A history of nursing in
Halifax and Huddersfield 1870-1960.

By

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Copyright Statement

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Wakefield Archives
The National Archives
Tolson Memorial Museum, Huddersfield.
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Acknowledgments

Abstract

A history of nursing in Halifax and Huddersfield 1870-1960.

Little has been written about nursing in the period 1870-1960 within the geographical boundaries and surrounding areas of Halifax and Huddersfield.
This thesis aims to explore the development of nursing within these towns.
The focus is on general nurses in hospital and community roles.
Rosenberg's eight areas of importance were used allowing the construction of an historical analysis of both nursing and nurses locally.
Archival sources were found in twenty-five main archives and twelve of these were investigated further. Primary documents belonging to local retired nurses such as personal documents, photographs and memorabilia were included. In total 1493 individual items were subjected to documentary analysis.
The second stage of data collection involved conducting oral history interviews to capture memories and experiences of local retired nurses. A total of 373 named nurses were identified, sixty-eight contacted, forty-four agreed to participate and twenty-one were interviewed. A life story approach recorded their personal lives and nursing careers. This approach required the ethical issues of biographical research methods and interviewing to be addressed. Interviews were recorded on audio tape and transcribed ready to be deposited in the University of Huddersfield archives.
Data was subjected to analysis using NVivo computer software and Rosenberg's eight areas of importance used as *a priori* themes.
Nursing in these two provincial towns changed during the ninety years under study often in response to local or national issues such as professional registration. Nurse education occurred in all but the early years and developed alongside the increasing specialization of nurses and as each nursing branch emerged. Nurses in West Yorkshire were subject to particular local issues such as its geography, environment and industrial heritage.
The merits of this research are it provides a unique account of the local development of nursing adding to the professions history and presenting implications for present day practice.

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List of Abbreviations

ADBO	Average Daily Bed Occupancy
ARRC	Associate Royal Red Cross
BDNS	Batley District Nursing Association
BJN	British Journal of Nursing
BNA	British Nursing Association
BTA	British Tuberculosis Association.
BWS	Bradley Wood Sanatorium
CMB	Central Midwives Board
CNA	County Nursing Association
CRH	Calderdale Royal Hospital
CSMMG	Chartered Society of Masseuses and Medical Gymnasts
CTA	Certificate of Tuberculosis Association
DHH	Dean House Hospital
DHW	Deanhouse Workhouse
DNAs	District Nursing Associations
GNC	General Nursing Council.
GP	General Practitioner
HDNA	King Edward V11 Memorial Halifax District Nursing Association
HDSPNA	Huddersfield District Sick Poor Nursing Association
HDVSNA	Huddersfield District Victoria Sick Nurses Association
HGH	Halifax General Hospital
HRI	Huddersfield Royal Infirmary
HMB	Hospital Management Board
HV	Health Visitor
KEMF	King Edward Memorial Fund
LGB	Local Government Board
MOH	Medical Officer of Health
MoH	Ministry of Health
NAWMM	National Association of Workhouse Masters and Matrons
nd	No date
NHH	Northowram Hall Hospital
OPD	Out-patients Department
QDNA	Queens District Nursing Association
QNI	Queens Nursing Institute
QDNI	Queens District Nursing Institute
QIDN	Queens Institute of District Nursing (1928 onwards)
QN	Queens Nurse
QVJIN	Queen Victoria's Jubilee Institution for Nursing
RFN	Registered Fever Nurse.
RGN	Registered General Nurse.
RHI	Royal Halifax Infirmary
RMN	Registered Mental Nurse.
RRC	Royal Red Cross
RSCN	Registered Sick Children's Nurse.

SCM	State Certified Midwife.
SLH	St Luke's Hospital
SMH	St Mary's Hospital
SMWCH	St Mary's Women's and Children's Hospital, Manchester
SRFH	Stony Royd Fever Hospital (Halifax Borough Fever Hospital)
SRN	State Registered Nurse.
TB	Tuberculosis.
TNA	The National Archives
TPR	Temperature, Pulse and Respiration observations
UKCC	United Kingdom Central Council.
WRCC	West Riding County Council
WRCNA	West Riding County Nursing Association
WYAS	West Yorkshire Archive Service
YPLNB	Yorkshire Poor Law Nursing Board

Glossary

Probationer - an early term for a nurse in training.

Candidate - a student of district nursing or midwifery in training.

Gynae – Gynaecological.

Chapter 1 – Introduction.

Chapter 1 provides an overview of the background of the study including the aims and philosophy. There is mention of the main issues the study addresses and related terms are described to ensure clarity.

Introduction to the study

This study proposes to explore the historical development of nursing and nurses in the two West Yorkshire towns of Halifax and Huddersfield. There has been little written about the role that nurses played in the period 1870-1960 within the geographical boundaries and surrounding areas of Halifax and Huddersfield.

The thesis explores the historical development of nursing in the two West Yorkshire towns of Halifax and Huddersfield. The scope of this study was large covering ninety years and therefore by necessity there are areas which have been considered in less detail then perhaps they would warrant if a narrower time period had been studied.

The context to the study

The specific focus is on the origins and development of nursing from 1870-1960. This includes hospital and community / district nursing but in order to narrow the focus the professions of midwifery, health visiting, mental health and learning disability nursing are not directly explored. However, they are considered in relation to aspects of historical development and changes in nursing practice and education. The rationale for this is to ensure the study was kept manageable within time and word limit restrictions. Further, the researcher needed to work within professional expertise and with no qualifications in these other forms of nursing, the need to study areas of general nursing was seen as important wherever possible. However, it was recognized that during the time period studied major changes and developments in the roles of health care practitioners occurred and this required exploration of some of these other forms of nursing.

The contribution of ordinary men and women towards the development and delivery of nursing services within the walls of the local hospitals in Halifax and Huddersfield and outside these walls in the community has not really received the tribute that it deserves. During the period under study in this thesis it is therefore argued that nurses locally did contribute to the nursing and social history of the two towns.

Why study the history of nursing.

This is an important question and when commencing this thesis there was a general interest from colleagues about the study of nursing history but no one else was studying the subject. There seemed to be an underlying question from others of '*why*' study history, indicating that they thought there was no reason or relevance to current nursing practice. An obvious if superficial answer could have been 'why not', but this did not address the underlying question and give a scientific rationale to support the focus of the study. Having had experience of

teaching the '*history of nursing*' to student nurses in the past, but noting that the subject had slowly been removed from the curriculum, the seeds of interest were sown. Within this thesis there are discussions of the reasons for studying the history of nursing and why it is important. Having spent many years reading and researching historical methodology, exploring and analysing archival data and, conducting, transcribing and analysing oral history interviews, the question seems to be more why do nurses not study nursing history. Personal experiences of studying nursing history have illustrated the wealth of rich data available and how the evolving qualitative methodologies can offer nurses a wide range of ways of exploring the distant and more recent past in nursing. By conducting these studies nurses can illustrate trends and changes within nursing that may help to explain some of the current dilemmas and issues that occur. Recent examples of this include the introduction of the '*Modern Matron*' role and the education of nurses.

Other personal experiences that influenced the decision to study nursing history was that during the authors career there had been numerous incidents of working with older nurses who eventually retired. Talking and listening to these nurses and their fascinating stories of how nursing was in the old days inspired an interest in nursing history. These nurses were one or two professional generations older and their experiences were very different than the authors.

So, the reasons for studying the history of nursing generally are many and are further explored within this thesis. One of the main drivers for this thesis was a lack of understanding of the local history of nursing and this is discussed further next.

Why study the history of nursing in Halifax and Huddersfield?

When considering this question some of the earlier thoughts about nursing history generally are also relevant. The '*why not*' answer is an obvious one and could be linked to this study if there was freedom to study and explore any subject without any justification. However, this thesis was subject to the usual assessment processes of any research degree including submitting a research proposal to the University Research Committee to gain ethical approval and having internal assessment by a supervisory team and external assessment by two external examiners. This provided an opportunity to defend the '*why not*' answer by giving a rationale to support the thesis and to address the limitations that it would be confined by such as time, money and other resource issues and the assessment process itself. The proposal outlined the potential data available and the plan of how these would be sampled and analysed. The main issue which seemed to be the most convincing reason for the thesis was the lack of any published or unpublished literature which provided a systematic and detailed study of the history of nursing in Halifax and Huddersfield. This thesis therefore attempts to fill this gap and create a unique record of this specific area of local nursing history. The value of this would be to provide a reference for other researchers to use which may give them ideas of subjects to study. For both nurse practitioners and educators the information about local nursing and nurses could be potentially used for practice or teaching purposes.

Also, the lack of any local nursing histories leaves a deficit in local history knowledge. This is particularly important in relation to the social issues such as health and illness and the employment of women within a historical industrial area of Yorkshire.

Where are Halifax and Huddersfield?

The relevance of the geographical location of these two West Yorkshire towns is discussed as appropriate within the thesis. The main issue of importance is that nursing histories of provincial towns like these are limited and there are obviously aspects relating to their location that impinge upon the development of nursing and nurses themselves. Both towns lie on the eastern side of the Pennine Hills within the county of West Yorkshire. Halifax lies about seven miles north of Huddersfield and their borders meet roughly along the route of the M62 motorway. Their town and surrounding district boundaries have naturally changed over time and this also impinges upon the thesis in relation to defining the areas accurately. Each town developed individually over time and their corresponding size in terms of population and land area are different. However, both towns include surrounding districts that are widespread over large areas of land many including isolated villages scattered across the moorlands. The undulating nature of the landscape for the two towns presented particular problems specifically for the community nurses travelling around.

Within Yorkshire Halifax and Huddersfield are surrounded by several large urban conurbations and five major cities. To the north of Halifax are the cities of Bradford and Leeds, with York further a field. To the south of Huddersfield is the city of Sheffield. All four of these had important health care institutions including '*teaching*' hospitals. To the east of the towns is the city of Wakefield which did not have any '*teaching'* hospitals. To the west of the towns across the Pennines is Manchester which had a '*teaching*' hospital. Within Lancashire there were several other towns and cities relatively local to Halifax and Huddersfield. Despite these local geographical and social aspects of the position of Halifax and Huddersfield there is evidence that they held fairly prominent positions within the sphere of nursing and health care. The local institutions on the whole were held in high esteem by the professional nursing bodies and records confirm the high standards that nurses in particular achieved. There is also evidence of important links between the institutions within these two towns in West Yorkshire and those in some of the surrounding cities.

Who is the researcher and what is their background?

This was an important question and when commencing this thesis there was a feeling of excitement and naivety that many novices to specialist subjects experience. It soon became apparent that the study of nursing history was not a new one nor was it an understudied area as previously thought. With any study there must be some element of personal bias in the choice of subject area and methodology. It was clear there was an individual interest in history generally but no skills or training in historical research methods. Personal interest

came from conducting research into family history and although this experience had developed some general skills in using libraries and archives this was limited.

During a career in nursing spanning thirty-six years there had been numerous experiences that had stimulated an interest in the historical background to nursing. From lessons on the history of nursing in basic nurse training and later at diploma level, it was clear this was a subject of personal interest. Listening to experienced older nurses and teachers it was obvious the changes occurring in the post-Salmon 1970s were not receiving their approval. They would often relate stories of the '*good old days*' suggesting nursing was 'better' then. This continued in other experiences as a qualified nurse throughout the different areas of nursing practiced. While working as a nurse patients would also talk about their past experiences of the '*olden days*' and how they felt standards had dropped. Throughout the years there seemed to be several occasions when colleagues had retired and this inevitably raised issues of their past careers and experiences. While working as a nurse tutor there was an older colleague who often recounted her previous nursing experiences during lunch breaks which provided further stimulation in the interest in historical aspects of nursing.

Arriving from the Midlands in 1989 as a nurse tutor in the School of Nursing at the Huddersfield Royal Infirmary (HRI), and living in Halifax, it was soon apparent that again many colleagues were retiring and many told stories of the '*good old days*' working in Halifax and Huddersfield. Shortly after starting at HRI there was a merger between the three local schools of nursing and it became evident that the different groups of nurse teachers, although able to integrate together, still held on to their own '*schools*' values and histories. It was at this time while planning a teaching session about the history of nursing a publication relating to historical research for nurses was read (Maggs, 1989) and this helped confirm this would form the focus of the thesis. Appendix 1.1 provides further curriculum vitae details including personal development activities related to the thesis.

Research aims and objectives.

Within the study aims and objectives were stated but there was no hypothesis as; '*In historical research, there frequently is no problem statement*' (Burns and Grove, 1995, p. 74). The original main area of investigation was on the role of the general nurse within the nursing profession, their contribution to health care provision and how this related to the organisation of health care facilities in Halifax and Huddersfield in the pre-NHS years 1870 to 1948. However, this was reviewed and changed following evaluation of the planning of the oral history interviews when it was realized that most participants would have experiences after 1948 and so the latter date was extended to 1960 to finish prior to the Salmon Report changes being implemented. Also, as local district nursing was closely linked to general nursing and was also not evident in the literature this was included within the term '*history of nursing*'.

Chapter 1 – Introduction.

The seven research objectives were devised in collaboration with the Supervision Team who gave constructive comments on their development. These were submitted to the University Research Committee for approval.

The research objectives were to:

1. Synthesize an account of the development of nursing within the two West Yorkshire towns of Halifax and Huddersfield.

2. Provide evidence of the major developments and changes within nursing in these towns.

3. Critically analyse the major developments and changes within nursing in these towns.

4. Identify factors which influenced nursing and nurses.

5. Identify individual nurses who made important contributions to nursing locally.

6. Compare and contrast the development of nursing in the two towns.

7. Evaluate oral history interviewing as a method of recording the working lives of local nurses.

The first six of these relate directly to exploring the history of nursing in the two towns and the seventh one to review the oral history technique as a research method.

Introduction to chapters.

Chapter 2 provides details of the literature search and review. The literature review considers the development of research in nursing, and in particular, historical research methods. It identifies an increased emphasis on the importance of historical research as a qualitative research method for nurses. Literature relating to wider national nursing history issues is explored as well as more local historical references. References to district nursing are also explored and literature related to historical qualitative methodologies is considered. The literature review identified a '*gap in knowledge*' of how and why local hospital / district nursing developed within West Yorkshire. From the literature review several questions arose; what was the role of the nurse and how and why did it change? How was nursing organised and delivered locally? To try to answer these questions the hospital nurse's role relating to the main hospital services in the towns was explored. Questions relating to district nursing also arose such as how did district nursing start? To address these there is an exploration of what care was provided prior to the commencement of a district nursing service, and subsequently how this service was delivered until the introduction of the National Health Service (NHS). Questions about pre-NHS experiences of what care they delivered and how, are explored. These research questions will be addressed during the study despite Burns and Grove (1993) arguing that often historical research has no problem statement or research question but a lack of information or evidence of local health care history is an adequate reason for exploration. This reflects the situation in this study. Therefore, the development of nursing overall will be explored to see how the district nurse's role evolved along side the hospital

nurse. The development of health care will also be considered, as nursing must be studied within the wider social, political, demographic and epidemiological issues of the day.

This results in a critical synthesis of the body of published research into nursing history, addressing international, national and local histories identifying the patterns and trends in the writing of nursing history and its strengths and weaknesses.

Chapter 3 provides details of the methodology used in the study. History is explained in relation to philosophical approaches and historical methods. A review and critique of Rosenberg's Conceptual Framework is provided with an explanation of how the eight areas of importance were applied. Details are provided about the data collection from the primary and secondary sources used including the archival and oral history data. Twenty-five archives were identified with twelve main ones providing the majority of data. The methodology focused on an inductive data driven approach (Edwards and Talbot, 1994). Historical archival documentary analysis and, in the later stages a small oral history project, were conducted. Twenty-one oral history interviews with retired nurses were recorded and transcribed. Discussion of the extent to which the evidence from documentary primary sources served to corroborate the evidence from the oral testimonies of retired nurses is offered. Details of the analysis of the data including the use of the computer package NVivo and its strengths and weaknesses and the application of Rosenberg's eight factors are provided. Triangulation of data collection and analysis was used to address the issues of validity and reliability. Ethical dilemmas of the study are identified and addressed including consent.

Chapters 4-11 provide discussion of the findings under Rosenberg's eight areas of importance.

Chapter 4 provides discussion of the findings under the 'New Institutional History' area of importance. This includes an overview of fifteen main institutions in both hospital and community settings.

Chapter 5 discusses the issue of 'Gender and the Professions' and provides findings in relation to roles of women and men in nursing, nurse-doctor relationships and professionalisation of nursing.

Chapter 6 discusses the issue of 'Knowledge and Authority'. Knowledge includes the two issues of the clinical ward areas and practice and the educational classroom settings. Authority includes the following eleven aspects, rules and conduct, discipline and conformity, authority and power, exploitation and social control, organisational hierarchies and routines and the role of the Matron.

Chapter 7 discusses the issue of the 'Role of Technology' and explores the role of technology for local nurses and nursing including the three issues of clinical care developments, medical advances and discoveries and the impact of war.

Chapter 8 discusses the issue of the 'Nurse as Worker' and considers the working life of nurses locally and considers this under the four main headings of student experiences, qualified nurses experiences, pay and conditions and methods of organising nursing care.

Chapter 1 – Introduction.

Chapter 9 discusses the issue of the 'Hospital as Problematic' as an area of importance related to three issues, the concept of institutions, pre-NHS and post-NHS health developments and the role of administration / management.

Chapter 10 discusses the issue of 'History from below – Ordinary Men and Women'. This examines the occupational and professional aspects of local nurses providing detailed accounts and images of how they lived and worked. Both archival and oral history sources provide a rich selection of stories and visual images that illustrate how nurses were involved in many work and social activities during their training and once qualified. Case studies of individual nurses provide detail of the history from below bringing it to 'life' allowing social and cultural aspects of nursing in the past to be considered and opportunities to examine them in relation to nursing today.

Chapter 11 discusses the issue of 'History as Meaning' and there is consideration of four issues in relation to the recognition of the importance of the past to nursing, the history of nursing locally and nationally, of local nurses as resources to local nursing history and links to present day developments.

Chapter 12 presents a discussion of the findings and their importance. There is discussion of the use of Rosenberg's eight areas of importance and the value of the archival, oral history and other sources used. The uniqueness of the history of nursing locally is discussed and the extent which it exemplified nursing history elsewhere considered. Nursing reforms like the movement for state registration are discussed, comparisons between the two towns made, and the nurse of 1870 and 1960 considered.

Chapter 13 provides a conclusion and reviews the studies aims and objectives and provides recommendations for further research illustrating issues of importance still needing to be addressed.

Conclusion of chapter.

This chapter represents an introductory overview of this thesis including the main subject areas, philosophical, ethical and methodological issues the research highlights. The literature review identified a 'gap in knowledge' which this thesis attempts to address and it is suggested that the methods chosen for the research design support this. The thesis provides a valuable historical insight into local nursing history by using Rosenberg's eight areas of importance as a framework.

The next chapter describes the conduct of the literature search and provides a review of relevant literature related to the history of nursing and the history of international, national and local historical nursing research.

Chapter 2 - Literature review.

This chapter describes the conduct of the literature search and provides a review of relevant literature. During the first three years of this research study a systematic non-exhaustive literature search was conducted using library resources to locate relevant journals and books with a concerted effort to ensure that as many varied sources as possible were sampled. An on-going opportunistic literature search continued throughout the study to ensure any new sources where included thereby maintaining reliability and validity. This relates to the concept of '*incremental searching*' which is similar to the concepts of '*contact tracing*', '*word of mouth*' and '*snowball samplin*g' (Crookes, Davies and Chiarelli, 2004, p. 29; Burnard, 1993).

The literature review presents a critical synthesis of the body of published literature and research into nursing history addressing international, national and local histories. The patterns and trends in the way that the history of nursing has been written are illustrated and the strengths and weaknesses in historical research conducted in the field highlighted. This identifies who has written the history of nursing, the approaches taken in studying nursing history, and gaps in the field. This provides a rationale of the study and sets it within the nursing and historical research arena.

There is discussion of two main areas of literature. Firstly the history of nursing research is addressed illustrating its development with an historical review showing its increasing importance during the professionalisation of nursing in the last fifty years. This is important as historical nursing research rests within the larger arena of nursing research. Secondly, the history of international, national and local historical nursing research is explored illustrating the increasing importance during the last twenty years of its development and use.

History of Nursing Research.

The history of nursing research is addressed illustrating its development with an historical review showing its increasing importance. This review concentrates upon the United Kingdom (UK) but also includes comparative examples from the United States of America (USA).

As part of the professionalisation of nursing world views of knowledge and a scientific approach to knowledge were adopted (Pearson, 1988). Developing a body of professional knowledge validates the importance of the nurse and the profession of nursing (Heartfield, 1996).

The concept of nursing research can be viewed in two main ways, studies done by non-nurses on nurses and nursing and studies done by nurses. During the Nineteenth Century nurses generally were poorly educated apart from a minority of women who entered nursing in the latter half of the century as the reform of nursing began. Therefore opportunities for research were limited and apart from Florence Nightingale no major nursing studies were published. Nightingale's work on data collection and statistics are examples of how scientific approaches to nursing were considered. Her focus on nurse training allowed for a more educated nurse and some opportunities for personal development. However, there were still gender and educational related restrictions on nurses alongside the general slow

development of the scientific establishment. In fact during the 1870-80s many UK nurses were illiterate so the need for education was vital to improve the professions educational stock. However, during the latter half of the Twentieth Century as the study of science developed there were more educational opportunities for nurses and women.

Clark (cited in Baly, 1995) identified that at international level nursing research had grown rapidly since its early slow start in the 1920s with research into occupational aspects of nursing. In 1931 the Lancet Commission on Nursing in the UK provided an early example of survey research (Lancet, 1931). However, in the UK this mainly seemed to have started in the 1940-50s (Baly, 1995). In the USA Wechsler and Kilbrick (1979) argued that little nursing research was done before the mid-1950s. The American Nurses Association (ANA) established a Master Plan for Research in 1950 (Newton, 1965) and the journal 'Nursing Research' commenced in 1952 (Wechsler and Kilbrick, 1979). The Committee on Research and Studies ANA Blueprint for Research in Nursing suggested areas of research including practice, services, education and organisation (ANA, 1962). These were similar to some of Rosenberg's (1987b) areas of interest.

An early example of UK nursing research was Norton et al (1962) who explored the problems of caring for the elderly in hospital. Although one of the authors was a doctor the study originated from the establishment of a 'geriatric nursing research unit' at Whittington Hospital started by two nurses. This nursing-medical collaboration allowed a multi-disciplined approach to the research subject. Other early research studies are found within district nursing including Queens Institute of District Nursing (QIDN) (1965), Hockey (1966; 1968), Skeet (1970), Roberts (1975), and Kratz (1978). General nursing research studies included Hamilton-Smith (1972), Wright (1974), and Hayward (1975). This illustrates that UK nursing research began to be published during the 1960-70s and these early studies provided nurses with opportunities to explore a variety of research methodologies although there was an emphasis upon quantitative approaches initially such as survey approaches like Norton et al (1962). Clarke (cited in Baly, 1995) suggests many of the early published research studies were the result of the increasing number of nurses studying for higher degrees. This increase in nursing research therefore tended to mirror the development of the profession and the increasing level of nurse education. However, these nurses were still few and far between and these trail blazers were perhaps examples of Melia's 'academic professionalizers' and therefore unrepresentative of most nurses of the day (Melia, 1987, p. 163). This contributed to the seemingly ever present theory-practice gap where nursing research findings were often not applied to practice.

In America the move to higher education and a graduate level entry gate into the profession during the 1950-60s exposed nurses to the academic rigors of research based study. With the introduction of Foucauldian and feminist views nurse researchers started to address some of these wider issues during the 1970s (Connelly, 2004). Foucault stressed the importance of power and included the three concepts of class, command, and state (Foucault 1963; 1977). This raised questions about doctors 'power' and domination of the medical

practice. Gastaldo and Holmes (1999) made links between nursing and history and Foucault and identified a trend among nurses in different countries to develop Foucauldian interpretations of nursing such as Jones and Porter (1994), Rose (1994), Allen (1996a), Heartfield (1996), Peterson and Bunton (1997) and Manias and Street (2000). This was suggested to be of importance to how nursing as a discipline and profession was viewed allowing nurses a wider '*interdisciplinary and critical scholarship*' (Gastaldo and Holmes, 1999, p. 231). Alongside the Foucauldian approach feminist views became more commonly used and nursing as a predominantly female occupation was seen as an important area of study.

Rafferty (cited in Cormack, 1996) provided a useful overview of research developments and concluded it had increased in the UK during the 1980-90s as nurse training moved into higher education. Since then even further developments have occurred as nurse educators have embedded themselves in the university sector with increased opportunities for their own personal development in research teaching and higher degree study. This development has occurred with the introduction of degree entry nurse education courses, and the need to provide student nurses with evidence based learning opportunities.

The history of nursing research illustrates that it is perhaps still in its infancy compared to other occupational and professional groups. However, its development over the last fifty years has been rapid and has led to an ever increasing body of knowledge and evidence based practice. Nurses have moved from quantitative approaches to using a variety of methods and in particular qualitative studies have increased. Within qualitative approaches Grbich (1999) identified an historical trend based around 1965 of which before this date there was a predominance of ethnographic and participant observation studies such as anthropology. Following 1965 she suggests approaches diversified and issues like the researchers' role and data collection rigour were debated. Nursing research would have been linked to this and it was often led by the general research community and its current trends. Within these trends nurses have increasingly moved from using general social science approaches to more specific '*nursing orientated*' approaches. Areas of nursing research have developed in a rather ad hoc way with exploration of its occupational status, organisation and management and clinical care some examples of this. However, the areas suggested by the ANA (1962) practice, services, education and organisation can be used to attempt to provide an umbrella approach to categorizing nursing research. It is suggested that there still remains the thorny issue of how nursing research findings can be applied to nursing practice and help to bridge the theory-practice gap. However, the body of knowledge for nursing has increased as nursing research studies have been conducted, findings published and nurses research skills improved.

Historical Nursing Research.

The history of international, national and local historical nursing research illustrates the increasing importance of the development and use of historical research methods in nursing.

Chapter 2 - Literature Review.

International historical nursing research.

Historical nursing research studies have become more common over the past twenty years. Earlier developments in this area included in the USA, Bay (1959) who identified sources as early as 1927 promoting '*historical mindedness,*' while Austin (1958) discussed the '*historical method*' in nursing. In the USA in the 1960s Newton (1965) identified a lack of historical research in nursing and stated the reason for the need for historical research to be considered by nurses was that; '*those individuals who cannot remember the past will be condemned to repeat it*' and because nurses have been;

> '*......oblivious to the great importance which other professions, such as medicine, law, and education, have placed upon history, and the way in which knowledge of their past has guided and inspired their forward movement*' (Newton, 1965, p. 20-6).

Marwick (1970) supported the former idea that the study of the past contributes greatly to our understanding of contemporary issues (cited in Cormack, 1996, p. 167). On the latter point Newton (1965, p. 20-6) stated; '*In comparison with medicine, law and education, historical research in nursing is pitifully meager.*' Rafferty highlighted that; '*Compared to medicine or science, little has been written about the purpose of history and the function of the historian in nursing*' (cited in Cormack, 1996, p. 166). Newton (1965) identified that the National Institute of Health created a History of Medicine Study Section in 1960 and enlarged its scope in 1962 to include the History of Life Sciences, and that between the years 1959-1965 fifty-one historical projects were supported but only two were nursing based.

Rafferty provided a summary of developments in UK nursing historical research since 1978 illustrating a later start (cited in Cormack, 1996). Sarnecky (1990) identified increasing numbers of historical research reports appearing in nursing literature supporting this. Grbich (1999) linked the increase in historical research in nursing to the increased use of qualitative research methods. This gave nurses access to methods more appropriate for exploring the art and science of nursing. Polit and Hungler (1993) provided further evidence of the increasing importance of historical research, and Sarnecky (1990) also promoted the importance of historical research in nursing. However this does not explain fully why nurses were moving towards an historical approach to study, perhaps because an aspect of the professionalisation of nursing was to explore its past as other professionals had done. Also the importance of history to the nursing profession can demonstrate its contemporary relevance and contribute to creating professional identity (Florence Nightingale Foundation, 2000). As more nurses were exposed to higher education it would be natural that some of their enquiring minds would have an historical aspect to them. Further to this as many of the early nursing history texts were written by non-nurses, often doctors, there was a move to redress this by nurses exploring their own past. Therefore a gradual increase in the interest in historical research, and the number of nurses conducting historical research over the latter half of the Twentieth Century, increased the historical body of knowledge of nursing which was poor in comparison with the history of medicine (Florence Nightingale Foundation, 2000).

Chapter 2 - Literature Review.

Historical nursing research in the UK.

Historical nursing research in the UK followed a similar pattern to the history of nursing research generally. Historical nursing research can be linked to nursing research in respect that it can be viewed in two main ways, studies done by 'non-nurses' and studies done by 'nurses' on nursing history. This does not detract from other areas of research such as;

> '*political, social and gender history, anthropology, social studies and medical history, and informal history groups studying the changing roles of women*' (Florence Nightingale Foundation, 2000).

Also studies of the history of '*nursing*' should be conducted as well as the history of '*nurses*' and the '*nursing profession*' (Florence Nightingale Foundation, 2000).

An early attempt to write a history of nursing was Tooley (1906) who wrote specifically about the British Empire and stated; '*No history of nursing has so far been published, and data for this volume has been obtained by original research'* (Tooley, 1906, p. vi). Dock (1912) covered nursing history making special reference to 1882-1912. Many earlier nursing histories tended to be done holistically covering all time periods, macro-histories, and as late as 1960 macro nursing histories were still being published (Bett, 1960).

Literature concerning the history of nursing in the UK concentrates on the main themes of national and regional institutions and individuals. These institutions were often in London and the individuals often famous. Chinn (1990) recognised that;

> '*Most of the history that is currently written about nursing concerns organisations, institutions, professional and political relationships in which nurses assume a responsive or reactive role'* (Chinn, 1990, p. viii).

The need to examine the nurse's role in more detail to specifically explore nurses in their wider environments and areas of their work and to study the history of '*nursing*' is therefore evident. The use of micro-history approaches allows researchers to focus on specific time periods, places and nursing issues. This trend to use micro-historical approaches has allowed nurse historians to focus more specifically upon '*nursing*' issues.

More recently there has been concern that the history of nursing has lost its place within the educational nursing curriculum and that as a subject it has been declining due to this (Florence Nightingale Foundation, 2000). In 2000 the Florence Nightingale Foundation recommended the development of the International History of Nursing Journal as a focus for published historical studies but its closure in 2003 has reduced its exposure to the wider profession (Florence Nightingale Foundation, 2000). During the last ten years a notable number of authors of nursing research textbooks have added historical research into their later editions illustrating the increasing trend to accept it as an important element.

Historical nursing research therefore has developed from simply chronologically describing history to scientifically examining the past and the nurse's role in it. Also, nurses themselves have started to write nursing histories instead of non-nurses.

National and regional institutional histories.

Institutional histories provide information about hospitals or other health care organisations. An institution is a collection of people working for a common cause within a defined building with its own cultures and values. The number of employees and consequent number of services provided indicates the size of the enterprise resulting in managerial issues that need addressing. Six main structures to health care institutions impacted upon nurses, nursing and the institutions they worked in during 1870-1960, the Poor Law and Workhouse system, Voluntary Hospitals and District Nursing Associations (DNAs), Local Authority hospitals, private organisations and the National Health Service (NHS). The histories of local institutions are considered but are not the central focus as the main aspect of the study will be nurses' roles within these institutions in relation to policies and political aspects of management. Strauss et al (1998) discussed the hospital and its negotiated order and the organization of medical work and gave an interesting account of some important issues to be considered related to work roles and institutional management. Institutional histories may not focus on nursing elements or institutional factors that impinge upon nurses and nursing as there is often no exploration of how and where nurses worked and how nursing was organised. This is not to say that institutional histories are not important or useful for nurse historians as they can provide detailed insight into a variety of social aspects related to nursing and provide the 'context' within which nursing was practiced.

A plethora of publications are available that chart the history of hospitals in the UK from the Poor Law workhouses to the introduction of the NHS. The functions and cultures of these institutions have been explored alongside the relationships between nurses and doctors and the changes that occurred during the Nineteenth and Twentieth centuries. Appendix 2.1 shows twenty-two selected examples of publications related to the history of healthcare and its institutions and hospitals. Although they do not specifically examine nursing itself they are useful to nursing historians to allow examination of the context in which nurses worked and they explain how nurses lived and worked in them. Several of these were written by non-nurses and many based upon the social and political aspects of health care. These therefore detract from the nursing elements although many do report on nursing activities of various sorts. Literature providing historical accounts of famous institutions, particularly the London hospitals, include Cope (1955), Helmstadter (1993; 1996; 1997), Yeo (1995), Knight (1997) and Baly and Skeet (2000). Apart from the London examples some major cities also had institutional histories but this was less so for provincial towns. Seagar (1996) provides a national account of the overall development of voluntary hospitals from 1850-1914. Appendix 2.2 shows twenty-four selected examples of regional and provincial institutional histories illustrating the variety of areas of interest and range of time periods studied. The study of hospitals and their histories was until recently mainly conducted by doctors or lay local historians. The medical domination of these histories was criticized as being elitist and unrepresentative of others like nurses;

Chapter 2 - Literature Review.

> '*The historiography of hospitals has been transformed in recent decades as historians have moved beyond the heroic, institutional histories of hospitals written by doctors that at one time characterised medical history*' (Thompson, 2003, p. 247).

Samuel and Thompson (1990) indicate the importance of non-elitist research in giving a voice to underprivileged minorities like nurses.

General Nursing.

General Nursing is defined as nurses who worked in '*general*' hospitals and were not directly caring for patients with mental health or learning disabilities. General nursing can also be linked to the role of the district nurse who provided '*general*' care to patients at home. It is recognised that in the early years of this study the roles of nurses and the categorization of patients in these terms was not appropriate. This can be illustrated by the Workhouses having a wide variety of patients admitted, including '*lunatics*', but not having any specialized nurses. Although simplistic this definition is an important aspect that concentrates the focus of this study.

Some examples of studies related to general nurses included Delgado (1970) who provided the opportunity for nurses with Florence Nightingale to tell their stories. An example of a probationer nurses experiences in 1910 is provided by Granshaw (1985). White (1994) describes how a patient in an isolation hospital was inspired to become a nurse and started training in 1928, and Owen (1992) gives an account of nurse training in the 1920s. Baker (1996) recalls memories of starting nursing in 1935 while Skidmore (1993) gives an account of learning as a nurse at Plymouth.

Four general nursing text books included Baly (1995) who provided a detailed examination of the history of general nursing. Dingwall et al (1988) examined the social history of nursing using a macro-history approach which included general nursing. Rafferty and Robinson (1996) also explored nursing history including aspects of general nursing. Rafferty (1996b) re-examined various aspects of nursing history and all four provide good examples of a scientific approach to scholarly nursing history.

