towards the end of the literature review. The 'liberal education' espoused by the Horder (1943) Report is not demonstrated and in general the nurses seem to conform to a discourse which is grounded in the practice formed in the preceding decades.

7.5 Conclusion:

The view of nurse education suggested by this analysis is supported by some of the literature. For example Stein (1978) suggests that the discipline's primary aim was to encourage conformity. In addition Maggs' (1996) analysis of the history of nurse education continues this theme by arguing that nurse education had little interest in caring as a concept, nor in developing a theoretical basis for nursing. Rather, it was focused on burying views which challenged the stereotypes and perpetuated the already established system of power and control.

Whilst I can select evidence from the data to support this view, it only provides a partial and unsatisfactory explanation. Alice's life story and the content of her transcripts suggest a woman who was intelligent and very forward looking in her work. Her description of the type of teaching which was given during Pre Training School contains a number of sessions including role play and experiential learning which indicate that her intention was to get student nurses to engage with the patient's experience and see nursing as much more that just a collection of tasks to be obediently performed.

Equally, the nurses described practice which was thoughtful and caring and spoke philosophically about patients as people who they truly believed were central to their role. Finally the Times and Mirror published articles, letters and essay competitions which champion a style of nursing and nurse education which challenges the rather sinister interpretation identified by Maggs and Stein.

Although these differences in analysis exist, I still conclude that the education system appeared to be the means by which people, (predominantly young females during the period studied), where transformed from women into nurses. This involved a complex mixture of education, lifestyle and an apprenticeship style of gaining practice experience and skills.

The extent to which a new discourse around education was being formed is difficult to asses. I would like to argue that an analysis of the discourses reveals a complex and subtle interaction. In this the nursing school and the culture within the nurses' home appear to contrast with the hospital to create an environment in which challenge was permitted and pockets of resistance could form. Examples of this include the new recruits refusing to attend Church, conducting parties in their rooms and singing on duty. However, as these existed in parallel with a strong ethic of obedience and duty or in the privacy of the cloistered nurse's home they did not significantly disrupt the status quo. Rather, they served to give an outlet to 'deviant' thinking and behaviour, protecting and thus sustaining the hospital system.

This research in examining the ways in which the nurses, contemporary journals and reports articulated the experience of nurse training contributes to an understanding of the ways in which the discourse around the characteristics of a good nurse were instrumental in achieving this.

Chapter Eight: Discourse and Nursing

8.1 Introduction

I set out to undertake this research because I was puzzled and frustrated by the apparent inability of nursing and nurses to change, despite quite radical developments in curriculum design and professional organisation. An argument emerged from the initial review of the literature which suggested that the discourses within nursing resist change so that whilst many things moved on, such as the profile of people engaging in nursing and the nature of nursing work, nursing itself did not. The preceding three chapters have undertaken an analysis of a number of factors related to this, identified through the study aim and guiding questions.

The data suggests that in the study period 1945-1955, despite 100 years of development and continuous change within the health service, the nurse was characteristically a respectable young female who was, or aspired to be middle class. Disposition was more important than intellect and in addition obedience, loyalty and a willingness to work very hard in harsh circumstances without complaint were the hallmark of a good nurse. I would argue that attempts to change the structure of nurse education, either as a vehicle for the advancement of women, or as an expedient to produce more nurses at a cheaper rate had minimal impact on the actual business of nursing.

Furthermore an analysis of the findings adds to an understanding of the influence of discourse in perpetuating these characteristics. Aspects of discourse: Biopower (Foucault 1979), gaps and silences, resistance and control are all evident in the findings.

8.2 The family model and Biopower

It can be seen from the analysis in the last three chapters that the strict routine, dress and behaviour codes all worked together to create a regimented hierarchical society in which non conformity on or off duty was suppressed. In addition two further stories from the nurses struck me as particularly illuminating of different aspects of this discourse.

- yes they were long hours the nursing was a very physical job, we did so much more for patients and they were in hospital longer, we did everything for them bathe them absolutely everything, they were expected to be this patient in this bed, which really for me was easy because that was how I saw life being very ordered, the pillow opening had to be away from the door and the lockers had to be tidy I was a very well disciplined nurse I do not find it easy to work where beds are untidy and people sit on the beds - - - cannot take away the skill of making a patient comfortable and putting the patient first, we cut their nails, we shaved them, we did everything for them(3)

I did not detect any tension between competing concepts in listening to this memory; the nurse appeared confident and proud of this as a positive and unremarkable assertion of her identity and role as a nurse at that time and her continued identification with this as an example of good nursing. The person - 'this patient in this bed' is expected to conform to having every activity of his or her life controlled - from nail cutting to the juxtaposition of pillow, bed and locker. The patient is beholden to the nurse for the performance of all bodily functions and can only perform these in the ritualised ways permitted within the hospital, to which the nurse is the gatekeeper. Even personal untidiness is not allowed as this will disrupt the orderly view of the ward; and yet the nurse declares that this is illustrative of nursing's goal of 'making a patient comfortable and putting the patient first'.

This fragmented, or task oriented approach to the patients' day means that they are simultaneously the precise object of the orderly routine and as individuals totally irrelevant. The regulation of human existence is the work of the nurse; her role is to ensure that all of the patient's physical needs are attended to, not as natural functions but as nursing procedures.

There is no provision, for example, for a left handed person to have the locker moved to the other side of the bed[39]

Again, I would argue that the findings support a thesis that the organisation of hospital based nursing in the 1940s and 50s was closely aligned with the 19th century developments of the industrial revolution. The mechanisation of health and illness, identified by Maggs (1983) was part of the dominant discourse in which the methods adopted in society's industrialisation were transferred to the hospital. The concept of 'Biopower' (Foucault 1979) was used by medicine and associated hospital reformers to exert their authority. Furthermore Sawicki (1991:140) states:

> 'Biopower was without question an indisputable element of the development of capitalism. The latter would not have been possible without the controlled insertion of bodies into the machinery of production and the adjustment of the phenomena of population to the economic process.'

The sense that the nurse and patient are part of a machine which must run smoothly resonates with the quote above, creating a strong link between the academic discourse and the data. The nurse's assertion that this way of nursing comes naturally to her 'that was how I saw life being very ordered' reinforces the embedded nature of the discourse.

By contrast a second story was retold in response to my question about what the nurse believed was expected of her in order to be thought of as a good nurse.

I don't know - I always thought I was a disgrace!!! We weren't encouraged to feel like that [i.e. that you were a good nurse] you always felt . . . particularly night duty . . I always thought how did I manage to get through this night   - I have not finished my work - in the course of those couple of hours when you were allowed to wake the patients up I mean it got that you were waking them up earlier and earlier because you would be left on the surgical ward and you would have to do well all the pre ops - all the enemas and washouts - well you know how long a washout takes theoretically you couldn't do it –

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[39] I have found myself reflecting on this: even in my much later training I have no recall of ever altering the layout of the patient's bed area to accommodate their personal preferences

I mean if you added up the time it would take you could not do it but you were supposed to do it, and somehow you would try to get through it so I always went off duty in the morning thinking I can't do it, I can't do this medicine round and all these enemas and things I'm not good at the job but it wasn't that - none of us realised at the time that no-one could do it . . so you never got that feeling that you were a good nurse – ever(4)

The absolute subordination of both patient and nurse to the system is shown here; the 'work' of enemas and washouts is entirely the nurse's responsibility ('my work') and both she and the patients must conform. It is not sufficient for their bed to be tidy and their external appearance clean, they must also be clean inside.

This type of work must be done at certain times of the day, hence her reference to 'those couple of hours when you were allowed to wake the patients up'. The 'dirty' work of enemas and washouts must be completed before the sister and senior medical staff arrive during the day, partly to avoid them seeing the less pleasant aspects of care, but also to ensure that the patients are prepared for any medical or surgical procedures that are due. Despite the assertion by the nurses that the objective of their work revolved around the patient's needs the findings show that the hospital routine and medical orders dictated all other activities. The concerns of both patient and nurse are secondary to the ward routine. The doctor must not be kept waiting because the nurse's work in preparing the patient's body for surgery is incomplete. Thus 'success' is measured not by patient satisfaction but by the completion of work tasks.

There are clear links between the way the nurses describe ward culture and the notion of the middle class household. In his discussion of discourses around sexuality Foucault (1979) argues that the 'family' model with clear gender and role demarcations, sexual repression and unquestioning obedience to a male father figure was the blueprint for hospital organisation.

Davies (1995) further states that to challenge this masculine domination of medicine is to attempt to disrupt the underlying principles on which the health service was founded. I would argue that the findings show that many years after this model was adopted in the Victorian voluntary hospitals it remained the controlling discourse for hospital based nursing.