In relation to this study the most important work on general nursing was done by Maggs who during the 1980s provided a variety of valuable published literature on both general nursing, archival sources and oral history (Maggs, 1980; 1981; 1983a; 1983b; 1984a; 1984b; 1984c; 1985; 1987; 1996a; 1996b; 1996c). These illustrate the increasingly scientific approaches to nursing history that were emerging. Maggs (1984b) provided detailed discussion of how nurse recruitment was conducted in relation to women's work and general nursing. Maggs (1981, p. 97) discussed control mechanisms within nursing and identified the importance of uniforms and their use to emphasize status and to '*establish a social distance between the nurse and the patient*'. Maggs (1981, p. 100) identified from oral history evidence that aspects of routine and the '*hierarchy of tasks*' which confronted nurses gave them a sense of certainty. Maggs (1981) argued this control was used within the nurse training syllabus to '*mould*' women into nurses during the late Nineteenth and early Twentieth centuries. This '*indoctrination*' of students allowed them to gain the professional behaviour required of qualified nurses. He

further identified that nurses performances were measured by the speed that they worked and how punctual they were at starting and finishing tasks. Therefore, it was suggested that, '*the inefficient, bad nurse, always ran out of time*' (Maggs, 1981, p. 99). Many of the main text books on the history of nursing include reference to the origins and development of general nursing such as Maggs (1983a). He also emphasised how any history of nursing should include consideration of a history of caring (Maggs, 1996a). Maggs (1989) explored how nurses work and associated industrial relations impacted upon professionalisation. Using national and regional sources Maggs allowed a detailed examination of these issues in relation to varied historical periods. There is however a relatively limited examination of '*general*' nursing overall and it is argued that examining general nursing locally can provide data that can contribute to the national picture of how this branch of nursing evolved.

District Nursing Associations.

It is important to recognize that the term '*institutions*' does not only relate to hospitals but also DNAs which provided home nursing and midwifery services. These were important institutions within their own right and several aspects of district nursing emerge in the literature including the history of district nursing itself, its organisation, DNAs and district nurses work experiences. Numerous authors have written about district nursing and studied its development and work done (Appendix 2.3). The general importance of these institutions is well documented with Stocks (1960) and Baly (1987) giving accounts of the overall history of district nursing, and Fox (1993b; 1996) debating the inter-professional relationships between DNAs and doctors from 1902-1914. Micro-history examples include specific time periods in the history of district nursing, individual nurses, institutional histories and how district nurses worked with doctors. Macro-histories of district nursing have also been published. However, district nursing has been classed as one of the '*Cinderella Services*' along with mental health and learning disability nursing and research within these areas is limited (Evans, 1997). Many text books on the history of nursing include reference to the origins and development of district nursing in the UK such as Abel- Smith (1960), Bett (1960), Maggs (1985), Dingwell et al (1988), Summers (1988), Baly (1995) and Judd (1998). Specific references to district nursing included discussion of research needs related to district nursing and research is found in a number of references which focus on specific issues related to its history or the historical resources used for its study. Personal accounts by district nurses provide examples of autobiographical sources while others explore the importance of team work. Therefore there is a need to consider DNAs in relation to history from below.

Institutional histories therefore can provide information about hospitals or DNAs and provide a context for nursing.

The increasing number of nurses writing studies from 1980 onwards perhaps reflects the increasing interest in historical studies. They provide evidence of the importance of local history and how the history of provincial hospitals can provide valuable information that can be used by others. However, a relative gap in the literature exists about provincial and regional nursing histories and the lives and work of '*ordinary*' nurses.

Local historical nursing research.

Existing historical research literature concerning the development of nursing in Halifax and Huddersfield was found to be very limited. The histories of local institutions include the roles of the nurse within them in relation to policies and political aspects of management. There were some institutional journal articles providing useful accounts of the development and history of some of the local hospitals in Halifax and some related to the war hospitals in Huddersfield. Although these made reference to some nursing aspects little was written specifically about nursing locally. They were mostly antiquarian local history sources written by non-nurses relating to general issues to do with local hospitals or general health care. There were no research studies of general or district nursing for either of the two towns. Even when looking wider across the whole of West Yorkshire there were limited nursing studies. Appendix 2.4 shows forty-six sources available for Halifax, Huddersfield and West Yorkshire.

West Yorkshire

West Yorkshire examples included three studies of the early Poor Law period. Other references included some nursing issues related to the development of the West Riding Health Services. Recruitment of Irish, Afro-Caribbean and Asian nurses during the Twentieth Century locally was not really addressed in any great way although Lee-Cunin (1989) provided a study of black nurses and Lewis and Patel (1987) discussed issues related to black women in West Yorkshire.

Institutions in Halifax and Huddersfield.

Literature related to nursing in Halifax and Huddersfield was limited and much was not directly focused upon nurses and nursing (Appendix 2.4). Much of the literature focused upon the institutional history or organisational healthcare systems in place without any detailed examples of nursing. Therefore there was little attempt to examine nursing in Halifax in any comprehensive and systematic way. There was no major study of how the two World Wars impacted upon nurses and nursing locally. Overall there was little scientific study evident of how general and district nursing developed in both towns and what roles nurses played during 1870-1960. The literature available provided '*ad hoc*' accounts of '*snippets*' of information but the lack of detailed nursing studies leaves questions about how the '*professionalisation*' of nursing occurred locally. Also social issues to do with nurse recruitment and nursing generally need to be addressed such as social class. The numerous diverse strands of local nursing that can be studied under the umbrella term of '*nursing history*' are problematic and there is a need to consider how historians can best deal with this. By focusing on general and district nursing allows some reduction of the massive areas for potential study. A cohesive account of general nursing locally is therefore lacking but this may be difficult to do as Melia (1998, p. 155) concludes;

> '……*nursing is too diverse an enterprise to be embraced by one name, and that the occupational group of nurses is too large and heterogeneous a group for its members to share the same view of what their work should be and how it should be organized*'

Despite this limitation there is scope for a study into local general and district nursing. There was no literature addressing how general and district nurses worked, what care they provided or how they were recruited or trained. Therefore an identifiable gap in the understanding of how nursing developed in these two towns was identified.

Internationally historical nursing research was slow to develop although many non-nurses had written '*nursing history's'* using macro-historical views like the '*Plato to NATO*' or '*grand survey*' approaches (Gress, 2004). Over time this trend of examining the whole history of nursing has moved more towards the use of micro-studies to examine specific issues. Nationally the trend of writing institutional histories of health care organisations although useful did not focus specifically upon nursing and many were London based. However increasing numbers of regional histories allowed documentation to be built up relating to provincial institutions. However, the lack of a systematic coverage of regional and provincial institutional histories means local histories are fragmented and nursing histories nationally incomplete. This study will contribute towards the local and national picture to provide a provincial insight into nursing. Nationally studies of local nursing history are limited and none exist for Halifax or Huddersfield. Most local literature was based upon institutional histories and written by non-nurses therefore giving impetuous for this study.

Historiography

During the last thirty years or more the nursing profession has been evolving and has experienced a '*professionalisation*'. As part of this nursing research has developed '*nursing models*' to help explore the nature of nursing and what nurses do. This has created methodological issues of how nursing research is conducted and raised questions as to whether nursing can be seen as either an art or a science, or both. This study will view nursing as both an art and a science. For the purposes of this study '*art*' will relate to qualitative and '*science*' to quantitative methodologies. This simplistic view is used to ensure the basic premise of obtaining and viewing data from a variety of different perspectives. Maggs-Rapport (2000) discussed issues related to combined methods in research supporting their use. The use of different forms of data to complement and enrich the study ensures the best quality of data is obtained. It also allows the analysis of that data to be robust; '*Researchers may use quantitative data to supplement qualitative data and analysis in historical comparative research'* (Yuginovich, 2000, p. 71).

The need for historical research in nursing is evident within the literature and there is a philosophical aspect of this as many nurses have no interest in reflecting upon nursing history. However, there are many who believe that there is a need for this;

> '*Provision must be made so that nurses of the future may look back to the nursing of today and preceding centuries, and draw both inspiration and direction from the professions past'* (Newton, 1965, p. 26).

Different types of historical sources have been used by nurse historians and therefore methods of data collection have varied. Many historical nursing studies have included the use of; hospital and nursing archives, newspapers, nursing journals, personal letters and others

forms of correspondence. Nurses' personal artefacts and memorabilia such as uniforms, record books, photographs and certificates have also proved useful. Biographies of nurses have been published including explorations of certain specific aspects of '*elite*' nurses. Autobiographies have also proved a valuable source of information for researchers. Oral history recording has become an increasingly popular form of data collection providing some valuable insights into individual nurses views of different periods of nursing history. Historical research can include a variety of historical topics allowing a particular focus on origins, epochs, events, movements, trends, patterns over stated periods, history of specific agencies or institutions, broad studies of the development of needs for specialised types of nursing, biographies and portrayals of the nurse in literature, art or drama (Simmons and Henderson, 1964). This array of concerns illustrates the disparate nature of this area of study and perhaps illustrates the need for a historical framework to structure nursing history and table 2.1 illustrates an example of this.

Table 2.1

Diagrammatical representation of the methods of historical research illustrating the continuum from impersonal to personal

Impersonal				**Personal**
Archives	Biography	Oral history	Life history	Autobiography
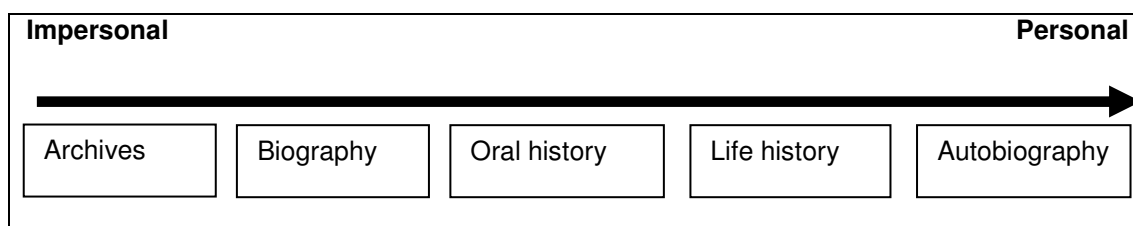
With all these sources available to the nurse historian, and the varied foci of investigations possible, there is a need for a multitude of methods of collecting data and that no one is better than any other and a pluralistic approach may be favourable for a comprehensive study.

History of nursing from below.

Methods of collecting history from below are varied and include biographic and autobiographical accounts of nurse lives and oral histories. These three methods are discussed to illustrate their contribution to the body of knowledge of nursing history.

Individual nurses – biographies

A large proportion of publications related to nursing history are biographies of famous or important '*elite'* nurses. Criticisms of early nursing history publications were that they tended to be descriptive and often only related to significant famous nurses and nursing events. Rafferty identifies a;

> '……*move from the hero-centred view of nursing, to a more critical form of research which located nursing within a wider social and political context'* (cited in Cormack, 1996, p. 166).

Laybourn (1995) supported the latter while Samuel and Thompson (1990) indicated the importance of non-elitist research allowing under represented groups a voice. Twenty-six

examples of '*hero*' literature are in appendix 2.5. This work is of immense value in charting how these '*hero's*' contributed to and shaped nursing history. With eighteen of these relating to Florence Nightingale there is a potential for bias in relation to all the other nurses who have worked since her. There is a need to consider leadership in relation to individual nurses and studying famous nurses may help. However, as they are few in number it can be argued they give an unbalanced view. By exploring the '*history of nursing from below*' a more accurate and complete story of nursing will emerge. Also, locally there would have been many nurses who could be classed as '*hero's*' for the work they did but have gone unrecognized. They would have demonstrated leadership within their roles locally and it is argued that they should be recognised in some way and their stories told. Therefore an objective of this study was to identify individual nurses who made important contributions to nursing locally. This would illustrate a local form of '*hero*' biography and allow them to be compared with other prominent regional nurses.

Autobiographies.

As well as biographies there are nurses' personal autobiographical accounts of their time in nursing as illustrated in appendix 2.6. Other examples included anonymous personal accounts of specific issues such as the rigid discipline nurses experienced in the Nurses Home in the 1930s (Anon, 2001). The typical autobiographical published accounts are mainly individual descriptive recollections that are not subjected to scrutiny and therefore although important they arguably have a tendency for bias. Dingwall et al (1988) attributed these sorts of anecdotal accounts to the cause of the '*myths and legends*' of nursing history which were not evidence based. The autobiographical accounts tended to be fairly specific concentrating upon either certain time periods or types of nursing experiences without a '*life story*' approach. These descriptive isolated accounts can however give useful first hand personal views of specific nursing issues.

So both biographical and autobiographical approaches to nursing history provide evidence of how nurses worked. Biographies have had a mainly '*elite*' approach consisting of famous or important nurses while autobiographical approaches have allowed some of the '*ordinary*' nurses to tell their stories and both can be subjective. There were no published accounts of nursing locally using either of these two approaches therefore they were of interest to this study.

Oral history and the life story approach.

One of the study objectives was to evaluate oral history interviewing as a method of recording the lives of local nurses. Oral history links to the feminist methodology as described by Hammersley (1992) and Kirby (1997/8) and the Marxist philosophy of recording a history of the ordinary people (Hallett 1997/8). Maggs (1983) suggests oral testimony data can offer a '*new slant*' on the history of nursing. An international oral history example includes Keddy et al (1992) who provided an account of Canadian nursing and the rank and file issues this raised. Oral history can therefore correct the relative lack of information about the experiences of basic '*average*' nurses. Empowering '*ordinary*' nurses ensures a balanced

view of nursing history is available. The researcher can capture either a '*life story*' holistic oral history or can focus on specific aspects of individuals nursing or life experiences. The latter can provide social history data about the individuals life like family and education. In order to capture in a more systematic way the '*ordinary*' nurse's lived experience of nursing researchers have used the oral history approach to help tell '*history from below*'. This has led to autobiographical sources being found within oral history projects with nurses providing life story histories of their experiences. Examples include the Royal College of Nursing's (RCN) Oral History Project in Edinburgh which has the largest collection of nursing oral histories with nearly three hundred interviews and the British Library National Sound Archive (BLNSA, 1997). At the University of Essex the Economic and Social Data Service (ESDS) Qualidata service led by the UK Data Archive (UKDA) contains datasets on oral history studies including nursing and health care related ones. An example is Soothill and Mackay's (2008) study entitled '*Doctors and Nurses: Allies or Adversaries? 1985-1990.*'

According to the UK Centre for the History of Nursing and Midwifery (UKCHNM) interviews with nurses also feature in two other oral history collections, the Imperial War Museum Oral History Collection and the '*Nurses' Voices*' at Faculty of Health and Social Care Sciences at Kingston University (UKCHNM, 2008). Oral history collections are increasingly being made available online such as the Berkley Oral History Online Project and the issues related to this practice were discussed by Bainbridge and Cunningham (1998).

Increasing numbers of oral history nursing projects have allowed accounts of nursing development at a local level address the lack of representation of the '*ordinary*' nurse. Appendix 2.7 shows twenty-three selected examples of oral history studies related to nursing illustrating their regional and institutional focus. Examples include Gates (1993) and Trees (1995/6) related to Merseyside and Carney (1996) who focused on selected London Boroughs during the interwar years. Oral history collections include examples of both the voices of nurses and patients illustrating it can be used to capture both. Appendix 2.8 illustrates fourteen selected publications related to oral history research.

No oral history collections existed relating specifically to local nursing although two local oral history collections for Huddersfield included the Pennine Heritage Society (2003) related to Storthes Hall Hospital (SHH) 1984-86 and the Huddersfield Local History Library Oral History Collection (1988) which included a nurse.

Leydesdorff (1999) argued that local oral history studies need to be linked to new patterns of history writing so that varied voices can be heard. These '*varied voices*' therefore include the '*ordinary'* nurse as well as the '*elite*'. Melia's work related to the rank and file concept relates directly to the issues of ordinary men and women within nursing which supports the concept of '*history from below*' (Melia, 1998, p. 156) allowing '*voices from the past*' to be heard (Thompson, 1998; 2000).

Many nursing oral histories have concentrated upon either certain time periods of the nurses' lives or their professional experiences without taking a more holistic view. Using a life story approach to oral history is one way of including both a professional and personal account of

nurses' experiences. This holistic biographical approach allows insight into not just the nurse's professional career but their family and life experiences. Data collected is therefore richer and allows for a more personal life story to be narrated. It is important to be able to put the social aspects of being a nurse in context of both time and place so that researchers can explore these. Appendix 2.9 shows thirteen selected publications related to life histories. The term '*life history*' can be related to the nurses overall history from childhood to the current day. The narrative content of their interviews is made up of their '*life stories*'. However, Atkinson (1998) cited in Roberts (2002, p. 3) draws a distinction between '*life story'* and '*life history'* suggesting a life story is the complete information a person wishes to provide which is an honest recollection of what they want others to hear. This is usually obtained by being interviewed by someone and the result is comprehensive narrative of the person's life as a whole with emphasis on priority events (Atkinson 1998). Roberts (2002, p. 3) defined life history as;

> '*the collection, interpretation and report writing of the 'life' (the life history method) in terms of the story told or as the construction of the past experience of the individual (from various sources) to relate to the story*'.

Therefore the nurses' '*life stories*' are the content of their interviews while the '*life history*' is the interpretation and use of them. Roberts (2002, p. 3) suggests the term '*biographical research*' can be applied when researchers use individuals stories. Relying on stories as data is however problematic as Denzin (1989) defines stories as '*fictional, narrative accounts of how something happened*'. He argues stories are fictions and a fiction is something made up or fashioned out of real and imagined events. He concludes that history, in this sense, is fiction. This is important for validity and reliability and needs to be considered carefully. However, collecting the occupational career stories of '*ordinary*' nurses in provincial local hospitals within a '*life story*' approach is an important, appropriate and valid use of oral history (Roberts, 2002). The use of narrative confirms Roberts (2004a; 2004b) suggestion that narrative analysis is increasing in areas of human and health sciences. Frid et al (2000) suggest that using narrative in nursing research is new, however, recent examples include Dyson (2003) and Frost and Cliff (2004).

Interviewing older people involved two theoretical aspects, reminiscence and memory. Oral history is linked to reminiscence and older people (Perks and Thomson 1998). Older people usually enjoy talking about the past, however, there can be incidences in which the interviewer needs to reflect on their responsibility if unhappy memories are recalled raising differences between memory and therapeutic dimensions of reminiscence (Church and Johnson, 1995). Bettelheim (1969); Ritchie (1995); Bornat (1998); Jones (1998); and Rickard (1998) and all discuss therapeutic issues further. Theoretical ideas include the issues of memory and perception. Oral history explores the nurses' memories and recollections of nursing and eight authors have addressed this; Thompson (1988); Samuel & Thompson (1990); Freeman (1993); Stanley (1993); Thompson et al (1994); Ritchie (1995); Howarth (1998) and Grbich (1999). Memory is particularly important in this study as all interviewees

were over fifty years old (Cornwall and Gearing, 1989; Bytheway, 1993). Field (1989, p. 44) identified that;

> '*Nothing is more fully agreed than the certainty that memory fails. Memory fails, leaving blanks, and memory fails by filling blanks mistakenly*'.

These blanks are filled in unreliably and can even include the researcher's objectives. It is therefore accepted that the interpretation of oral history data is susceptible to memory faults and that only by triangulation of data can this be relied upon.

Overall collecting life stories within an oral history project will allow nurses working and private lives to be recognized, recorded and rewarded to ensure that the history of nurses and nursing locally is celebrated. This will go some way to providing the local ordinary male and female nurses from below a voice.

Archives: newspapers, memorabilia, artefacts, photographs.

One of the main sources historians have traditionally used has been archival collections including museums, libraries and audio-visual records.

However, nursing archival sources have been criticized as being uncoordinated and having some duplication of sources (Florence Nightingale Foundation, 2000). They suggested there needs to be a single list of UK nursing history sources available to ease the investigation of archives and provide an easily accessible information base for the history of nursing. Many sources have recently been made more easily available on the Internet. The National Archives have a health related section within which nursing is catalogued and many local archives used in this study have similar systems. Searching for and using historical documents demands certain skills on the nurse historian including the ability to work quickly and efficiently in order to make the most of this time consuming activity. Within archival records a variety of sources are found such as reports, newspapers, minutes of meetings, record books, personal and official letters and photographic images. Often catalogue descriptions and tiles are misleading and are not obviously linked to the researchers study so care has to be taken in avoiding wild goose chases down dead end trails. However, these are often part of the process and some times lead to lucky finds of unexpected data. Appendix 2.10 showing twenty selected publications related to archival research with Sweeney (2005) providing some good advice. In addition to archival sources historians can gain much from memorabilia and artefacts provided by participants and these need to be included within the data as appropriate. These often include photographic evidence which needs to be carefully analysed and can provide valuable social information for national and local nursing history (Wheeler, 1990; Ashton, 1991; Prosser and Schwartz (1998).

Gender

Gender plays an important part in the history of nursing for both men and women. Often described as a female orientated occupation nurse historians cannot avoid examining what part gender played in the history of nursing and how it affected its development.

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Roles of men and women in nursing

In relation to this study there were enormous social changes relating to gender and nursing from 1870-1960. Scott (1998) supported the use of gender as an important category for historical research. When considering the '*history from below'* concept and the need to include '*ordinary men and women*' it is important that gender as an issue is explored. Recognizing the roles of women and men within nursing and how gender impacted within the nursing profession historically is important because as nursing is a female orientated profession there is a need to examine men in nursing as well. Therefore the concept of gender relates to the historical development of nursing locally. Nurses have traditionally mainly worked with the medical profession and this nurse-doctor working relationship relates to gender issues generally and more specifically power. Bunting and Campbell (1990, p. 11) identify that;

> 'The *fact that nursing is primarily a women's profession has overwhelmingly influenced the principles on which it is based as well as its historical evolution*'

The role of women and men within nursing locally has not been addressed in relation to how they worked and why they became and stayed nurses. The wider issues of the role of other forms of '*female work'* within West Yorkshire wherever possible are explored and compared and contrasted with nursing. So the need to consider the female role within society and nursing allows the voices of women to be heard and also highlights the invisibility of the male nurse in general nursing prior to the 1940s. Gender cannot be considered without some mention of the professionalisation of nursing and the social change that surrounded nursing during 1870-1960 and a variety of literature related to this is in appendix 2.11. Key issues related to gender included the reform of nursing, the fight for registration, industrial relations, the occupational socialisation of nursing and the concept of '*semi-professions*'. These support the view that nursing as a developing profession with its occupational sub-cultures is complex. Other aspects of professionalisation and social change included the development of nursing, the impact of the NHS, nursing work, nurse's knowledge, careers pathways, medical sociology and the organisation of medical work. Within these key areas the national issues of nursing registration and the impact of social factors such as the role of women were important. It is suggested that the development of nursing to some extent mirrored the emancipation of women and the roles of men and women within society. Also, there has been a long debate within and without nursing about its status as a profession. It is not the intention to add to this debate here but instead to explore local history for evidence of any aspects of the professionalisation of nursing. As nursing and nurses have wrestled with this issue for a long time it is important that local aspects are brought to the fore to provide historical data of

The work of nurses.

The work of general and district nurses, and therefore women, had an impact on how nursing was perceived and evolved professionally. A variety of authors have written about the role of women at work generally including Vicinus (1985) and Sharpe (1998). Other authors have

discussed issues related to women at work, gender and other sociological issues as listed in appendix 2.12.

General aspects of gender historically include the changing experience of women and employment while Beechey and Whitelegg (1986) discuss the wider issues of contemporary roles for women. Beechey and Perkins (1987) provide useful information about women and part-time work which is very pertinent to the nursing profession which has in the last fifty years provided nurses with a variety of part-time contracts. In relation to gender in health care and nursing Digby and Stewart (1998) explored the issues of gender across a variety of health and welfare issues. Tronto (1987) reviewed a theory of care related to gender issues and Littlewood (1991) took a wider view of gender providing useful perspectives on gender issues related to nursing. Littlewood (1991) continued by discussing the concepts of gender, role, and sickness, while Davies and Rosser (1986) discussed gendered jobs in the health service. All these contribute to the wider issues of the role of women at work and have a direct bearing upon nursing. Maggs (1984a) provided detailed discussion of how nurse recruitment was conducted in relation to women's work raising the issue of the use of an entry '*age bar*' which guaranteed new nurses had employment experience. This was confirmed by Howse (1989, p. 33) who suggested that '*matrons preferred recruits who were at least 21 years old, so most nurses had worked before training*'. Another bar to the employment of women was the '*marriage bar*'. Beddoe (1989, p. 80) stated that; '*Marriage and nursing were seen as incompatible*'. This was particularly evident in nursing but emerged generally after the First World War in some public services to cut costs in 1922 (Braybon and Summerfield, 1987, p. 138). Although prior to this many nurses had been single it was common practice for the '*matron*' of workhouses to be married to the Master. These '*matrons*' may not have been nurses themselves but were in charge of nurses. Summerfield (1989, p. 14) further clarified that; '*imposing a marriage bar enforced the ideology of the male breadwinner and female dependant*'. This is suggested to be a social control method creating a gender imbalance within employment. Summerfield (1989, p. 14) further stated it was; '*……unwritten practice to dismiss a woman on marriage in many industries……*'. This was often experienced within nursing, and in particular nurse training with recruitment criteria and rules of employment excluding married women. This was often not the case for married men who were allowed into nursing. Within this discussion the historical aspects of '*supply and demand*' of nurse recruits nationally is emphasized as often being a secondary factor to the staffing of wards in local hospitals. The culture of rules and regulations that existed for the majority of time under investigation was an important part of nurses' lives, both on and off duty. This authority was important to the organisational success of the institutions that nurses worked in and although they seem draconian now it was accepted by most nurses. Women working within these institutions were therefore both '*cared for*' and '*controlled*'. Maggs' work contributes greatly to the understanding of these gender based issues for general nursing.

Female nurses

Varied authors have written about the roles of female nurses and associated issues as listed in appendix 2.12. In relation to women in nursing Bunting and Campbell (1990) and Roberts and Group (1995) discuss the role of feminism.

Discussion on power related to nursing and political relationships were features of this. Gender socialisation examples included girls being exposed and socialized into the female nurse's role via nurse recruitment campaigns with female images of nurses emphasized or within childhood play. The concept of '*vertical segregation*' explained how women often worked in low paid jobs and were often found in low paid industrial sectors ('*horizontal segregation*'). These two terms would appear to be applicable to nursing and offer some explanation of how and why nursing developed as it did. In support of this Summerfield (1989, p. 12) suggested that prior to the Second World War; women worked in jobs of low status and low pay like nursing and school teaching. This gives a clear indication of the low ranking that nursing had. For women therefore these two occupations were obvious choices for employment. Beddoe (1989, p. 76) identified there was a gradual rise in women in nursing from 1921-1931 (Appendix 2.13). By 1931 a third of women in work were in nursing and this clearly makes nursing an important female occupation.

It is recognised that men have been in the minority numerically and that within general nursing this has been particularly the case. Therefore female nurses are an important occupational group in relation to gender.

The general issues of gender are numerous and their relation to nursing often very strong. There is a historical theme of power and possibly even discrimination in relation to how women worked and how nurses themselves in particular organised work for the male and female members of the profession. There seems to be an indication that the nurses worked at a low value level within the world of work enforcing a subservient position for nursing in relation to medicine and other male orientated professions. Melia (1987) provided interesting accounts of the issue of medical dominance and nursing. This relationship with doctors is examined in the next section which continues the feminist aspects of women and work and the sexual division of labour that this section has hinted at.

Nurse-doctor relationships

Perhaps gender is particularly relevant for nursing historians to consider in relation to the roles that nurses played working with doctors who were usually men. The working relationships nursing had with health related groups of professionals has concentrated upon the nurse-doctor relationship because more recent relationships with other professionals such as physiotherapists and occupational therapists mainly involved female staff, were not significantly part of the time under study and nurses had less direct contact with them. Various authors have provided discussions on several associated issues related to gender and elements of the nurse-doctor relationship as listed in appendix 2.14. Etzioni (1968) suggested although nurses apply knowledge their training is a lot shorter than doctors and the prescription of treatments left to doctors. This illustrates some of the complexities of this

professional relationship and associated power balance. Hearn (1987) suggested that there is a common situation where male professionals order and arrange the work for the mostly female '*semi-professionals*' to do. This is an example of a commonly heard saying that nurses are '*doctor's handmaidens*' suggesting there was a hierarchical servant based relationship. Oakley (1998, p. 192) made two generalizations about gender division of labour in health care; '*First, the vast majority of the world's health care workers are women'.* The second generalization she stated was; '*that the medical profession is male-dominated'* (Oakley, 1998, p. 193). This clearly indicates that there are numerous women working in jobs like nursing and that men mainly work as doctors conveying medicine had a masculine culture (Oakley, 1998, p. 193). She further suggested that; '*Doctors are rational, scientific, unemotional and uninvolved'* and further identified a '*gender division between medicine and nursing'* (Oakley, 1998, p. 193). This gender aspect of these two professions can be explored within the local history of nursing. However, in the Nineteenth Century as new trained nurses appeared doctors found this problematic as the nurses often came from higher social class backgrounds than themselves and was suggested as a reason why the nurse's role became very strictly controlled (Oakley, 1998). There is a need therefore to consider alongside gender the potential for class issues, '*……to read these practices as only gender-related can miss the class based dimensions as well'* (Gottfried, 1998, p. 462).

As care is a complex concept and often stereotyped as women's '*natural*' work the gender division of labour and the power relationships between male doctors and female nurses tended to marginalize care to '*the little things*' (Smith, 1992). This was evidenced in doctors often prescribing '*basic nursing care*'

Feminist views of professional relationships are dictated by the wider social roles and responsibilities that men and women may have like invisibility and stereotyping (Chinn, 1990, p. viii). These two concepts in relation to nursing are useful to consider and relate to the philosophy of oral history.

Voysey (1984, p. 34) identified Matrons wanted recruits who had virtues, such as; *obedience, truthfulness, and kind-heartedness.*' Oakley concluded;

> '*If Florence Nightingale had trained her lady pupils in assertiveness rather than obedience, perhaps nurses would be in a different place now'* (Oakley, 1998, p. 193).

This is a vitally important point about the culture of nurses and nursing and relates to both the earlier and later time periods under study and the relationship between nursing and medicine. The perceived roles of men and women within the family and society, and the concept of patriarchy therefore are important historical issues. Further examination of the origins of the nurse-doctor division included the need to consider the concept of '*domesticity*'. The dawn of nursing in the 1850s came from domestic work origins (Oakley, 1998, p. 191). This '*domestic work*' concept is an important theme linking to the role of women and nurses. Helmstadter (1989, p. 105) stated that before 1880 nurses were; '*recruited largely from the group of women who made up the domestic service class*'. Beddoe (1989, p. 79) supported this by

stating nursing was exclusively female and similar to domestic service. In the UK it was difficult to identify the roles of domestic servants and nurses;

> '*Not until 1891 did the census introduce the term 'sick nurse' to differentiate between hospital nurses and household servants*' (John, 1986, p. 18).

This clearly makes it difficult to explore what nurses did and supports the argument that nursing has some of its origins in the '*domestic*' aspects of women's work. The concept of domesticity is therefore an important issue relating to the history of nursing which has been explored by many authors (Appendix 2.15). Results of these studies indicate that the nurse-doctor relationship had both positive and negative aspects. For many nurses it was accepted that at that time the role of female nurse and male doctor reflected how society viewed gender. The relationship between nursing and medicine has mirrored that of men and women in society as a whole (Chinn, 1990, p. viii).

To view the nurse-doctor relationship as a negative issue was questioned by Melia (1987, p. 181) who found that nurses were satisfied with the medical dominance they worked with stating; '*They recognize medical dominance for what it is and do not allow it to interfere with their conception of nursing'.* This acceptance however could be seen as part of '*obedience*'. Oakley (1998) therefore suggested that obedience, assertiveness, the altruistic aspect of womanhood and nursing, and service are four concepts for consideration. These would appear to be important aspects of the nurses' roles and responsibilities in the whole of the time period under study. Nurses being the doctors '*hand maidens*' clearly represents this obedience and service approach. Nurses were often socialized or indoctrinated into the profession by instilling the notion of '*to serve*' as being central to their role. Oakley continued;

> '*One of the most impressive mechanisms for denying the importance of caring work is to disenfranchise and disadvantage the people who do such work'* (Oakley, 1998, p. 194).

Oakley (1998) further suggested that as caring is the; '*main work of nurses, nurses are likely to come up against two barriers.*' Firstly low status low pay work and secondly an inferiority complex compared to medicine (Oakley, 1998, p. 194).

These two barriers she concluded mean; '*nursing needs to lose its association with femaleness in order to achieve full professional status'* (Oakley 1998, p. 194).

The views on the roles of men and women in society changed greatly during the time period examined in this thesis and it is important to consider these two barriers when examining aspects of the female nurse's role and their work. The nurse-doctor relationship was an important area and with the suggestion that it had a gender or class base there are clear links with how the profession of nursing evolved. Gender is therefore an important issue to examine in any investigation of nursing history. The role of the male nurse therefore needs to be considered.

Male nurses

The issue of men in general nursing is an important aspect of this study as they were absence in great numbers until after the 1940s. Overall, within general nursing and district

nursing men have predominately made up only a small percentage of the nursing workforce. However, their contribution to nursing locally is important to document.

Villeneuve (1994) discussed contemporary recruitment and retention of men in nursing relating this to the historical image and labelling of nursing as women's work with examples of job titles like '*Sister*' and '*Matron*'. It was suggested that after Nightingale '*modern nursing*' was feminized and the association of men with nursing ended in the mid-Nineteenth Century. Nightingale firmly established it as a women's occupation with every woman a nurse, and women entering nurse training were doing; '……*what came naturally to them*' (Evans, 2004, p. 323). At the start of the Twentieth Century the lack of male nurse training was because; '*where similar efforts have been attempted, they have not proved in practice a success*' (Anon, 1907, p. 165). The separation of male and female nurse training is an example of gender segregation within nursing itself. At the beginning of the Twentieth Century there was a suggestion that; '*Male nurses will no doubt mostly consist of men who have served in the Army or the Navy*' (Anon, 1907, p. 165). This link between male nurses and the armed forces was a consistent theme during and after military conflicts.

Overall, there is a growing amount of evidence based literature which examines the male nurse's role and history (Appendix 2.16). Gray (1989) provides evidence that the;

> '……*percentage of nurses who are male has been declining steadily since 1949, but the decline seems to have levelled off in recent years, and in the unqualified grades the proportion of male nurses apparently is now increasing*' (Gray, 1989, p. 15-16).

It is unclear if Gray meant general nurses or all types but this decline in male nurses goes against often commonly held beliefs that men came into nursing after the Second World War in large numbers and that before that they were small in numbers. Edwards (1989) described the founding the Society of Registered Male Nurses in 1937 stating that by 1945 there were 3,470 men employed as nurses in general hospitals. He further reports that; '*In June 1945 there were 24 training schools and five affiliated training schools for male nurses*' (Edwards, 1989, p. 53).

The role of men in nursing is therefore an important issue to consider and in particular to shed light upon how male nurses worked within West Yorkshire.

Conclusion of chapter.

This chapter has provided a detailed overview of the literature underpinning the important issues. Historical research developed slower in the UK than the USA and was incorporated within the general increase of nursing research during the latter half of the Twentieth Century. This increase in historical nursing research provided an important impetus for this study. Often originally written by non-nurses histories of nursing have increasingly been done by nurses and there has been a move from chronological studies and '*hero*' type studies to more analytical and micro-history approaches allowing nurses to research their own professional heritage. The importance of nurses researching nursing is a trend that has emerged alongside the need to use appropriate methods that explore all aspects of nursing history. Many nursing histories are written by non-nurses and there has been a concerted effort to

address this with nurses researching their own professional heritage. The production of institutional studies provides information for nurse historians on the context of how nurses cared for patients. However, there is a need to explore the nurses' roles in more detail in relation to their work and lives.

The increasing use of qualitative methods like oral and life history approaches to data collection and the improved techniques for nurse historians to use within archival data collection have allowed nurses to develop greater skills in these areas.

The importance of gender as an issue was addressed by reviewing some of the literature related to this and underlying concepts.

Therefore the story of local nursing history is not available and this gap in the literature will be addressed by the study objectives. Developing a synthesis of the history of nursing within the two West Yorkshire towns of Halifax and Huddersfield will identify the major developments and changes and the factors which influenced nursing and nurses. The identification of nurses who made important contributions to the development of local nursing history should aide our understanding of this individual element. The study will compare and contrast the development of nursing in the two towns to ensure their uniqueness is captured. By evaluating the use of oral history interviewing as a method of recording the working lives of local nurses there will be some consideration of how this contributes to local history. Historical research in nursing allows further exploration of this methodology and can contribute towards the body of knowledge that nursing has steadily developed in relation to the history of its profession.

In chapter 3 the philosophical aspects of the study are considered and a critique of Rosenberg's areas of importance is provided. There is an explanation of the methodology of the study including descriptions of how the archives searched were selected and how the data was collected. The oral history stage of the study including how the sample was chosen and how the interviews were recorded is described. Data analysis using NVivo software is discussed along with the ethical and legal issues of the study.

Chapter 3 – Methodology.

This chapter debates how the methodological aspects of the study inform the methods used for data collection, analysis and the overall research design. There is an explanation of how the methodological approach links the studies aims to the data collection and analysis strategies and methods. The two data sources of archival documents and oral history interviews are explored.

Research Philosophy.

When considering the question '*what is history?*' nurse historians need to consider the philosophical issues when giving an answer.

The philosophy of this historical study of nursing is based on an inductive data driven approach (Edwards and Talbot, 1994). The study is based on Voltaire's view that history has moved from chronicling to critical analysis (Carr, 1987). This links to the need to examine overall trends in development (Burns and Grove, 1993).

The concept of truth links to historical theories such as the empirical view by Elton (1967, in Hallett 1997/8) and the interpretative view by Carr (1987, in Hallett 1997/8). Historians need to be confident the data they collect are trustworthy and also that their interpretation of the '*facts*' is accurate. Rorty (1982, 1989, 1991, in Hallett, 1997/8) refers to a '*liberal ironist*' approach suggesting it's impossible to attach any absolute truth to a concept, but judgements and interpretations should be made.

The study considers the three philosophical schemes identified by Heller (1982) as a basis for discussion (cited in Burns and Grove, 1993). Firstly, that '*history reflects progress in the development from lower to higher stages*' which links with the professional development of nursing. Secondly, '*that history has a tendency to regress - development is from a higher to lower status...*'. This will link to district nursing still being a '*Cinderella service*'. Thirdly, '*history shows a repetition of developmental sequences in which patterns of progression and regression can be seen*'. These three schemes help analyse issues related to nursing today and in the future, and help answer questions about how nursing can plan for the future if it does not know where it's been or how it arrived there (Christy 78 cited in Burns and Grove, 1993).

When studying history related to nursing there is a need to define the terms nurses and nursing. A history of nurses allows investigation of the individuals who worked in this role in the past and often includes the '*hero*' types of historical narratives. A history of nursing can have two meanings, firstly a history of the development of nursing as a profession, and secondly a history of nursing care or nursing practice (Baly, 1993) or as Maggs (1996a) discussed, a history of caring. Therefore history can be seen as a systematic and methodical narrative of past events and the benefits of studying history include the development of intellectual skills and enjoyment (Sturley, 1969).

History can also be considered as '*learning from the past*' which links to the first, second and third roles of history which Newton identified (Appendix 3.1). These roles are to recognise the

good practices nurses should nurture and the ones they should ignore in order to learn from the past allowing the creation of a positive professional future.

To reflect this philosophy the research methods are based in both the sciences and the arts as supported by Newton (1965) who suggested historical research gives training in both science with data collection and art with the interpretation and description of the data. Questioning what is history is a fundamental aspect of nursing history research. History is the result of the historians activity in the interpretation of the historical '*facts*' and the resultant reconstruction of these into a '*history'* (Munslow, 2001). Reconstructing history is therefore subject to the historians approach and skills in ensuring objectivity and truth.

Within this there have been various approaches included such as cultural, feminist and social which have increased the complexity of history. Despite these methodological changes Munslow (2001) suggests the epistemology of history has remained steady: empiricism and rational analysis. He argues that the empirical-analytical model has become important for undertaking the study of the past. He describes how this traditional view has been challenged as to whether it does identify the true meaning of the past?

Finding historical data and reconstructing it allows the historian to apply meaning to the past via stories that represent history. However, Munslow (2001) asks do historians provide the truth of the past as they represent it or as they find it? He suggests this is the essence of the postmodern challenge. The resultant narrative-linguistic representation allows historians to describe the past within text making history a self-evidently authored literary activity (Munslow, 2001). This emphasis supports history as a reconstructive activity which by the nature of historians being individuals is less objective than the empirical-analytical approach. This results in history being a narrative of the past and Munslow (2001) concluded; '*is history what happened, or what historians tell us happened?*' Cannadine (1999) described history as a way of making; '*plain the complexity and contingency of human affairs and the range and variety of human experience*'. For nursing history this is an important element as nursing and healthcare are complex areas involving a variety of humans. Therefore nurse historians need to re-create via narrative nursing's past in all its complexity.

An important author who discussed what is history was Carr (1990). Evans (2001) suggested Carr was responsible for promoting the need for history to become more sociological and to be politically relevant. Evans (2001) further argues that Carr described history as a process and that it had to be studied in its entirety to ensure contextual issues such as the continuity of history and its interconnections with wider issues. Evans (2001) also credited Carr with supporting the subjective nature of historical writing as something all historians have to grapple with. In relation to local or regional history there are specific reasons why this is important for nursing history. Firstly, it allows provincial histories to be told of nurses who worked away from the bigger towns and cities. This contributes to local heritage and provides a voice for nursing which is often lacking. For example local history text books for both Halifax and Huddersfield did not have specific chapters related to nursing in them and this deficiency impedes our understanding of the past. Secondly, by studying local nursing history there is an

opportunity to compare it with other parts of the UK widening our understanding of nursing and highlighting patterns and trends. Comparing and contrasting local nursing histories can identify commonalties and differences and capture the uniqueness of areas. It can also allow documentation of how local nursing impacted upon and was affected by changes such as geographic, environmental, economical, political, industrial, demographic, social and religious factors. Highlighting local nursing history allows a form of '*history from below*' to be read providing an important contribution to both local and national history.

Finally Cannadine (1999) discussed the importance of history for understanding the present by using the '*here and now*' and '*there and then*' examples. Using this model history can help us understand how the nursing '*world*' got to be the way it is and how other '*worlds*' got to be the way they were and the way they are. Therefore nursing history is a vital part of aiding nursing as a profession to be self-aware of its current position within the healthcare world and the broader society it operates in.

Methodology.

Original ideas for conducting the study included using the Roper, Logan and Tierney (1980) activities of daily living nursing model to examine how nursing care was practiced in the past. The literature suggests the practice of nursing has been neglected and therefore this could have been advantageous. However, it was decided that this would be problematic as the surviving data available for the majority of the time under study was sparse either because it had not been written in the first place, or had not survived. Although the oral history stage of the study could have been used for this it was felt that the earlier period under study would be problematic. A second idea considered was to use the work of Foucault (1963; 1977) as a framework. This seemed attractive in relation to issues such as power, obedience, discipline and institutions. There has been an increasing use of Foucauldian concepts in nursing research and examples included May (1992a), May (1992b), Cheek and Rudge (1994), Henderson (1994), May and Cooper (1995), Gilbert (1995), Porter (1996) and Kuokkanen and Leino-Kilpi (2000). However, it was decided a Foucauldian approach would not cover all the issues that would need to be examined within the local history environment so a more nursing focused approach was sought that would allow a variety of issues to be addressed.

Rosenberg's eight areas of importance.

The use of Rosenberg's eight areas of importance was an opportunistic result of the literature search. With concern for the need to find a framework with which to capture and structure the history of local nursing these eight areas were attractive as they represented issues in a holistic way allowing nursing history to be integrated within its institutional context and its professional boundaries. It also encouraged a historiographical approach and allowed gender aspects to be considered as well as the role of the nurse. The use of these areas of importance is discussed explaining how they were selected and highlighting their strengths

and weaknesses. A short review of Rosenberg's work is provided and his views on history considered.

Charles E. Rosenberg.

Currently Charles Rosenberg is Professor of the History of Science and the Ernest E. Monrad Professor in the Social Sciences at Harvard University. As a non-nurse he has written widely on the history of medicine and healthcare including nursing. He is credited as one of the authors to move medical healthcare historiography from the '*hero*' biographic approaches to include more social history considerations such as nurses (Connelly, 2004). He was a keynote speaker at the UK Society for the Social History of Medicine Annual Conference in 2006 illustrating his prominence and has contributed to the '*vibrancy and diversity of medical history'* (Stevens, 2008, p. 417). Recently, Rosenberg was described as a major American historian (Rogers, 2008, p. 423; Tomes and Greene, 2008, p. 456; Tomes and Reverby, 2008, p. 413; Stevens, 2008, p. 414). Despite Rosenberg not being a nurse or a medical doctor he is an experienced healthcare historian and his interest in the nurse's role illustrates the link with the eight areas of importance (Tomes and Reverby, 2008, p. 412). During his forty years experience history has changed from the '*new social history to the new cultural history*' (Tomes and Reverby, 2008, p. 413). Yet Cooter (2004) was concerned about a general lack of consideration of class issues, the State, and theoretical questions (Tomes and Greene, (2008, p. 457). Another criticism of Rosenberg's work includes a lack of attention to race (Rogers, 2008, p. 432).

The strengths and weaknesses of Rosenberg's approach are considered and in relation to the strengths three related to this study are;

> '*the clinical relevance of medical history, the challenge of writing Twentieth Century history and the difficulties of exporting American concepts into non-American settings*' (Tomes and Reverby, 2008, p. 413).

Clinical aspects of medical history.

Rosenberg has made attempts to consider the clinical aspects of medical history with his work on epidemiology of diseases and the doctor–patient relationship. The nursing elements of his work have been focused upon the clinical aspects of the nurse's role. One of the strengths of his work is the inclusion of nursing and nurses and he was one of the first historians of medicine to imagine nurses within the '*world of clinical practice*' and within the intellectual world of the '*"new" medical history*' (Fairman and D'Antonio, 2008, p. 435). They suggest Rosenberg challenged nurses to consider how they and their care impacted upon the clinical and social world of practice and therefore nursing can be classified as being '*deeply embedded in the relationships and social order of clinical practice'* (Fairman and D'Antonio, 2008, p. 435). Rosenberg also stressed the importance of the multi-disciplinary approach to clinical practice (Fairman and D'Antonio, 2008, p. 436). This is supported by the suggestion that his historical approach encouraged '*integrative quality*' (Rogers, 2008, p. 423). Fairman and D'Antonio (2008) give a detailed account of how Rosenberg helped put nursing into

medical history because nurses made hospital and medical practices possible. They argue nursing is not just a part of medical history but is an analytical category which can give '*new notions of historical significance*' (Fairman and D'Antonio, 2008, p. 436). They consider what a history of clinical practice would look like from a nursing and patient perspective, a caring approach (Fairman and D'Antonio, 2008, p. 438). This they argue would give the '*human element*' of the history of clinical practice (Fairman and D'Antonio, 2008, p. 439). However, when reviewing the fifty-six dissertations done by Rosenberg's students listed by Anon (2008) only three were nursing related illustrating an under representation. Of the ninety-eight history of medicine dissertations listed by Erlen (2008) only one had a nursing title.

Rosenberg was interested in the men and women who nursed in the hospitals and thought it was the; '*nurses and the student nurses who actually defined their and their patients' day-to-day experiences*' (Fairman and D'Antonio, 2008, p. 440). He has supported the study of feminist issues in both his role as teacher and researcher (Rogers, 2008, p. 432). Rosenberg saw a common class link between nurse and patient during the early Nineteenth Century move to a nurse doctor link as they became trained and nursing's status as a job for women improved (Fairman and D'Antonio, 2008, p. 440). This led to the eventual subordinate relationship between nurses and doctors (Fairman and D'Antonio, 2008, p. 441). They concluded that Rosenberg helped nursing to become; '*central to the history of clinical practice as it is already to our health care system and to our American society*' (Fairman and D'Antonio, 2008, p. 446). One of Rosenberg's strengths is suggested to be the resistance to categorization within the history of medicine as he has studied a variety of areas which have promoted the discipline of history (Stevens, 2008, p. 416).

Weaknesses of Rosenberg are that he does not support the creation of a unitary discipline and has not considered in detail the history of mental illness and psychiatry or the history of specific diseases like tuberculosis or diabetes (Stevens, 2008, p. 414; 420). However, his overall wide ranging interests illustrate an integrative approach to the history of healthcare and that nursing has been included in this, albeit mainly focused upon clinical practice.

The challenge of writing Twentieth Century history.

Tomes and Reverby (2008) did not explain this issue but it is clear that Rosenberg's main focus has been during this time period with all its change, continuity and uncertainty. However, he is a supporter of archival sources, oral biography, oral history and life story as important historical methods (Rogers, 2008, p. 429-30), but there was concern expressed by some about the worth of oral history to the history of medicine (Tomes and Greene, 2008, p. 464). In relation to Rosenberg's approach to history Tomes and Greene (2008, p. 358) posed three questions or goals; '*develop common narratives, participate in present-day debates, and develop transnational and transhistorical discourse*'. Stevens argued that the first of these, common narratives, could be encouraged by researchers working together on '*different aspects of medical history that may (or may not) prove to have similar patterns*' (Stevens, 2008, p. 419-420). She suggested these could be facilitated with better links between historical scholars in different university departments such as medicine, nursing, public health,

technology and social services. She provided the example of the University of Pennsylvania's nursing school's flourishing nursing history program (Stevens, 2008, p. 420). This multi-disciplinary (MDT) joint research approach would allow for common narratives to be explored such as nurses researching doctors views of the nurse's role in the past. Fairman and D'Antonio (2008, p. 435) discuss how medical history might be viewed if nurses and nursing history was used as the '*analytical lens*'.

The export of American concepts into non-American settings.

This is an important aspect that relates to this study in particular. Using the eight areas of importance in a local history study in the UK would potentially be problematic if they were not compatible. However, it is argued that his work in this case is relatively broad and that the eight areas are transferable into the UK. This is because they are written as ideas and not defined in any great detail allowing a flexible interpretation of them. Also it can be argued that although the healthcare systems of the UK and USA are different they have similar issues in relation to the roles of doctors and nursing, the development of these two professions and the relationships between them.

Rosenberg's themes and questions.

His eight areas of importance for nursing history research were published in a short article giving an account of his '*array of themes/questions*' about approaches to nursing history which were directed to nurse researchers. The array of themes and questions were not proposed as anything more then that and were presented for discussion (Rosenberg, 2008). Written in 1987 in the American Nursing Research journal Rosenberg's eight areas of importance were also found in the textbook '*Practice of Nursing Research. Conduct, Critique and Utilisation*' (Burns and Grove, 1993, p. 77). Despite this there is no indication that any nurse researchers have used the eight areas of importance (Rosenberg, 2008). Why this is the case is unclear although as they were only '*ideas*' this would have been a little prohibitive. However, it was felt there was scope to utilize them to see if they could aide nursing research. Rosenberg's (1987) model provides a framework to structure data collection, analysis and presentation of results. Rosenberg (1987) suggested they should be considered when doing historical research and it is asserted here that they can be used for nursing historical studies. Rosenberg's eight areas of importance are;

- history from below - ordinary men and women
- gender and the professions
- knowledge and authority
- role of technology
- new institutional history
- the hospital as problematic
- the nurse as worker
- history as meaning (Rosenberg, 1987b, 1987c).

Chapter 3 – Methodology.

The model provides elements that relate to nursing itself and some of the important wider social aspects of health care. This prevents nursing being studied in isolation and provides a more holistic view of nursing. Using this medical based framework for a local nursing history study would seem unusual but it was believed that trying it and reviewing its effectiveness would be beneficial. Appendix 3.2 provides a SWOT analysis of its use for this study illustrating the varied issues identified. In addition to Rosenberg's model a number of key words were identified in appendix 3.3 providing further aspects of nursing and health care that helped define and apply the eight areas of importance during the data collection, analysis and presentation of results.

Issues considered under Rosenberg's eight areas of importance.

The following section indicates the issues considered under Rosenberg's areas of importance. There is recognition that having eight themes limits the amount of detailed discussion and debate about each area so only the main points are dealt with. This results in some of the areas of importance having a more detailed discussion than others.

History from below.

The concept of history from below in this study is to capture data about, and from, general and district nurses working in small non-teaching provincial hospitals. They were valuable and important individuals who contributed to nursing, and to the local populations they worked in, providing many years of service. The data collection, analysis and interpretation of the archival and oral history facilitated a '*history from below*' approach. Social class issues were considered as they relate to both gender and power issues within nursing and link to some of the other areas of importance.

Gender and the professions.

This area of importance allows for consideration of the role of women and men as general and district nurses locally. In particular the female nurse-doctor relationship is explored to consider how this linked to the hierarchical nature of working practices during the majority of the time period under study. Finally the impact of gender on the professionalisation of nursing is considered.

Knowledge and authority.

Although Rosenberg does not explain this area of importance explicitly it is interpreted to include several issues under the two key terms, knowledge and authority. Knowledge is related to nurse education and training in both theory and practice.

Authority issues included ten key words / terms used to compliment Rosenberg's eight areas of importance;

- rules and conduct
- discipline and conformity
- authority and power
- exploitation and social control
- organisational hierarchies and routines

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These issues contributed to an understanding of the concept of authority as the relationships between nurse and nurses, and nurses and doctors were important parts of organisational authority. The role of the hospitals administrator and professional governing bodies were also linked to power relationships.

The role of technology.

The role of technology allows for exploration of the impact upon nursing of clinical care developments. Nightingale's promotion of the miasmatist theory, with the corresponding focus on the importance of hygiene and the need for nurses to be trained to ensure cleanliness and follow orders, illustrates an early technological development. A second technological aspect was the medical advances and discoveries that occurred during 1870-1960 and thirdly, the impact of war on local nurses.

New Institutional history

New Institutional history was a difficult area to define and the interpretation for this study was that there was a need to consider the nurses views of their hospitals and institutions. The number and type of hospitals and organisations varied and needed to be explored.

The Hospital as problematic

The hospital as problematic was another difficult area to define and for this study related to the concept of institutions and their strengths and weaknesses. There was an exploration of the impact of the implementation of the NHS with consideration of pre-NHS and post-NHS health developments. Finally the role of administration and management within institutions was examined.

Rosenberg's assertion that '*hospitals are problematic*' must first be considered with its associated themes of '*internal order and social function*' (Rosenberg, 1987b, p. 68). These suggest that the internal dynamics and social functions of institutions affected nursing history and therefore questions if institutional histories '*had to develop as they did*' (Rosenberg, 1987b, p. 68). Consideration of institutional histories in this study provides detailed insight into a variety of social aspects related to nursing. Rosenberg concluded that;

> '*Studies of the hospital's social history are inevitably studies of nursing's social history*' (Rosenberg, 1987b, p. 68).

Rosenberg also discussed the '*hospital as moral universe*' and how Nightingale influenced the development of hospitals and ward design. The moral responsibilities and obligations of hospitals to provide '*acceptable*' care were obvious but there are many examples of how these were not fulfilled such as the incidence of hospital acquired infections. Nightingale's belief that '*hospitals should do the sick no harm*', later dealt with by Woodward (1974), was an important concept that illustrated the institutions responsibilities and obligations to patients. Rosenberg's account of '*the care of strangers*' in relation to the rise of America's hospital system provides an important aspect of institutional nursing. Caring for strangers illustrates the move from families caring for loved ones to a more '*industrialised*' form of health care with nurses caring for '*strangers*' (Rosenberg, 1987a). With national and local authorities charged with providing health and social care for in particular the '*sick poor*' this increasingly involved

more '*nurses*'. The rise of philanthropic endeavour within society and the power struggles of class, gender and medicine all converged to provide an environment which would allow women to be trained to work as nurses. As the training of nurses increased the institutions power and control over the nursing workforce allowed them to provide services to patients with the nurse's role as student emphatically secondary to their role as worker. The need to consider whether hospitals were problematic in relation to nursing and nurses locally is therefore relevant.

The Nurse as worker

The nurse as worker was an important area as it allowed the student nurses and qualified nurses' experiences to be considered. The general issues of nurses pay and conditions included comparisons with national and regional institutions. How nurses planned care and the methods of organising nursing care linked to ward routines and hierarchical aspects of task delegation.

History as meaning

History as meaning was interpreted as the need to recognise the importance of the past to nursing, the history of nursing locally and nationally and of local nurses as resources to local nursing history. These three issues allow some discussion of the philosophical question of what history is and how it links to present day developments. Recognizing the importance of the past to nursing can be considered from individual and professional viewpoints. Individual nurses may develop an interest in the past because of personal reasons, natural inquisitiveness, studying it or from published literature. However, not all nurses develop an interest in the past and it is important that new nurses are at least exposed to history to promote future research. Newton (1965) identified the need for a balance between research into practice and history. She argued that studying current issues without investigating the relevant past may result in ineffective research.

Throughout this examination of Rosenberg's eight areas of importance there have been examples of how history and historical events can have links to current day developments. This ensures that the history of nursing is embedded within a historical framework that gives it credibility, reliability and validity.

The application and integration of Rosenberg's model.

Finally it is important to consider how this model is used in the study. The eight areas of importance are used as a framework to structure the investigation and in particular the analysis of the data and presentation of results. In appendix 3.4 there is a diagrammatic representation of how the archival and oral history data collections compliment each other, confirming that oral history has a limited time span and that the earlier time periods investigated are not covered by both sources. Appendix 3.5 further provides illustration of how some key words linked to the archival and oral history data collection ensured all these issues were related to Rosenberg's eight headings were emphasized.

Summary of Rosenberg's model.

Although Rosenberg's eight areas have been considered separately above it is inevitable that there will be overlap and links made between each of them during data collection, analysis and interpretation. It is recognised that some of the sub-headings of the eight areas of importance are similar but they are designed to look at the issues from different view points. One example of this is the '*Role of Matron*' which can link to a few of the areas of importance but is designed to illustrate different aspects of the role. The methods used are therefore integrated within Rosenberg's framework.

Methods.

The methods used in this study consisted of two main approaches to data collection, archival sources and oral history interviews. The study was deigned in four stages loosely adapted from Hagemaster's (1992) six steps to life history (Appendix 3.6). Figure 3.1 shows the four stages.

Figure 3.1

Diagram of the adapted approach to using a life story approach based upon Hagemaster's Six Steps to Life History.
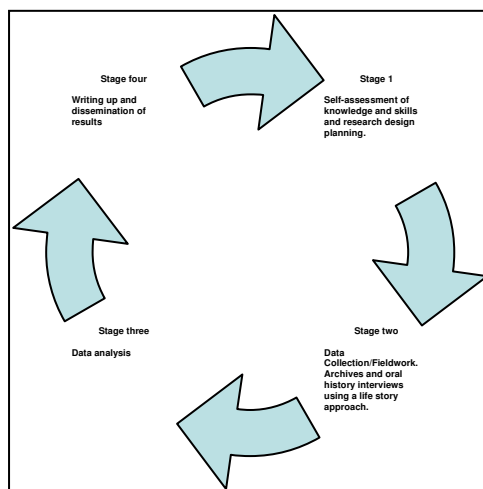
Stage 1.

Self-assessment of knowledge and skills and research design planning occurred early on in the study which was designed using a mainly qualitative approach. Attendance on research modules, courses and conferences related to nursing history, data collection, oral history interviewing and archival searching allowed knowledge and skills to be improved.

Stage 2.

The data collection was in two parts, firstly documentary evidence, both archival primary and secondary sources and secondly, oral history life story evidence.

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Archival documentary evidence.

At the outset of the study the amount and quality of data was unknown and therefore it was difficult to plan and predict what the eventual results might be. The process below was used to obtain an overview of the archival sources identified and the type of data they provided:

- what resources were available (types of data)
- where they were (location and reference of data)
- how access was gained (viewing arrangements of data)
- what was in them (overview of content of data)
- how they were searched (method and data collection)
- how they were recorded (data recording)
- how they were analysed (data analysis)
- how they were reported (data presentation)
- how they were reviewed (data evaluation)

Once the enormous size of the data available was realised it became important to use as much as possible to illustrate the local nursing history as well as the stories of individual nurses. As with many historical studies there were gaps and inconsistencies which are highlighted to show the '*incompleteness*' of data.

Selection of archives.

A variety of resources were available containing different types of data including primary and secondary documentary archive sources (Cormack, 1996; Grbich, 1999). These were identified from local record offices, libraries and hospitals. The expertise of the archivists was relied upon to aide the identification of sources and to speed up the exploration. Key words for searching the archives were used to narrow the focus as much as possible (Appendix 3.7). Also the names of the various institutions in both towns were used. The time scale of 1870-1960 was also used to focus the sources although this was problematic due to some archival sources having combinations of data and some having collections of annual reports covering long time periods often overlapping those under examination here. Using archive catalogues and indices proved advantageous by speeding up the searching process. Sources were examined in detail and their context noted in order to ensure validity and reliability. The author of the documents was identified and the relevance of this to the data considered. The date of publication or writing was also noted and how this may have influenced the content. Sixteen photocopies of relevant archival documents were obtained to save reading time at the archives (Appendix 3.8). The types of archives searched and the categories identified are in appendix 3.9.

Each source was recorded on the specially designed archive research forms to ensure accuracy (Appendix 3.10; 3.11). Sources were referenced and indexed according to type; primary, secondary, written, audio-visual or photographic and by location, subject and usefulness / importance and additional references identified from the source were also recorded. All the records were typed up in order for it to be used within NVivo. Consideration

of the reasons for the author of the source writing the material and the '*time and place*' factors that may have influenced its creation or may hinder current interpretation were noted. Critical review of each source ensured the materials were not taken at face value. Wherever possible data from each source was compared with others to check its compatibility, and archival data relating to the oral history time period was compared to the interview data. In this way attempts at triangulation of data were made to improve and address the issues of validity and reliability. The quality of each record varied, some were in very good condition and easily readable while others were almost illegible. There was a need to try to interpret data from these poor quality sources in order to extract as complete a record of the content as possible. Some handwriting within documents was difficult to read and this was particularly problematic in relation to people and place names.

There were numerous sources available and it became obvious at an early stage that not all sources would be able to be searched due to travel costs and time and so they were prioritised in order to ensure as much as possible could be extracted. It was found that some sources were closed for security reasons and therefore unavailable. This restriction is important to acknowledge as it creates a loss of data that needs reporting in order to allow for follow-up research. All archival access and copyright guidelines and policies were adhered to.

Archives searched.

Archives were identified in Halifax and Huddersfield, Yorkshire and nationally such as London and Edinburgh. They are reported here individually by geographical location not order of importance. Twenty-five different archival sources were identified as listed in appendix 3.12. They are grouped regionally to represent local provincial and national sources. Both public and private sources were studied; the latter including the personal records of the oral history interviewees and other retired nurses. Appendix 3.13 illustrates that twenty-six sets of archival data were sampled and explored including written or visual documents or nursing memorabilia retired nurses owned. The '*Records*' are the actual archival sources with reference codes and '*Items*' are the additional pieces of information that these contained. The accuracy of these numbers was limited by the problem of recording them during data collection and therefore these figures are estimates but nevertheless important in showing the number of sources investigated. The '*Russian doll*' effect of individual catalogued records having multiple sub-items within them led to longer then expected searching. The relationship between volume and / or quality of archival and oral history data accessed can be seen in appendix 3.14. This indicates that quality and volume are independent variables in both archival and oral history research as there might be a large volume of good high quality data from a source or a small volume of limited poor quality data or visa versa. The volume and / or quality of archival sources remain fairly static unless new sources are discovered while oral history sources obviously change over time and are individually variable. This is particularly relevant to the age and health of the retired nurses and their ability to recall memories. For this reason oral history interviews were considered a priority and the researcher concentrated on these initially. Archives were visited once the details of sources were identified.

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Time spent in the archives totalled 173 hours excluding time for travelling, planning visits, searching the Internet or typing up the source forms. The time consuming nature of archival searching is illustrated by providing details of how much time was used within individual archives (Table 3.1). Time spent in each archive varied depending on the sources and opportunities available. There was a need to orientate to the different cataloguing and ordering systems in place so the actual '*reading*' time was less. The largest amount of time was spent at the National Archives which was unexpected and led to extra journeys being made. These archives revealed a rich source of data including the General Nursing Council (GNC) Inspectors reports for many of the local hospitals from 1930-1960.

Table 3.1

Number of hours spent in the twelve most productive archives.

	Archives	Hours
1.	The National Archives, Kew, London	52
2.	University of Huddersfield Archives and Special Collections	30
3.	Kirklees District Archives	24
4.	Halifax Royal Infirmary Hospital Archives	19
5.	Wellcome Institute for the History of Medicine	13
6.	West Yorkshire Archives, Wakefield	13
7.	Calderdale District Office	8
8.	Saint Mary's Hospitals, Manchester	5
9.	Royal College of Nursing Archives, Edinburgh	4
10.	Huddersfield Examiner Newspaper Records / Archive Library	3
11.	Bankfield Museum, Halifax	1
12.	Apothecary's Shop at Shibden Hall Folk Museum Halifax.	1
	Total	173

Collection of archival data.

The sources were identified from the literature search and some were searched and others not searched at all depending on their usefulness rating so the detail about each source varied. Gaining access to archives was planned to ensure maximum effective use of travelling costs and time.

Sources in Halifax.

Calderdale District Archives (CDA) was part of the West Yorkshire Archive Service (WYAS) within the Halifax library. Within the '*Guide to Calderdale District Archives*' (West Yorkshire Joint Services Committee, 1999) twenty-three resources were identified (Appendix 3.15). Nine sources were found in the Local Board of Health records and within the Hospitals and Hospital Boards records a further seven nursing related sources were identified (Appendix 3.16). There were fifteen pieces of information from the guide to the Calderdale Archives (West Yorkshire Archive Service, 1990) (Appendix 3.17). Halifax Local History Library provided references to local general history sources and included some health and nursing related documents (Appendix 3.18). Other sources included the RHI hospital archives which was accessed and proved a valuable resource. During the study the RHI and HGH hospitals

closed and the new Calderdale Royal Hospital (CRH) opened so the archives were transferred to the WYAS in Wakefield and re-visited there. The Halifax Antiquarian Society was accessed to identify hospital and health based articles. Bankfield Museum, Halifax had a small collection of health and nursing related materials including a nurse's wartime uniform section. There were photographic and art pieces related to hospitals and nurses and also some old invalid carriages. At the Apothecary's Shop at Shibden Hall Folk Museum a variety of medical equipment such as electric shock devices and inhalers were identified but there was no direct local or nursing history data. At the Calderdale Museum and Arts Photographic Collection (Shibden Hall) photographic resources identified here included a photograph of the '*Stainland and Old Lindley*' horse drawn ambulance of 1910 and a colour lithograph of '*a view of the infirmary*'. The local Halifax Evening Courier newspaper records had limited references and the newspaper library and photographic archive were accessed indirectly by telephone without any real sources identified. The Elland Historical Society, Halifax was identified as a source but was not searched due to time restrictions.

Sources in Huddersfield.

The Huddersfield Local History Library (HLHL) provided references to local general history sources including health and nursing related documents. The Kirklees (Huddersfield) Archives (KDA), part of the WYAS, had a varied selection of health records including those pertinent to Poor Law, voluntary and municipal institutions. There were some specific archival documents with information related to the HRI. Using the Internet based National Records Database a further three institutionally based resources in Huddersfield Library were identified; Holme Valley Memorial Hospital (HVMH), St Luke's Hospital (SLH) and SHH (Appendix 3. 19). At the Tolson Memorial Museum in Huddersfield (TMM) there were nursing related photographic negatives and several sources relating to the Huddersfield War Hospital. The University of Huddersfield Archives and Special Collections provided access to a wide variety of sources including general historical texts, nursing specific sources including a partial collection of the Nursing Illustrated journal and two volumes of the GNC Nurses Register. The main newspaper was the Huddersfield Examiner which limited references but the Examiner Library assisted with post 1947 historical photographic and article evidence.

Sources in Yorkshire.

At the WYAS in Wakefield references included three specific sources; the West Riding Health Committee minutes and Departmental Records, and the WYAS Annual Reports (1997; 1998). These were explored and 152 main records identified. The WYAS provided a variety of good nursing based records for general and district nursing and local hospitals in both towns. The Yorkshire Film Archive at the University College of Ripon and York St. John was accessed by telephone, email and post. There were two main pieces of film from this source, one relating to Huddersfield and the other to Halifax (Appendix 3.20). It proved difficult to view these but summaries of them were reviewed. The Thackeray Medical Museum in Leeds was not visited as Internet checks revealed there were no relevant local history sources held there. At the Leeds University Archive Database Departmental Records: Department of Community

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Medicine there were details of the Medical Department of the Yorkshire College in 1884 and the School of Medicine in the University of Leeds in 1904. These are important as some of the nurses locally studied Health Visiting, District Nursing and the Sister Tutor Course there (Appendix 3.21). At Leeds District Archives no relevant archival data was found.

Sources in Manchester.

Saint Mary's Hospitals, Manchester (SMH) was accessed and established confirmation of reports from both oral history and other archive materials of an affiliation between the training of nurses at SMH and HRI. A variety of types of archival data were found including photographs of buildings and medical staff and midwifery and gynaecological patient admission books and clinical attendances. There were numerous nursing records for SMH, a series of hospital Annual Reports, Board of Management Minutes, and a selection of Committee and Sub-committee meeting minutes. A detailed list of the sources identified is in appendix 3.22.

An Internet search and telephone and email correspondence with the Manchester Archives and Local Studies Department proved unsuccessful in finding any data related to nursing in Halifax and Huddersfield.

Sources nationally.

At the National Archives the Poor Law records for Halifax and Huddersfield were found in the MH Series (Appendix 3.23). After 1870 no Poor Law or County Hospital records existed so the Poor Law Union, Almshouses, Friendly Societies and Out-relief records were searched. Overall four archive sources were closed for access.

The Contemporary Medical Archives Centre at the Wellcome Institute for the History of Medicine was visited and included sources related to family planning, district nursing and HRI (Appendix 3.24).

The Royal College of Nursing Archives (RCN) in Edinburgh were visited once and then followed up during the study on the Internet or by correspondence with the Archivist and staff. The RCN searchable On-line version of the British Journal of Nursing was extensively used as was the RCN general web site and on-line RCN library.

The United Kingdom Central Council for Nursing (UKCC) was at an early stage of the study identified as being unproductive in providing any information about local nursing. The Queens Nursing Institute was after telephone and postal enquires found to not have any relevant data. The Florence Nightingale Museum was not accessed following Internet enquires confirming there was no local history data available.