The nurse, with the value of hindsight, can see that her ability to succeed was actually being tested by a task that it was impossible for her to complete successfully. There is no expectation within the discourse that she would question the time or number of people available to do the work, still less to question the appropriateness of the tasks she is being asked to perform. Such behaviour would be 'deviant' (Usher and Edwards 1994), and would therefore suggest she is unsuitable to train, the very thing that she aspires to achieve. Thus the discourse works both on the level of organisation and the individual. Embedded into it is her understanding of the correct order of things: it is she who is a bad nurse 'I'm not good at the job' not the system that is wrong.

Interestingly this nurse had humorously described herself as lacking order and discipline, a source of criticism during her training:

well unfortunately I was a bit bolshie (4)

hair of course was an awful bind and terrible important to me because I have this very sort of light fly away hair which has never ever been tidy - and when matron was doing her rounds she was always complaining about my hair because I just did not have that kind of hair . . . it never would be controlled and of course I was always in trouble (4)

Both in temperament and appearance nurse (4) has poor control, in contrast to the disciplined nurse (3) 'I was a very well disciplined nurse'. However they demonstrate a shared understanding of their role as women and nurses in attempting to maintain order though routine and control, of their own and their patient's bodies. The self regulating nature of the discourse is just as effective with both nurses, despite their different temperaments.

8.3 Permission to speak

The care of the physical body and of the ward environment appears to have been pivotal to the nurse's conceptualisation of themselves as nurses. They were able to talk in detail about the minutiae of life and to describe their uniforms, their way of life and the ward routine in close detail. By contrast, emotional and sexual needs are implied and hidden within the discourse. I noticed through the interviews and the life history that whenever this subject came close to discussion the nurses tended to trail off into silence. This included many examples where they were talking about their own behaviour and appearance:

we used to sing all the pop songs but there was no (trails off to a pause) – no-one went out, we had no money. On the first payday in PTS and subsequent two pay days we went to Betties in - - - for a cup of tea and a cream cake for 1 and sixpence and that was our treat there was no (trails off to a pause), nobody ever went (trails off to a pause) (2)

we would not have got tarted up I mean when we went out we might have worn a bit of lipstick but eye shadow just wasn't (trails off to silence) (4)

and of course we had no contact with men until we were on the wards and that was a completely different thing [in role - -in uniform] but you would never have dreamed of (trails off into silence) - - (2)

What was less obvious and made me reflect were the areas of silence related to their own and their patient's emotional welfare. In Chapter Five it was noted that the discourse included a strong message that nurses should not engage in any emotional relationship with the patients, even if they believed this might be therapeutic:

there was a distance wasn't there -   don't get too close it could end up (silence) - -I don't think we were ever told that (silence) - - (5)

The nurses also knew that any public display of emotion, from being tearful or angry because they were upset to singing on duty was not allowed. I would argue that the suppression of their emotional selves was a further measure of their ability to conform to the discourse as presented.

In Chapter Seven the nurses identified that they were drawn together though the introduction in Pre Training School, through their experiences of nursing and through the structure created in the nurse's home.

The findings add to an understanding of how the discourse was used to control and suppress emotional and sexual behaviour. Foucault (1979) states that one of the ways discourse controls sexuality is by creating whole areas which are not discussed, where the lack of discourse then serves to reinforce rigid but unspoken rules of behaviour. Thus the discourse manifests itself, not just in actions, but in the language that is used or avoided and the knowledge and thinking behind these.

8.4 Resistance

Although many of the findings fit well into the discourse around respectable obedient females, there are numerous notable exchanges within the interviews where the nurses did not conform.

Many of the nurses related stories where they had rebelled, for example the refusal to attend the evening Church service and they all talked about being 'wild' behind the closed doors of their rooms in the nurses home. In addition two particular stories relate different aspects of resistance:

that was another thing the war affected of course, we did not get enough to eat - -we did one morning go on strike -((5) -oh yes!) We would not leave the dining room until we were given some food. - - I think it was our second night duty they used to give us a meal when we came off duty and they presented us with one potato and half a piece of Spam I can see it sitting on my plate now . (4+5)

It would have been interesting to know who instigated the 'strike', for example was it a qualified person who the students then followed, or was it a student led revolt. Either way it represents a striking challenge to the authority of the hospital to control every aspect of the student's lives. Reflecting back to the findings in Chapter Six regarding the ways in which profession and vocation are understood, I would suggest that the implicit contract that the nurse has with the hospital is broken here: she has given up her freedom and accepts the privations of ward work as part of her 'calling', but in return expects that her domestic needs are catered for.

A further form of resistance is typified in a number of stories the nurses told of 'taking the system on'. Many of these have already been discussed in other sections (for example the nurse who was reprimanded for singing on duty and not wearing the correct uniform because her foot was in plaster). In addition the story below was significant because it involved a doctor:

- -the most rebellious thing I did was in theatre when I was a junior runner we had a surgeon who was doing a mastectomy and he threw it at me - it landed on my chest and I was horrified and I walked out of the theatre and I had to go to matron and I can remember what she was saying that you must put up with the vagaries of surgeons and I said I'm not putting up with it, I said it was very disrespectful of the patient. And the surgeon laughed and said that the patient was unconscious and I said it does not matter and that was the most rebellious thing I ever did – I was quite prepared to be sacked for it – the surgeons were gods (2)

There are a number of aspects to this exchange and my interpretation of these is influenced by my own experience as a theatre sister: in general, within an operating theatre environment, surgeons are permitted by other staff to behave quite badly, using offensive humour or being gratuitously rude if and only if they are also seen by the staff observing them to be skilled at surgery. The matron's expectation that the student should 'put up with the vagaries of surgeon's alludes to this. The horseplay remembered here acts as an outlet of tension during difficult surgery and as a means to assert the surgeons authority: he is the only person who would dare behave in this manner. His assertion that he is not disrespectful to the patient is I suspect, within his own professional code, correct.

I believe that the objective in throwing the breast is to shock and humiliate the outsider (in this case the student nurse, although it could equally have been a young medical student) and thus dare anyone to complain[40]. The student knows that the direction of respect between herself (as a female and junior nurse) and the surgeon is one way: she must respect him without any expectation that this will be reciprocal. Thus she justifies her behaviour by asserting that she is defending the patient's rights. These incidents add to an understanding of the concept of 'resistance' within discourse as in both cases the nurses make a stance in threatening to withdraw their labour.

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[40] There is a parallel here with the morphia and Bunsen burner incident: in the two stories the sister and the surgeon both demonstrate their power by displaying a behaviour which no one is supposed to challenge.

Usher and Edwards (1994) discuss the use of resistance suggesting that it can disrupt, challenge or change the discourse, but it has to be continuous for this to happen. If it is not, then the resistance itself becomes another form of control. I suggest that the resistance offered by the nurses sits within the discourse, allowing them an outlet for some of their frustrations, without seriously challenging the status quo.

8.5 Control over the discourse

I would argue that one of the major areas of interest in nursing discourse is the collusion with the male dominated, medical organisation of health care. This allows for the 'artistic' side of nursing to be promoted as a strength to the exclusion of attempts to improve the educational standard of nursing. This assertion draws on data from the Horder Report and the Journal articles. It is illustrated in Chapter Six where the vision from the Horder Report (1943) and others that the curriculum could and should be strong educationally is accused of leaving the 'practical art of nursing panting to catch up with the preoccupied mind of the student nurse' (NM 12.4.47).

The data from the Journals shows the polarised views expressed between the adoption of a more academic approach to practice through better education and the bedside-based apprentice or craft approach in which increased educational achievement (and thus status) are seen as damaging nursing's essential purpose.

The findings presented in Chapter Six show that the dismay at increased educational content in the 1952 GNC curriculum was disproportionate to the actual changes. Thus the discourse offers an inaccurate account which serves to split the nursing community. A further extract written by Dr. Margaret N Jackson Assistant Editor of the Lancet, who had been invited to speak on the 'importance of bedside nursing' at the RCN conference in 1947 stands out as typical of this discourse.

It is particularly interesting for two reasons; firstly because it was delivered by a (female) doctor and secondly because the Mirror chose to print the entire speech. As this was not accompanied by a critical editorial, I believe it to have been identified as an important and valued opinion on nursing and one on which the Mirror was eager to have the weight of a senior medical writer:

'Two years doing nothing else [but bedside nursing] – tested at the end on performance rather than theory. . . . I want the amount of compulsory theory in the syllabus to be small – as small as possible . . . . I want the examiners at the end of the two years never to ask a theoretical question when a practical one will do . . . two years experience of the kind I have outlined could be as rewarding to the intelligent and highly educated girl as to the born nurse, with nothing to offer but good hands and a good temper. Such ordinary girls are often very intuitive about a patients needs just as they are intuitive about the needs of children. Current training saps that intuition I think, and destroys their mild natural self confidence' (NM 29.3.47)

There are a number of powerful messages embedded in this text. The language suggests that an intelligent girl is not a born nurse and thus that a training which requires intelligence is by definition flawed. She implies that wanting more for nursing than a craft based, hands on practical training is ill-advised.