Overall there was a wide ranging selection of archives searched and used which provided a varied and rich array of information.

The use of archival evidence.

Using archival evidence is problematic as documentary records are often very varied in their nature and are notoriously unreliable. They are often only small pieces of the larger jigsaw puzzle of the past and can therefore only show us those parts of the historical picture. Sweeney (2005, p. 64) suggests the existence of documents of events does not prove they

actually happened or that the author witnessed it. Therefore the accuracy and trustworthiness of archival records has to be carefully considered. Sweeney (2005, p. 64) raises three dilemmas for historical researchers, can they;

1. interpret documents objectively (Hallett 1997/98).
2. ensure the '*jigsaw puzzle pieces*' reflect historical proceedings and can be confirmed as factual.
3. ensure the '*objective truth*' in a scientific way from '*conflicting interpretations of reality*'?

From this Sweeny (2005) concluded;

'*as Church (1987) contends, what constitutes knowable truth in historiography relies upon careful analysis and synthesis of sources and some element of interpretation*'.

Sweeney (2005) discussed '*external criticism*' which involved putting emphasis on the researcher establishing document authenticity. '*Internal criticism*' in addition involved the researcher in considering the meaning of the documents contents and its trustworthiness (Sweeney, 2005). Positive criticism involved the researcher in ensuring that any terms used in documents were understood for that time period while negative criticism required the researcher to try to date documents and affirm the authors as valid (Sweeney, 2005). These four '*tests*' were considered when archival documents were assessed. Many nursing and healthcare official records were found which could be seen as trustworthy in their content however their completeness can be questioned. Examples at HRI and SMH included record books which raised questions about if they had records of '*all*' the nurses involved in them or whether some were missing. The researcher could not really assess this but some signs this may have been the case were incomplete pages or sections, gaps in sequences of entries and the possibility of missing pages. Also with these record books it was unclear if these were the only surviving books and whether other data was therefore not available. Therefore checking the title of individual record books allowed for some estimate of whether other books may have existed.

The varied nature of historical documents included how and why they were written, by hand or typed, official or private and published or unpublished. From 1870-1960 many documents were handwritten bringing with them the complexity of trying to accurately read and document their contents. This was done honestly with any illegible text noted and either attempts to decipher them made, and acknowledged as such, or they were not included in the analysis. Scrutiny of documents was important and it was vital that notes made were legible once away from the source. This rigour was important to ensure data was reliable and easily transcribed into computer form.

The use of photographic evidence.

Two types of photographic evidence materialised, formal official and informal casual images. These both provide insight into the individual nurses in both towns, the types of uniforms worn

and internal and external views of local buildings. This is particularly powerful when trying to consider '*history from below*' and illustrate the ordinary nurses' experiences. Comparisons of both the formal and informal allow exploration of official and unofficial versions of nursing history. As with any hierarchical organisation there may often be more photographic evidence of senior staff and therefore images that show junior employees are rarer. However, in nursing there was a tradition of taking photographs of nurses when they commenced or completed their training courses which provide formal records of these events. Obviously many individuals are unnamed and this creates problems of trying to ascertain who they were. However, much can be gleamed about the nurses and nursing from viewing these images. Prosser and Schwartz (1998) when discussing the use of historical images discussed four aspects that should be considered. Firstly, that the context of the situation may be missing and that the historian needs to take account of this. Secondly, the relationship between the photographer and subject(s) has to be understood so that this can be included in any analysis. Thirdly, the fact that certain images survive when others do not is another factor that needs to be well thought out as the surviving image may or may not be representative of the actual situation. Finally, they suggest that the photographer's motive for taking the picture has to be clearly investigated so that the image can be explained carefully. Grbich (1999, p. 145-46) discussed the use of photographs in research and identified three steps to analysing groups of photographs in an album;

1. determine its purpose
2. determine its narrative
3. identify themes.

Grbich (1999) further argued that a single photograph could be analysed as well citing an example of this by Farran (1990).

Many images of hospitals in the early Twentieth Century were commissioned by the administrators as '*show case*' images and therefore photographers would have to show the institution in a good light. From the photographer's point of view working as a commercial business meant they had a vested interest in ensuring their images were used and that they developed a good name for themselves to secure more business. Photographs were produced as postcards and therefore could be sent around the country selling both the photographers skills and the content of the picture. Images containing nurses show examples of uniform in group poses that indicate formal arrangements of staff. However, images from oral history interviewees included some informal pictures which showed a different view of their experiences. Also, as cameras were not freely available due to their cost many nurses were unable to own one so the informal image was less common than the more formal professionally taken ones. Taking these issues into account visual images can prove to be valuable sources of historical evidence that illustrate the documentary and oral history data.

Conclusions relating to archival sources

The archives searched provided a variety of sources containing a wide range of data. The sources included hand written and typed records and photographic evidence. A systematic approach to data collection was conducted to ensure reliability and validity of data. Wherever possible the data was transcribed to computer files for analysis using NVivo. Details of local hospitals and the nurses working in them proved invaluable in understanding what nurses did and how they worked and was particularly important for the earlier years of the study as these were not covered by the oral history interviews. The Local Government Board (LGB), Workhouse and Poor Law records were particularly important to provide details of how nurses worked and trained. However, the archives also supported the oral history data for the latter years of the study. GNC Inspection reports provided detailed accounts of both the nursing staff and hospital facilities. The researcher gained experience of searching archives and recording data although data collection was time consuming there was satisfaction in discovering old documents with important unknown information about local nurses. The next section describes the collection of oral history data.

Oral history.

The aim of the oral history part of the study was to create a collection of memories from retired nurses and compare/contrast their individual experiences. Theoretical and methodological issues included memory, reminiscence, reliability, validity and gender. Faraday and Plummer (1979) and Atkinson (1998) provide detailed analysis of the knowledge and skills required to perform oral history interviews. They describe the oral history interview process as four main stages; planning, doing, analysing and interpreting. Adapting this list, the oral history stages of the study are described under the following five headings:

1. planning and preparing the interviews,
2. sample,
3. interview process,
4. social skills of interviewing,
5. transcribing the taped interviews.

Interviews were semi-structured and biographical in nature, subject participation being the prime objective.

Planning and preparing the interviews.
Personal development.

In all interviewing circumstances it is important to prepare both the interviewer and interviewees. In order to prepare for this the interviewer attended a number of events listed in appendix 3.25. Interviewees were prepared by full explanations of the process and informed consent.

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Devising an interview schedule and questions.

The interviews were designed to provide a rich amount of previously unknown information about how nursing was delivered in Halifax and Huddersfield and what the interviewee's felt about their experiences. Recognition that interviewing skills can be learnt and experience is helpful it was acknowledged that preparation was important as there can be no second chances to record interviewees' experiences. Richie (1995, p. 58-60) identified that the skill of producing interview schedules was important to collect the retired nurses' memories. The interview schedule contained prompting and probing questions that supported the interviewer if the interviewee was not answering questions freely (Appendix 3.26). The questions or methods used to gain interviewee co-operation are the most important indicators for gaining quality answers (Atkinson, 1998). Atkinson also emphasized the importance of the skilled use of closed and open questions. The interviewees were not given prior details of exact questions to ensure immediacy and spontaneity of reply (Howarth, 1998). Interviews were based upon a '*life history*' or '*life story*' biographical approach and therefore took the form of in-depth semi-structured interviews to encourage interviewee participation (Atkinson, 1998). General themes explored in relation to the nurses were their:

> * motivation to be a nurse,
> * first memories of nursing,
> * descriptions of how nursing care was delivered,
> * reflections and experiences of being nurses.

The interviews were thematic in design following a life history chronological format based upon the RCNs Oral History Project Interview Schedule (Appendix 3.27). Semi-structured interviews were used so interviewee's could tell their own story;

> '……the less structure a life story interview has, the more effective it will be in achieving the goal of getting the persons own story in the way, form, and style that the individual wants to tell it in' (Atkinson 1998, p.41).

Pilot study

Two pilot interviews with retired female nurses were conducted. They had trained and worked at HRI and were aged fifty-seven and sixty-three. The resultant transcripts totalled 18,919 words (10,330 and 8,589 words) and provided interviewing experience including questioning and using the interview schedule which was not changed for the main interviews. It also allowed practise of using recording equipment although a different recorder was used for the main interviews. Transcription gave useful experience of how this was best done and confirmed its time consuming nature. The content of these interviews proved valuable and for this reason they were with permission included in the NVivo analysis.

Sample

Contacting potential interviewees.

The age chart in appendix 3.28 guided sampling by ensuring a suitable selection of nurses who had lived and trained as nurses during different time periods were sampled. Subjects were identified and approached for consent and the five important facets of initial contact

were considered (Church and Johnson, 1995). Letters with attachments were put in the local newspapers, hospital newsletters and nursing journals to identify possible subjects (Appendix 3.29; 3.30). A feature about the study was included in the two local papers (Anon, 2000c; Anon, 2000d). An email was sent to relevant nursing staff within the university in order to check if there were any contacts they knew about from their experiences as nurses (Appendix 3.31). This supports the view that interviewees are often found by '*word of mouth*' (Harrison, 1973; Ritchie, 1995, p. 62). Kirby (1997/8) describes this as '*snowball sampling*'. This opportunistic sample resulted from retired nurses providing information about their colleagues similar to '*convenience sampling*' (Denscombe, 1998, p. 16). The sample for interviewing was based upon criteria such as representation of the two towns, type of nursing, age, gender and the decade when they started nursing. Interviewees were selected who had trained or worked in either Halifax or Huddersfield hospitals before 1960, however many nurses who responded did not fit this criterion. The sample was by necessity from the older population and interviewees were selected to ensure they formed a representative strategic sample (Kirby, 1997/8). The collection of names was organised in four cohorts of retired nurses representing the four decades from 1920 to 1960. An overview of the sampling process can be seen in appendix 3.32.

Sampling identified 373 named individuals ranging from 58-97 years old with 328 (87.9%) female and forty-five (12.1%) male nurses. There were 222 (59.5%) nurses from Halifax, 192 (86.5%) female, thirty (13.5%) male, and 151 (40.5%) from Huddersfield, 136 (90.1%) female and fifteen (9.9%) male. Of the total number of names forty-five (12.1%) were known to have died, thirty (66.7%) from Halifax and fifteen (33.3%) from Huddersfield, leaving an initial available sample of 328 (87.9%), with 192 (58.5%) from Halifax and 136 (41.5%) from Huddersfield. Not all of these had contact addresses or telephone numbers and so were not processed any further. Opportunistic contact was made with sixty-eight (20.7%) of these, forty-seven (69.2%) from Halifax and twenty-one (30.8%) from Huddersfield, leaving 260 (79.3%) retired nurses who were not contacted. Of these 145 (55.8%) were from Halifax and 115 (44.2%) were from Huddersfield. Fifteen (22%) retired nurses were contacted by post, thirteen (86.7%) from Halifax and two (13.3%) from Huddersfield, four (5.9%) from Halifax by telephone and forty-nine (72.1%) by preliminary face to face visits. These visits were to thirty (61.2%) nurses from Halifax, twenty-seven (90%) females and three (10%) males, and nineteen (38.8%) from Huddersfield, eighteen (94.7%) females and one (5.3%) male.

Prior to confirmation of the final sample as many as possible of the potential interviewees were contacted by telephone or post and if they agreed an initial thirty minute informal exploratory meeting was conducted (without audio recording) which allowed a decision to be made about if they were suitable and whether they wished to be interviewed formally. If a visit was not possible the initial interview form was posted to the interviewee (Appendix 3.33).

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Basic biographical details were collected as well as nursing experience data and the identification of relevant personal nursing documentation and memorabilia. Although thirty minutes was planned for each pre-interview visit in practice they often lasted longer. Pre-interviews were supported by Paterson and Bramadat (1992) and Grbich (1999). Of the ten Halifax interviewees two did not have a preliminary visit and three from the eleven Huddersfield interviewees were not visited prior to the main interview (Appendix 3.34). Interviewees were given preliminary information over the telephone or during the pre-interview meeting as required and provided with written confirmation if they agree to participate. They were informed of the interview aims, length and venue and letters were sent to them prior to the actual recorded interview (Appendix 3.35). A consent form was attached and they were asked to read and sign this and present them at the interview (Appendix 3.36). The pre-interview meetings allowed further selection of appropriate nurses for interview and an opportunity to explain the study and gain informed consent.

Geographical location of the nurses in the sample.

Of 192 retired nurses identified who had worked in Halifax hospitals, and who were believed to be still living, the contact addresses of seventy-six (40%) were available. Analysis of the addresses found that sixty-seven (88.2%) were living in Yorkshire, seven (9.2%) in the UK and two (2.6%) overseas. Of the 136 retired nurses identified who had worked in Huddersfield hospitals the contact addresses of sixty-eight (50%) were available and analysis of the addresses found that sixty-six (97%) were living in Huddersfield and two (3%) in other regions of the north of England.

Selection of interviewees from the sample.

Of the sixty-eight nurses contacted a total of seven (10.3%), four (57.1%) from Halifax and three (42.9%) from Huddersfield, declined to participate in the study or were too ill. Twelve (17.6%) remained undecided, eight (66.7%) from Halifax and four (33.3%) from Huddersfield, and were not troubled any further. Five (7.4%) of the nurses did not meet the research criteria for selection for interview, four (80%) from Halifax and one (20%) from Huddersfield. This left a total of forty-four (64.7%) who agreed to be interviewed, thirty-one (70.5%) from Halifax and thirteen (29.5%) from Huddersfield. Of the forty-four nurses only one (2.3%) was male. Of those forty-four who agreed to participate the decade when they started nursing was checked and there was one (2.3%) in the 1920s, nine (20.4%) in the 1930s, twenty-two (50%) in the 1940s and twelve (27.3%) in the 1950s (Appendix 3.37). Reducing the sample to the twenty-one was done against the criteria of having trained or worked in one of two towns before 1960. The interviewees career and experience was considered to reflect a variety of nursing backgrounds but marital status was not a factor.

From the forty-four retired nurses available the resultant interviewee sample consisted of twenty-one (47.7%), ten (47.6%) from Halifax and eleven (52.4%) from Huddersfield meaning twenty-three (52.3%) of the available retired nurses did not participate. All the twenty-one interviewees were female nurses with an average age of 76.5 years and age range of 65-97 years (Appendix 3.38). Detailed individual profiles of the twenty-one retired nurses

interviewed are in appendix 3.39. Fourteen (67%) were married and seven (33%) single (Married it this case included widows). The Halifax cohort consisted of five married and five single women and the Huddersfield cohort consisted of nine (81.8%) married and two (18.2%) single women. Although four male nurses were contacted and visited it was not possible to interview any of them as two died before interview, one declined to participate in the study and one did not meet the interview selection criteria having worked mainly in mental health nursing.

The majority of interviews were conducted locally in the two towns. However, four were conducted outside Yorkshire, three in Lancashire and one in Oxfordshire. The selection of four interviewees who lived outside the two towns was in part an opportunistic occurrence. In one case the potential importance of the interviewee's contribution made it necessary to travel. The other three were included to provide a varied geographical location to the sample and to reduce the risk of any '*group think*' as many of the retired nurses knew each other well and in some cases met up on a monthly basis. This would presumably give them opportunity to share and retell their stories and perhaps mix up their own and others stories. There is a possibility that they would therefore be influenced by this and tell the same or similar stories. Of the interviewees who trained elsewhere before working in Halifax one had trained in Hull and two at Leeds and in Huddersfield the one had trained at Leeds. Appendix 3.40 provides details of the decade the interviewees trained, number of interviewees per town and training hospital. Of the sample interviewed the main decades when they trained were from the 1930s-1950s and therefore provided a limited span of years in relation to the studies 1870-1960 period. However, interviewing nurses from different backgrounds, ages, types of nursing and training hospitals provided a varied range of data. This allowed triangulation of data and also prevented repetition. Appendix 3.41 provides further detailed information about the actual years when the interviewees started their first nurse training courses. It can be seen that the interviewee sample was consistent across the two towns in relation to both numbers interviewed and the years they started training.

Interview Process

Interviewees were offered the opportunity to be interviewed at the University but none took this up. It was recognised that as an elderly population some had difficulty travelling and others were too far away. All interviews were recorded in interviewee's homes, in one case a nursing home. Two interviewee's had relatives accompanying them throughout the interview, a husband and a daughter, and two had a spouse join during the interview. The twenty-one interviews were conducted from 29 June to 21 December 2001. Interviews were planned to last no longer than two hours but this became difficult to control due to interviewees' individual circumstances. Although Thompson (cited in Kirby, (1997/8) recommended interviews last between one and a half to two hours to prevent subject fatigue, this study took Hagemaster's (1992) advice and considered the individual subjects age and level of energy. For the ten Halifax interviews the length of interview ranged from one hour twenty-seven minutes to two

hours fifty-one minutes and one hour forty to three hours nine minutes for the eleven Huddersfield interviews. Appendix 3.42 illustrates the total time of the twenty-one interviews was forty-five hours, with interviews ranging in length from one hour twenty-seven minutes to three hours nine minutes.

Interviewees were told to ask for the interview to stop, or ask for the recorder to be switched off, at any time, for any reason or to allow for any breaks they may require. Ritchie (1995, p. 72) discussed issues related to turning tapes off. The interviews followed the guidelines in appendix 3.43.

As Hagemaster (1992) recommended follow up interviews were planned to be done weekly to maintain continuity as required.

Recording techniques.

A '*Walkman*' type tape recorder was used for the two pilot study interviews. However recording was eventually done using a Marantz CP430 stereo tape recorder and two tiepin microphones as recommended by the British Library and Oral History Society. Nineteen of the interviews were recorded using Maxwell Original Position Normal IEC Type 1 UR 90 audio tapes; one was recorded on a TDK SA 90 High Position IEC11/Type 11 and one on a Maxwell Original Position Normal IEC Type 1 UR 120. Although at the time of preparing for and conducting the interviews there were discussions about the emerging digital recording formats these were not used. Haigh (2001) provided insight into the arguments for and against the use of audio tapes and digital media and highlighted the issues of preservation in archives and accessibility to recorded material on-line. Prior to interview a short introductory statement was recorded onto the tape (Appendix 3.44). A summary of the key points of the interview was transcribed during copying (Appendix 3.45) and an Interview Log and Data Sheet completed (Appendix 3.46). Each tape was coded, labelled and stored securely in a locked draw.

Social skills of interviewing.

There was consideration of the social skills needed to interview twenty-one retired nurses and every effort was made to ensure both interviewer and interviewee safety and comfort. Developing interviewer / interviewee rapport and its impact upon the reliability and validity of qualitative data was recognised. Gorden (1969b, p. 308) identified that one basic interviewer task is, '*......maximising the flow of relevant information*'. Developing a rapport with the interviewees reassured them and if they '*dried up*' the interviewer prompted them. The interview schedule and open and closed questions minimised the need for re-wording of questions which was an important skill when clarifying questions for interviewees. Attempts were made to avoid the use of multiple or leading questions and interviewees allowed to respond naturally. The importance of listening skills was recognised in helping to check interviewee statements by saying, '*you mentioned earlier......*'. This links to Gorden's (1969b,

p. 309) two points, *'……accurately receiving information'* and *'……accurately hearing the respondent'*.

There was consideration of the important issue of the interviewee's experience of the interview. Rickard (1998, p. 35) suggested;

> *'Oral history is a shared experience and I feel that as much in matters of process as in matters of content, interviewees are experts'*.

She further suggested;

> *'Oral historians have increasingly recognised that in an interview situation, interviewers and those who are interviewed do not share one purpose'* (Rickard, 1998, p. 37).

Therefore two aspects of the interview to consider were the interviewer's aims and the stories the interviewees wanted to tell. Rickard in her research findings identified; *'……people had a complex range of reasons for deciding to be interviewed and a need for differing amounts of information prior to interview'* (Rickard, 1998, p. 37). With both the planning and execution of these interviews the interviewee's motives and needs were considered. Rickard (1998, p. 36) further identified six areas to consider about how the interviewee may be feeling which were used as guidelines (Appendix 3.47). Rickard (1998, p. 40), further identified that;

> *'……there was general agreement amongst the co-respondents that the process of recording the interview was draining and people felt they relaxed more into it as it progressed and as the relationship with the interviewer developed'*.

As the average age of interviewees was 76.5 years this was important and their health and welfare was monitored throughout the interview visit.

The fact that the interviewer was a nurse was an important consideration as it could be argued it may have had a potential positive or negative impact upon the interviewees and the interview. The interviewers nursing knowledge may have caused some interpretation problems as an interviewer with less nursing knowledge may have elicited more detailed data by asking more clarifying questions. Knowing the interviewer was a nurse teacher may have been problematic as the interviewees may have believed that the interviewer knew more than them. They may have therefore felt inhibited about demonstrating their perceived '*ignorance*' or wanted to impress the interviewer with their knowledge, resulting in either more or less information being given about their experiences. Familiarity needed to also be considered as responses may have changed due to interviewees thinking the interviewer understood or already knew particular data. This was particularly important for local hospital and town information where the interviewees often had much more knowledge and it was important that the interviewer allowed them to give as much detail as possible or re-checked with them by asking supplementary questions to clarify and gain further details of information they presumed was already known. As the interviewer was not originally from the local area, knowledge of the two towns was limited and therefore this was not as big a problem as it could have been. Coming from a similar background means the interviewer / interviewee relationship could have been affected and must be considered when reviewing the findings as certain factors need to be taken into account like; '*……the theoretical perspective you choose*

to read the story according to or the objective stance you take' and; *'your own experiential frame of reference and subjective perspective that you bring to the story'* (Atkinson, 1998, p.58).

Within this issue of nurses interviewing nurses is the more general issue that the personality of an interviewer may influence the interviewee by either producing additional information or encouraging concealment. This links to the interviewers character and interpersonal and communication skills. This was considered and ways of ensuring a positive impact explored with each interviewee. Prins (1991) refers to this suggesting the interviewer is interactively part of history. Atkinson, (1998, p.59) stated;

> '*There is a creative relationship that develops between the two people involved in the life story interview that may determine to some degree what actually gets told or even how'*.

The interviewer communicated in a professional manner both verbally and in writing. Each interviewee was treated with respect and dignity and during the interview their welfare catered for. It was recognised that as the retired nurses were elderly interpersonal and communication skills needed to be adapted to their needs as some were hard of hearing or had visual difficulties.

Acknowledging there was an age factor between the interviewer and interviewees was considered prior to, during the interviews and analysis. Aspects such as terminology and age related issues to do with the time period being discussed were considered. Examples included general educational terminology, nursing care practices and items such as clothing and food, where clarification questions were asked to gain an understanding.

Although they had agreed to be interviewed and felt able to cope with it, in reality some found it more difficult then expected. However, the majority seemed to enjoy the experience overall. Many said they had found the interview cathartic and therapeutic and Perks (1990) suggested interviewees often gained personally from the experience. Rickard (1998, p. 42) discussed emotional problems post interview and she would stay in touch with interviewees for a while and if needed refer them to support agencies. If interviewees were upset the interviewer planned to address this by talking and listening to them and giving clear support contact information. If necessary the interviewer would re-visit the interviewee to check if they are all right at a later date. A third person with expertise was to be contacted, with their consent and permission, to help any interviewee who was very distressed. However, none of the interviewees needed any form of support. The interviewer did make return calls to see them to return memorabilia, re-check interview data, provide them with a copy of the tape and transcript or to see information they had found after the interview. The need to return to some interviewees allowed for some follow-up and posting out transcripts and tapes for feedback also maintained some contact.

Reflections of what could have been done better by the interviewer were written down after each interview forming a personal development diary of actions which could improve subsequent interviews.

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During the interviews there was a need to maintain concentration and listen intently. Turning the tapes over after forty-five minutes was a 'natural' break in proceedings. Other issues surrounding biographical interviews with older people were also addressed (Cornwall and Gearing, 1989).

Ending the interview was done by thanking the interviewees for their cooperation and contribution. After the tape had been turned off, the interview experience was discussed and interviewees informally de-briefed if necessary. Explanations about what would happen to the audio tape and transcript were repeated and interviewees invited to sign the release form.

Transcribing the taped interviews.

It was recognised that effective recording techniques would help to reduce the chance of poor sound quality recordings. Powney and Watts (1987a, p. 146-152), Breakwell (1990, p.103), and Atkinson (1998) all described transcribing as time consuming. However, transcription can be a worthwhile experience allowing the transcriber time to analyse, interpret and reflect upon data. When transcribing remembering information received during inaudible parts of a tape was difficult, and Smith (1995, p. 12) identified the, '......advantages of recording include not having to take notes.' However, the interviewer did use notes occasionally to; aid memory for questions to ask or points to return to; substitute for the lack of visual data from video recording; and note non-verbal information (Breakwell, 1990, p. 86). Powney and Watts (1987a, p. 143) described the latter as 'unrecorded data'.

The format and structure of the transcripts was based upon the full and complete transcript of the narrative as supported by Powney and Watts (1987a, p. 148), Smith (1995, p. 18), the British Library National Sound Archive (BLNSA, 1997) and the Centre for Study of Lives at the University of Southern Maine (Atkinson, 1998).

A 'transcriber' tape recorder was used to try to reduce the time spent on transcription and transcription skills improved with experience (Atkinson, 1998). The interviewer endeavoured to do the transcribing as soon after the interview as possible in order to help recall (Ritchie, 1995).

Two technical matters included the potentially confusing aspects at transcript time of narratives not been in chronological order, and the interviewee dropping into whispers when discussing sensitive issues or abandoning words for gestures. Transcription occurred from October 2001 to March 2004 with the interviewer transcribing fifteen of the recordings, paid assistance allowed five others to be transcribed by secretarial support and one was transcribed by a volunteer. The advantage of using others to transcribe was mainly the time saved but disadvantages included not having control over style and accuracy.

The ten Halifax interviews resulted in 237,114 words with the eleven Huddersfield interviews producing 276,364 words, a total wordage of 513,478 as illustrated in appendix 3.48. This large wordage was an expected consequence of conducting life story / life history interviews with a professional connotation which by their nature contained individual detailed and rich accounts of personal and professional lives. It was recognised that a large proportion of the

interview data would not be used in this study as it would be related to events outside its parameters. However, this additional data was felt to be important for future use via archival storage. It was planned to deposit the tapes and transcripts in the University of Huddersfield archives and in some cases also, with written permission, the RCN Oral History Collection.

Summary of oral history.

Atkinson (1998) suggested that what we are looking for in the life story is trustworthiness more than truthfulness and it is argued this interview data is trustworthy. This is important as the interview data gained contained minute detail of how nurses worked and delivered care. The oral history data provide an addition to the history of labour (Carpenter, 1981), and particularly the role of women in work. The twenty-one oral histories provide a unique collection of Twentieth Century life stories of nurses working in these two provincial West Yorkshire towns.

The number of hours recorded, recording techniques, tape storage and transcribing methods are provided as information about the process (Ritchie, 1995, p. 83, 91).

Memory is an important concept and its influence on interview data needs consideration (Ritchie, 1995, p. 11-17). It was recognised that reminiscences taken at a distance, up to sixty-six years, '……*may suffer distortion, favourable or unfavourable, and may be simplified and exaggerated*' (Russell, 1997, p. 494).

The interviews provide a rich amount of previously unknown information about how nursing was delivered locally and what nurses felt about their experiences. It is suggested the interviews record perceptions and interpretations needed for the making of history. Oral history produces material not available in other forms, what Hareven (1984) described as '*generation of knowledge*', not merely the retrieval of information (cited by Church and Johnson, 1995). Also;

> '……*in spite of the limitations of the oral method - and the complexity of testimony with its irrelevancies and obscurities - the anecdotes have an intrinsic value giving a flavour of the basic day to day care in past times, through their provision of historically minute detail'* (Russell, 1997, p. 495).

Analysis and interpretation of archival and oral history data.

Stage 3 - Data analysis.

This section describes the methods used to analyse the data as it was identified that this process is often not written about in detail (Powney & Watts, 1987b). Analysis consisted mainly of a qualitative approach, but some quantitative analysis was identified as well. The problems of reliability and validity were addressed by ensuring triangulation of data wherever possible. The data was originally to be subjected to computer analysis by using a Quality Data Analysis Programme such as NUD*IST (Burnard, 1994; Cormack, 1996; Durkin, 1997, p. 100). However, with the development of technology the later version of this software NVivo was used as Cormack (1996) suggested. Breakwell (1990, p. 86) and Wolcott (1990, p. 32) discussed the use of computer based analysis as did Durkin (1997). The decision to use this approach was because of a personal preference in relation to how to manage this large data

set and to take advantage of an excellent learning opportunity. Therefore the analysis of the interview data using computer-assisted qualitative data analysis software (CAQDAS) was conducted using NVivo. Atkinson (1998, p. 57-58) states;

> '……just as there is much more to interviewing than turning on a tape recorder, there is more to interpreting the interview than just simply reporting it'.

Interview data was subjected to content analysis (Cavanagh, 1997). The researcher was involved in the design of the study and the data collection process and as Burnard and Morrison (1990, p. 10) state, 'you must have decided how to analyse data before you begin to collect it'. For this study the data analysis method was only partly confirmed prior to data collection due to the researcher's lack of knowledge of the latest software.

All the archival and oral history data were transcribed onto computer Word documents and then converted into Rich Text files for importing into NVivo (Appendix 3.49; 3.50). Oral history evidence was analysed and the importance of 'memory' and 'interpretation' considered. Analysing the transcripts identified responses relevant to the themes and unexpected responses unconnected to the questions. Denzin (1989) identified methodological gaps between reality, experience and the expression of 'life'. These gaps were considered during analysis and interpretation, and triangulation used to try to ensure reliability and validity.

As suggested by Powney and Watts (1987a, p. 166) 'Analysis was an iterative process of reading, discussion, reflection and examination.' Using NVivo provided opportunities to reflect upon the data and re-examine it. Analysis confirmed that the archives and interviews had produced 'an enormous amount of information' (Breakwell, 1990, p. 83). It was important to select out the data that was useful for this study and to leave the remainder. This was not difficult within the archival records as most of them related to specific times but it was planned that only the data up until 1960 would be used from the life stories. Template analysis was chosen as it was important to thematically analyze the data within the studies time frame and not to analyze data referring to after 1960 or outside West Yorkshire (King, 1998; King, 2003). However, the whole transcripts were coded because the content was not in chronological order and therefore relevant data needed to be highlighted throughout. Denscombe (1998, p.136-7) identified that data analysis can be problematic and this was an aspect of qualitative research that needed acknowledging. However, the richness of the data obtained was considered a particular strength of this method.

Guba (1978) suggested that effective analysis involved looking for recurring regularities that represent patterns that can then be sorted into categories which were further discussed by Powney and Watts (1987a, p. 159).

Coding - using *a priori* themes.

Burns and Grove (1995, p. 401) identified that coding of data can occur, '……at the time of data collection and when entering data into a computer'. Jones (1985, p. 94) suggested that to help coding data into categories; '…..the quickest and easiest way to do this is to decide upon your categories in advance'. By sub-coding Rosenberg's areas these became the categories that could be used to organise the data effectively. Wolcott (1990, p. 31)

suggested; '*Identifying the broadest categories imaginable*' helps in the initial sorting of data and this proved the case. By making basic categories such as '*decade when started nurse training*' or '*town first trained or worked in*' helped to group the data together. This allowed for detailed examination of data at an early stage and gave ideas on how data could be included under each theme to identify categories. This technique helped obtain a clearer view of the important issues under each theme and in fact create new categories. The advantage of using *a priori* themes during analysis was that it quickened the initial coding phase (King, 2003). Other items of data that didn't fit into the *a priori* themes were accounted for separately. This was because the data; '*all too easily become structured within the a priori definitions of the researcher'* (Jones, 1985, p. 94). Although acknowledging this statement the importance of using *a priori* themes to organise large data sets was seen as an important tool in effectively coding and analysing the data. It was important to be aware that initial categories may originate from the analysers own bias as stated by Jones (1985). King (2003) advised to produce the initial template at a fairly early stage. This could have been problematic as it interfered with attempts to approach the transcripts with a '*fresh*' view and an open mind. Therefore during the NVivo analysis efforts were made to avoid concentrating on the a priori data to the neglect of other data (King, 2003). Trying to ensure other data was coded as well guarded against this. Coding was defined by Burns and Grove (1995, p. 401) as the '*means of categorising*'. The initial themes created were reviewed to ensure none of the a *priori* themes became ineffective in their portrayal of the data. They were also considered '*initial*' and potentially therefore could be changed or adjusted later in the process (King, 2003). Guba (1978) suggested; '*that in focusing the analysis of qualitative data an evaluator must deal first with the problem of convergence'.* This involves figuring out what things fit together but it can lead to a classification system for the data. Wolcott (1990, p. 31) suggests; '*Identifying the broadest categories imaginable*' helps in the initial sorting of data. During the analysis Burnard's (1994, p.13-42) '*sentence busting*' technique was used. This allowed detailed examination of data under each theme to identify categories allowing comparison between different data sets and clarify meanings (Burnard and Morrison, 1990, p. 63).

Preliminary analysis of the data was conducted by distinguishing answers to the *a priori* themes of Rosenberg's areas of importance related to the questions set out in the interview schedule (Appendix 3.51). Firstly, the data relating to each of Rosenberg's headings were identified which was difficult initially and because of this analysis was attempted in a variety of ways. Breakwell (1990, p. 87) sees this as a positive tactic recommending, '*Allow yourself time to analyse the same data in several ways.*' Data analysis was; '*......conducted to reduce, organise and give meaning to data*' (Burns and Grove, 1995, p. 545). This was similar to Powney and Watts (1987a, p. 160); '*reduction, abstraction and interpretation*'. Analysis was also based around Miles and Huberman's (1994) model, data reduction, data display and conclusion drawing and verification (Appendix 3.52). Data Display is; '*......an organised, compressed assembly of information that permits conclusion drawing*' (Denzin and Lincoln,

1998, p.180). Data Reduction involved looking at the interviews and; '……*making data summaries, coding, finding themes, clustering, and writing stories'* (Denzin and Lincoln, 1998, p. 180). Story writing was possible with profiles of the individual nurses mentioned created. The process of analysis and coding was guided by authors such as Smith (1995), Burns and Grove (1995) and Mason (1996). These were considered during the analytical process with an interpretative approach adopted. Denzin (1970) discussed the importance of reliability, validity and credibility of data and the concept of *'truth telling'*.

Breakwell (1990, p. 83) identified interview data can be overwhelming and analysers get bogged down in it and; '……*then do not know how to interpret it,'* so care was taken for this not to happen by ensuring coding was done systematically.

The archival and interview data was examined for quantifiable data such as dates, names of nurses, biographical details of the interviewees, hospital details and nursing terms.

The use of NVivo.

As a life history approach to the oral history interviews had been conducted there was a large amount of data which was not needed for the study itself and so this needed to be extricated from the data. Also archival data contained some information that was either not relevant to the study or was outside the time period under study and this needed sorting out. The *a priori* themes were coded and sub coded but also *c*odes were added to identify the categories and themes that started to emerge. Coding was based on key words taken from the interview schedule and mentioned in the transcripts. Initially the data (each document) was read completely twice to get an initial flavour of the content as suggested by Smith (1995, p. 19). The initial reading was sometimes during transcription. On subsequent reading key points were highlighted by using colour coding stripes within NVivo and making notes as suggested by Smith (1995, p. 19) and Gibbs (2002b). Two examples of the use of the colour coding stripes in NVivo are found in appendix 3.53; 3.54. This computer system of colour coding is similar to the use of coloured highlighter pens as described by Field and Morse (1985, cited in Burns and Grove, 1995, p. 402).