This message is consistent with the filtering process identified in Chapter Seven where potential nurses self select prior to commencement of training on the basis of the prevailing discourse within society about what it takes to be a good nurse. Thus intelligent girls may apply, but must expect to find their intellect a hindrance, rather than an asset.

The 'good hands and good temper' of the born nurse, plus the 'mild self confidence', the reference to child care and the 'intuition' suggest to me the soft feminine sweetness to be found in the works of Ruskin (1895), which belies the picture of hospital life drawn by the nurses' interviews. This language contrasts sharply with her pejorative descriptions of training 'sapping' and 'destroying' the natural talents the right sort of women bring to nursing. The implication of the text is a dumbing down of nurse education such that 'intelligent' girls have no place in nursing unless they are able to perform in the same way as 'ordinary' girls.

I have struggled to understand the doctor's polarisation of women as intelligent or ordinary and the bracketing of what might be considered the stereotypical attributes of womanhood with ordinariness (i.e. affection for children, intuition, mild self confidence, good hands and good temper).

I believe that her view is consistent with the discourse around hospital reform which was identified in the review of the literature. In this discourse it is necessary for the nurse to perform a specific role in providing cheap, round the clock service but not to challenge the balance of power: anything that nurtures an independent spirit in the nurses is a threat to this.

Notwithstanding the fact that the doctor in the article is female this role demarcation is overtly gendered. Savage (1987) suggests that the sexual objectification of nurses (rather than just as women) is particularly pronounced and that the stereotypes which this creates are powerful.

The emotional and physical suppression of the nurses, including the ways in which they were expected to render themselves invisible in their day to day work and their minimal contribution to the development of policy and practice, can be explained from this perspective. For Savage the dichotomy of female power in the mothering role against female weakness in society mirrors the tension created where nurses have power over patients at the bedside but are excluded from power at a more strategic level.

Gamarnikow (1991) and Davies (1995) both acknowledge that gender and identity are closely linked in nursing and that this is fundamental in the shaping of the profession. Davies (1995:38) states that:

> 'Nurses are expected to uphold the values of female identity in the face of a masculinity that is profoundly ambivalent about it and in the face of institutions which are imbued with the same masculinity'

So it is that the phenomenon that was 'hospitalised medicine', in which nurse training was placed, was strongly masculine in its conception and further was embedded within the capitalist ideologies of industry, science and mechanisation. Within such a system the only role that nurses could play was the same subservient one as that of women generally in society.

Whilst I accept the validity of this feminist position, I believe that it is not sufficient to explain the finding of this research. I have already postulated that the two Journals are representative of mainstream views in nursing, because they survived through subscription, so I must also assume that at least some working nurses agreed with these sentiments.

I would argue that the findings show many of the restrictions placed on nursing were self regulating and that the worst examples seen in the data of privation, sacrifice and subjugation into the role seemed to be self managed within the predominately female nursing profession, rather than something imposed from without.

The conceptual framework sets the nursing discourses within wider discourses from the work of Foucault around discipline and power (Foucault 1991) and it would appear that this offers a more comprehensive critique of the findings. On reflection then, a feminist critique is valuable as an alternative way of looking at the findings but I am interested in analysis in terms of the people and discourses involved. Usher and Edwards (1994) suggest that there is a mixed relationship between feminism and postmodernism in mainstream educational research, so this position appears consistent with nursing education.

8.6 The good nurse

Having explored the ways in which the findings contribute to an understanding of nursing discourse, I want to suggest that the good nurse is a derivation from discourses around 'woman' and 'middle class', Such that:

- motherly caring must be conveyed but without any apparent emotional engagement
- femininity must be conveyed but without any overt sexuality
- masculine/ military attributes such as discipline, punctuality and emotional distance must be developed without the nurse becoming masculine
- an intimate understanding of the physical self must be conveyed without any apparent acknowledgement of the implications of such knowledge, or its relationship to emotional and sexual self.

These characteristics typified the philanthropic women described by Brooks (2001) of the late 19th and early 20th century who engaged in Christian work supporting the sick poor and who formed the early ranks of nursing pioneers such as Florence Nightingale (Cecil Woodman –Smith 1950) and Sister Dora (Manton 1971). However they seem strangely dated when applied to 17 and 18 year old grammar school girls in the post Second World War period.

This must have presented a complex and confusing metamorphosis for them, particularly as the nurses were so young and innocent, having little life experience to draw upon. On the one hand they have to draw on the resources of being female – the apparent innate ability to 'care' and quickly acquire nursing skills, but on the other they knew that if they displayed weakness, became emotionally or sexually involved with their patients or revealed too much of their individuality they would be singled out as unsuitable.

The literature states that a significant feature of discourse is the ways in which it is reinforced at all levels and is not a 'top down' imposition. Foucault (1980) uses the analogy of capillaries; where the power of the discourse reaches the 'grain' of the person and thus becomes so embedded into their existence as to be indivisible from them. Thus once the role 'nurse' is accepted; the self regulation which nursing is so proud of does the rest.

Therefore I would argue that the creation of nursing as a career for women, which may have been seen as emancipatory and reforming, actually becomes the primary method of restriction. In addition the 'panoptic gaze' from Bentham's prison design (discussed in Cheek 2000), which theorises that if people think they are being constantly observed they will act into the expected role even when in fact there is no observer, ensures that when the nurses are unsupervised they self regulate. This phenomenon is further supported by Gore (1985) who through research in schools suggests that power is self regulating within institutions.

The findings add strength to this analysis; for example the seamless gap between the absolute power nurses had over the bodily functions of their patients and their powerlessness to influence treatment, or to engage in any critical discussion of diagnosis. Also the emotional detachment required such that they were not 'tainted' by the proximity to their patients. Still more evidence can be seen in their total identification with the role: not just, as Gamarnikow (1991) suggests female nurses, but nursing as a separate female construct. They remained nurses off duty and after retirement. A further quote illustrated this, when one of the nurses was asked about correct behaviour:

yes, er we were told a lot about decorum and how to behave out side the hospital, we were told never to run unless it was fire or haemorrhage and till this day the only time I have ever run is for some O Negative blood (3)

I really believe that this nurse meant this not only on duty as a nurse, but in her personal life.

8.7 Conclusion

This chapter has explored the contribution of the findings to an analysis of the ways in which discourse regulated nursing and thus limited the amount of change that was possible. The discourse that emerges presents the good nurse as ambivalent concept in which it is difficult to resolve all of the contradictions. However despite obvious flaws it is powerful and self – perpetuating. The subjugation of self, the carefully constructed interpretation of femininity and the unquestioning obedience are all essential to the nurse's role.

It would appear that nursing discourse is not something which was imposed upon the profession, or regulated by external forces such as medicine. I would argue that nursing self regulated through the careful selection of candidates, through promoting a particular image, through the education and training system and through publication in its Journals.

Chapter Nine: Conclusions and Recommendations

9.1 Introduction

The aim of the study was to establish the discourses that shaped nurse education during the period 1945 -1955, using three guiding questions to direct the research: *'what did it appear nurse training was trying to achieve', 'how was the experience of training/ learning to nurse expressed', and 'what are the connections with the discourse surrounding the good nurse'*.

A conceptual framework focusing on discourse was adopted and the review of the literature identified six discourses that influenced the development of nursing from its early identification as an occupation from 1850, to the formation of the National Health Service in 1948. A further discourse around nurse education appeared to be forming in the period preceding the Second World War. Four chapters of discussion have explored the way that discourse presented through the life story, interviews and documents gathered in this research.

It is acknowledged that the findings support a number of theoretical positions already established in the literature. These include a cluster of concepts around gender; for example a feminist critique (Davies 1995), anti –intellectual biases (Rafferty 1996) and the importance to nursing of the image of (white[41]) middle class femininity (Hallam 2000). Additionally concepts around the nature and power of discourse are examined (Foucault 1979, 1980 & 1991, Usher and Edwards 1994, Usher et al (1997) and Cheek (2000).

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[41] Race and colour are aspects of the discourse that did not arise, although they are clearly important, this will be discussed within the limitations in section 9.3

Through the detailed examination of the discourses prevalent during the study period this thesis adds to an understanding of the ways in which discourse is pivotal in the socialisation and creation of power relationships in nursing and the influence this has on the educational system.