Within NVivo over 2,000 nodes were created from 387 archival and oral history transcripted documents. Appendix 3.55 provides selected examples from the documents. Appendix 3.56 provides selected lists of the nodes created illustrating on pages three and four nodes 2,139-2,221 which covered the decades for the 1920s-1990s illustrating some data was outside the 1870-1960 time frame. However, sifting out this superfluous data was helpful in identifying quickly what was relevant. But within both archival and oral history sources it was often not possible to date the events so this was problematic. This was particularly the case with the interview transcripts when the nurses were discussing their experiences and it was unclear whether they were talking about when they were a student or qualified nurse. This led to a second stage of coding to ensure only specific data before 1960 was coded. The free nodes that were related to nursing before 1960 were then linked to Rosenberg's themes creating a second template.

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During data analysis Rosenberg's (1987) model was adapted to form three main groups (Appendix 3.57). Although considered separately within the three groups it was inevitable there would be overlap and links made between each of them. These emerged after discussion with colleagues and seemed to be natural combinations. They all linked to nursing but the '*nursing issues*' were specifically related to nursing. The role of technology could have been within the nursing issues section, but it was thought it was wider than just nursing with organisational aspects to it. These three headings allowed for the data to be dealt with systematically and the eight subheadings were further broken down into categories and in NVivo the subheadings are listed as '*children*'. Figure 3.2 illustrates the historical issue categories accommodating two of Rosenberg's areas of importance within NVivo and the associated number of '*children*'. The fifty-nine '*children*' were further subdivided into other categories illustrating the cascading effect of the coding. The history from below category contained mainly biographical data about the interviewees. History as meaning issues included the importance of; the past to nursing, the history of nursing locally and nationally, local nurses as resources to local nursing history and making links to present day developments.

Figure 3.2

Diagram of the Historical issues categories devised to accommodate Rosenberg's eight areas of importance within NVivo.
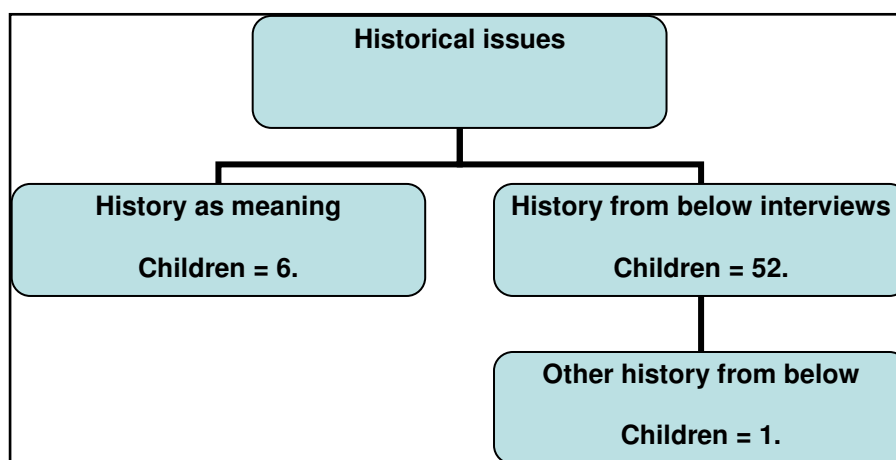
Figure 3.3 illustrates the nursing issue categories accommodating three of Rosenberg's areas of importance and the thirty-one '*children*' which were further subdivided into nearly 300 other categories including, the role of women and men in nursing, nurse-doctor relationships, authority and power, ward and classroom based education, the nurse as a worker, pay and conditions, and the role of the Matron. Figure 3.4 shows the three organisational issue categories and the associated fifteen '*children*', of which there were over 900 additional categories which included nurses' views on local hospitals, technology, war and hospital visiting, and length of stay.

Figure 3.3

Diagram of the Nursing issues categories devised to accommodate Rosenberg's eight areas of importance within NVivo.

```
                    ┌─────────────────┐
                    │  Nursing issues │
                    └─────────────────┘
                            │
        ┌───────────────────┼───────────────────┐
┌───────────────┐   ┌───────────────┐   ┌───────────────┐
│ Gender and the│   │ Knowledge and │   │  The nurse as │
│  professions  │   │   authority   │   │    worker     │
│               │   │               │   │               │
│ Children = 7. │   │ Children = 8. │   │ Children = 16.│
└───────────────┘   └───────────────┘   └───────────────┘
```
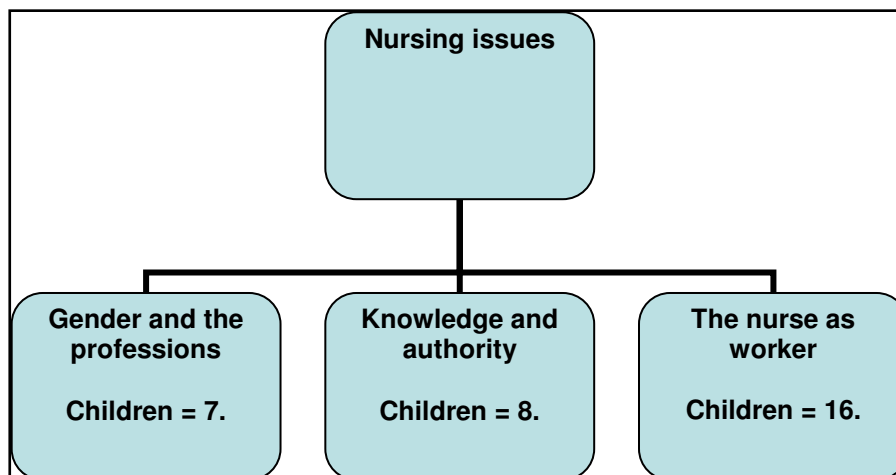
Other areas were found to be important when looking at the types of information the archival and oral history interviews provided which was a useful guide to analysis (Appendix 3.58).