This chapter will include three sections, examining the contribution of the findings, reassessing the limitations and offering recommendations.

9.2 Discourse and power

The discourse identified through the literature had its origins in the emergence of nursing as an occupational group in the second half of the 19th century. The six elements: nursing as reform, the development of medicine and the rise of the hospitals, nursing as social control, nursing and the military, nursing as female vocation and the good nurse controlled the conduct of nurses and the development of the educational system. The further discourse, nursing as an educational endeavour began to emerge in the literature toward the end of the literature review period. It features in the policy and educational documentation of the study period 1945 -1955, but does not feature in the discourse as presented by Alice and the nurses. In addition, it has been acknowledged that a parallel set of discourses, generated within the Poor Law and asylum nursing areas existed that has not featured to a great extent in current historical analysis, including this thesis.

Significant aspects of the findings are the powerful influence of the discourse around being a good nurse and the ways in which this has been perpetuated and promoted in current nursing practice. This section aims to summarise the findings and their relevance to nursing then and now.

9.2.1 Discrepancies in the discourse

On careful examination of the discourses as presented in the findings there are a number of discrepancies where the discourse and the nurse's situation seem to be mismatched:

 Firstly they were all required to be well educated and capable of further study in order to get onto the course, but then the amount of theoretical learning seems to have been minimal.

Secondly, the education system seems to have a primary role in socialising them into behaving respectfully and to maintain absolute obedience to anyone more senior to them; this does not sit well with the expectation that they are joining a profession. Indeed, their descriptions of work on the ward are closer to those of servants than professionals. All work was prescribed and delivered in a ritualised pre agreed fashion. All activities were performed strictly to the routine of the ward, which in turn was dictated by the doctor's orders. Success was measured on their ability to get through the work in the allotted time - no matter how unreasonable - and to continue to appear innocent, respectful and clean throughout. Any deviation from this pattern either in terms of dress, behaviour or attitude was met with disapproval.

Finally a hallmark of professionalism is generally some degree of autonomy: the nurses appeared to have none. Possibly the greatest discrepancy is the belief, expressed by most of the nurses and mirrored in the Journals, that the patient's interests and well being was the central aim of nursing. The nurses' and patients' complete obedience to the hospital routine means that two contradictory discourses run in parallel.

Whist some of the elements of the paradox this creates may have changed in the past 50 years I would argue that nurses continue to manage the ambiguous position they find themselves in between the rhetoric of policy and the reality of practice; the examples may have changed but the theoretical position is constant. For Boschma (1997) this relates to the discrepancy between concepts of holism, which are espoused through nursing theory and the regimented, task oriented nature of hospital routines. For me Boschma offers just one example of a pervasive phenomenon. Nurses continue, now as then, to 'get through the day' of hospital based nursing work with their patients, creating a best fit between the theoretical construct of 'nursing' and the lived reality of the hospital routine.

9.2.2 A role for altered womanhood

The Victorian origins of nursing are embedded in a discourse around family values and femininity which allows nursing to be presented as an institution which can simultaneously show absolute obedience and loyalty to the male dominated hospital and medical authorities, self regulate and exercise control over the sick poor. The nursing discourse created at that time implies that women of a certain class and disposition were born to this role. Despite much change in the intervening years the nurses interviewed talked about themselves and nursing in a way that was remarkably similar to this earlier discourse. This supports the view that discourse acts as a controlling force, limiting any change which challenges its central assumptions.

The sense that the women interviewed had not 'done nursing' but had 'become nurses' was strongly supported through the data. They identify a clear understanding that their personal attributes were essential to their acceptance into the nursing school and that the system once they entered it acted as a filter and controlling mechanism to ensure that they moulded themselves on a very stylised model not only on and off duty, but also beyond their nursing career into their personal lives and marriages. The discourse dictated what they were permitted to think, say and know. This was reinforced by the profession's self image perpetuated through the journals. Their description of themselves, 50 years after they trained, suggested that their identification as women was permanently altered through the experience of becoming a nurse.

Thus a discourse close to that of nurses 100 years earlier was maintained both by individual nurses and systematically through education and hospital – based work practices. This discourse had such power that it permanently altered the way the nurses viewed themselves. However I would suggest that there are a number of incongruities.

The Victorian nurses were women at least in their mid twenties and often older; the nurses in the study were girls at 17 or 18 years old. The opportunities for respectable, worthwhile employment for Victorian women were very limited: the nurses in the study had good grammar school education and thus could have chosen university, teaching or a large number of other good jobs. In addition changes in social behaviour and in the position of women in society meant that the need to legitimise women having intimate contact with people who are not their kin was no longer an imperative.

One explanation could be that the discourse continued to exert a protective function over the recruits in the study period who were particularly innocent and vulnerable. However I would suggest that there remains a subtext in which the personal strength and integrity needed to be a nurse was perceived as a threat and thus contained by the discourse. Nurses showed great strength and determination within the narrow confines of what was prescribed as their role in managing the day to day running of hospital wards and in ensuring the patients care fitted into the hospital routine. However with regard to policy and educational development their influence was negligible and as an occupational group they appear weak and ineffective.

Then as now gender was an important aspect in the socialisation of nurses into their role but the way in which gender is conceptualised in nursing has changed. Hallam (2002) identifies that media images allow nursing a more positive role in healthcare and dramatic representations include black, male and gay characters. The extent to which this has altered the concept of the good nurse will be explored in section 9.2.4 below.

9.2.3 Discourse and the education system

Despite the incongruence of many aspects of the discourse the findings suggest that it powerfully resisted all attempts at change. The ways in which the 'new' discourse of nursing as an educational endeavour was resisted illustrate this. The government, hospital authorities and the RCN[42] all supported the feasibility of a two year training system but this was effectively blocked by the GNC and influential nurse leaders.

Bearing in mind the apparent lack of influence nursing appeared to have in most aspects of its function, to have achieved this successful resistance seems remarkable. It is however consistent with a belief that the discourse was strongly embedded and controlled the development of the profession. If acquiring the title 'nurse' embodies the discourse and an apprentice –style education system is the vehicle for moulding each nurse then it follows that changes to the education system will challenge the central discourse.

Thus if an educational system based on the nurses' ability to grasp intellectual concepts and student rather than apprentice status could have delivered the small taught content and practical training in two years, then the core discourse around nursing is under threat. Such a system assumes that nursing can be taught; it is a matter of having the ability to learn rather than disposition or breeding. This then in turn threatens the system where obedience is essential and where challenge to the status quo is not welcome.

Despite this resistance to change it may appear that the battle to recognise nursing as an educational endeavour has now been won. Nursing in the UK has been located in Higher Education since the 1980s and participants are students rather than hospital apprentices. However, the imperative to staff the ward areas at a competitive rate remains and it may be argued that in reality the change in educational delivery has made little difference.

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[42] As can be seen in the Athalone Report 1939, the Horder Report 1943 and the Wood Report 1946

In the 1940's and 50's the registered nurses did little of the bedside care. Most was completed by either assistance nurses, (newly identified as enrolled nurses from 1943), and the apprenticed student nurses. Currently the registered nurse manages the business of patient care and the increasing technical aspects of treatment and surveillance, with the bed side care delivery generally performed by Health Care Assistants (HCAs) who are even more disempowered and gain less recognition for their work than the enrolled nurses and students before them.

As a result the student nurse position today is interesting and disturbing. I would argue that the 'privilege' of their student status makes their place in the hospital environment even more ambiguous than in the past. Firstly they are not employees so they have no remuneration that might make the 'work' of nursing they do seem more valuable. Despite this in order to be assessed practically they have to act in the role of a team member, so appear to the public as staff members. Secondly rather than being expected to avoid emotional involvement they are expected to show that they are emotionally engaged both in their actions and in the way they write about their practice experience.

The surveillance of the physical and sexual behaviour of the nurses in the study has been replaced with surveillance of the emotions and thought of students today. Finally the Horder report's 1943 declaration that nursing could be an educational movement has been realised with courses now at a minimum of undergraduate diploma level, but the strong anti –intellectual bias in the NHS means the students must still not appear too clever if they want to be accepted into ward teams[43].

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[43] It is not the aim of this thesis to make any detailed analysis of contemporary nursing but it must be acknowledged that this tension is embodied in the 'too posh to wash' challenge from Beverley Malone at the 2004 RCN congress.

In the study period the stressful environment in practice was tempered by the protective buffer offered by living in the nurses' home. The nurses in this thesis had no need to worry about laundry, bills, food or shelter and had a ready –made close knit group of people with whom to share their experiences. None of these privileges exist for student nurses today and there is evidence that poor morale is just as prevalent as can be seen in research on bullying (Randle 2003a), poor self esteem (Randle 2003b) and burnout (Deary et al 2003)).

9.2.4 The good nurse

Throughout this study I have been attempting to understand what it means to be a 'good nurse' and the significance of the discourse which accompanies this concept.

During the study period it appears that the title 'nurse' brought with it a number of advantages. On starting their training the students immediately acquired an honorary middle class status. That this might have been aspirational makes it all the more important as it represented a way, other than marriage, for women to gain a socially relevant status. Nursing gave them a privileged position both on and off duty. On duty there was an expectation that patients, regardless of any difference in age and class, treated them with respect. Off duty this was manifested in recognition and generosity which was displayed to them. Several of the nurses cited being given tickets to the theatre and cinema and generally being treated as privileged and special.

Perhaps the most pervasive element is the value added status that being a nurse gave them in society. Because 'nurse' carries with it more than a job description being a nurse makes the individual more than 'just' a woman, wife or employee.

In return the good nurse accepts an alteration and suppression of self. This is manifested in the subjugation to the hospital routine and to their acceptance of a position of power over individual patient's daily routine, whist having no power over decision making in policy or practice. Nurses, in line with Foucault's concepts of disciplinary control (1991), do the 'work' of surveillance and control over individual patients and over their illness, whilst simultaneously doing the same for themselves and their profession. Thus the self regulation of nursing by nurses mirrors the role that mothers are expected to play with their families within society.

The findings suggest that the malleability of nurses in terms of their own and their patient's well-being and in terms of absolute obedience to a male dominated medical model of care is entirely congruent with the discourse. Furthermore, that the education system, combined with the 'raw materials' of the recruits and the hospital –based care system, effectively nurtured this discourse well beyond its useful lifespan.

I have reflected on the ways in which these findings may have relevance for current nursing practice and development. In the opening chapter I expressed my frustration at teaching within a nursing education system which never seemed to quite match the expectations of the profession or the public. It can be argued that the expectations of nursing are very different now from the 1940's. Changes in the NHS and in the technology of health care, evidence based practice and the government –promoted business culture necessitate a wide range of different skills related to knowledge and academic ability.

Even more significant is a complete reversal within one generation of the emotional expectations of nurses. The gaps and silences in the discourse, identified in chapter 8, showed how nurses had learned to embrace a discourse in which they did not get too close to patients, focused only on the physical manifestation of their patient's needs and did not acknowledge their own weaknesses. This contrasts remarkably with the current literature in nursing on caring, reflection and emotional labour.

The change in emphasis regarding 'care' can be dated in the literature from the 1960's and suggests that caring *for* (i.e. surveillance and control) is no longer sufficient and that caring *about* (i.e. emotional engagement of self) is an essential part of professional care [examples of this extensive literature are Noddings 1964, Benner and Wrubel 1989, Swanson 1991]. The development of reflection and reflective practice was introduced to the professional discourse in the 1980's through the seminal work of Schon (1983) and has been identified through extensive phenomenological research (Benner 1884, Benner et al 1996, Macleod 1996) as a feature of expert (and thus good) nursing. Nursing is described as 'emotional labour' (James 1989) in which there is an expectation that nurses draw upon their emotional (gendered) selves in order to care for patients[44]. All of these concepts contribute to a current discourse within nursing in which the emotional engagement of self (an expectation that the nurse understands, cares about and overtly expresses empathy with the social and psychological needs of the patient), the imperative for continuous self-reflection and for academic improvement are embedded in educational programmes and literature for nurses. Two quotes serve to illustrate this change.

Taken from the 1946 probationer's notes for St George's hospital (cited in Rivett 2006):

> '… she must be observant and possess a real power of noting all details about her patient. She must be promptly obedient and respect hospital etiquette . . . . A nurse's manner to her patient should be dignified, friendly and gentle, but no terms of endearment must be used. She should surround herself with mystery for her patient and never discuss her own private affairs.'

By contrast Johns (2005:3) describes reflection as:

> 'being mindful of self, either within of after experience, as if a window through which the practitioner can view and focus self within the context of a particular experience in order to confront, understand and move towards resolving contradiction between ones vision and ones actual practice. '

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[44] There is no suggestion here that 'emotional labour 'is solely a nursing phenomenon. Any occupation where the use of one's own emotional self is expected in the discharge of duty shares the same tensions.

In which his vision is to 'ease suffering and nurture growth through the health –illness experience'.

Clearly these represent hugely different expectations of nurses: one in which the nurse creates a barrier between herself and the patient and the second in which nothing less than total engagement is acceptable. I argued earlier in chapter 8 that the discourse reinforced a distorted view of womanhood where the 'desirable' aspects were promoted and the undesirable suppressed. It may be argued that the discourse related to caring, reflection and emotional labour is just another gendered distortion and that the imperative that nurses embrace and positively use their emotional selves in their practice is just as controlling as being required to suppress it.

In the study period nursing discourse mirrored the dominant (gendered) discourses of the day, expecting nurses to be unquestioningly obedient and to have respect for the authority of the medical staff, matron and the hospital. I would suggest that nursing today is equally coerced into obedience by emotional manipulation and the tyranny of being required to 'care' in a system which, despite the rhetoric of current policy (commissioning a patient led NHS, DOH 2005) is no more patient centred than in the past.

This current NHS policy makes judging the relevance of the 'good nurse' concept to contemporary nursing difficult. Hallam (2002) argues that although the media representation of nursing has changed significantly much of the gendered nature of nursing's image and the inequalities with medicine remain in tact. I suggest that 'goodness' now requires far more of nurses than in the past and that the rewards, in terms of social identity and respect are less clear.

9.3 Limitations

The main limitations have been identified in the methodology chapter and on reflection these remain important. A limitation which emerged whilst gathering data in the RCN History of Nursing archives was that I was aware of the vast amount of other material that was relevant to the study period. In addition, since my data gathering stage, the archive has made two nursing journals available electronically. Having agreed population and sampling criteria for the archived material I did not wish to alter this, but I am aware that further data would have enriched my analysis.

The decision to focus on hospital based adult nursing, to the exclusion of other nursing groups has led to a rich source of data regarding this particular group of nurses but cannot be said to represent nursing in its many and varied forms. I have justified this exclusion by arguing that hospital based adult nursing is the dominant nursing image and that its discourses are pervasive in their influence on other nursing disciplines in both public and professional arenas. Whilst this remains true, the findings are limited by this factor which must be taken into account when judging the value of the main conclusions.

A further limitation is that whilst a number of the texts used in the review of the literature claim to be written from a biographical or autobiographical perspective the findings do compare a largely literary based identification of discourse from the formation of modern nursing with a much more intimate personal view gleaned from the interviews from the 1940s and 50s. As I could not interview nurses from the 19th century directly, I acknowledge that they may have talked about nursing in different ways and thus may have altered my interpretation of the development of discourse in that earlier period.

Related to this, the decision to look closely at the nurses' voice in the discourse has excluded a very interesting and potentially valuable further element, which is the voice of the patient.

Little can be gleaned from this study about the ways in which they experienced the care that nurses gave, or the changes to their perceptions over time.

During analysis when using a phenomenological approach it is suggested that it should be possible to put aside one's 'fore knowledge' and view the data with fresh eyes. Having completed this study I am uncertain of how possible this can be. I have remained aware of the principle; but the thesis itself has become part of my own life story, as a nurse and nurse educator, so it may be argued that this text now becomes part of the continuing discourse.

An example of this is that one further limitation only came to light as I was proof reading the whole document. Hallam (2000) refers to the image of 'white middle-class femininity': throughout the study I have referred to the strong parallels between this image and the discourses within the data but at no stage have I, or any of the nurses, discussed the issue of race.

Finally, having chosen a conceptual framework based on a postmodernist interpretation of discourse it is implicit that this work represents one particular interpretation out of many.

9.4 Recommendations

Two recommendations emerge from the findings: One with relation to the development of nurse education and one with regard to future research.

9.4.1 Discourse and nurse education policy

This research was initiated following frustration at sustained criticism of nurse education for producing the wrong sort of nurses. The findings suggest that nursing is subject to powerful discourses which are predicated on values of service and obedience and an adaptation of more general discourses around womanhood[45]. Whilst this is an historical perspective the suggestion from the findings is that the discourse is slow to change and resists attempts to challenge its central assumptions.

Policy directives which tell nursing what it should do and how it should be done seem unlikely to yield the changes required unless there is a massive paradigm shift within the profession. Nursing and nurse educationalists need to have a much clearer vision of what they want nursing to be and to have realistic expectations of the extent to which this threatens the central discourses that control them.