Figure 3.4

Diagram of the Organisational issues categories devised to accommodate Rosenberg's eight areas of importance within NVivo.

```
                    ┌─────────────────┐
                    │  Organisational │
                    │      issues     │
                    └─────────────────┘
                            │
        ┌───────────────────┼───────────────────┐
┌───────────────┐   ┌───────────────┐   ┌───────────────┐
│New Institutional│ │Role of technology│ │ The hospital as│
│    history    │   │               │   │   problematic │
│               │   │ Children = 4. │   │               │
│ Children = 3. │   │               │   │ Children = 8. │
└───────────────┘   └───────────────┘   └───────────────┘
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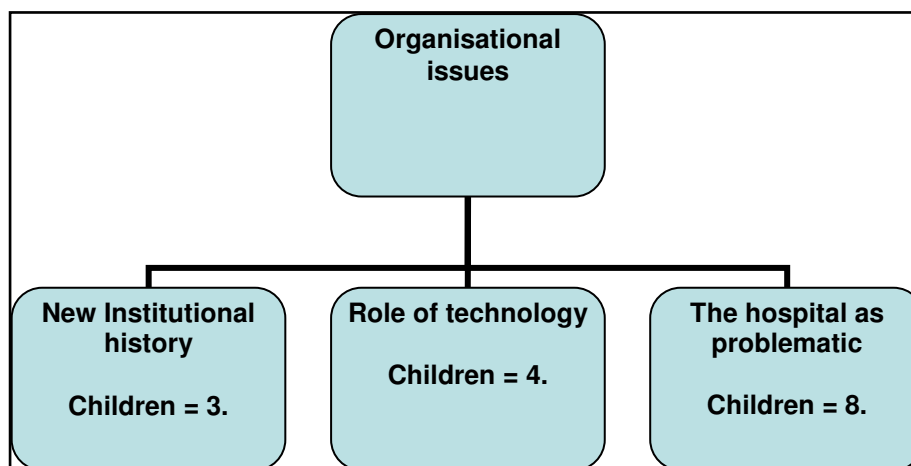
Memos

During analysis memos were made following the guidelines provided by Richards (1999, pp. 47-51) and Gibbs (2002a, p. 85). Examples of these for two of the interviews are in appendix 3.59. Each memo was used to provide information about the thinking in relation to the name and content of the nodes created.

Chapter 3 – Methodology.

Interpretation of data.

Validity.

According to Grbich (1999) validity is similar to trustworthiness and can be checked by comparing oral history data with other oral histories or supporting documents. In relation to the analysis and interpretation of data, Altheide and Johnson (cited in Denzin & Lincoln, 1998) discussed criteria for assessing interpretive validity. There are validity questions over the process of interpretation which can be subjective on interviewer and interviewee aspects because of its complex nature (Josselson and Lieblich, 1995). Interviewees' memories needed to be analysed carefully as;

> '……interpretation has everything to do with meaning and validity, but this is complicated by the fact that the meaning and the validity of the life story may be different for the one who has told it than for the one recording it' (Atkinson, 1998, p.58).

Atkinson (1998, p.58) described two important factors in establishing the meaning and validity of data calling these;

> '……the quality of the relationship you have with the storyteller, and the specific interaction you have with the storyteller during the interview itself'.

Within this study the first point was dealt with by the interviewer creating an honest professional relationship. The second point related to the social and questioning skills of the interviewer. It is argued by Lieblich et al (1998) that no reading is free of interpretation, they continue by implying that the act of conducting the interview involves the continuous explicit and implicit processes of communicating, understanding, and explaining. The interpretation process was therefore conducted with these issues in mind.

There was recognition of bias, cultural, linguistic, and gender differences when looking for common themes emerging from the data. Bias as a concept was seen as an important factor (Grbich, 1999) and comparisons were made with documentary evidence to provide some validity and reliability. There was a reasonable conclusion that; '*oral recording proves an invaluable way of recapturing the past'* (Russell, 1997, p. 494).

Reliability.

Truth is difficult to define however in this study truth was what the interviewee believed to be true to them. Denscombe (1998, p.136-7) suggested reliability can be affected by interviewer impact and the fact that the data is often unique, and interviewer effect may mean what interviewees say may not be truthful. One example was guarding against the interviewee trying to impress the interviewer by exaggerating stories. Whyte (1982, p.115) stated that, '*informants may desire to please the interviewer'*. He also discussed distortion of data and identified three forms of this called, implausibility, unreliability and informants mental set (Whyte, 1982, p. 116). Therefore it could be argued that independent interviewers may have gained different data. Triangulation of data was one method of trying to avoid this.

Credibility.

Rosie (1993) discussed issues to do with truth and lies while Samuel and Thompson (1990) discussed the issues of folklore and myth. As the interviewees were retired nurses there was

a view that their memories and recollections would be credible. As professionals they would have been trained to be loyal and honest, be aware of ethical and moral issues and therefore be truthful. However, this cannot be relied upon and therefore needed to be considered when interpreting the data.

Authenticity.

Thomson et al (1994) questioned the authenticity of memory and this was taken into account during data analysis (Thompson, 1988). The accuracy of memory and recall was considered by checking across data and identifying themes within it. As the age profile of the interviews was high there was an expectation that memory loss would occur. Within the interviews there were numerous examples of interviewees forgetting things and their memories failing them. Apart from prompting them if appropriate, and using visual aids such as photographs to help them remember, there was no other way of dealing with this and these '*gaps*' in data had to be accepted.

On the subject of reliability and validity, some question whether these are useful in this type of research; '……*reliability and validity are not necessarily the most appropriate valuative standards for the life story interview*' (Atkinson, 1998, p. 59). Atkinson (1998) further suggested the storyteller should be considered both the expert and the authority of their own life. Jackson (1987, cited in Atkinson, 1998, p. 59) said;

> '……*no two researchers will record a life story in a completely replicable way, and no two researchers will analyse the life story data in a replicable way either, because there are many ways of analysing narrative data*'.

Gender difference was considered in analysis and interpretation. Validating the researcher's interpretation of the transcript was done by sending completed transcripts back to interviewees for feedback. Rickard (1998, p. 43) suggested;

> '*For most oral historians, it is accepted practice to return tapes and transcripts to interviewees, working through the process of editing and interpretation together*'.

Rickard (1998, p. 43) identified that for interviewees; '……*just listening back to your tapes has huge implications in the context of trauma and taboo*'. An example stated was where an interviewee listening to their tape would; '……*see them as a mistake and would want to re-record them differently*' (Rickard, 1998, p. 43). In this study some interviewees after listening to their tapes and reading their transcripts returned their transcripts with numerous changes including perceived grammatical and punctuation errors. There were other examples of major changes in the wording and content of the transcript being returned with comments such as; '……*this sounds terrible, I do not talk like that, and I don't want this to be heard by anyone……*' Rickard (1998, p. 44) identified there may be a case for;

> '……*warning interviewees that owning a copy of your own life-history tapes and thinking about listening to them can be a disarming experience in itself*'.

This was mentioned to the interviewees when discussing aspects of interviewing and tape recording prior to them giving informed consent. Also, when transcripts and tapes were

returned to interviewees the accompanying letter included an advisory statement about this (Appendix 3.60). Rickard (1998, p. 44) also identified that;

> '*For interviewees, decisions about letting friends and family listen to tapes and the implications for revealing to people the fact that you have been interviewed are also difficult*'.

As part of the consent process interviewees were recommended to discuss the interview with their families and next of kin to ensure they had their support. The majority of interviewees had no qualms about involving their families in the process and allowing them to hear the tapes or read the transcripts. During one interview an interviewee said something detrimental about one of their children and asked for the tape to be stopped, rewound and the offending statement recorded over prior to continuing. This was obviously a conscious decision and indicates the interviewee was aware that others may listen to the recording or read the transcript.

According to Atkinson (1998) a balance between subjectivity and objectivity is what usually works best in interpreting the life story. Interviewees were often quick to give their own personal thoughts and feelings on other nurses, or staff they worked with, and about the hospitals they worked in. Comparisons of the oral history evidence with the archival documentary evidence were made to ensure these problems were minimised as suggested by Burns and Groves (1995) and Hallett (1997/8).

The editing role of the interviewer was discussed by Ritchie (1995, p. 83) and needed to be considered during analysis and interpretation. Conclusion, drawing and verification involved the researcher in interpretation of the data displays including, comparison/contrast, noting of patterns, and themes and clustering. Powney and Watts (1987a, p. 158) stated; '*analysis is the act of constructive interpretation*'. Verification of analysis and authentication of interpretation were discussed by Breakwell (1990, p. 87). Cormack (1996, p. 168) identified that; '*……interpretation lies at the heart of the historiographical endeavour,*' and that; '*……interpretation is a dynamic and interactive process'* (Cormack, 1996, p. 172)*.* Burns and Grove (1993, p. 74) defined this as; '*Interpretative history - make sense out of it - search for meaning*'. Newton (1965, p. 21) identified that the researcher is;

> '*……not only seeking facts from the past, but must think about those facts, discover relationships, draw inferences, and even call his imagination to interpolate between certain events*'.

All these issues were considered within this study in order to ensure that data analysis and interpretation was conducted in an appropriate way to ensure the study's validity and reliability.

The strengths and weaknesses of using of NVivo.

The main problem of using NVivo was found to be the time taken to learn how to use the software and thereby gain access to its capabilities, and Walsh (2003) identified this as a problem. Even after attending a data analysis module in which the assessment allowed the opportunity to use NVivo, the skills needed to fully gain maximum benefit from the software

were still rusty. The analysis of data took longer because of this learning process. Figure 3.5 shows the strengths and weaknesses of using the NVivo software.

Figure 3.5

Strengths and weaknesses of using the NVivo Software for analysis.

Strengths.	**Weaknesses.**
• Quick search facility • Node function allows easy production of codes and themes. • Large capacity for data. • Easy colour coding facility to code text. • Good for mechanical analysis of large amounts of data.	• Time consuming typing up archival and oral history data in order to import files into NVivo. • Time consuming and difficult to learn to use. • Complex facilities such as memo and ?? • Cannot help with conceptual aspects of analysis. • Needs technical support if problems occur with the software.

Conclusion of methods.

The researcher gained valuable experience at both the skills of analysis and using NVivo. Developing a template was useful for analysing the data and the method proved a useful and flexible approach to take to this large amount of rich data. The size of the data proved to be restrictive in allowing the author to code and sort the data. The use of NVivo was undoubtedly a big help in managing this data effectively and efficiently. The identification of relevant parts of the transcript that included reference to Halifax and Huddersfield pre-1960 proved to be an unexpected problem. Attempts to overcome this included identifying approximate dates for extracts from the interviews to provide signposts to the time period being addressed. Denscombe (1998, p.136-7) identified data analysis can be problematic. This is an aspect of qualitative research that needs acknowledging as there can be problems in dealing with the issue of convergence in the analysis of qualitative data trying to figure out what things fit together and developing a classification system (Guba, 1978). As Gibbs, (2002a, p. 57) stated, '*Coding…is an essential procedure*'. The skills learnt in analysing this data have aided the researcher in developing some proficiency in qualitative analysis. However, as Jemmott (2004) identified for novice researchers, qualitative analysis presents a number of challenges. The analysis therefore confirms there is still some work to be done to ensure the skills needed to use NVivo to its full potential are learnt.

Ethical issues.

The majority of ethical issues related to oral history as the archival documents were covered by policies and procedures which were abided by. The oral history interviews were conducted with the subjects safety and protection as a prime concern throughout all stages of the process. Conducting oral histories with retired nurses raised the issue that Reinhartz (1992)

suggested, '*Oral histories are typically, though not exclusively, done with two overlapping types of people: older and relatively powerless people*'. It is debatable whether they were powerless but to ensure their safety ethical guidelines were followed. Confidentiality, anonymity and interviewee rights were observed throughout as mentioned by Behi (1995). Any contact of whatever kind with individuals who may have been potential interviewees had to receive prior approval from research supervisors. This was achieved by setting out a clear study proposal and action plan and was reported at supervision meetings. University guidance on research was followed paying particular attention to questions of access and informed consent. Ethical issues were addressed by ensuring adherence to the RCNs Oral History Project Guidelines (RCN, 1995) and the Oral History Societies Ethical Codes (Ward, 1995). Potential interviewees were contacted by a personal approach to ascertain interviewees' interest and co-operation. In the majority of cases initial preliminary interviews were conducted prior to the actual recorded interviews. This oral history project was subject to scrutiny by the University of Huddersfield's Ethics Committee. Punch identifies five ethical issues in research;

1. Harm
2. Consent
3. Deception
4. Privacy
5. Confidentiality of data (Punch, 1994).

Other similar ethical issues considered were;

- Harm and risk
- Honesty and trust
- Informed consent
- Benefits
- Privacy
- Costs and reciprocity
- Competence boundaries
- Worthiness of the project
- Confidentiality and anonymity
- Intervention and advocacy
- Research integrity and quality
- Ownership of data and conclusions
- Use and misuse of results (Miles and Huberman, 1998).

Questions arise about editing tapes and transcripts in order to remove offending data, thereby protecting other people's rights not to have derogatory statements made about them, and protecting the interviewee, the interviewer, their employer and the archivist from legal action by the third party. This is represented in appendix 3.61 by an adapted version of a model by Dunaway and Baum (1996) and discussed further by Thurgood (2002; 2003).

Informed Consent.

Interviewees were asked to complete and sign consent forms and were given full details of the research and their role in it to ensure informed consent was obtained. Informed consent included permission for audio tape recording, and explaining the interviewees' rights to the material on conclusion. These were discussed and explained prior to interview and

opportunities to ask questions provided before, during and after the interview stage. Copies of the Informed Consent Form were posted to the interviewees with their introductory letters. Prior to the interview they were given signed copies and the interviewer kept a copy. Prior to interview emphasis was made that participation was entirely voluntary. It was explained that they were free to refuse to answer any question or withdraw from the research study at any time. They were asked to request the interview to be stopped, or ask for the recorder to be switched off, at any time, to allow for any breaks they may require. It was made clear to the interviewees how the tapes and transcripts would be stored (Firby, 1995).

Confidentiality.

Confidentiality was considered throughout all aspects of this study. Transcripts and audio tapes were kept by the interviewer and stored securely and safely. Interview tapes were identified only by codes such as HX 1 for Halifax and HUD 1 for Huddersfield. Interviewees were offered the chance to see the transcripts of their interview and make comments on content and context. If requested interviewees were to be sent summaries of the findings of the interviews. The interviewees were reassured verbally that the interview data would be kept strictly confidential and anonymous. It was explained that excerpts from the interview may be used as part of the study report but under no circumstances would their name or any identifying characteristics be included in the study without their written permission. Interviewees were informed the study and interview data would not be for publication without their permission and would only be seen by University staff involved in the assessment of the research. They were informed that the thesis would eventually be stored in the University library for the use of future students. In addition to this it was explained that with the interviewees' written consent and permission their audio tapes and transcripts would be offered to be deposited in the University of Huddersfield Archives and Special Collections. Access to them would be controlled via the procedure stated in appendix 3.62 and under the scrutiny of the University Archivist.

Interviewees were told they could request the audio tapes and transcripts to be kept 'closed' for any length of time to ensure confidentiality, although none did.

Rickard (1998, p. 40) identified that in relation to tape storage in archives;

> '……*it is in my interests and the interests of the archive, not to discourage people from recording accounts or making them accessible*'.

One other example of confidentiality was when a retired nurse wrote asking for colleagues details so that she could contact her. No details were given but she was asked to give permission for her own details to be passed on to the other person (Appendix 3.63). Gorden (1969a) stated anonymity needed to be considered when interviewing. Anonymity was ensured by not using individual's names in the study findings without permission. Originally, all recognisable identifiable reference to individuals was to be removed from the data and results. If there was a need to use data in an identifiable manner the interviewee was asked for permission and a consent form completed. Anonymity was protected by not discussing the study with anyone else except supervisors, ensuring safe storage of audio

tapes and transcripts and not stating interviewees' real names in any part of the study (Rose, 1994, p. 23). Interview audio tapes and transcripts were stored securely in the author's office. Each set of interview tapes was copied as soon as possible following the interview to ensure a duplicate was available. The original copies were deposited into the University Archives for safe keeping but closed for access for ethical and legal reasons.

Maintaining anonymity of third parties was an area of interest that emerged (Thurgood, 2002; 2003). Many of the interviews contained reference to other people including family and friends, nursing colleagues, other hospital staff including doctors, and patients. However, as with other oral history collections this was viewed as an issue which could not be addressed without editing or closing access.

While writing up this thesis it became clear that as all the interviewees had agreed to deposit their audio tapes and transcripts in the archives, ensuring their confidentiality and anonymity within the thesis was not required. This was particularly because it seemed unfair to make their stories anonymous when they wanted them to be heard. As a result a further consent form was sent requesting permission to do this.

Copyright.

Aspects of copyright of the data within the interview audio tapes and transcripts were considered and Copyright Ethics of the Oral History Society Ethical Guidelines followed (Ward 1995). The issues related to copyright as discussed by Eby (1995) were addressed. The copyright of the data within the tapes and the transcripts was addressed via informed consent. Interviewees were given a second chance to consent once they had read their interview transcripts and heard their interview tapes (Appendix 3.60). Those interviewees agreeing to deposit their stories in the University Archives were required to sign over the copyright to the University by reading the Copyright Agreement, Clearance Note and Deposit Instructions and completing the Archive deposit form (Appendix 3.64).

Following any editing process, with the interviewees written consent and permission, their tapes and transcripts were deposited in the Archives. Appendix 3.57 illustrates the general problematic issues raised and guidance on potential resolutions, and the specific issues for this study and potential solutions are in appendix 3.66.

Documentary and oral history collaboration.

The extent to which the evidence from documentary primary sources served to corroborate the evidence from the oral testimonies of retired nurses varied. Comparisons of the oral history data were made with documentary evidence such as those in the written records at the hospitals. The accuracy of written and visual imagery was questionable, as was interviewees' memory. However, for the latter three decades under study there was evidence that triangulation of data was possible with nurses confirming details in documents and in photographs. Examples included details of the hospital wards nurses worked on and the names of nurses and doctors. This included nurses from all levels of the nursing hierarchy, in particular Matrons and Ward Sisters. Also details of GNC Inspection reports compared

favourably with oral history evidence. There was a positive link between some verbal data and archival sources in relation to nurse training courses and nursing care practices. Some other examples included nurses relaying the same data in their interviews as was in local newspaper reports. It was during data analysis that this collaboration was most obvious and NVivo allowed these comparisons to be made.

The importance of cross checking for corroboration via hospital archives was stressed and of not discarding aspects of narratives not substantiated. This latter point was important as it was not possible to access all archive materials and also the archival sources were often not complete as some materials either had not survived or had not been preserved.

Overall, there was evidence for the latter three decades under study that the archival data corroborated oral history data in a number of areas. This further supported the validity of the data.

Stage 4.

The study was written up, presenting the methodology, results, findings and recommendations forming the basis of the thesis. Results took the form of detailed accounts of the archival documentary and oral evidence and how they compared. Correlation with national developments was made as required to ensure the wider issues of nursing history were linked to local developments. The historical development of local general and district nursing was presented and discussed. The importance of the findings was assessed and indications for further research needed made. Analysis of the historical research methods and how they helped was made. A reflective account of the researcher's personal development and experiences of using historical research methods was written. Dissemination of results is planned via conference papers and article publications. The West Yorkshire History of Nursing Internet web page will provide an abstract of the work and include other useful sources of information.

Conclusion of chapter.

This chapter reviewed philosophical aspects of the study and considered the question '*what is history*'. A critique of Rosenberg's work and eight areas of importance illustrated some of the reasons for using it and some of the concerns about its use.

Following this the archival and oral history data collection and analysis and the overall research design were described. A variety of methodological issues related to the process of data collection from archival and oral history sources were discussed. These include gaining access to the data, ensuring an appropriate sample, reliability and validity of data, and ethical and legal aspects. Discussion of how the archival and oral history data correlated identified that there were many examples where they supported each other and provided evidence of triangulation of data.

Chapter 3 – Methodology.

In the next eight chapters the results of this research will be presented using Rosenberg's areas of importance.

Chapter 4 - New Institutional History.

This chapter addresses Rosenberg's 'New Institutional History' area of interest which is interpreted in relation to the nursing elements of the institutions. Nurses were trained and worked in a variety of local institutions and this chapter contextualises these. The internal order and social function of these hospitals is important to consider as nurses were both influential in the development of them and influenced by them. Information about hospitals and other health care organisations where nurses worked provides historical details for both the professional identity of local nurses and for the wider social aspects of local history. As most local institutional histories do not focus on nursing and nurses this 'new' institutional history attempts to redress this. However, there is no intention to write institutional histories but identify where nurses worked in an attempt to illustrate their roles and how nurses and nursing evolved historically within these institutions. The outcome of this is a hitherto unknown account, a new institutional history, of nurses and nursing within the two towns. This establishes the institutional buildings and their functions as well as the nurses' roles within them and the presence of training schools. It also identifies that these institutions were usually for the poor therefore meeting important social needs.

Overall twenty main organisations developed either from Voluntary, Public or Poor Law, Isolation and District nursing origins which laid down foundations for further developments on the original sites or new build institutions until the eventual introduction of the NHS.

The majority of results are from archival data with some data from oral history testimonies and personal memorabilia of local nurses for the later time period under study.

To set the scene the institutions nurses worked in prior to 1870 are discussed.

Nursing in Halifax and Huddersfield prior to 1870.

Prior to 1870 three forms of health care institutions evolved. During the Eighteenth Century local villagers who had special skills or interests in 'healing' did most 'nursing'. Families or friends cared for their own sick and some religious orders also offered 'caring' roles. However, with no recognised health care system and medical and surgical treatments either non-existent or primitive, the early Nineteenth Century social welfare reforms resulted in the Poor Law workhouse system providing opportunities for local 'nurses' to provide institutionalised care. Alongside the workhouse system the development of Voluntary hospitals financed by local benefactors created another form of health care establishment, and finally the isolation fever hospitals emerged during the 1860s.

Halifax had a workhouse from 1635 as well as other smaller workhouses in surrounding townships such as Nathaniel Waterhouse's Workhouse (Longbotham, 1902, p. 10, p. 22; Hanson, 1921; Kendall, 1956; Porritt, 1961; Chadwick, 1996; Higginbotham, 2006). The amalgamation of these smaller workhouses in 1834 saw the development of Halifax Union with its workhouse opening in 1840 (Hargreaves, 1999, p. 152).

Huddersfield's first workhouse was built at Birkby circa 1814 (Hobkirk and Curson, 1883, p. 5; Walker, 1897). Huddersfield Union formed in 1837 and was the second largest in the country

(Knott, 1986). Prior to 1870 Halifax and Huddersfield spent heavily on workhouse buildings (Rose, 1985).

The first local Voluntary hospitals, called Dispensaries, were established in Wakefield (1787) and Doncaster (1792). Dispensaries were usually small buildings offering limited health advice and treatment. Halifax General Dispensary opened in 1808 with 100 beds (Anon, 1894, p. 234; Washington, 1996). Appendix 4.1 shows details of a patient in 1809. Halifax Infirmary and Dispensary opened in 1838 as a more substantial hospital paid for by public subscription (Appendix 4.2). In 1894 the Matron Miss ME. Wharton was supported by five Head Nurses and seventeen Nurses. The Infirmary had 100 beds with probationers aged 24-30 training for three years (Nursing Record and Hospital World, 1894, p. 234).

Huddersfield General Dispensary opened in 1814 (Marland, 1992) (Appendix 4.3). The Huddersfield and Upper Agbrigg Dispensary was for the local industrious poor functioning like a First Aid post (Huddersfield Royal Infirmary, 1921; Grainger, 1937; 1947). By 1828 it was inadequate and a new Infirmary was proposed (KC311/18/12, 1828-33; Walker, 1897). Accordingly the first Huddersfield Infirmary opened in 1831 (Appendix 4.4). Mrs Newstead was Matron in 1831 until 1836 when Miss Clay succeeded her (KC311/18/12, 1828-33; Huddersfield Royal Infirmary, 1921). Appendix 4.5 illustrates the work of nurses in 1831-2.

In the 1860s control of infectious diseases was becoming important and in Huddersfield the Colne and Holme Joint Isolation Hospital Committee was operational in 1861 (Sykes, 1905, p. 415). This was the start of a series of fever hospitals in both towns.

In these three different forms of institution some sort of 'nursing' care was delivered by various types of 'nurses' including 'village nurses'. The main issues were the competence, control and education of nurses and standards of care. These three types of 'hospitals' represented the early institutions that nurses worked in prior to 1870. The next section details the institutions that developed from 1870-1960.

Halifax Institutions 1870-1960.

The significance of nurse training status was an important element in the development of Halifax Institutions as they provided new nurses for the institutions. This also opened the institutions up to external scrutiny by the LGB and later GNC in approving and reviewing training schemes.

From 1870-1960 Halifax had eighteen different types of institution at one time or another (Appendix 4.6). As many of these were small, or did not remain open long, the following seven hospitals and nursing organisations where nurses worked are considered in no particular order:

1. St John's Workhouse / Hospital (SJH).
2. Halifax General Hospital / St Luke's Hospital (HGH).
3. Royal Halifax Infirmary (RHI).
4. Northowram Hospital (NHH).
5. Isolation Fever Hospital, Shelf.
6. Halifax District Nursing Association (HDNA).
7. Spring Hall Convalescent Auxiliary Hospital.

St John's Workhouse / Hospital (SJH).

St John's Workhouse later known as a hospital (SJH) was a large institution with 2,854 paupers in 1870 (Leeds Mercury, 1870c). Evidence of '*nurses*' who worked there in 1881 included Lunatic Attendants Jonas Wright and Kate Manley (Higginbotham, 2006). Early in the Twentieth Century two Union Hospitals, SJH and St Luke's Hospital, later named Halifax General Hospital (HGH) existed. They catered for Poor Law patients until Public Assistance control was approved in 1930 when management of SJH went from the Boards of Guardians to Halifax County Borough Public Assistance Committee (C332 Wakefield; RD7 3/6/18). Evidence of a nurse working at HGH at this time was the Matron Mrs LB. Harris (RD7 3/6/18, p. 7-8). By 1939 SJH had gained joint Provisional Approval as a Training School for the Nurses Roll with NHH (TNA, DT 35/43, 1921-1963). This was significant illustrating that the GNC was satisfied that the institution and staff were of a suitable quality to be awarded training status. It continued nurse training links with NHH and SLH until its closure. In 1945 SJH was used for old and infirm persons (C332). SJH continued to care for elderly patients until its closure in 1970 when services transferred to NHH, and SJH buildings were demolished in 1972 (Washington, 2000).

Halifax General Hospital (HGH).

As SJH became too small St Luke's Hospital the town's Municipal Poor Law Workhouse opened in 1901 reducing over crowding in SJH (Washington, 1998; Hargreaves, 1999, p. 153). Two hundred and twenty SJH patients were moved there with seventy convalescent aged inmates remaining at the workhouse (Brompton, 1999). Both institutions dropped the word '*workhouse*' from their titles and St Luke's Hospital was renamed Halifax General Hospital (HGH) in 1934 (Chadwick, 1996; Brompton, 1999: Health Records, WYAS). In 1901 Miss Wilkie the Matron was supported by Miss Bolton her Assistant. In 1902 it was reported that the HGH had better facilities than the Royal Halifax Infirmary (RHI) (White, 1978). HGH had two types of hospital ward design, round and pavilion. The '*round ward'* buildings provided an interesting architectural alternative to the traditional '*Nightingale*' pavilion long straight wards found in both HGH and RHI. The round wards were not unique to HGH and originated from Professor John Marshall in 1878 (Taylor, 1988; Thurgood, 2003a) (Appendix 4.7). HGH provided nurse training opportunities throughout its history and educational developments continued until its merger with RHI School of Nursing in the 1960s. Probationer and trained nurses were required to live in the Nurses Home in the main block of the hospital (Appendix 4.8).

Royal Halifax Infirmary (RHI).

The first Infirmary closed in 1896 when too small and the second named the RHI opened in July 1896 (Washington, 1996). Appendix 4.9 shows its opening ceremony official programme. The RHI had pavilion wards originated from post-Crimean War sanitation reform (Taylor, 1997, p.5). This design required large areas of land to ensure adequate bed numbers (Appendix 4.10). The RHI provided nurse training throughout its history and from 1898-1932 455 probationers started training (C448/5 Addnl, 1898-1919; C448/6 Addnl, 1920-1933).

A forty bedded Nurses Home opened in 1929 with two storeys added in 1940 providing twenty-six more bedrooms. After 1945 trained nurses lived away from the immediate hospital environment in two residential houses.

In contrast to HGH the RHI wards had benefactors names (Appendix 4.11). An example in 1945 was Mr Arthur Selby McCrea of Warley who left £341,230 (£8,854,918.50 = 1945)[1] (BJN, 1945, p. 129; O'Grady, 1982, p. 6). The RHI wards and departments provide insight into where nurses worked until its closure in 2001.

Northowram Hall Hospital (NHH).

Northowram Hospital, north of Halifax, originally provided infectious disease services and was named the Isolation Hospital (Washington, 1999; Brompton, 1999). Also known as Northowram Hall Hospital (NHH) it opened in 1934 (C448/6/3). NHH replaced the Halifax Borough Fever Hospital (HBFH) at Southowram, also known as Stoney Royd Fever Hospital (SRFH).

The need for isolation hospitals increased in the 1870s with outbreaks of fevers and SRFH opened in 1872 (Washington, 1999; Brompton, 1999). In 1888 Miss Sabina Seymour Carey was Matron illustrating a nursing presence (Nursing Record, 1888c, p. 513). By 1900 Matron Wilson and the nurses also staffed the; '*Small-pox Hospital, Belle Vue, Mount Tabor*'. In 1928 SRFH gained approval as a Complete Training School (DT 35/43).

Fever Training occurred in both NHH and SRFH with five GNC inspections conducted from 1928-1949 (DT 35/43). As NHH opened and SRFH closed during 1934-36 Miss Wilson remained the Matron. NHH then made links with Shelf Sanatorium (Washington, 2000).

By 1945 decreasing patient numbers meant students went to other hospitals to ensure suitable experiences, and withdrawal of GNC approval for Fever training occurred in 1956 although it continued general training links with other institutions (DT 35/43). From 1967 NHH delivered elderly care services between NHH and SJH until its closure in 2001.

Isolation Fever Hospital, Shelf

Shelf Isolation Hospital, Halifax, also known as Shelf Sanatorium, treated TB patients and opened in 1914 (Brompton, 1999, p.4). Prior to opening the Matron Miss M. Lamble was appointed in February 1914 (BJN, 1914, p. 159). At the same time there were advertisements for a one year course to take the Certificate of Tuberculosis Association (CTA) (BJN, 1914, p. 159).

From 1946-1948 Shelf was catering for over sixty patients including children (DT 33/255; DT 33/258) (Appendix 4.12; 4.13). In 1946 Shelf formed part of a Combined Training School with NHH. Two external views of Shelf are in appendix 4.15; 4.16. During the 1950s nurses continued to work at Shelf until it closed for fever patients in 1956 (Appendix 4.17; 4.18). Fever nurses therefore worked at Shelf Fever Hospital from 1914-1956 in line with national policies (Currie, 1997; 2005).

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[1] NB Figures in brackets indicate this amounts spending worth in today's (TNA, Currency converter, 9 September 2007).

Chapter 4 - New Institutional History.

King Edward V11 Memorial District Nursing Association, Halifax (HDNA).

Nursing care was provided for large numbers of patients in the community by the HDNA. Formed in 1911 HDNA was one of the later DNAs to open and was not the only one in Halifax (MISC/493/3-9, 1936). In relation to the County Nursing Association (CNA) there were still unaffiliated DNAs in 1929-30 and although smaller were nonetheless important (RC/679, 1929; 2 April 1930; 5 May 1930). On its opening Miss Dora Laycock was appointed Superintendent having earlier trained as a nurse at RHI and district nurse at Blackburn (BJN, 1911, December 2, p. 459). She remained Superintendent for eleven years until 1923 (MISC: 493/3-9, 1936). The Association's constitution was;

> '……to provide skilled nursing for the sick poor and working class in their own homes without distinction or creed' (MISC: 493/3-9, 1936).

As a voluntary institution services were free to the very poor and an Assessment Committee decided patient contributions related to services rendered (TNA 30/63/491). Initially HDNA had two nurses increasing to six by 1912 necessitating the need to rent more accommodation (MISC: 493/3-9, 1936). QVJI Inspector Miss Crowther confirmed a, '*very satisfactory report*' indicating HDNA was well regarded nationally (Appendix 4.19).

Initially midwifery services were not provided by HDNA however, with work increasing midwifery services opened in 1917 with more accommodation added (TNA 30/63/491; MISC/493/3-9, 1936). During 1911-1938 staff numbers steadily rose to meet demands with additional work in Siddal District in 1925 and Northowram in 1926 (MISC: 493/3-9) (Appendix 4.20). During 1927 the nurses gained their first car and in 1936 a further three cars were promised (MISC: 493/3-9).

Due to developments HDNA moved from Clare Road to Kirby Leas in 1932 (MISC: 493/3-9, 1936; MISC: 493/10).

In 1948 the NHS transferred liability for home nursing services to local health authorities (Barrows, 1974). HDNA continued to provide services and received Queen's Nursing Institute (QNI) inspections from 1962-67 finally closing circa 1975 after the Briggs Report reorganisation (SA/QNI/X.27/1, 1917; Briggs, 1972; MISC: 493/46).

Spring Hall Convalescent Auxiliary Hospital, Halifax.

This military hospital is discussed more fully in chapter 7 related to the impact of war. It opened in 1916 and was used in both World Wars (Duncombe, 1920). Mrs Shaw, who had nursed in Egypt during the Gallipoli campaign, founded it with voluntary contributions and it was run by volunteer ladies. It closed in 1919 having cared for 3,619 patients (Duncombe, 1920). This number of patients indicates the need for nurses and at least twenty female nurses are identifiable in photographic evidence.

Conclusion of Halifax institutions

These seven institutions represent the main organisations nurses worked in from 1870-1960. They are not inclusive and other buildings have been referred to. It is important to state that although these organisations were often geographically situated very close to each other they were usually managed and staffed individually. There is limited evidence of them working

together although more examples of collaborative working occurred after the Second World War as the NHS was introduced. The next section deals with twelve Huddersfield institutions.

Huddersfield Institutions.

From 1870-1960 at least thirteen different types of institutions opened in Huddersfield (Appendix 4.21) In no particular order, the following twelve institutions, hospitals and nursing organisations are considered:

1. Crosland Moor / St Luke's Workhouse / Hospital (SLH)
2. a) Huddersfield Royal Infirmary (HRI) and b) Green Lea Hospital.
3. Bradley Wood Isolation Hospital / Bradley Gate Sanatorium (BWS)
4. Mill Hill Sanatorium (MHH) / Fever Hospital
5. a) Huddersfield District Victoria Sick Nurses Association (HDVSNA) and
   b) Huddersfield Municipal Maternity Hospital/Princess Royal Hospital (PRH)/Municipal Maternity Home (MMH)
6. Deanhouse Workhouse / St. Mary's Hospital, near Netherthong, Holmfirth (DHH)
7. The Huddersfield War hospital and:
   - a) Holmfirth Auxiliary Hospital
   - b) Denby Dale and Cumberworth, Skelmanthorpe, and Clayton West Military Auxiliary Hospitals
8. Holme Valley Memorial Hospital (HVMH).

St Luke's Hospital (SLH).

SLH opened in 1872 and was reported as the; '......*second major institution built by Guardians of Huddersfield Poor Law Union,*' the first being DHH (C348, 1971). SLH became; '......*the home of the poor*' and, '*a fever hospital and two vagrant wards*' were added in 1877 (Hobkirk and Curson, 1883, p. 5; Walker, 1897, p. 149; Sykes, 1898, p. 409).

In 1881 Fanny Susannah Jenner was Matron but it is unclear if she was a nurse. She had three nurses on her staff; Sarah Ann Steward, Elizabeth Ramsden and Sarah Ann Driver and there were 488 residents (Higginbotham, 2000). In 1893 there were two '*nurses*' (Hall, 1895, p. 191). Nurse Training rules and regulations for probationers in December 1899 indicate a scheme was in place (Huddersfield Royal Infirmary, 1921). During the 1920s a Sister Tutor was appointed and SLH and HRI started a joint training scheme (DT 35/42, 1952). In 1930 SLH was taken over by Huddersfield County Borough and in 1931 it became St Luke's Hospital transferring to public use in 1934 (DT 35/42, 1930-31; C348, 1971; Schofield, 1996, p. 147). SLH was extensively rebuilt after the NHS was introduced (C348, 1971). It had GNC approval for combined Assistant Nurse training schemes with several local hospitals, such as in November 1960, MHH, HVMH, DHH and SLH (DT 33/265, 1951; DT 35/42, 1960). GNC concerns about the quality of SLH may have contributed to developments in 1962 as the Ministry of Health provided finance to demolish the old buildings for a new hospital (Schofield, 1996, p. 147). From 1870-1960 SLH changed from a workhouse to a hospital and nurses contributed greatly to the care of patients as recognised within GNC reports. SLH with its origins as the public assistance Poor Law Workhouse was seen by many as the second main hospital in Huddersfield.

Chapter 4 - New Institutional History.

Huddersfield Royal Infirmary (HRI).

Huddersfield had three infirmaries the second opening in 1831 and closing in 1966. Evidence of increasing numbers of nurses in 1872-73 resulted in extra nurses accommodation been built. The earliest record of nurse training locally was when Miss Adeline Griffiths trained from 1879-82 denoting the importance of the hospital (Nursing Record and Hospital World, 1895, p. 328). In 1888 Miss Nott-Bower was Matron staying until circa 1890. By 1894 the Matron was Miss Frances A. Jones and there were sixteen nurses and probationers. Mrs Mary Tobin confirmed that when she trained circa 1906-09 Miss Barry was Matron (Huddersfield Royal Infirmary Old Nurses League, (HRIONL), 1966, p. 20) (Appendix 4.22).

In 1910 eighteen bedrooms were added to the Nurses Home following the addition of another twenty-four bedrooms indicating increasing numbers of nurses (Tomlinson, nd).

In 1928 an Affiliated Training for State Registration existed between HRI and SMH until 1951 (SMH, Three Years Training commencing 1923 Book; SMH, 2nd Book of Nurses Record of Training, p. 4). Another affiliation scheme existed between Mirfield Memorial Hospital (MMH) and HRI which was discontinued in 1946 (DT 35/42, 1946).

In 1929 a Preliminary Training School (PTS) was established and a full-time Sister Tutor lived in the PTS which was originally at 156 Trinity Street moving in the late 1950s to Ellerslie (HRIONL, 1959, p. 14). Nurse training continued with regular GNC inspections up until 1960. Pressure on existing hospital facilities increased during the 1920s-30s due to rising patient demands and technological advances like radiography. In response other local towns opened new larger Infirmaries such as Doncaster in 1930 (Swann, 1973, p. 133). At HRI in 1931 a scheme to extend building stock began (Johnson, 1937; Chadwick, 1946). The 1930s saw a rapid growth for the HRI and despite apparent financial difficulties it was the sixteenth largest Provincial Voluntary Hospital, well equipped and had competitive running costs compared to other institutions (Johnson, 1937).

Green Lea Hospital.

Green Lea was indirectly linked to HRI and before 1934 midwifery cases went to '*Greenlea Puerperal Sepsis Unit*' (MH 52/297, 1935, p. 23). Later Green Lea admitted private patients and in 1946 of the twenty-seven beds at the '*Greenlea Annexe*' eight were for isolation patients (Chadwick, 1946, p. 28) (Appendix 4.23). HRI nurses provided oral history evidence of working there.

HRI as a hospital and nurse training school developed throughout the Twentieth Century. Further demands on services and the need to provide technological equipment to deliver care and treatment led to the opening of a new hospital in 1966.

Bradley Wood Sanatorium (BWS).

Increasing incidents of infectious diseases like Smallpox occurred from 1870 (Leeds Mercury, 1870, p. 8; 1870, 23 May, p. 3; 1870b, p. 7). Nurses were needed to staff the hospital and there was an Assistant Nurse in 1870 (Leeds Mercury, 1870c, p. 8; Marland, 1992). It consisted of the old workhouse and newly created wards (Hobkirk and Curson, 1883; Eagles, 1984). By 1930 BWS had become the local TB hospital continuing this role until 1948 when it

became a long stay hospital (Keeling, 1998, p. 25; C361, nd). During the 1950s BWS provided experiences for students training.

BWS was an important hospital in Huddersfield during the Nineteenth and Twentieth Centuries continuing this role until at least 1960. Nurses contributed to the fight against infectious diseases until the advent of antibiotics and vaccinations reduced the need for specialised fever nurses and hospitals.

Mill Hill Hospital (MHH).

MHH opened in 1898 (Chadwick, 1946, p. 9). In 1899 Miss A. Mulligan was appointed Matron from Wolverhampton Fever Hospital (Nursing Record and Hospital World, 1899b, p.52). Evidence suggests that probationers were trained from its opening (Appendix 4.24). GNC Inspectors reported upon MHH at least twenty-eight times from 1931-1968 and appendix 4.25 details three (TNA, DT 33/265; DT 35/42). In 1931 MMH became a complete training **s**chool for Fever Nursing and a training school for TB opened in 1933 (DT 35/42, Film 5, 1932; Keeling, 1998). In 1937 the GNC recommended building extensions and by 1938 there were three further blocks (DT 35/42, Film 5, 1937; Film 6, 1937; DT 33/265, 1957). In 1937 the Matron was E. White (Huddersfield County Borough Directory, 1937, p. 1xxii). Training continued during the war and she was Matron from circa 1931 to 1955 (C381/1/47, 1944, p. 4; DT 35/42, 1949; DT 33/265, 1957). Miss E. Howarth was appointed Matron in 1955 until 1960 (DT 33/265, 1957; DT 35/42, 1957; 1960).

In 1949 the GNC warned Fever Nurse Training may not be viable and in 1957 it was discontinued (DT 35/42, 1949; DT 35/42, MHH, 1957; 1958; DT 33/265, 1957; DT 35/42, HRI, 1958). Oral history supports this decline;

> '…… ward one, that, they'd been closed, when, I suppose when the new ones were built. When……as……the……infectious diseases started fading out' (HUD 9, Mrs B. Lukash).

She confirmed the change in patient type; '……*they opened ward two, they opened it as an overflow for Geriatrics,……*' (HUD 9, Mrs B. Lukash). Eventually a thirty-four bedded unit for chronic sick men opened in 1957 (DT 33/265, 1957). During the 1950s combined nurse training courses with other local hospitals were approved such as the 1958 Component Training School for Assistant Nurses with SLH and HVMH before withdrawal in 1968 (DT 35/42, MHH, 1960). In 1996 MHH closed with many nurses having trained or worked there during its ninety-eight year history.

Huddersfield District Victoria Sick Nurses Association (HDVSNA).

At the end of the Nineteenth Century in spite of the emergence of hospitals nurses continued to work in patients homes. Since 1885 one Nurse had worked in Huddersfield and paid 2,119 free visits (Walker, 1897). In 1897 local '*Free nurses*' were regarded as; '*……the best friends of the suffering poor*' (Walker, 1897). In 1890 many Yorkshire towns had poor or nonexistent Nursing Institutions and a Miss Murray was to start; '*a venture in the shape of establishing a Nursing Institute in Huddersfield' (*Nursing Record, 1890, p. 261). Encouraging provincial towns to open DNAs was important but it took Huddersfield seven more years until the HDVSNA was founded by subscriptions (Nursing Record and Hospital World, 1897, p. 192;

KC291, 1911; C347, 1946). Regionally a District Nursing Scheme had already started at Doncaster but it is unclear if this was Queen Victoria's Jubilee Institution for Nursing (QVJIN) affiliated (Swann, 1973, p. 81-2).

In 1897 the HDVSNA applied for QVJIN affiliation, adopted the Victoria Institute Rules and engaged a superintendent and two nurses (KC291, 1911). The first Superintendent Annie Francis Lunn commenced work in 1897 having trained at Macclesfield and St. Thomas' and as a District Nurse at Chertsey and Bloomsbury (TNA 30/63/495, 1897). Six months later she went to Northampton (TNA 30/63/495, 1898; KC291, 1911).

In 1898 accommodation in Clare Hill was obtained as headquarters and remained until at least 1962 (KC291, 1911; C347/1/14/51, 1946; C497 4/1, 1975). Local nurses described its continued use by staff from HRI with a Night Nurses Home and another building opposite from Clare Hill used (Hud 10, Mrs B. Beaumont; HUD 11, Miss M. Kirkbride). HDVSNA had specific geographical boundaries as illustrated in 1900:

> '*the Superintendent be instructed that the association do not nurse in the district covered by the Marsh and Lindley Nursing Association without their consent*' (KC291, 1911).

However, in 1928 the HDVSNA assumed responsibility for nursing in Lindley, Marsh and adjoining areas (C347, 1946).

The HDVSNA trained and employed nurses and midwives and from 1917-20 five midwives trained between HDVSNA and Huddersfield Union Infirmary (BJN, 1917, p. 364; 1918, p. 179; 1919, p. 380: 1920, p. 179).

The number of nurses during 1930-47 fluctuated between six and sixteen as illustrated in appendix 4.26; 4.27. Workloads also varied and during 1931-32 nurses had 2,823 cases, made 82,828 visits and had 282 patients on the books (TNA 30/63/495, 1932). By 1945 these figures rose to 4,187, 107,327 and 349 respectively (TNA, 30/63/495, 1945).

By 1937 4,000 DNAs and over 8,700 district nurses existed in England, Scotland, Ireland and Wales (Irving, 1937, p. 25, 27). HDVSNA was one of these with fourteen other DNAs in surrounding villages. Some were QVJIN affiliated and some not but; '*…… many of their nurses have had the Queen's training, and all uphold a high standard of district work*' (Irving, 1937, p. 25, 27). The HDVSNA provided services throughout the war and the 1947 QDNA report stated the; '*Work of Huddersfield District Nursing Association continues along excellent lines*' (TNA 30/63/495, 1947). During the 1940s-50s nurses gradually started using cars making it easier to cover further distances quickly.

NHS implementation changed organisational structures and working practices, Diabetic specialised nurses and Health Visitors developed and in 1958 nurses did diabetic work (Appendix 4.28).

Princess Royal Hospital (PRH) / Municipal Maternity Home (MMH).