For example the change from an apprenticeship system to student status happened 20 years ago and is based on a philosophy of nurses being professionally accountable people who should have the knowledge and confidence to question practice that is inappropriate and should view themselves as equal partners with other health professionals in the delivery of patient care. However the bulk of nursing is still learned through practice placements with supervision from a qualified nurse mentor within a hospital – based ward environment.

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[45] I am aware that this assertion appears to deny the presence of men in nursing. This is not the intention. Rather, it is an acknowledgement that the discourse of altered womanhood is there, regardless of the gender of the nurse.

I suggest that this control over moulding the character and behaviour of student nurses will tend to override any theoretical model which the students have been presented with in an academic setting. Bolting an academic education onto what is, in practice if not in name, a continuation of the apprentice system is unlikely to yield the radical change that successive governments and nurse education leaders' desire.

9.4.2 Further research

Having identified the importance of discourse in controlling the conduct of nursing and nurse education, further research identifying the discourse as it is now could make a positive contribution to the development of nurse education and policy. Elements of this include:

- The ways in which nursing now views itself as a profession, and the place of vocation within this.

- The role of men in nursing; is the gendered nature of nursing work mediated or challenged by their influence, or does the discourse require them to adapt their masculinity?

- The place of education within nursing and the ways in which the discourses have adapted to accommodate changes in health policy and training practice.

Much has happened in the NHS, nurse education and healthcare since the study period. The move to a university based curriculum in the 1980s has required a major paradigm shift, but despite this there remains a strong resistance to change and a romantic belief in the values and effectiveness of 'traditional' nursing.

I suspect that the 'real love of attending to the sick and helpless, strong constitution (and) equitable temperament' identified from the work of Ashdown (1934:1) at the commencement of this thesis still resonate more with nurses and the general public as pivotal to good nursing than the ability to understand and justify the care given. A greater understanding of the ambiguities this creates in the relationships between nurses and their patients and between nurses and the other health professionals they work with is a worthy subject for greater and continuing scrutiny.

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Appendix I: Alice Life Story

Life in Walthamstow

Alice was born in Walthamstow, London, in the autumn of 1915, the second daughter of an Engineer, working for London Transport. Tragically, her mother died from puerperal sepsis following the birth of her sister, when Alice was 6 and her older sister 8, and for a time the family were separated. The new baby was cared for by the Paternal Grandparents and her father, unusually for that day, remained as a single parent juggling his job and the care for the two young sisters. Happily four years later he married again, the family were reunited and her final sibling, a boy, was born, who is 10 years younger than Alice.

Alice completed her Cambridge School Certificate at North Central Girls School which included, as well as the standards subjects, Geography, French, Botany and Bookkeeping. As she was capable of carrying on, she continued to study her 'highers' at the Girls High School, with the expectation of a good job - perhaps being able to go to college and train to teach. However, in 1932, Britain was in the throws of the depression. Colleges were shutting, and places were limited. Her forward looking school invited a careers advisor to speak to the girls and she suggested nursing as a good profession. Alice was inspired by this suggestion 'it *just clicked with me and I thought - that's what I want to do'* she returned home to tell her father that she intended to nurse. To his credit he supported Alice. She remembers fondly his response of *'well my girl you do as you like, but you make your own bed and lie on it'*, in the light of the many beds she has made in the 5 decades of her career. In the summer of 1932 at '*17 and 10 months'*, Alice left high school a year early and hoped to start nursing training.

Tuberculosis (TB) Nursing

The age threshold for State Registered Nursing (SRN) training at that time was 18, but 17 year old Alice was eager to get started so she commenced her career by undertaking the pre-registration British Tuberculosis Certificate. She was accepted for a place at the TB sanatorium in Black Knotley near Baintree in Essex. On her first day Alice travelled by train to Cressing station, and walked the 1 ½ miles to the sanatorium. She arrived in time to be given tea, a uniform and to commence work on the wards, assisting with the evening nursing duties.

Although TB by this time was beginning to be understood, the pasteurisation of milk was not compulsory and, prior to the development of antibiotics, there was no cure. TB was at epidemic proportions[46]. Treatments consisted of fresh air, good food, good nursing and surgical interventions. The sanatorium took both adults and children and catered for surgical as well as pulmonary TB. Treatments included the removal of TB glands from the neck, draining of TB hip abbesses and Pneumothorax - a surgically induced deflation of the lung in order to 'rest' the affected area. All patients tended to stay for many months and children with TB hips or spine might be in for 12 -18 months, so a classroom was provided. The ward layout was typical of the time *'the wards were open, the patients were all in cubicles with doors that shut and you walked down a sort of outdoor corridor, which was just covered over'* . Alice remembers a lovely nurse's home, but the work was potentially dangerous. There was no BCG inoculation available at the time, and the nurses were not even X- rayed. There were stringent cross infection measures, Alice remembers that all patients had a 'sputum pot' with a sealed lid - these were then paced in a special sterilisers unopened and not handled until after sterilisation. Also the nurses were very well cared for and the open air treatment of the day reduced

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1 [46] Although quite a bit was known by the 1930s about the causes and spread of TB, the antibiotic cures were not identified until 1950 (Fanu 1999)

the risk, however at least one of the nurses contracted TB and became a patient.

Alice enjoyed her spell at Black Knotley. The physical condition of the patients, and the necessity for such long stays in hospital meant that good nursing care and good nutrition were essential; this made it an excellent place to learn nursing. However Alice felt she was *'getting on a bit - nearly 19'* and it was time for her to start her SRN training. The deputy matron had trained at Bart's[47] and secured Alice an interview with the Matron there. The interview however was rather frosty and not related to Alice's nursing skills, or dedication to the job.   The major teaching hospitals in London had an international reputation and were as interested in the social standing of their students as much as anything else.

> *'She said could my father give me an allowance? So I said well - he had four children - and he just couldn't. So she said what does he work at? And I said he is an engineer for London Passenger Transport. She was not happy with that; you see he ought to have been a Bishop, or a Headmaster or something of that sort'*

She also said that she liked 'her girls' to have money so they could take advantage of being in London. But Alice had lived all her young life in the City, visiting art galleries, going to plays and Sadler's Wells, so she had no need to see the sights. Another colleague recommended the Royal Sussex in Brighton, where Alice was accepted. In retrospect, she has no regrets over this change of plan.

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[47] St Bartholomew's : one of the elite London teaching hospitals

SRN Training at the Royal Sussex

The Royal Sussex was a beautiful place to train. *'The hospital was so nice, we had a lovely nurses home, we could look out over the sea, and we could walk out of the back door onto the downs'.* In addition to the location Alice remembers the nursing care to be of a very high standard and that the sisters were excellent teachers. Student uniforms were provided, apart from the cloak, shoes and stockings which she purchased herself. Students wore a pretty blue dress with a white apron which crossed over at the back, starched belt and collar 'which *nearly cut your head off'* and of course a cap. First years wore a little cap with pleats at the back. From the second year onwards the hospital cap was worn, with a red and blue band on the uniform denoting second year and a red band for third year. Stockings were black, as were shoes, which had to be of a specific design supplied by a shop for the hospital. Towards the end of her training the hospital decided to modernise the uniform. The starched collars were replaced by peter pan ones, sleeves became short and coloured 'lisle' stockings with brown shoes were permitted.

The training for SRN was three years and the Royal Sussex asked for students to remain 6 months as staff nurses after this. Alice commenced in 1936, and thus registered in 1939. At that time there was no Preliminary Training School (PTS). On arrival new students commenced directly on ward work and were required to attended lectures regularly through the week - usually three lectures per week, plus work set by the sister tutor - regardless of if they fell during on or off duty periods. The sister tutor taught '*the basics'* but most learning was given by the ward sister. Theoretical underpinning would occur at the bedside and a staff nurse might accompany students to theatre to explain the procedures. Alice remembers the standard hours at the time as 56 per week. Day shifts were 7.30 -9.00, with a break during the day with one

day off per week on days, and 2 per fortnight on nights. '*Those were the days when work was work!*'[48]

She was clearly an exemplary student and was awarded the gold medal for her year, the prize for gaining the highest marks in the final examinations. There was a formal prize giving ceremony where the Duke of Norfolk attended and gave out the prizes. On qualification she worked on night duty in a post affectionately know as the 'night ass' (i.e. assistant to the night sister). This involved patrolling the hospital and reporting to the night sister, helping out, particularly in the busy morning period, in the areas most in need.

England was by now at war, and the Royal Sussex, like all hospitals, was prepared and braced to receive casualties[49] . The first war wounded Alice remembers were two airmen who came down on the Downs. However the real shock came with Dunkirk.

> '*They dropped the worst casualties on the south coast. I was the 'night ass' at the time and I remember going up the stairs and Matron was in her grey and red Territorial Army uniform - - - she pulled up and said 'nurse B-, don't go to bed, the men from Dunkirk are coming in' They were in such a state it was awful - -I was sent to theatre but they were doing operations on the ward, wherever they could find a space. Quite a few died and quite a few lost limbs. Its always there, you don't forget it. But the thing was they were so brave and so pleased to be in a clean bed and clean cloths, they must have wondered if they would ever get home*'

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1 [48]The literature (Dingwall et al 1988, Abel Smith 1960) suggests that the hours on duty were changing during this period. A 96 hour fortnight was common, which makes 56 hours per week seem excessive, but this may well have been true for the Royal Sussex.

2 [49]Following poor organisation in the 1914 -18 war the health services and the Government were determined to be prepared. England had been split into a number of areas, each managed by a medical committee. Numbers of nurses in training had been increased and a force of volunteers was offered a short training. Many experienced nurses had joined the armed forces and been posted abroad. These preparations had been started in the summer of 1939, but it was not really until the Dunkirk evacuation and the Blitz that they were tested. (McManus 1956)

Despite all the preparation for casualties the reality of maggot filled wounds was a sobering reminder of the war.[50]

Despite the offer of a post in casualty at the Royal Sussex and the danger of the Blitz, Alice was keen start midwifery and to return to London and her family. At the time (and until very recently) a midwifery qualification was considered to be needed for an all round training and Alice was accepted for this at the Middlesex.

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3 [50]These clearly remain vivid memories - expressions '*crawling with maggots - in a terrible state - -such a shock'* come up in each visit and Alice's body language and voice change.

Midwifery at the Middlesex

Midwifery training consisted of two parts, a short 6 month course (part 1) or a full year. Alice chose to complete the full course. In addition the Middlesex was still operating a two tier system of fee and non fee paying students. If you could pay a fee, you had a salary of £36 per annum and were free to leave at the end of your training. If not, the salary was the same, but you were contracted to continue for a further 6 months as a qualified midwife on the same salary scale. Uniform, books and bicycle - an essential component of the community care- were not provided.

Lectures were provided on the job by the tutor. The training was split between 3 areas of practice: the Middlesex itself, a city centre Voluntary Hospital; a council built and run small maternity hospital in Walthamstow (and thus back home for Alice); and a period living with the district midwifery team in their house. This involved cycling with hooded lights through the blacked out London streets to offer midwifery care to families. Alice had two tutors, who supervised the deliveries she performed, a lot of supervision was given and this was of high quality. One of her supervisors went on to be head of the Midwives Board.

This period was affected greatly by the war. At the Middlesex the patients had to be carried, with the aid of the boy scouts, down from the 5th floor each night to the basement, as the bombing was so severe.   The senior Paediatrician made the cocoa, and everyone was issued with a mattress, blanket and pillow. These were none too thick and Alice and a friend teamed up to share mattresses and blankets to keep warm. The worst part for Alice was that when the fires were bad water was so severely rationed that they could not bathe the babies.

One wing of the hospital was bombed so that it could only be reached by walking across planks. They also had to abandon the beautiful panelled dining room - part of the luxurious nursing home donated to the hospital - to take their meals in the less picturesque but safer basement.

The Royal Waterloo and Battersea Polytechnic

By now Alice had decided that she would like to teach nursing. Full time
tutors courses had been stopped due to the acute staff shortages caused by the
war *'every one had to be hands on'*. There was a three year part time programme
offered at Battersea Polytechnic, which required attendance 2-3 afternoons/
evenings per week. This however was not possible on day duty, as shift
patterns were not that flexible, and time off could not be guaranteed. Alice
saw an advert for a night Sister at the Royal Waterloo and took the post when
offered - this gave her the opportunity to study - getting up early from sleep
to travel by tram from St Thomas's to Battersea and then coming straight on
night duty. The areas taught on the tutors course included elementary
psychology, history of nursing to 1919 (i.e. the formation of the GNC),
nursing ethics, elementary science and hygiene.

By 1946 Alice had completed her tutor's course and was looking for a
teaching post. The Matron at the Royal Waterloo, who had trained further
north in Liverpool, saw an advert for a post in another northern city, and
encouraged Alice to apply, as she knew that it was a very important hospital
and had heard of the good reputation of the School of Nursing there. Alice
got the job, one of her new colleagues, 'M', from this point became Alice's
lifelong colleague and friend.

The Move North

Alice and M were assigned the running of the Pre Training School for SRN students. This was an important part of the nurses training and at the time consisted of a 3 month period, in which students, from the relative safety of the training school, would gain knowledge and experience of all aspects of basic adult nursing. An examination at the end of the period ensured that all students going forward to continue their training were ready and prepared. The Nurses home was not really big enough to accommodate the Pre Training School, so when a large Hall was released from its war time duties as a women's hospital, it was made available for the Pre Training School and nurses home.

The Hall is typical in many ways of the accommodation used at the time. A beautiful old house set in its own grounds and, with an extension, enough space for teaching and sleeping accommodation for the students during their first 3 month period. Alice and M had a cottage in the grounds, Alice stayed for 10 years until 1956.

Students arrived at the Pre Training School '*wet behind the ears'* and were introduced to nursing life. The uniform was worn throughout the period, a chance to get used to it and learn to accurately fold the hospital cap, which had to be '*exactly 11 inches across at the top'*. Classes included nursing skills such as bandaging, washing and bed making - these could be practised in the school, but also a bus took groups of students to the hospital where Alice and M were able to teach bedside care in a real setting. Anatomy, physiology and elementary science were taught, as was invalid cookery (much to Alice's horror, as cookery was not her strong point) and public health. In addition to practical classes role play was used to help students understand their patients and their own feelings, and to improve their communication skills.

Whilst the syllabus set down the areas to be taught the methods of teaching allowed for a degree of leeway. Alice and M played to each others strengths - Alice was better at drawing so did the illustrations for anatomy and physiology. M was the better cook and coached Alice through the invalid cookery demonstrations.

Although there were already some male nurses working in adult nursing, this period saw the first intake of male student nurses at this nursing school. Most were more mature than the 18 year old female entrants and had come from jobs as medical assistants in the army and navy.[51]

In the first three years Alice continued to study part time in order to add to her tutor's course and complete the London Diploma. There were only two diploma courses in nursing at the time: Leeds University (which M had completed) and the London Diploma, which could be taken by distance learning. Alice remembers getting up at 5 am to study prior to work. A hard time, but worth it to gain her Diploma in 1949.

Alice and M felt isolated out at the Hall, as they were a distance from the hospital and main nurses' school, so they were encouraged to gain some wider experience Alice decided to apply for a Red Cross Scholarship, which gave her the opportunity to study for one year at Teachers College in New York.

4[51] These were the only students at the time in her nursing school who were not young white females; Alice has no memory of any black or commonwealth students at this time which may be more typical of voluntary hospital nursing schools, than across the whole training spectrum.

Teachers College

Teachers College was then a prestigious Teaching College, Indeed the only one offering this level of education to nurses in the world, thus it attracted an international cohort of students. Alice left England by boat on August 27th 1954 and arrived at New York on 4th September. She stayed at International House, in midtown Manhattan, overlooking the Hudson River. This residence was provided for foreign students, there were 500 of them from over 60 countries. A lively social life was organised at the house, a highlight being Sunday suppers, where a visiting speaker was invited. These included such people as Mr.David Rockerfeller, Mr. Van Kleffens (President of the United Nations assembly) and Monsieur Auriol (former president of France). *'Colour race and creed seemed to be insignificant factors. Students made friends from all corners of the world.'* [52]

The course at Teacher's College consisted of an intense full time year of taught modules from a broad and varied curriculum including English, Education studies and Nursing. In addition there were numerous visits to hospitals and nursing schools in the area. Although some of the areas were familiar to Alice, some were still new to Nursing Education in England. For example more progressive adult education theory, the concept of the learning nurse as a student, rather than apprentice and the beginnings of the American nursing theorists concept of holistic nursing care. All students were expected to read widely during their year, to share and value their diversity and to engage in international debate about nursing issues.

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[5][52]When I read the narrative Alice was surprised by this detail, not having reread her own report from some years - thus much of this section is not part of Alice's current memory

Sadly, her father's deteriorating health meant that Alice returned to England without the opportunity to complete the summer school at Teachers. Had she completed the final module, she would have returned with a BSc in Nursing, a qualification unavailable at that time in the UK. Alice did however have enough time to travel 7,000 miles by bus with a fellow international student, crossing North America. She sailed for England from Montreal on 4th July 1955, arriving on the 10th.