Opened in 1929 MMH provided midwifery services until the last birth in 1984 and closure in 1985 (Chadwick, 1946, p. 9; HRIONL, 1984, p. 20; HRIONL, 1985-86, p. 5).

HDVSNA continued until local authority control in the 1970s having for the majority of the Twentieth Century being the main district nursing provider.

Deanhouse Hospital (DHH) Netherthong, Holmfirth.

Deanhouse Workhouse (DHW) opened in 1862 (Walker, 1897, p. 149). In 1910 the Superintendent Nurse was Miss E. Ruddock (BJN, 1910, p. 249). Eventually the institution's name changed to Deanhouse Hospital (DHH). In 1913 Mr and Mrs AO. Crockett the Master and Matron of DHH were on the No 12 District Association of the National Association of Workhouse Masters and Matrons (NAWMM) (Association of Health and Residential Care Officers (AHRCO), 1913, p. 49; (AHRCO), 1914-5, p. 36). A newspaper account in 1914 described the nursing staff at DHH;

> 'One could say much about the work of the nursing staff - these brightly clad ministering angels who do their work so quietly, yet so efficiently; about the orderliness and cleanliness of every part of the whole establishment, in which sweetness and light are so evident;……' (Anon, 1914).

This account provides further evidence of its apparent value locally (Appendix 4.29). DHH was renamed St Mary's Hospital under the Local Government Act 1929 (Keeling, 1998, p. 21). During the 1940s and 1950s the hospital continued to provide elderly care and in 1957-65 was approved as a component training school for Assistant Nurses with HVMH and SLH and adopted the 1964 training syllabus (DT 35/42, DHH, 1957; 1960; 1964; 1965). By January 1968 DHH was closed (DT 35/42, DHH, 1968; HRIONL, 1984, p. 19). The nurses who had trained and worked at DHH had provided care to Poor Law and Municipal patients for 106 years.

The Huddersfield War Hospital and Auxiliary Hospitals.

Huddersfield institutions used as War Hospitals included Royds Hall Wood which was an Open Air War Hospital paid for by voluntary subscriptions. It had 600–2,000 beds and was open from 1915-1918 accommodating 17,200 soldiers. The Holmfirth Hospital opened in November 1914 and over forty female nurses worked there before closing in February 1919. The Denby Dale and Cumberworth, Skelmanthorpe, and Clayton West Military Auxiliary Hospital operated from October 1916 to February 1919. These three institutions are discussed more fully in chapter 7.

Holme Valley Memorial Hospital (HVMH).

HVMH was a voluntary institution in Holmfirth financed originally by a collection for a War memorial in 1919 and opened in 1920. GNC reports mention HVMH throughout the 1950s-60s in a variety of combined training schemes (DT 35/42, HVMH, 1952, 1955, 1957, 1958, 1960; DT 35/42, SLH, 1952; DT 35/42, HRI, 1952, 1954, 1958, 1960; DT 33/265, MHH, 1957). In 1965 HVMH adopted the 1964 nurse training syllabus prior to withdrawing training approval in 1968 (DT 35/42, HVMH, 1965, 1968). Nurses continue to work at HVMH to this day.

Conclusion of Huddersfield institutions.

These twelve Huddersfield institutions represent the main organisations nurses worked in from 1870-1960. They are not inclusive and it is recognised that nurses worked in others.

Chapter 4 - New Institutional History.

Conclusion of chapter.

This chapter has provided a review of the institutions that nurses in Halifax and Huddersfield worked in. It addresses Rosenberg's 'New Institutional History' which is interpreted in relation to the nursing elements of the institutions and therefore focuses upon the nurses themselves and nursing practice, education and management. The internal dynamics of the organisations and their social functions varied across the different sectors, but show how nurses were affected by these.

From 1870-1960 nurses were involved in working in a variety of institutions and nursing developed accordingly. Nurses worked in Poor Law Municipal institutions, Voluntary Infirmaries, isolation fever hospitals, DNAs and NHS organisations and were involved in changes with their opening and closing. Nurses from many parts of the country came to train or work locally and many locally trained nurses moved around the country, many gaining high prestige jobs.

Information about healthcare and other organisations where nurses worked provides historical details for nurses and historians. This illustrates their roles and how nursing evolved. Analysis of the types of institutions and how nursing was organised explains the importance of these institutions to nursing history. The outcome of this is a hitherto unknown account, a new institutional history, of the nurses and nursing locally. This contextualises the data obtained from archival and oral history sources.

The next chapter considers how gender and the professions relate to the men and women who worked as nurses in these Halifax and Huddersfield institutions.

Chapter 5 - Gender and the professions.

This chapter considers gender and the professions including the roles of women and men in nursing, nurse-doctor relationships and professionalisation of nursing.

This chapter draws upon both archival and oral history sources to consider the emergence of women within the workplace and nursing. The impact of war upon the role of men and women is used to show how female nurses were affected by the changing employment conditions and how male nurses emerged after the Second World War.

Oral histories are used to examine what motivated women to become nurses during the 1920s-60s and in particular explore three issues related to their childhood;

1. the impact of dolls and play
2. the impact of their experiences of personal or family illness
3. having '*always wanted to be a nurse*' from a very early age.

Another theme which emerged from the oral history data was the concept of '*comradeship*' which resulted from the closeness that nurses felt particularly during their formative training years. This was linked to them coping with adversity together within the hierarchical disciplinary regimes that existed.

Using archival and oral history data evidence is provided that there were local age and marriage bars employed within nursing and some of the effects of this on male and female nurses reviewed.

As nurses often worked closely with doctors the '*Nurse-doctor relationship*' is examined using oral history evidence to consider how the matriarchal role of Matrons compared with the patriarchal medical fraternity.

The professionalisation of nursing within Halifax and Huddersfield is considered using archival and oral history data as local women and later men contributed to what was an important part of the social history of West Yorkshire. Some individual nurses during 1870-1960 contributed to the development of nursing.

The interrelationship between the status of nursing and the status of women in patriarchal society is recognised and it is suggested that nursing's struggle to overcome oppression and gain increased autonomy and political power can be considered from an historical perspective (Roberts, 1995). Women worked in low status low paid jobs and those in nursing and domestic service were linked. There were exceptions to this with Matrons who if not nurses themselves were in charge of nurses, often paid well and in prestigious jobs. Nursing overall however was classed the same as domestic service and; '*as a "natural" sphere of employment for women*' (Summerfield, 1989, p. 9; 12). This was further linked to the industrial areas of northern England;

> '*......the public appearance of wage earning working women, resulting from industrialisation in certain areas like Lancashire, West Yorkshire and the Potteries, produced and continued to produce endless comment, usually hostile, from contemporaries*' (Roberts, 1988, p. 13).

Chapter 5 - Gender and the professions.

In Todmorden in 1911 seventy-six percent of women in full time work were unmarried. It was one of twelve towns reported to have over twenty percent of married or widowed women working full time. This compared to the West Riding where fifty-five percent were unmarried (Roberts, 1988, p. 45). Nationally the picture did not change as in 1931 seventy-seven percent of occupied women were single, sixteen percent married and seven percent widowed/divorced (Summerfield, 1989, p.13).

After the First World War the national rate of unemployment for women was higher than in Huddersfield possibly indicating these women were able to gain employment more easily in local textile and engineering industries and in healthcare (Phillips, 1995, p. 38-39). After the War there were fears that nurses nationally would be unemployed because of the numbers of untrained and trained nurses recruited (Baly, 1980, p. 186). No evidence was found to suggest this occurred to any great degree locally. Overall, the textile industry was the third largest user of women's labour (Braybon, 1981, p. 28). Women in the Yorkshire woollen industry were said to have been indispensable due to wartime production demands while after the war they were marginalised and went back to domestic labour which may have included caring roles (Bornat, 1986).

During the interwar years this was evident in the retention and recruitment of nurses. In Halifax and Huddersfield as elsewhere employment prospects for most fourteen year old girls leaving school; '*depended greatly on what was available locally*' (Braybon and Summerfield, 1987, p. 139). The majority of local women entering nurse training during the interwar years were in their early or late twenties so the age profile was relatively young. Nursing was classed in the category of low status work with long working hours, often over fifty hours per week, and poor pay. By the end of the Second World War nurses would be working less hours and the emergence of male nurses would be one result of the removal of the age and marriage bars and the introduction of more part-time working.

Female nurses.

Within Halifax and Huddersfield during 1870-1960 the majority of nurses were female with a few more men emerging in general nursing after the Second World War. The status of women and nursing during the Nineteenth and Twentieth Century are important to consider as they provide an insight into the way they were socialised into the profession and how they themselves experienced it.

Motivation to become a nurse.

The motivation to become a nurse included three main issues, firstly the impact of dolls and play in childhood, secondly the impact of their experiences of personal or family illness, and thirdly comments that they had '*always wanted to be a nurse*' indicating some sort of '*calling*' or strong feeling about it from a very early age. This first example includes all three categories;

> '*I always seemed to want to be a nurse, umm,…...I don't know, maybe with me father always being poorly, or something like that, err,……and when I had dolls, err, and the*

> *legs and arms use to break off very easily, they were made of celluloid, and I used to bandage them up, (Laughter) put some red paint on, (Laughter)...... (Laughter) so umm, I always wanted to be nurse, there wasn't anymore......nurses in the family,......'* (HUD 4, Mrs F. Wimpenny).

The impact of dolls and play in childhood.

Nurses stated that play and particularly the use of dolls were powerful reasons for wanting to become a nurse. An example of childhood experiences impacting upon a nurse's career decision was described by Miss Armitage who trained at HRI in 1939;

> '*It is 50 years ago that my childhood game of 'Doctors and Nurses' with a long-suffering grandfather finally materialised when at 18 years of age I entered the profession as a probationer nurse*' (Armitage, 1988-89, p. 27-29).

An example of the use of play and dolls as ways of practising nursing included;

> '*I used to......bandage, try and bandage the cat, and...... err, put it in the pram, you know, and take it out,......and that was from being about three and four. And err, and dolls I used to treat as......patients, you see'* (HX 1, Mrs P. Titchmarsh).

Using dolls as patients was a common game and the mention of dolls and their use as patients supports the strong feeling nurses had from an early age. Oral history evidence indicates that the earliest age of '*playing*' was from two-four years of age (Appendix 5.1). There is a dual focus here of playing with dolls and family illness. The final extract illustrates it was not the doll that was the issue but how the child played with it;

> '*......Mom always was worried because as she said my friends used to dress their dolls up in pretty clothes, my always were poorly, and she couldn't understand that, they were always in a bed'* (HX 9, Mrs B. Honour).

This strong social influence on the women as young children to become nurses is not the only factor in their motivation as it appears they had personal experiences that gave an impetus to the way they played with dolls.

The impact of nurses' experiences of personal or family illness.

Many nurses seemed to have '*got the nursing bug*' by watching nurses working. Nurses' experiences of family illness had a big influence on their caring aspirations and as they often were not hospitalised would have seen them more within extended family structures.

An example of personal illness influencing a child's decision to become a nurse was Mrs Higginson who as a ten year old child spent more than a year in MHH due to Scarlet Fever and Diphtheria (Appendix 5.2). This example of parental separation and spending long periods of time in hospital with nurses would have been a powerful experience for a young child. A second example of personal illness influencing a nurse's career choice as a child was Mrs Honour;

> *I used to wear callipers,......because, err, I had my tonsils out at the Infirmary, and following that I didn't walk anymore for sometime,......and they never really found out why, but I had callipers and they used to call me tin legs*' (HX 9, Mrs B. Honour).

Family illnesses were another reason for children wanting to become nurses. Miss Mulligan gave a detailed account of how her mother's illness and the family's positive views of, and experiences with nurses, affected her career choice (Appendix 5.3). Another example of

family illness was Mrs Titchmarsh whose experiences when she was seven with her aunt's illness having a major impact upon her (Appendix 5.4). A similar example illustrates how a nurse visiting family members at home was a strong childhood influence;

> '*It was during the time that the nurse was coming to my brother and my mother that I began to be interested in nursing*' (HUD 2, Miss L. Nattrass).

Alongside playing with dolls and experiences of illness during childhood many nurses also spoke about always having wanted to be a nurse from a very early age.

I always wanted to be a nurse.

Many nurses expressed a feeling of always wanting to be a nurse and talked about it as though they did not know why; '*……something was in me even then, I don't know*' (HX 9, Mrs B. Honour). Others tried to explain it and often linked it to playing with dolls from an early age or personal or family illness experiences (Appendix 5.5). For many the urge to nurse was strong from an early age but there were other ways of becoming interested in nursing including reading up on it. These were strong feelings of almost devotion to the cause of becoming a nurse but there were limited references to religious reasons.

Motivation to nurse links to gender stereotypical aspects of society believing nurses are female, nursing is a female orientated vocation and men are excluded. Specific examples included playing with dolls and the powerful impact in early childhood of health related '*sick role*' models and personal experiences of illness. Observing female nursing role models as a child was an important factor in swaying nurses' desires to become a nurse. Also recruitment images accompanied by the words; '*the best nurses have the essential qualifications before they go to school*' (Smith, 1992, p. 2) seems to negate the need for any educational experiences or any training to be a nurse and degrade nursing as low grade female work. The motivation to nurse was probably no different in Halifax and Huddersfield then elsewhere but with the textile industries offering women alternative employment some may not have been able to fulfill their nursing vocation.

Comradeship

Another aspect of the nurses' experiences which was evident in the oral history testimonies was the comradeship that their nurse training gave them, particularly the PTS. This was emphasised as important to not just their work but to their lives as many struck up life long friendships. The gender aspect of working and living in a predominantly female environment seems to have been a factor in how nurses viewed their formative years in their careers. This may be similar to other all female environments such as girls schools and convents. It is possible that if male probationers had trained with them this comradeship may not have been so strong. Certainly living together in the Nurses Home often sharing bedroom and bathroom facilities meant these young women lived like a family with the Home providing a substitute for their real families. This camaraderie for many was very powerful and seemed to have partly emerged from the feeling of them all being in the same boat together. In relation to PTS at HRI in 1939 Miss B.E. Armitage recalled that; '*we enjoyed the comradeship and happiness of*

those two months' (Armitage, 1988-89, p. 27-29). In 1991 Nurse M. Jackson (Nee Ellison) recalled similar feelings when starting her nurse training at HRI in 1943 (Jackson, 1991-92, p. 19). These life long friendships are illustrated in appendix 5.6. There was an emphasis on their experiences in the Nurses Home where they spent their off duty time as Miss Nattrass emphasised; '*you developed a sort of family atmosphere*' (HUD 2, Miss L. Nattrass). The general theme of the Nurses Home seemed to be a good one and the life long friendships were commonly mentioned with affection (Appendix 5.7). This comradeship lasted over time and distance for many as each nurse went their own way in life. The experiences the nurses went through created an '*Espirit de Corps*' with a supportive teamwork approach (Appendix 5.8).

Therefore female nurses found comradeship a supportive aspect of their training experiences and many made life long friendships. Experiences in their formative adult lives of living and working in a predominantly female environment were important and most enjoyed this time in their careers. Locally during the 1950s the requirement for probationer and qualified nurses to '*live in*' was relaxed and opportunities to experience comradeship and develop friendships reduced.

Age and marriage bars.

Age and marriage bars were formally introduced circa 1922 but locally seem to have been practiced prior to this. They existed locally until the 1950s when they began to be relaxed. Archival and oral history sources provide evidence of the impact of these bars on local nurses and the effect their removal had. Local female nurses described experiences of working with senior nurses who had often trained in the '*old style*' and were from a '*different generation*'. One example provided by Mrs Beaumont from HRI stated the older nurses were usually unmarried and had '*devoted*' their lives to their nursing careers (Appendix 5.9). Evidence of a marriage bar locally was found in both archival and oral history sources. This bar meant nurses were not allowed to marry during training and appendix 5.10 provides two quotes from nurses at HRI illustrating the marriage bar was particularly strict during training and still in operation during the 1940s-50s.

Archival evidence from two Halifax institutions, RHI and HGH, supports the existence of both an '*age bar*' and '*marriage bar*'. At RHI from 1898-1933 the average number of probationers per year was 10.54 (Appendix 5.11). Their average age was consistently over twenty with only one year, 1920, having an average below 20 years of age (Appendix 5.12). The range of average years was 19.75-26.13. There were two years when the average age was more than twenty-six, 1908 and 1918. There is no obvious reason for the former date but perhaps the First World War had an impact on the latter. The figures for the 1920s onwards indicate a slight fall in the average age overall which may be related to changes to nursing such as Nurse Registration. The majority of these probationers were single females apart from one widow and one non entry (C448/5 Addnl 1898-1919; C448/6 Addnl 1920-1933). Similarly, at HGH eighteen Probationer Nurse Training Agreements from 1923-24 confirm they were all

single women aged from 19-26 with the average 21.8 years illustrating both an age and marriage bar (PL 55; PL 56/1). The marriage bar was mainly for those in training and Mrs Dyson provided an example of how it was implemented (Appendix 5.13). There seemed to be a definite rule that marriage was not allowed during training and this was not just a local hospital issue but a GNC one. Mrs Dyson indicated that changes to the marriage bar may have occurred at HRI at the end of the 1940s with the introduction of qualified married State Enrolled Assistant Nurses (SEANs) in the post-war period. This changed the regime of only employing single women linking to changes to women's work nationally (Appendix 5.14).

Male Nurses.

To address the issue of the male nurse data from both archival and oral history sources is used to examine how this role developed from few males being involved as qualified nurses in general nursing in 1870 to larger numbers entering training in the 1940s and many qualifying and working in all areas of general nursing by 1960.

Prejudice against men in the recruitment of nursing is difficult to prove as it may have been that many men did not wish to become nurses and there were plenty of other types of work locally within the textile industry for them. Apart from male nurses working in local lunatic asylums and as lunatic attendants in workhouses there were few men in qualified general nursing roles until after the Second World War.

Early evidence of male nurses in Halifax and Huddersfield working in workhouses included an example in January 1880 when Janus James Wright was appointed attendant nurse in a Male Imbecile ward at the Halifax Workhouse (1881 Census: Residents of Union Workhouse, Halifax). His appointment was due to a vacancy following the resignation of James Hardy in September 1879 who left to; *'……learn the business of a baker'* (MH 12/14986, 1879; MH 12/14987, 1880). James Wright had started work at Halifax Union Workhouse in November 1879 (MH 12/14987, 1880). In January 1880 it was reported he had been dismissed as a porter from Keighley in August 1879 because of '*disobedience of orders'* related to the Master (MH 12/14986, 1879) (Appendix 5.15). The Halifax Union Visiting Committee informed the LGB that Wright seemed an exceptionally good nurse and that it would be improbable he would disobey the Halifax Master. The LGB allowed the Halifax Board of Governors to decide his fate not objecting to his appointment (MH 12/14986, 1879). In February 1880 Jonas Wright had; *'……discharged his duties in a very satisfactory manner, and the Governors have every reason to be satisfied with his conduct'* (MH 12/14987, 1880). Another male nurse included Arthur Robinson a Male Attendant at SJH who in November 1913 was paid £1 4s 7d (Net) (£52.93 = 1915) (OR PL/33).

Hostility was not noted locally to the inclusion of a male nurses part to the nurses' register during the 1919-1921 period however the lack of male nurses in the records may indicate its effect. There were no male entrants out of the 369 who commenced nurse training at RHI from 1898-1934 (C448/5 Addnl 1898-1919; C448/6 Addnl 1920-1933). At HGH the eighteen

probationer training agreements for 1923-24 were all female (PL 55; PL 56/1).[2] This reflects national figures for this period with proportionally very few male qualified nurses. Only 435 men registered from 1921-1938 and in England and Wales in 1931 only 100 were employed in general hospitals (Thompson, 1989, p. 147; 148).

From 1939-45 GNC approved Male Nurse training schools increased from nine to twenty-four (Thompson, 1989, p. 146; Ardern, 2005, p. 205). Locally during the 1940s male nurses entered nursing in larger numbers and Mrs Sleight recalled male nurses starting at HGH circa 1942;

> '……well I remember the first male nurse came…….to, to, to, to train with me, err,……on Ward 2 surgical ward, it must have been err,……it must have been about 1942 I suppose' (HX 2, Mrs A. Sleight).

GNC approval for Male nursing schools linked to the integration of men from the armed forces after the War. SJH applied for Approval as a Complete Training School for Assistant Nurses (Male and Female) in 1946 (DT 33/258, 1946). By 1948 of the thirty-nine Assistant Nurses at SJH seventeen (44%) were male (DT 33/258, 1948, p. 2). The RHI gained two years approval as a Complete Training School for Male Nurses from 1947;

> '……provided that the number of male nurses in training at any one time is not detrimental to the training of the Female student nurses' (DT 35/43, 1947).

This was confirmed in a publicity booklet; 'In April, 1947, our Infirmary was approved as a training School for Male Nurses' (Anon, nd; HX 5, Miss M. Sykes). The proviso that including male nurses should not be detrimental to the female students illustrates there was still a negative view of men in nursing. In Huddersfield HRI gained provisional two year approval as a Training School for Male Nurses in 1947 (DT 35/42, 1947). At HGH in 1947 fourteen female students stayed in the Saville Close Home while the three men stayed in lodgings outside (Anon, pre interview meeting notes). Miss Spilman the Matron gave male nurses Sundays off as she felt sorry for them as most were married (Mrs M. Mulligan, pre interview meeting notes).

Debate surrounds who was the first male general nurse at HRI but an anonymous nurse, Mr Clifford Spate, Charge Nurse Reddington and Colin Littlewood were the first to train or qualify there (HUD 5, Mrs M. Dyson; Anon, pre interview meeting notes).

By 1949 RHI and HGH worked together as a Complete Training School for Female and Male Nurses continuing until at least 1957 (DT 35/43, 1949). In 1949 Mr Hart was one of the first male DNs working at HDNA (MISC: 493/140, p. 2).

Many of the local female nurses told stories of their first experiences working with male nurses but for brevity only five are provided which illustrate the main points related to men entering nursing after the war. At HRI Janet Velma was a friend of Eric Mountain a male nurse who originally trained at SHH as a psychiatric nurse. They did their State Finals together and while students both worked on the same ward. Mrs Velma recalled she was

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2 These two records may not document all staff employed so they cannot be relied upon as complete records so there may have been male nurses there.

often given the mop to polish floors and she felt he should do this occasionally. On asking the Sister why, she said; '*……he's much older than you and he's a man,…….*'. The Sister said; '*……get along*' but Mrs Velma concluded by saying; '*……I must admit, she didn't do it straight away, but a few days later she gave him the mop*' (HUD 6, Mrs J. Velma) (Appendix 5.16). The Medical Superintendent at HGH Mr Deitch was keen to introduce male nurses and Miss Johnston recalled they had no training but he wanted to train them (Appendix 5.17). Miss Johnston worked on the War Ward and then ran the two year male nurse training course Appendix 5.18). Men got a '*married allowance*' and equal pay issues were dealt with by local hospitals. Miss Johnston suggested two of these male nurses were Arnold Crossley from the Air Force and Robert Barnes from the Navy. Mrs Bland recalled Mr Crossley at HGH; *we had an excellent Charge Nurse, I was Ward Sister and he was Charge Nurse, Mr Crossley, oh, he was fantastic*' (HX 6, Mrs W. Bland). He had worked in the RAF prior to starting nursing at SJH and he qualified circa 1950 and was Charge Nurse on Ward One at HGH. At RHI Steve Donahue was one of the first seven male nurses to train (Anon, 2000, p. 15). He qualified in 1949 and worked as a Staff Nurse and Charge Nurse on Crossley ward becoming a Nursing Officer in 1973 prior to retiring in 1980 (Pre-interview meeting, 16 May 2000). Mrs Galvin at HRI stated;

> '*the men were coming back from the War and the first male nurses……were being employed,……you know, cause it was unheard of, umm, and so we'd two really very nice men*' (HUD 3, Mrs E. Galvin)˙

In the early 1940s male nurses arriving at local hospitals did not always have friendly experiences facing hostility from their female peers. Three nurse's oral history evidence is used illustrate the strength of feeling they had when male nurses first arrived. The introduction of male nurses locally generated disquiet and some nurses felt there were inequalities in relation to pay and not having to live in (Appendix 5.19). Mrs Bland remembered the general negative feelings of female nurses towards men at RHI giving an account of a discussion she had with Steve Donahue;

> '*……he was in the first lot of nurses and I said, you've no idea what we've said about you when we thought men were coming into the profession, a women's profession*' (HX 6, Mrs W. Bland).

She recalled his reply was;

> '*……interlopers into the profession, he said, and you will never know how we felt when we stood at the door of the dining room and saw all of these…… female faces looking at us (Laughter)*' (HX 6, Mrs W. Bland).

This gives insight into the male nurses' experiences of the hostile reception received. Mrs Bland explained how upset they were using the word '*fierce*' (Appendix 5.19). However, eventually the men were accepted and were useful for heavy work! (Appendix 5.20). At HGH Miss Mulligan described her experiences of working with a male nurse;

> '*……and they'd never promoted a man at the General Hospital,……and there was a vacancy for a Night Sister, and this Male Nurse applied,……*' (HX 7, Miss M. Mulligan).

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There is an indication of possible prejudice in that men had never gained promotion although there may have been limited opportunities. His promotion was not confirmed as he went on three months trial as a staff nurse on night duty (Appendix 5.21). This indicates indecision and that the promotion was subject to him proving '*capable*'. Miss Mulligan as a young woman described her feelings about working with this older man during the whole night but found out he was very good at medicine (Appendix 5.22). She had little experience of working with male nurses even though she had worked with male doctors. She was evidently very apprehensive about this but explained that he; *'......was so wonderful and taught me so much it was, it was fantastic really'* (HX 7, Miss M. Mulligan) (Appendix 5.23). The allocation of wards however was flexible with the male nurse sometimes restricted to certain wards (Appendix 5.24). The relationship ended on a positive note with the male nurse gaining a Charge Nurses job (Appendix 5.25). This may have been one of the first male promotions at HGH.

In relation to male nurses and the nursing hierarchy Miss Mulligan provides a useful description of how the male nurses at HGH were seated at meals times on their own table and were served first with the staff nurses (Appendix 5.26).

During the 1950s further moves occurred to incorporate men into nursing locally and nationally male nurses gained senior posts. In 1950 HRI was granted full approval as a Complete Training Course for Male Nurses receiving continued approval for Male and Female training in 1955 (DT 35/42, 1950). In December 1951 the Matron at NHH had one male application for Fever Training who was unable to train anywhere else so the GNC agreed he could start. In 1952 NHH asked for permission to operate a Training School for Male Nurses but due to limited clinical experiences was not approved (DT 35/43). By 1956 the staffing establishment for NHH included twenty-seven nurses including ten males (DT 35/43, 1956). During the 1950s the Male Nurses Syllabus recommended hours per subject (Appendix 5.27). However, later in this decade it was suggested that; '*Male and female nurses did the same training but took different examinations*' (Ardern, 2005, p. 205). For example, female nurses were examined in gynaecology while male nurses were tested in genito-urinary medicine. This effectively excluded male nurses from winning hospital gold medals (Ardern, 2005, p. 205). The HRI table of gold medal winners only specifies initials and surnames so it is difficult to establish the gender of winners. However, the first identifiable male winner was Mr Terence Mallinson in 1959 (HRIONL, 1959, p. 9, 15).

In the community in 1958 at HDVSNA seventeen nurses are listed with two (11.76%) male nurses, George W. Cunnington and Jack Hardy (SA/QNI/T 1/44, 1958).

Appendix 5.28 shows the number of male and female nurses recruited and discontinued from training at RHI from 1958-1961. During this time male nurses made up just over nine percent of the total number recruited with an overall loss of thirty-nine percent of student nurses who entered training. Although the numbers of male nurses recruited was small the percentages that discontinued were higher than the female nurses perhaps indicating a reaction to the hostility some experienced.

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After 1960 evidence of further appointments of local male nurses included jobs as Nursing Assistants, Enrolled Nurses, Nurse Tutors and an Assistant Matron (DT 33/258, p. 2) (Appendix 5.29).

Within general nursing locally male nurses mainly worked in unqualified supporting roles prior to the Second World War. However, afterwards qualified male nurses within the general nursing field tended to emerge in large numbers alongside the increase in GNC approved Male Nurse training schools. Female nurses locally were initially hostile to male nurses although this hostility eventually waned as they became accepted.

Nurse-doctor relationships.

As nurses often worked closely with doctors the '*nurse-doctor relationship*' is examined using oral history evidence to consider how the matriarchal role of Matrons compared with the patriarchal medical fraternity. Nurses reported they usually had early contact with doctors during their training within the wards as well as in lectures.

It is important to remember when discussing the '*nurse-doctor relationship*' that it occurred within a certain historical and cultural context. Society was based on a fairly rigid class system which also had gender connotations to it. The male/female and middleclass/lower class scenario of the nurse-doctor relationship created a hierarchical structure that mostly defined the nurse as subordinate. The relative dominant position of medical men in hospital structures was partly a creation of the '*scientific management*' philosophy that prevailed for much of the time under study and partly a remnant from the Nightingale era (Sturdy and Cooter, 1998). Therefore, it is important here to consider this relationship within the culture and societal values of the day and not pass judgement on them from our current position. The nurses' experiences are not presented here to represent a dysfunctional aspect of the hospital as a social organisation but rather to illustrate the nurses' experiences of these gender relationships. Three areas are covered here; firstly archival documents provide evidence of a nurse-doctor relationship in the 1870s. Secondly another nurse-doctor relationship at HGH during the middle of the Twentieth Century is considered and thirdly examples of probationer nurses attending doctors' lectures are reviewed.

Nurses worked with doctors in two ways, as probationers in training and qualified nurses. Qualified nurses worked with doctors in various ways as part of the hospital team (Appendix 5.30). An example of how doctors influenced nursing was when Halifax Workhouse Medical Officer Dr. T. Dolan ordered the appointment of a temporary nurse; '*Dr. Dolan was instructed not to send any cases of measles to the Borough Hospital and it resolved to engage a temporary nurse*' (TNA, 1879, MH 12/14986). In June 1879 he drew attention to overcrowded wards and made comments about nurse staffing levels (TNA, 1879, MH 12/14986) (Appendix 5.31). Acting as '*patient and nurse advocate*' Dr Dolan ensured the lack of nurses was highlighted (Appendix 5.32). By 1893 improvements had occurred (Nursing Record Hospital World Supplement, 1893, p. 14). He also aired his views about the registration of nurses which would be;

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> '…..welcomed by those members of the Royal British Nurses' Association who have remained true to the principles upon which their Association was founded' (Nursing Record and Hospital World, 1896, p. 170) (Appendix 5.33).

Therefore Dr Dolan influenced nursing in Halifax Workhouse by supporting nurses and nursing. He recognised that by improving the professional standing of nurses and aiding the professionalisation of nursing patient care would improve.

Municipal hospitals employed doctors as Medical Superintendents who were in charge of many administration issues and worked closely with Matrons. In 1921 part of their role was teaching nurses (Appendix 5.34). The most frequently mentioned Medical Superintendent in the oral histories was senior surgeon Mr Harry Deitch from HGH. He was remembered with affection by many nurses as he met the students early in their training (Appendix 5.35). This 'father figure' role provides an insight into the male / female roles of the doctor and nurse. Miss Johnson worked closely with Mr Deitch and she recalled how they developed a strong friendship;

> 'And we had the most amazing Medical Superintendent, now I had come from a Voluntary Hospital and I didn't know what a Medical Superintendent was, ……' (HX 4, Miss M. Johnston) (Appendix 5.36).

In relation to another situation she recalled that if he asked her to do something she normally did; '……so I had to do it, you have to do what he said,……' (HX 4, Miss M. Johnston). This indicates an authoritative relationship that she was quite happy to conform to. She continued by providing an example of his leadership in relation to care;

> 'Now when I came to Halifax Mr Deitch didn't believe in cleaning the mouths out,…… he gave them sweets…to suck and made their own saliva and spit out,……and it was just as effective,……' (HX 4, Miss M. Johnston).

Another nurse who worked with Mr Deitch was the Matron Miss Nellie Spilman:

> '……I don't think they really liked each other but as far as the hospital was concerned they worked very well together,……' (HX 7, Miss M. Mulligan).

Here there is an indication of a less friendly but professional relationship. Nurses working with Mr Deitch illustrate the type of relationship they had and how their roles were important for organisational effectiveness.

Probationer nurses made early contact with medical staff when attending doctor's lectures in their formative training years. Many local nurses recalled these with great affection and remembered considerable amounts of detail (Appendix 5.37). The doctors gave lectures on their medical speciality and were powerful figures as indicated by a HGH nurse;

> '……in a way they were like gods to us,……you know, it was Sir this and Sir the other, umm, but they gave us our lectures as well,……' (HX 9, Mrs B. Honour).

Lectures occurred in the morning or the evening often in the nurses off duty time and students found this strenuous. Appendix 5.38 provides oral history extracts relating to this from HGH and HRI. These quotes illustrate the strict regimes existing in nurse training and the control over the nurses' work and personal time. Mr Gledhill's lectures at HRI made a big impression on some nurses and two other consultants were mentioned (Appendix 5.39).

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As part of their working relationships at times like Christmas there were more relaxed activities illustrating the social part of team working. At RHI doctors joined in with the nurses and were often involved in '*carving the turkey*' and helping to serve dinners (Appendix 5.40). Nurses at HRI also described this Christmas activity and photographic evidence was available. As a probationer at HRI during 1922-25 Nurse Harling gave a similar account of Christmas in her diary (Appendix 5.41).

Nurse-doctor relationships were therefore an important component of nurses' experiences during both their training and qualified careers. As individual nurses and doctors were in their jobs for many years' strong relationships were often built up.

Professionalisation of nursing

Within Halifax and Huddersfield nursing as a profession can be seen as an important part of the social history of the West Yorkshire region. During 1870-1960 nursing developed from its origins in the early Poor Law and Voluntary institutions, through national nursing registration and the introduction of the NHS. Examples of nursing and nurses becoming professionalised are provided here to illustrate how local nurses were able to ensure nurses continued to care for patients.

Examples of local female nurses who were active nationally in professionalisation issues included Miss Wharton and Miss Wilkie. In 1894 Miss ME. Wharton was Matron of RHI and in 1897 was one of seventy Matrons who signed a resolution against the admission of Asylum Attendants to the Royal British Nurses' Association illustrating she was active nationally (Appendix 5.42) (Nursing Record and Hospital World, 1894, p. 234; 1897, p. 34).

Miss Wilkie, Lady Superintendent of Halifax Workhouse Infirmary, presented a paper entitled '*The Best Means of Providing and Training Nurses for the Indoor Poor*' at a Conference of Poor Law Guardians in February 1899. She discussed recent improvements in nurse training and working conditions and highlighted the problem of; '*inadequate supply of nurses qualified to fulfil the requirements of the Nursing Order of 1897*' (Wilkie, 1899, p. 150). She outlined via published literature the issues and raised the problem of the standardisation of nurse training suggesting;

> '*There is no standard. Every hospital sets its own. There is neither uniformity of training nor of standard of attainment*' (Wilkie, 1899, p. 150).

She recommended;

> '*All examinations should be held at fixed intervals, and all papers of answers should be returned to, and judged at, headquarters*' (Wilkie, 1899, p. 150).

She set out recruitment guidelines stating; '*candidates only to be admitted on three months' trial,……*' (Wilkie, 1899, p. 150) (Appendix 5.43). She wanted to ensure that; '*……otherwise suitable women ……*' should be allowed to enter training by '*scholarships*'. She suggested it was important to have prizes and proficiency medals in theoretical and practical work. She suggested nursing inspectors should visit hospitals and probationers practice be examined on regular fixed periods (Wilkie, 1899, p. 151). She suggested a certificate be given to

probationers after two years and the following two years should provide; '......*further development of character and powers of management and organisation*' (Wilkie, 1899, p. 151). She made other recommendations many eventually re-emerging via the GNC (Appendix 5.44). In a conference report Miss Wilkie was praised for her contribution (Appendix 5.45) (Nursing Record and Hospital World, 1899. p. 152). Appendix 5.46 provides a conference summary.

The fight for registration.

During the years of the registration debate there were concerns about the '*qualifications*' of nurses and what constituted a good standard. In Halifax a district nurse who was suitably qualified was Miss Laycock the Superintendent at HDNA from 1912-1923 who had both general and district nursing qualifications illustrating the development of the qualified nurse's role (MISC: 493/3-9, 1936). In May 1913 as the fight for registration continued a local nurse Miss F.A. Borrett of RHI is listed as an elected member of the Society for State Registration of Nurses (BJN, 1913, p. 390-1). The HDNA was active in the registration debate locally when in 1916 it invited the Hon. Arthur Stanley, M.P. to speak at its annual meeting on; '*the College of Nursing*' (BJN, 1916, Dec 16, p. 492).

After registration continuing development of nursing locally included both towns having well established DNAs and increased staffing numbers to meet demand in the 1930s.

After the NHS was implemented there were more developments with other health care professions emerging and in 1954 a rehabilitation team with physiotherapists was created in Huddersfield (Mrs E. Galvin, Pre-interview meeting notes).

Oral testimony related to the RCN was limited with only two nurses mentioning it and one being an active member despite both towns having RCN branches.

Conclusion of chapter.

Gender and the professions as an area of importance allowed exploration of many aspects of the nurse experiences locally. In particular the roles of women and men in nursing, nurse-doctor relationships and professionalisation of nursing were considered to illustrate that during 1870-1960 there were a number of changes which affected both male and female nurses. Nursing was a female profession and recruitment often relied upon young women who had wanted to be nurses from an early age based upon social stereotypes. Marriage and age bars ensured employers had a rigid control over these young women allowing them flexibility in use of the nursing workforce. Oral history evidence indicated that female nurses living in formed lifelong friendships and felt that comradeship was a major factor in the formative careers. Locally male nurses were employed more after the Second World War, and female nurses provided oral history evidence that they were not welcomed, but despite this initial hostility towards them by 1960 they were occupying various jobs.

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The professional development of nursing locally was evident in selected examples of nurses who had been involved in local or national developments. However, evidence indicates that local nurses were not in any major direct way involved in national policy making.
Therefore from 1870 women played the major role as qualified nurses until the 1940s when with the introduction of male nurses men started to have an impact on clinical, educational and managerial jobs.

The next chapter considers the knowledge and authority area of importance. '*Knowledge*' relates to the issues of the clinical ward areas and practice and the educational classroom settings. '*Authority*' links to ten aspects; rules and conduct, discipline and conformity, authority and power, exploitation and social control, and organisational hierarchies and routines.

Chapter 6 – Knowledge and Authority

This chapter explores the issues of knowledge and authority. Knowledge includes the two educational issues of clinical ward practice and educational classroom settings. Authority includes the following ten aspects;

- Rules and conduct
- Discipline and conformity
- Authority and power
- Exploitation and social control
- Organisational hierarchies and routines

A combination of both archival and oral history sources provide evidence of these issues giving an overview of how education was interspersed within the work nurses did and how authority within both the training and working lives of nurses was evident.

From 1870-1960 the training of local nurses developed from simple managerial assessment of the nurse as a worker and resultant employment and possible promotion, to a fully structured system of professional education sanctioned by the GNC. Prior to 1890 there does not appear to have been an integrated approach to nurse training locally and often any training was done informally without certification. The LGB was responsible for the standard of nurses employed within Poor Law institutions and some local Medical Officers of Health contributed to the argument for the need to employ trained nurses. During the 1890s a movement to develop local nurse training schools gathered pace in both the hospital and community sectors. The QDNA approved and regulated local DNAs and this central control continued until 1960. Educational developments continued slowly until the early 1920s when following the creation of the GNC local hospitals and their training schools were regularly inspected and approved. This created an increase in the number and type of training school and included affiliations between local hospitals. This was in response to the increasing demand for more nurses as health care institutions developed and specialised. This development continued right up until the 1950s-60s with the closure, or change of speciality, of some training schools. The GNC records provide an invaluable insight into both educational and institutional nursing aspects of local hospitals.

During the time period under study local nurses' experiences were subjected to various degrees of discipline and they often worked in authoritarian environments. They were subjected to a range of rules and routines and the nurses success in both training and working relied upon them displaying behaviours which conformed to these. The conduct of nurses was therefore a major factor in both the educational and working experiences of nurses. Examples of the use of power within this authoritarian regime included the role of the Matron and Ward Sisters. The hierarchical nature of nursing led to some evidence of bullying and the wider issues of exploitation and social control illustrate the gender aspects of employment such as age and marriage bars. These issues were evident throughout the ninety years under study, however there is some evidence that nurses seemed more likely to leave or resign during the first fifty years. Following the 1940s the discipline and authority appeared to become more relaxed.

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Knowledge.

Clinical ward areas and practice.

Experiences of nurses in Halifax and Huddersfield during their nurse training and subsequent careers were linked closely to the apprenticeship style of training where nurses learnt from role models; '*……by sitting next to Nellie,……*' (HUD 10, Mrs B. Beaumont). The apprenticeship system evolved during the latter part of the Nineteenth Century with a service-education split meaning qualified nurses were responsible for both care delivery and student education.

During 1870-1960 in both hospital and community settings various forms of practical training existed. In 1880 practical ward based training was provided by Ward Sisters who recorded the probationers progress (Bradshaw, 2001, p. 14). The inclusion of Sisters and Matrons as teachers was embedded in this early system.

The LGB played a role in monitoring standards of nursing within the Poor Law workhouse system. The learning environments were regularly inspected by the LGB who were indirectly able to recommend and enforce care standards. In Voluntary hospitals this inspection role was mainly done by hospital administrators and Matrons. In 1894 at RHI the Matron Miss ME. Wharton was in charge of its training school, one of 228 provincial training schools. She was supported by twenty-two nurses and probationers were aged 24-30 (Nursing Record and Hospital World, 1894, p. 234). At SLH nurse training was under control of the Hospital Management Board which laid down rules and regulations for teaching probationer nurses in 1899 (Tomlinson, nd). In 1901 Huddersfield participated in a scheme to approve the Training and Certification of Workhouse Nursing and was represented on the Yorkshire Poor Law Nursing Board which moved to standardise workhouse nurse training giving probationers a two month trial on the three year course (P/HU/ZZ/33, 1901). This '*probation*' allowed hospitals to dismiss nurses early if weak. Practical skills were assessed and a '*Certificate*' provided. The scheme was jointly run with the Yorkshire College in Leeds who agreed to assess theory but not practice. The College stipulated practical training should meet certain criterion pre-empting the GNC's approval role. This education-service partnership aimed to standardise training schemes in Yorkshire workhouses (Appendix 6.1). By 1902 a three or four year nurse training scheme had been in existence for several years at HRI (Tomlinson, nd).

The General Nursing Council's role.