On return to England Alice began to think about her career again. A post as Principal Tutor at another hospital was advertised, and she applied. She had some doubts about being appointed as the other short listed candidate was trained there, but she got the job, and remained as Principal until her retirement in 1973

This was a very different hospital; although it did not come historically from a voluntary hospital tradition it had an excellent reputation, and gained its Royal University Charter in 1963. Alice remembers it as a very efficient hospital, due to the good relationships and co-operation amongst senior nursing, medical and administrative staff and the strong liaison between hospital and nursing school.

Principal Tutor

Principal Tutor was a senior nursing post, the highest academic post for nurses and carrying a salary, at about £3,000, slightly greater than the hospital matron. During her time there Alice commissioned the new nursing school, a purpose built new block, which was equipped to the highest standard, including modern audio-visual and teaching equipment. She was also involved in setting up the first nursing Degree in the city, in conjunction with the local Technical College (later to become the local Polytechnic). This was highly commended by the GNC, who saw it as a truly nursing degree, rather than social science.

In addition to the management role, Alice was still closely involved with teaching. Although she had a much wider remit than previously, she kept an 'open door' policy with her student nurses. Most Consultants were actively involved in teaching their discipline, and a case history approach was used to integrate aspects of care.

Alice was an active Royal College of Nursing member, and there was a thriving branch in the north. For a time Alice was Chairman; she served a '*5 year stint*' on the national tutor committee. She was also a GNC examiner, in both jobs. This involved marking exam papers and taking practical exams locally and also taking practical exams externally for Northern Ireland.

As a RCN member Alice attended the International Congress of Nurses (ICN) in Frankfurt [Alice cannot remember the year for this] she and a group of other nurses commissioned a bus at the end and travelled through Europe. Also she and M made a new friend - Bridie, who was matron of a large Mental Hospital in Downpatrick, and who they visited for holidays for many years.

Retirement

M retired a few years before Alice and then together they sold their property in the city and moved to a smaller town nearby. They holidayed in America, at the invitation of a New Jersey Professor who they had met, but in the main were happy to visit and entertain their many relatives, and to holiday in the Lake District. M's health has deteriorated during the last 10 years, and during the compilation of this history she has had to move into a local residential home. Alice hopes to sell the bungalow and join her in the near future.

Post Script:

Alice did sell the bungalow and join M. Sadly Alice died before this thesis was completed. A version of this history, drafted to be more personal has been shared with her family and friends in the Nurse's League.

Appendix II: Themes from life story analysis

Appendix II Themes from life story analysis

Data was gathered through 5 visits, and consisted of field notes and audio taped interviews. The repetitive nature of the data gathering process means that the themes which emerge are less clearly defined and more detailed than is the case with the single interviews in stage two below. For example her experience of Dunkirk, of midwifery training and of teaching PTS is repeated, with variations on at least three occasions. The 10 emergent themes are as follows:

	Main theme	Sub themes and notes
1	Training	There are a large number of sub themes for this area – as it includes both Alice's own periods of training, and her experience of training others: 1.1 TB Nursing 1.2 SRN Training 1.3 Midwifery Training 1.4 Tutors course 1.5 Teachers college 1.6 Running PTS 1.7 Managing a nursing school 1.8 Dealing with students
2	The 'good' nurse	This was not a theme which Alice identified with, but there are clear sub themes which relate to this 2.1 types of student nurses 2.2 what to look for when interviewing 2.3 her own expectations/ experiences regarding behaviour and character
3	Financial issues	These particularly relate to her own early training, which offers interesting contrasts to her experience as an education manager later in her career.
4	The war	There are two clear subsets: 3.1 Dunkirk

		3.2 the Blitz
5	Nursing school PTS	This includes all subsets relating to her role as tutor for PTS 5.1 subjects taught 5.2 interviewing candidates 5.3 conduct in PTS/ preparation for nursing 5.4 relationship of nursing school to hospital
6	Nursing school - education management	This includes all sub sets relating to her final post as a senior education manager 6.1 commissioning the building 6.2 relationships with medical & hospital staff 6.3 developing new courses 6.4 relationships with students
7	Experience outside of nursing	These are two distinct sub sets 7.1 growing up – pre nursing experience 7.2 retirement and old age
8	Why nursing	A single theme around her reasons for nursing - which is closely aligned with the same stage two interview theme
9	Other work	Alice was involved with both RCN and GNC work, particularly in the later periods of her career 9.1 RCN 9.2 GNC examining
10	Male nurses	A single theme discussing the first male nurses she taught

Appendix III: Themes from interview analysis

Appendix III Themes from interview analysis

Nine interviews were completed. Each took between 45 -60 minutes. Interviews were semi structured, using the cue questions:

1. why nursing? Memories of why you applied, what the interview was like and why you chose a particular school

2. what did you learn to do in PTS?

3. how were you expected to behave – dress, religion, speech, manner

4. what did being a good nurse entail? Did you start to learn the skills etc to do this in PTS

Each interview was audio-taped, transcribed and initial analysis line by line, to identify the themes. 28 themes were noted:

1. Why nursing
2. Why this particular nursing school
3. Entry profile
4. Pre nursing
5. Nursing experience' thrown in at the deep end'
6. Uniforms
7. The war
8. NHS
9. PTS – general experience of
10. PTS – activities – cleaning
11. PTS - activities – classes
12. PTS – safety and protection
13. Hunger
14. Age/class profile

15. Behaviour and use of first names	
16. Religion	
17. Fear/ relationships with seniors	
18. Being in trouble and dealing with unhappiness	
19. Pay	
20. Behaviour/ attributes of a good nurse	
21. Usefulness of PTS	
22. Mealtimes	
23. Experience of training	
24. Shift patterns	
25. Attitude of parents to nursing	
26. How you felt about nursing	
27. Men in nursing	
28. Contrast between hospitals	

Many of the themes can be clustered around the cue questions. However several of the themes did not easily fit into the questions, so three further clusters emerged. These relate to the 'profile' of the interviewees, 'how they felt about nursing' and 'experiences of nursing'. These themes emerged as they were inclined to reminisce about the *whole* of their nursing experience, both in training and in their subsequent careers - talking just about the initial period in PTS was not meaningful for them without the context of their pre and post experience of this event.

More meaningful emergent themes and sub themes would therefore seem to be:

1	Profile	1.1 Entry profile
		1.2 Pre nursing
		1.3 Age/ class profile
		1.4 Men in nursing
2	Why nursing? Memories of why you	2.1 Why this particular nursing

	applied, what the interview was like and why you chose a particular school	school 2.2 Why nursing 2.3 Attitude of parents to nursing 2.4 Contrast between hospitals
3	What did you learn to do in PTS?	3.1 PTS – general experience 3.2 PTS – activities – cleaning 3.3 PTS - activities – classes 3.4 PTS – safety and protection
4	How were you expected to behave – dress, religion, speech, manner	4.1 Use of first names 4.2 Religion 4.4 Fear/ relationships with seniors
5	What did being a good nurse entail? Did you start to learn the skills etc to do this in PTS	5.1 Behaviour/ attributes of a good nurse 5.2 Usefulness of PTS
6	Experience of nursing	6.1 Thrown in the deep end 6.2 Uniforms 6.3 The NHS 6.4 The war 6.5 Hunger 6.6 Dealing with unhappiness 6.7 Pay 6.8 Mealtimes 6.9 Experience of training 6.10Shift patterns
7	Feelings about nursing	71. How you feel about nursing

Appendix IV: themes from documentary analysis

Appendix IV: themes from documentary analysis

In my scanning of the journals I tried to remain close to the key guiding questions of: *'what did it appear nurse training was trying to achieve', 'how was the experience of training/ learning to nurse expressed' and 'what are the connections with the discourse surrounding the good nurse'.* Both journals contained a wide variety of material which was not relevant to the research – for example all references to nursing other than general nursing were ignored. Themes which had been significant in the literature search but had not been explored in the life history and interviews were also noted but not collected. There was for example a wealth of material relating to the development of male nursing throughout the period, however initial analysis of the interview transcripts and life history offer little insight into this. The themes have been drawn from:

- articles describing changes in the structure of nurse education and its development over the period of study
- any materials that shed light on the experience of being a student nurse in the period
- opinion, in letters and editorials on the direction that nursing education was taking
- any material which sheds light on the 'good nurse' concept, and the image that the journals wished to portray of nursing.

There were 11 relevant emergent themes:

	Emergent theme
1	The treatment of and attitude towards nurses
2	Training methods
3	Religion and nursing
4	Developing health and nursing policy
5	'living out' – health and wellbeing of nurses
6	Lifestyle of nurses

7	The good nurse
8	Nutrition and nursing
9	Advice on study
10	Dealing with staff shortages
11	Entry qualifications

Appendix V: GNC Syllabus 1952

Appendix VI: GNC circular 73/7/16

See separate document.