An aspect of professionalisation is that of the nursing governing body, the GNC. After Nurse Registration the GNC started to perform rigorous inspections of training schools and their associated hospitals. GNC inspections occurred to approve or re-approve training courses and to monitor standards. If there were any concerns Inspectors had the power to remove GNC approval with serious potential consequences for the hospital's nurse recruitment. Inspector's recommendations were usually adhered to and could include new buildings or equipment. The GNC therefore ensured standards were consistent across England and provided prestige to approved schools. Locally from the 1920s onwards GNC Inspections provided audits ensuring local hospital environments were suitable and adequate numbers of supervisory staff were available. In Halifax a GNC visit to SRFH in 1928 prior to the opening of NHH in 1934 was the first of five from 1928-1949 (Appendix 6.2). The GNC Inspector reported that the Matron of SRFH appeared;

> '……very capable and keen. Hospital is very clean and well kept and the nurses smart and professional in appearance. Recommended to be approved as Training School……' (DT 35/43, 1928).

The fourteen SRFH staff included the Matron, one Sister, six Assistant Nurses and six Probationers (Appendix 6.3).

In Huddersfield MHH received GNC provisional approval as a fever training school in 1936, 1940 and 1946. In the latter year the GNC confirmed that a Minimum Average Daily Bed Occupancy (ADBO) rate of not less than 100 would come into effect (DT 35/42, Film 5, 1936; Nursing Illustrated, 1940, p. 374; DT 35/42, Mill Hill Isolation Hospital, 1946).

In 1946 Shelf Sanatorium formed part of a Combined Training School with NHH. The thoroughness of GNC Inspections is illustrated by three recommendations that;

1. the NHH Sr. Tutor visited Shelf three times weekly
2. NHH students visit Shelf for a TB lecture and associated demonstrations
3. Shelf Nursing Assistants go to NHH for evening coaching by the Sr. Tutor (DT 33/255).

Learning – the good and bad.

Oral history comments about learning varied from good to bad with two illustrating the continuum. A positive example included; '*We felt it a privilege to be working together in an environment we loved*' (Jackson, 1991-92). A less favourable view was; '*……you were just used as a pair of hands,……*' (HUD 10, Mrs B. Beaumont) (Appendix 6.4). Other negative issues included being frequently moved from wards to meet workforce needs which caused resentment but was accepted. Secondly, the use of students as runners on night duty; '*……me first night duty, err, cause you were literally the runner,……*' (HUD 11, Miss M. Kirkbride). '*Runners*' relieved wards with only one nurse on duty for meals (Appendix 6.5). The role was stressful but provided experience as nurses did night duty throughout their training (Appendix 6.6). Mrs Velma's story of performing last offices at night shows the students vulnerability (Appendix 6.7). Thirdly, the hierarchical allocation of nursing tasks was explained by Mrs Higginson at HRI;

> '…….you would stand round the ward, round the desk and, and the Sister would read the report……and she'd……err, tell each nurse what their job was' (HUD 8, Mrs M. Higginson) (Appendix 6.8).

'*Task allocation*' had a hierarchical approach with junior staff doing basic mundane tasks and seniors more complex ones (Appendix 6.9; 6.10). Using ward reports and workbooks to allocate tasks was not always successful and led to role confusion (Appendix 6.11). The final negative aspect was a lack of supervision and care with nurses having upsetting experiences (Appendix 6.12; 6.13). Supervision was mainly for discipline to control the nurse's work and not directly linked to teaching or learning (Appendix 6.14).

Assessment of theory and practice.

From 1870-1920 no structured systematic assessment of theory or practice seemed to occur but during the Twentieth Century assessment was formalised and eventually regulated nationally by the GNC. By the 1950s final practical examinations for both hospital and community student nurses

occurred at external hospitals training schools (Appendix 6.15). Nurses remembered having to find equipment in unfamiliar surroundings;

> *'Err, the hardest thing was the equipment wasn't like the equipment you was used to, so you could spend a bit of time trying to find something that resembled what you was used to'* (HX 9, Mrs B. Honour) (Appendix 6.16).

One nurse recalled an assessment requiring her to prepare an operating theatre tray having never worked in theatre (HUD 10, Mrs B. Beaumont) (Appendix 6.17). This '*artificial*' assessment was seen as unfair (Appendix 6.18). Appendix 6.19 illustrates students also attended an external hospital for their oral and practical preliminary examinations. Mrs Honour suggested there was more than one external assessment (Appendix 6.20). The assessment process was formal with probationers wearing uniforms. Patients were used in some form and there were medical and surgical assessments. Nurses from several hospitals were assessed concurrently and written medical and surgical examinations were also sat at external hospitals. Appendix 6.21 shows the GNC final examination notification form for Mrs Honour to attend St Luke's Hospital, Bradford in 1952. Anonymity of name and training school was ensured by the use of centrally set examination numbers.

As assessment of nursing theory and practice became formalised during the Twentieth Century local and national developments meant nurses trained on GNC approved placements. Nurses were supervised, taught and assessed locally by administrative staff and more increasingly specialist educationists and external examiners. Clinical hospital staff and specialised nurse teachers were responsible for nursing courses and students' wellbeing.

Educational classroom settings.

With no structured '*taught*' component of nurse training apparent until the early 1900s most learning occurred '*on the job*' via the apprenticeship system of training. However, oral history evidence recognised that experiences of nurses who trained after the 1920s were strongly influenced by their formative classroom experiences.

The Sister Tutor's role.

The Sister Tutor's role was introduced in 1914 to aid Matrons and Home Sisters to teach probationers (Ardern, 2005, p. 79). In 1922 to implement the Nursing State Registration Act of 1919 HRI appointed a full time Sister Tutor (Tomlinson, nd). The same year HRI received initial GNC approval for affiliated training with SLH with full affiliation in 1933 and in 1938 two probationers, M. Denson and MG. North, had passed the course (Nursing Illustrated, 1938a, p. 38; DT 35/42, 1952). In 1929, the HRI Preliminary Training School (PTS) was established. Nurse Olive Guyll wrote;

> '*Miss Long introduced the first PTS in 1929, prior to that we went straight on to the wards with no introduction*' (HRIONL, 1981, p. 3).

The Sister Tutor lived with PTS probationers at 156 Trinity Street prior to Ellerslie.

District Nurses.

Assessment of theory and practice also occurred for district nurses and midwives who trained locally and large towns had a Central Home with a Superintendent. District nursing students were called '*candidates*' and in Huddersfield they were training in 1897, and in Halifax 1911. They also took external examinations outside of their training establishment (HUD 4, Mrs F. Wimpenny).

Chapter 6 – Knowledge and Authority.

In 1938 there were four West Riding midwifery training institutions, three in Halifax and one in Huddersfield (Nursing Mirror and Midwives' Journal, 1938e, p. 583). In Huddersfield all QNs were fully trained SRNs who needed special techniques to adapt their skills to work in homes with poor sanitation and hygiene (Irving, 1937). The QNs studied a six month post-graduate course with a practical examination which was; '......*time enough to make up her mind if it is a branch of nursing that really appeals to her*' (Irving, 1937, p.25, 27). The HDVSNA Superintendent gave lectures and candidates had two lectures on venereal diseases at HRI. Further lectures were given on a monthly basis as indicated in appendix 6.22 and candidates wrote up a summary of the lectures which were checked. Student district nurses had lectures from the technical college, doctors and the Assistant Supervisor (HUD 4, Mrs F. Wimpenny). Attending technical college illustrates developments in nurse education and how nursing was moving into other areas of educational provision.

Classroom experiences of nurses in Halifax and Huddersfield provide invaluable insights into how and where nurses were taught. In both towns teaching occurred in various '*classrooms*' within the individual hospitals and community organisations.

At HRI Mrs Beaumont confirmed there was a classroom used specifically for teaching near Ward Ten and nurses had morning prayers there (Appendix 6.23). The use of the word classroom is problematic as lectures for small numbers of students could have occurred in any suitable room. Mrs Beaumont confirmed the PTS was at Ellerslie which had purpose built classrooms (Appendix 6.24). An example of a HRI classroom in the late 1950s is shown in appendix 6.25 with Pre-Nursing Course students and Sister Blanche Shaw who later became a Clinical Teacher.

Joint and Affiliated Training Schemes.

From the 1920s joint training schemes between local hospitals existed as the GNC did not approve smaller institutions on their own. During the 1930s-50s HRI was one of six hospitals affiliated with Saint Mary's Hospitals for Women and Children in Manchester (SMH). After two years training in Manchester students transferred to HRI for a further two years. Overall forty-eight probationers transferred to HRI during 1930-1951 (Annual Reports, 1929-1947, SMH; Student Nurse's / Sister's and Staff Nurse's Book, SMH (1930); 2nd Book of Nurse's Record of Training, SMH).

During the 1950s SLH students had six months fever nursing experience at both MHH and BWS with the GNC expressing concern at this repetition (DT 35/42, 1949; DT 33/265, 1951). At HVMH in 1952 provisional GNC approval for a two year scheme of training with SLH and BWS was granted (DT 35/42, 1952). Shortened two year general training courses for fever-trained nurses also existed (DT 33/265, 1951). To relieve pressure on qualified hospital staff Huddersfield started an Assistant Nurses training scheme including SLH (Huddersfield Examiner, 1998). In 1951 the GNC reported that SLH was more suitable for assistant nurse training (DT 35/42, 1951).

During the 1950-60s various and complex local affiliated Assistant Nurse training schemes operated involving HVMH, BWS, DHH, MHH and SLH (DT 35/42, 1951; 1952; 1957; 1958; 1965; DT 33/265, 1957). GNC concerns about the quality of the ward environment, nursing care standards and supervision of students illustrates the important role they had in granting and withdrawing approval. By the 1960s the Assistant Nurse Training Scheme at SLH had a forty-three percent attrition rate (Appendix 6.26).

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These examples illustrate teaching was wide spread during the 1940s-50s within different types of courses.

Authority

Authority was a main part of the nurses working life both as a student and nurse and often impinged upon their personal time. The following ten issues are considered here to illustrate how local nurses were affected by authority;

- Rules and conduct
- Discipline and conformity
- Authority and power
- Exploitation and social control
- Organisational hierarchies and routines

It is important to remember when discussing these authoritarian and disciplinarian approaches to nursing that they occurred within their historical and cultural context. The organizational structures and social processes within the institutions reflected the values of society to a certain extent. Society was based on a fairly rigid class system that emphasised a hierarchical approach. During the 1870-1930 era there was a predominance within managerial practice of structuring working practices along the lines of Taylor's '*scientific management*' theory (Sturdy and Cooter, 1998). This emphasised the control and command approach with a clear manager-subordinate split and an authoritarian leadership style. It also emphasised the importance of time and production by using time and motion studies to ensure efficiency when performing tasks. Therefore, the nursing structures and organisational frameworks were part of this managerial culture. It is important to consider these within this culture and not to pass judgement on them from our current position. They are not presented here to represent dysfunctional aspects of the hospital as a social organisation but rather to illustrate the nurses' experiences. In the era before antibiotics and vaccinations the nurse's work was even more important to supervise and control to ensure standards of care and safety were upheld. The way the nursing hierarchy functioned by using practices such as '*petty rules and regulations*' and '*authoritarian routine*' like the Matron's round provided a structure to ensure a strict system of training and nursing practices were performed. Also, having task oriented routines allowed staff to ensure patients received their care and treatment effectively and efficiently and contributed to the successful running of the hospital.

Rules and conduct.

The use of rituals, rules and procedures within nursing ensured nurses had structure and organisation on various aspects of their working and often private lives. Ritualistic behaviours were embedded within nursing and nurses had to conform to disciplinary regimes and routines as Ward Sisters were convinced of the need for it (Bradshaw, 2001, p. 89).

Two examples of Huddersfield nurses working conditions and the rules they abided by are illustrated at SLH and DHH in 1875 and 1882 respectively in relation to smoking (Hall, 1895, p. 192) (Appendix 6.27). Also, at SLH staff had to return their uniforms if they left before six months (Appendix 6.28).

Nurse Elsie Harling training at HRI in the 1920s stated; '*It was always understood that Christmas Day was patient's day and no one went off duty*' (KC981/2/1, p. 20). She further described a rule where new patients had to be bathed explaining that;

> '……*old man had been admitted & when I asked him if he'd go & have a bath before getting into bed he was astounded, & said 'a bath? Why lass I haven't had a bath in 40 years & then it wor in't cut*' (KC981/2/1, p. 4).

She concluded; '*After explaining that it was the rule which had to be obeyed he reluctantly agreed to do as I asked*' (KC981/2/1, p. 4). Rules were used to control nurse's behaviour on and off duty. Nurse's lives were strenuous and three qualifications were suggested as essential for a good nurse, a love of caring, good health, and a level head (Ashdown, 1928). Appendix 6.29 shows demands on probationer nurses in 1928 and therefore rules were needed to ensure nurses behaviour and conduct reflected them.

Local nurses found some rules and rituals petty and two examples of these included, ensuring pillow case openings were away from drafts, and bed wheels were turned inwards to avoid anyone tripping over them (Appendix 6.30). These were common practices for many years and nurses were either unaware of them or did not know the reasons for them. Although seen as '*petty*' they presumably had some relevance to health and safety of staff and patients. However, by 1939 there was disquiet about these practices (Appendix 6.31). Appendix 6.32 shows rules of conduct and employment guidelines for both probationers and qualified nurses at RHI illustrating their roles and responsibilities. The work ethic of nursing meant nurses had to look busy or they were reported; '*……you had to be nursing all the time because……I mean it was down on the, on the report if you didn't do your job,……*' (HX 6, Mrs W. Bland). Miss Astley explained that she could not go off duty until the work was completed and if her peers had not finished she had to wait for them (HX 10, Miss J. Astley).

Rules often originated from GNC policy and Miss Marsden when discussing her relationship with the GNC as a Nurse Tutor suggested procedures were important to follow or the School would be accountable; '*……there were some rules and regulations that,……well if you didn't……follow them……there was trouble*' (HX 3, Miss D. Marsden). Nurses therefore adhered to various rules designed to ensure appropriate behavioural standards. Conformity was obligatory to survive this regime of discipline.

Discipline and conformity.

To ensure rules and conduct were adhered to nurses were subjected to discipline and conformity in relation to their working and private lives. Workhouse nurses conformed to rules and regulations such as the Halifax Board of Guardians policy since 1900 of recruiting probationers from outside the Union to ensure discipline (Appendix 6.33).

Nurse's behaviour was a strong disciplinary feature and while training at RHI in the 1920s Mrs Rushton recalled getting into trouble; '*……and she said, when you're matron you can do, oh it was matron I answered back,……*' (HX 8, Mrs D. Rushton). Nurse Elsie Harling training at HRI at the same time told a story of a lack of discipline;

> '*……but someone's carelessness then could have had serious results, and the nurse responsible for labelling medicines got herself a good telling off*' (KC981/2/1, p. 6-7).

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Obedience to discipline occurred with junior nurses obeying senior nurses and doctors both on and off duty. An example of off duty discipline was provided by Mrs Honour at RHI (Appendix 6.34). Another respect aspect of discipline was junior staff standing up when seniors were present such as during the Matron's round or at lectures (Appendix 6.35).

Other examples of discipline and conformity included the rituals of doctors and Matrons' ward rounds, the use of surnames to address junior colleagues, formal names when juniors spoke to senior nurses, and formal use of patient's names (Appendix 6.36). Further disciplinary issues included having to report breakages of equipment such as thermometers and abiding by the Nurses Home rules. Also, the wearing of uniforms was a very common theme of the oral history interviews (Appendix 6.37).

Authority and power, and exploitation and social control.

In order for the discipline and conformity to be maintained authority and power were needed which raised three issues; patriarchy, nurse-doctor relationship and the nurse's subservient role and obedience. Authority and power linked very closely to exploitation and social control and for this reason are dealt with together. Patriarchy is defined as a system of male dominance that places women in a derogatory position within an organisation (Appendix 6.38). Nurses were expected to be obedient to Matrons and Masters and to medical practitioners who were usually men. Subservience and obedience were part of the nursing ethic within both practice and education. However, obedience was not always practiced and during the 1870s at Birkby Fever Hospital in Huddersfield Dr Pritchett appeared;

> '……to have been at odds with the matron who flatly and rudely refused to obey his instructions. Although she was dismissed shortly afterwards it is an indication as to how things stood at the time' (Eagles, 1984, p. 22).

Employers in Huddersfield Workhouse had the power to dismiss nurses, and at HGH in 1901; '*Miss Wilkie, Matron, Miss Bolton, Assistant Matron, and 5 charge nurses resigned their posts at St Luke's* (Brompton, 1999, p. 6).

Examples of power included the ability of senior staff to be kind and supportive (Appendix 6.39). The term '*tartar*' was used by a number of nurses to describe senior staff, particularly Ward Sisters portraying a negative view of staff (Appendix 6.40). Nurses found ways around the obedience such as changing what they were supposed to be doing (Appendix 6.41). Appendix 6.42 illustrates a nurse under strict supervision making light of the issues and getting into trouble. This nonconformity existed occasionally as probationers '*tested the water*'. Senior staff could abuse their power taking advantage of junior staff as in appendix 6.43. The Clerk of the Guardians of Huddersfield Union provided five examples of control of staff (Appendix 6.44). The need to control nurses in relation to negligence or misconduct shows the importance of patient safety. Justification for having a disciplined approach and '*petty*' rules was suggested in 1939 (Appendix 6.45). Oral history evidence suggests some nurses could see the value of a disciplined approach (Appendix 6.46).

Rules and regulations, discipline and authority were used to indoctrinate nurses in appropriate professional behaviour. Exploitation and social control therefore, although contentious terms, do help to explain the way nurses were treated in often very authoritative organisational cultures. Authority and power and exploitation and social control were important for nurses locally and impinged upon their working and private lives.

Organisational hierarchies and routines.

Working and living in authoritarian environments nurses were subjected to a strict hierarchy of tasks with a staff chain of command and ward routines. Nursing care was prescribed using a task allocation system which depersonalised patients and reduced individualised patient care. The work included time-ordered duties and performance was assessed by the standard of nursing and speed of work. The apprenticeship type of training often meant probationers were '*thrown in at the deep end*' resulting in potential stresses. The hierarchical structure of nursing relied on various nursing ranks to function. An example of senior nurses supervising junior ones included; '*……I think you automatically felt as you got more senior, that you were responsible for this poor little soul who, who arrived*' (HUD 7, Mrs A. Mullany). Seniority was relative to the nurse's organisational position and not previous experience as illustrated by Mrs Titchmarsh a qualified Children's Nurse working as a probationer at RHI (Appendix 6.47). At HRI there were rules about how junior nurses walked on the corridors and interaction between probationers and qualified nurses was limited including their social lives (HUD 2, Miss L. Nattrass; HUD 5, Mrs M. Dyson) (Appendix 6.48; 6.49). Work done by juniors included routines like cleaning but not lighting fires (Appendix 6.50). Also, probationers were often dropped in the deep end and many could not cope with this and left (Appendix 6.51).

Nurses described the use of rank when going for meals in the dining room with several recalling their distress at having to comply with hierarchical table seating systems for yearly probationers groups, Staff Nurses, Male Nurses and Sisters, and it was not until the 1950s that the HRI and HGH Sisters separate dining rooms closed. The meal times were best described by Mrs Mulligan at HGH (Appendix 6.52). Serving meals based on rank was resented by RHI probationers who had to wait for meals; '*……first years, well we went last because the third year seniors went first*' (HX 9, Mrs B. Honour) (Appendix 6.53). Miss Sykes described her negative feelings about this (Appendix 6.54). Mrs Honour recalled gaining permission to eat was linked to seniority and that the priority was to get back on duty not complete the meal (Appendix 6.55). HRI probationers were also segregated and not allowed to socialise with a table rotation system reinforcing seniority (Appendix 6.56; 6.57). Despite this different ranks did communicate at RHI (Appendix 6.58). Discipline was conversely also used to ensure nurses went for meal breaks and this '*caring*' approach illustrates the '*nurturing*' element of the Matron's role which conflicts with the nurses' dining room experiences (Appendix 6.59). The photograph in appendix 6.60 illustrates the formality of the dining room at RHI during the 1950s. The use of meal times and the dining room to enforce hierarchical discipline and create an intimidating environment was an important part of many nurses' experiences.

Conclusion of chapter.

This chapter explored the issues of knowledge and authority. Knowledge was considered under the two issues of clinical ward areas and classroom settings illustrating that local nurses had to conform to discipline and authority at work and in classroom settings. Authority was a strong aspect of local nurses' experiences with examples such as rules and conduct and conformity to disciplinary regimes. Authority, power, exploitation and social control aspects of local nurses' experiences were considered as were the organisational hierarchies and routines. Throughout the time period under study nurses

and nursing was controlled by regulatory bodies and employers to ensure the staff were safe and worked effectively. This was mostly within a '*scientific*' management style of organisational structure based upon hierarchy and efficiency.

The next chapter considers the impact of technology on nurses learning and working lives.

Chapter 7 – The role of technology.

This chapter explores the role of technology for local nurses and nursing, and results of archival and oral history sources are used to provide details of issues raised under three headings. Firstly, clinical care developments included; methods of maintaining hygiene, the use of equipment, district nurse's use of cars and public health. Many of these would be defined as '*low tech*' equipment but in those days they were the nearest nurses got to using any advanced technical equipment. Secondly, medical advances and discoveries included; the reduction in infectious diseases and fever nursing, and developments in drug therapies such as antibiotics. As there was limited mention in archival or oral data of the use of antiseptics and other issues such as pioneering surgical techniques and anaesthesia they are not included here. Thirdly, the impact of war examines the changes that occurred in relation to the role of men and women in nursing and the profession as a whole during the two World Wars.

Clinical care developments.

Four issues are discussed here, methods of maintaining hygiene, the use of equipment, district nurses use of cars and public health.

Hygiene.

From 1870 onwards there were moves to improve the calibre of nurses and the skills they practiced. Nurses had low levels of skills reflecting the relatively '*low tech*' nature of the care. With the general improvements in sanitation and increasing awareness of the importance of cleanliness nurses were expected to have the ability to perform skills often requiring the use of equipment. This change was suggested to be part of the nursing reforms; '*…..the metamorphosis of domestic cleaning into the "science" of hygiene is clearly documented within the reform of nursing and nurse education*' (Hargreaves, 2005, p. 16). Nurses were involved in hygiene maintenance throughout this time period involving both physical cleanliness of patients and cleaning the patient environment. Locally a detailed list of tasks for bathing patients included turning on the cold water first, bathing one patient at a time and not leaving the patient unattended (Appendix 7.1). These instructions ensured standardisation, quality and health and safety. During the 1940s the nurse's role changed slightly with domestic staff cleaning but junior nurses were still involved in this role at RHI (HX 5, Miss M. Sykes) (Appendix 7.2). Many nurses interviewed talked about cleaning jobs such as;

- Sluice
- Bed side lockers
- Beds
- Linen
- Crockery and cutlery
- Medical equipment

Cleaning occurred during the nurses training and was established as part of daily routines which many disliked feeling it was a menial and laborious job (Appendix 7.3). Appendix 7.4 shows a photograph of the operating theatre of HRI circa 1910 with equipment such as antiseptics, sterilised bowls and instruments. PTS probationers had to clean the Nurses Home including fireplace brasses and front door steps and their peer's shoes (HUD 5, Mrs M. Dyson) (HX 7, Miss M. Mulligan)

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(Appendix 7.5). Hygiene therefore was an important aspect of nursing work which involved a lot of time and effort.

Use of equipment.

Nurses used or were involved in working with a variety of equipment from small to large including weighing scales, nursing care aids, syringes, sterilizing equipment, x-ray and iron lung machines. In 1898 District nurses at HDVSNA used wound dressings which patients could purchase (KC291, 1911). In 1899 patients could keep air cushions if they paid a rate of three pence per week. In 1901 a new '*water bed*' was provided and other resources used (KC291, 1911) (Appendix 7.6). During the early Twentieth Century specialised high tech equipment was limited. Appendix 7.7 shows a photograph of a RHI ward with low tech equipment including an open fire, weighing scales and bowls. At Shelf Sanatorium the GNC indicated concern about a lack of kitchen resources reporting that a refrigerator had recently been installed but there was '*no crockery steriliser*' (DT 33/255). The syringe was a common piece of equipment nurses used and initially made of reusable glass and sterilised. However, disposable glass and plastic syringes became available during the 1950s. At Huddersfield district nurses were involved in giving injections and in November 1959 it was stated that; '*Disposable syringes are in use and it is hoped to introduce Sterile Dressings shortly*' (SA/QNI/T/1/44, 1911). Mrs Velma recalled the practice of giving injections using a glass syringe (HUD 6, J. Velma) (Appendix 7.8). The sterilising of equipment was a frequent task for nurses and Mrs Velma described her operating theatre experiences (Appendix 7.9). Junior nurses were given the important task of cleaning and sterilizing equipment (Appendix 7.10). Another common example of equipment was bandages which were used extensively. Nurses were taught bandaging in PTS and spent long periods preparing and stocking bandages and other pieces of dressing material like gauze which were all packed in drums and sent for sterilizing. Nurses had to wash their own bandages and rubber gloves (HUD 5, Mrs M. Dyson). Other equipment used included a modern sputum destructor at Shelf Sanatorium and at MHH pan sterilisers were installed (DT 33/255; 33/265). Equipment for testing urine was also a major part of many nurses' roles. During 1948-49 at SJH new equipment was ordered including insulated food trolleys, poisons cupboards with individual ward keys and modern bedpan washers (DT 33/258). Mrs Velma recalled seeing the first commodes at MHH circa 1958 (Appendix 7.11). Photographic evidence showed other equipment nurses used such as beds and trolleys (Appendix 7.12).

Specialised equipment was restricted due to limited technology or finance, however x-ray machines were available and nurses often worked with them at HRI, HGH and RHI (Appendix 7.13). Mrs Titchmarsh responded to an advertisement for nurse training at RHI in 1939-40 which included an X-ray course (Appendix 7.14; 7.15).[3] Circa 1939 a special training for staff nurses appointed to the X-ray Department gave them; '……*opportunity of studying for the M.S.R. Certificate under the supervision of a qualified full-time Radiologist*' (Anon, nd, p. 16). Not all hospitals had x-ray facilities as at MHH; '……*I think they had to go down to Bradley Sanatorium for check X-rays……*' (HUD 9, Mrs B. Lukash).

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3 This awarded a Certificate from the Society of Radiographers (M.S.R).

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At RHI during the 1940s-50s PTS nurses went on educational visits involving technology including filter houses, sewage disposal works, the Odeon cinema to see the PLENUM ventilation system, and a pasteurisation plant (DT 35/43; Surin, 2002; Hargreaves, 2005, p. 165).

As communications technology was primitive before 1960 the limited availability of telephones combined with restricted hospital visiting regimes created communication problems. In 1950 NHH relatives relied on daily newspaper reports giving patients conditions by numbers as shown in Table 7.1.

Table 7.1

Northowram Hospital Report regarding the condition of patients via numbers in local newspapers.

Condition of Patient	Patient Number
Is ill	115, 117
Progressing favourably	85, 88, 97, 100, 101, 103, 104, 105, 106, 108, 110, 111, 112, 113, 114, 116
Convalescent	94, 95, 98
For discharge tomorrow	109

Source: GLE 260. Halifax Infirmary Ball Committee. (1950) WYAS, Calderdale Archives.

This system was also used in Huddersfield (Appendix 7.16). Appendix 7.17 illustrates the nurse's role at visiting time.

Oral testimony of nursing patients in iron lung machines within fever nursing environments resulting from infectious diseases including diphtheria was another example of the use of equipment by nurses (Appendix 7.18). Mrs Mullany recalled caring for the patient's personal care and social needs (Appendix 7.19). The machines took up a lot of space and varied in number at each hospital and were not used all the time (Appendix 7.20). Mrs Honour described the care these patients received and that some patients were allowed out of the iron lung for short periods (Appendix 7.21). Another care example is in appendix 7.22 indicating some patients were only in the iron lung for a few days. Mrs Bland expressed some anxiety when nursing patients at NHH;

> '……I looked after patients in iron lungs. Frightening. Oh, I think so, having that thing sucking at your……chest' (HX 6, Mrs W. Bland).

Mrs Honour told a story that illustrated the limitations of this technology when there was a power cut (Appendix 7.23). These fever nursing experiences illustrate some of the technical aspects of the nurse's work at this time

Therefore nurses used or were involved in working with varied pieces of equipment which were mainly low tech initially but which increasingly became more complex over time.

District Nurses use of cars.

Although not directly linked to clinical care another technological advance was the use of cars for district nurses. At HDNA no bicycles or other means of conveyance were to be provided for travelling longer distances as it had a good tram service (TNA 30/63/491). However during 1927 HDNA nurses gained their first car which by 1934 was '……about on its last legs' (TNA 30/63/491).

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In Huddersfield during the 1940s-50s nurses gradually started using cars more. By 1945 five cars were available, increasing to eight in 1946, and in 1947 HDVSNA nurses also had bus passes (TNA 30/63/495, 1946; 1947). There were no bicycles, often the common image of the district nurse during this era, possibly due to wartime restrictions or difficulty riding them in the undulating landscape. Appendix 7.24 shows two photographic images of Huddersfield district nurses circa 1947-50. Therefore the use of cars enabled district nurses to visit patients more easily and cope with the increasing demands on their services.

Public health.

Huddersfield played an important role in the development of public health and infant welfare services during the early Twentieth Century (Appendix 7.25) (Parton, 1981; 1983; Marland, 1991; 1992; 1993). Huddersfield had School Nurses and Health Visitors as early as 1909. The Child Health and Maternity Care Scheme was described as unique to Huddersfield involving voluntary notification of pregnancy since 1916 and domiciliary visits by lady doctors (Keeling, 1998).

From 1910-1919 developments in public health and school nurses services occurred and a local example was Miss Dorothy Wood who for twenty-seven years was a school nurse and health visitor in the Colne Valley (Thurgood, 2001). She was involved in a variety of work such as in 1933 when the Marsden Clinic inoculated 244 children from three schools (Colne Valley Guardian, 1933b). Also in December 1935 a serious outbreak of diphtheria caused three fatalities (Colne Valley Almanack, 1936-9, p. 76). By 1938 the West Riding had 117 school clinics and by 1939 there were 130 child welfare centres (Barber and Beresford, 1979, p. 52; p. 57). Preventable disease was still prevalent during the 1940s-50s with poliomyelitis epidemics taking eighteen lives in the Huddersfield area in 1949, with ten cases reported in 1955 (Huddersfield Daily Examiner, 1994, p.149). Appendix 7.26 shows a photograph illustrating the nurse's role in vaccination programmes. By the time Miss Wood retired in 1956 seventeen Health Visitors and School Nurses were working with her and held fifty-one child welfare sessions in Marsden Clinic (C381/11/11, 1956, p. 2a; 19a).

These developments in hygiene, equipment use, use of cars by district nurses and public health illustrate how nurses were involved in some aspects of the changing world of technological advances.

Medical advances and discoveries.

Medical advances and discoveries included the reduction in infectious diseases and fever nursing and antibiotics. From 1870 onwards the threat of infectious disease was prevalent and despite the introduction of immunisation therapies many patients contracted untreatable diseases. An indication that technology was advancing in 1921 was the increasing complexity of medical diagnosis and treatment the nurses had to deal with (Nursing Times, 1921, p. 500). During the middle of the Twentieth Century the decline in infectious diseases reduced the need for fever nurse training mainly due to the impact of the pharmaceutical advances of vaccinations and antibiotics.

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Antibiotics.

An important defining moment in medical history was the introduction of antibiotics (Thurgood, 2005). Nurse's narratives of their everyday experiences illustrate the early use of three antibiotics; penicillin, M and B 693 and streptomycin. Within the oral history testimonies the majority of nurses did not tell antibiotic stories either due to memory loss or the perception their experiences were not significant.

Penicillin.

As a junior student nurse at HGH in 1943 Mrs Wimpenny was seconded to Pinderfields War Hospital Wakefield to care for German prisoners of war and she confirmed they were not given antibiotics (Appendix 7.27). The experimental wartime use of antibiotics was confirmed by Anon (1943). Mrs Wimpenny continued by describing the use of penicillin in Halifax in the early 1940s confirming it came in powder form, was stored in a pantry as there were no fridges, and was mixed with water prior to injection (Appendix 7.28). Miss Mulligan who started nurse training in 1947 at HGH identified availability of antibiotics increased in the late 1940s (Appendix 7.29). The Ministry of Health increased supplies of penicillin to civilian hospitals free of charge in 1945 until June 1946 (Anon, 1945b; Anon, 1946). Mrs Sleight recalled the first penicillin was introduced at HGH during the war to a soldier with an infected appendix (Appendix 7.30). Mrs Titchmarsh remembered antibiotics at RHI were kept in the pathology laboratory (HX 1, Mrs P. Titchmarsh). Another nurse at HRI remembered penicillin starting on ward 11 in 1946 and mentioned that there was no ward fridge so it was stored in the Pathology Laboratory (Anon, Initial Interview, 26 June 2000). Miss Sykes provided descriptions of her experiences at RHI indicating different types of drugs were used and the first penicillin was dispensed in a test tube (Appendix 7.31). She described the introduction of antibiotic injections and their revolutionary impact (Appendix 7.32). Mrs Rushton recalled antibiotic injections were unpopular due to the pain experienced (Appendix 7.33). This pain was often quite severe and the injections frequent; '......we gave penicillin three hourly in those days,......' (HX 7, Miss M. Mulligan).

M & B 693.

Miss Dorothy Marsden described her first experiences of antibiotics;

> '......the first thing I ever saw in fever training way back in 1940 I suppose was M & B 693 and somebody had two tablets in a glass which she was carrying so carefully along the corridor, and everybody was......what's going to happen?' (HX 3, Miss D. Marsden).

She explained the impact of this practice following the use of M & B 693; '......we discovered that in less than a day the patients were quiet, their cerebral state was alright' (HX 3, Miss D. Marsden). When asked what M & B 693 was she explained what she could remember (Appendix 7.34). She continued with an explanation of how antibiotic use gradually increased (Appendix 7.35). Miss Marsden recalled antibiotics being used for special cases like children and infectious diseases, but with limited availability (Appendix 7.36). Mrs Dyson recalled other antibiotics were also used (Appendix 7.37). Miss Nattrass recalled that even though the antibiotics worked there were side effects (Appendix 7.38).

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Streptomycin.

Another antibiotic mentioned was streptomycin often used for TB patients. At MHH Mrs B. Lukash saw patients given Streptomycin (Appendix 7.39). In Halifax Mrs Honour recalled nursing TB patients at NHH (Appendix 7.40).

During the 1950s increased use of antibiotics meant district nurses had to visit more patients (Appendix 7.41). Overall nurses recalled seeing antibiotics introduced and having dramatic effects upon patients. Nurse's experiences of the early antibiotics provide unique memories of how they perceived their '*everyday working life*' experiences in '*ordinary*', or as in war time, not so ordinary, settings.

The impact of War.

The role of local nurses and nursing during the First and Second World Wars is explored to illustrate the impact of war. Local women's limited work opportunities meant they readily responded to shortages of qualified or unqualified nurses and playing an important role in both wars.

Wartime in West Yorkshire.

In the West Riding due to a shortage of military hospital nurses for the thirty-six hospitals and over 1,650 beds an appeal was made and 500 qualified women offered help with two hundred being placed in responsible positions (KC 799/14/8, 1919) (Appendix 7.42). Nurse recruitment problems were exacerbated by some competition from the worsted industry where large percentage increases occurred in the numbers of females employed in the worsted industry from 1914-1917 for Halifax and Huddersfield in comparison with Bradford and the UK (TNA, RECO 1/801, 1918). Nevertheless some women employed in the textile industries in low-income low status jobs found nursing an attractive alternative. Some nurses attended a course at Bradford Technical College for munitions workers as part of the war effort (Yorkshire Observer, 1981, p. 49).

Halifax in the First World War.

During the First World War both civilian and auxiliary hospitals and private homes were used to treat and care for casualties (Brompton, 1999, p. 6). HGH became Halifax War Hospital and the Matron was Miss Sarah Ellen Ada Kidson (PL 54, nd). She was congratulated on her high standards of efficiency by Sir Henry Burdett in 1914 (Washington, 1998, p. 102) (Appendix 7.43). Because of this demand civilian patients had to be treated in SJH (Higginbotham, 2006a). Four hundred beds were used for military use with 302 more in marquees in the grounds in 1915 (Hargreaves, 1999, p. 151). Appendix 7.44 shows a photograph illustrating HGH had 800-900 beds available, more than mentioned above (Thurgood, 2003a). In total 1,300 beds were provided for military use in central Halifax including RHI (Hargreaves, 1999, p. 151). At RHI there were two changes noted in the number of recruits during the First World War including, an above average number of recruits in 1914, and a large annual increase in 1917 possibly due to the demand for more nurses nationally (C448/5 Addnl, 1898-1919; C448/6 Addnl, 1920-1933). Some RHI nurses of this era served either at home or aboard but the majority worked locally. Miss Jessie Ethel Hills started as Matron of RHI in 1913 (Anon, 1913, p. 289) (Appendix 7.45).

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Halifax had six military hospitals with Spring Hall Convalescent Auxiliary Hospital (Spring Hall) the main one (TMM, 1916, p. 7; Duncombe, 1920). Appendix 7.46 shows the Annexe opened in 1917 with 116 beds indicating the need for substantial numbers of nurses. Photographs in appendix 7.47 show two aspects of Spring Hall including nurses and patients. There were five other Auxiliary War Hospitals in Halifax and seventeen nurses worked there (Appendix 7.48). Evidence of nurses working normally during the conflict included Miss Dora Laycock Supervisor of HDNA from 1911-1923 (MISC/493/3-9, 1936).

Huddersfield in the First World War.

As in Halifax most of the wounded were treated either in civilian hospitals or; '*......by taking over large private houses as War hospitals*' mainly staffed by volunteer female nurses (Rumsby, 1992, p. 158). Storthes Hall Asylum provided accommodation for; '*......injured front-line soldiers and sailors*', with acute wards used as an Emergency Hospital (Littlewood, 2003, p. 30) (Appendix 7.49).

HRI placed one hundred beds at the disposal of the War Office and convoys of sick and wounded were admitted direct from the front in the first three years. Many nursing staff joined the armed services and former members who had retired temporarily took their places (Huddersfield Royal Infirmary, 1921; Littlewood, 2003, p. 81). At SLH during the early war years the Matron was Mrs Hoyle and at DHH Mrs Crockett occupied this role. It is unclear if they continued during the war or if DHH was used for military purposes (SA/AHR/B.1/1, 1913; SA/AHR/B.1/2, 1914-15). Other institutions used as War Hospitals included Royds Hall Wood Estate Paddock which was paid for by voluntary subscriptions totalling £30,000 (£1,291,800.00 = 1915) (Brook, 1968, p. 227). It housed nurses in the mansion, had 600 beds and 17,200 soldiers were accommodated until its closure in 1918 (Balmforth, 1918, p. 86; Brook, 1968, p. 227) (Appendix 7.50; 7.51; 7.52). The king in April 1917 awarded seven Huddersfield War Hospital nurses the RRC including Sister Hawson and Staff Nurse Cook (TMM, 1917) (Appendix 7.53). With patients staying an average thirty-four days a large number of nurses were needed, with estimates of up to forty-eight female nursing staff available, and in appendix 7.54 Matron Miss Jekyll is shown with some of her staff while appendix 7.55 shows patients and nurses. The Huddersfield War Hospital was affiliated with nine auxiliary hospitals (TMM, 1916) (Appendix 7.56). The photograph in appendix 7.57 provides another view of nurses and patients with no apparent injuries indicating they may be due for imminent discharge from Holmfirth Auxiliary War Hospital. The Denby Dale and Cumberworth, Skelmanthorpe, and Clayton West Military Auxiliary Hospital operated from 1916-1919. Appendix 7.58 provides a photograph of a group image of twenty-two VAD nurses at the Denby Dale part of the hospital. In 1916 the several convalescence homes used as Military hospitals to relieve Huddersfield War Hospital had to meet five criteria, one being to have competent Matrons (KC 799/14/8, 1919). This demonstrates the importance placed on the quality of nurses, particularly as auxiliary hospital nurses were usually unpaid volunteers (Abel-Smith, 1960, p. 85).

Interwar years.

At a West Riding of Yorkshire Division meeting at Leeds in 1933 VADs were given training in anti-gas measures and the treatment of gas-bomb casualties indicating women were still involved in VAD nursing between the wars and this was also done in Camberwell London (Anon, 1933, p. 349).

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The Second World War.

The national shortage of nursing staff, and unattractive pay and working conditions, was reflected locally when numbers recruited at '*War Worker Week*' fell far short of the targets set in Bradford in December 1941, when only 498 volunteered indicating numbers would have been even smaller in Halifax and Huddersfield (Appendix 7.59).

Halifax in the Second World War.

During the Second World War nurses in Halifax cared for wounded soldiers in both HGH and RHI (Hargreaves, 1999, p. 164). Spring Hall was again used as a convalescence war hospital and there was a strong British Red Cross detachment and St John Ambulance Brigade representation (Gee, 2000, p. 49; Hargreaves, 2003, p. 202). The RHI Nurses Home built in 1929 had two storeys added in 1940 providing sixty-six rooms for nurses (Anon, 1940, p.4). Twenty-two nurses and their tutor from King's College Hospital London used these new rooms when they were evacuated as per GNC regulations (TNA, DT 15/28, 1939; Washington, 1996). Local nurses found this irritating as they had to use the existing older bedrooms (Appendix 7.60). However, the RHI Board suspended the building of a new ward and Out-patients Department (OPD) owing to the war despite Government funds being available (Anon, 1940, p. 4; Price, 2000). In contrast a new X-ray department was opened at HGH in 1940 (Washington, 1998, p. 110).

At RHI during the war the staff including nurses arranged and performed a concert for the soldiers (Appendix 7.61; 7.62). At NHH in 1942 the Matron Miss Wilson announced her retirement with the GNC report stating;

> '......it is perhaps well that Miss Wilson is retiring. She has evidently had a very difficult and tiring time. There is no one to relieve her, and she has had no holiday since the outbreak of war' (TNA, DT 35/43, 1942) (Appendix 7.63).

In 1941 the proposed retirement of Miss Johnstone the Superintendent of HDNA was discussed with the Committee believing it would be difficult to replace her in wartime. However, Miss Mary Hall who had trained at Widnes was appointed in 1943 (TNA, 30/63/491, 1944).

At HGH Ward Twelve was used as a War Ward and Miss Johnston who was Ward Sister in 1942 confirmed patients went to Ovenden Army Camp for convalescence (HX 4, Miss M. Johnston). Appendix 7.64 shows the HGH staff continued with social events during the war period. At RHI oral testimony indicates that Porter Ward was used as a War Ward (Appendix 7.65). The atmosphere on Porter ward seemed to be good and Mrs Bland's experiences were remembered as happy times (Appendix 7.66). Miss Sykes recalled that the men had serious injuries (Appendix 7.67). Other nurses described having to cope on wards with blackout curtains and limited light. Most nurses described how rationing affected them during and after the war having limited sugar and butter to use. Nurses elsewhere reported similar rationing (Merson, 1998, p. 44). Miss Sykes recalled water was not rationed so nurses could have hot baths whenever they wanted.

Other institutions affected by the war included the Halifax Woman's Welfare Clinic whose; '......doors remained open sometimes without a Dr, our nurses have dealt with the increased work successfully' (SA/FPA/A4/J113/2, 1944-45).

Chapter 7 – The role of technology.

Huddersfield in the Second World War.

Nursing in Huddersfield continued relatively normally but national shortages of nurses meant that recruitment was an important issue. The need for nurses was confirmed in 1940; '*Nurses needed at Deanhouse, St. Mary's Hospital, near Netherthong.*' It had been greatly extended and nurses and nursing auxiliaries were urgently needed (Anon, 1940, p. 335; 401). At Storthes Hall Asylum nurse staffing levels fell and a policy of employing married nurses was implemented (Littlewood, 2003, p. 84). At HRI over two hundred auxiliary nurses were trained from 1939-1940 to manage nurse shortages (Anon, 1939, p. 240; Anon, 1940, p.749) (Appendix 7.68). HRI nurse training continued relatively normally during the war and appendix 7.69 provides two examples of this (Anon, 1940, p. xi). In relation to the social life of nurses at HRI during the war, Matron Miss Long organised several social events (Appendix 7.70).

SLH was up-graded to take any type of casualty with a fully equipped operating theatre provided and two hundred beds reserved for Governments needs (Anon, 1940, p. 4). In 1940 SLH was supported by an auxiliary institution at Salendine Nook and nurse training continued during the war.

Miss E. White was the Matron of MHH during the war and in 1939 GNC Inspectors granted permission to run its nurse training course stating; '*Due to present state of emergency extended till 22 November 1940*' (TNA, DT 35/42, 1939; 1940; TNA, DT 15/28, 1947). Nurses worked in hospitals not directly related to the war such as Miss Maud LG. Clark Matron of BWS in 1944 (C381/1/47, 1944). Nurse Elsie Harling was admitted to the '*Air Raid Precautions Auxiliary Reserve*' of the St Johns Ambulance Brigade in 1940 and a member of the Civil Nursing Reserve (KC 981/1/5, 1940; KC 981/1/7, 1940). Mrs Muriel Plucker (Nee Heaton) trained at HRI in the early war years before joining the Queen Alexandra's Nursing Service serving in Burma and then returning to HRI as Night Sister and Home Sister. During the war Miss Ellen Dunn was Superintendent and Miss Alice Moore her Assistant at HDVSNA and they ensured this work continued throughout the hostilities (TNA, 30/63/495, 1941).

Post war.

After the Second World War the Ministry of Health recommended that trained nursing staff should be housed away from the immediate environment of the hospital so RHI brought the Poplars and the Willows. Appendix 7.71 shows a photograph of nurse training at HGH continuing normally with an award ceremony for nurses. At HRI in 1946 it was confirmed that male nurses were formally incorporated into the profession (DT 15/28, 1946) (Appendix 7.72). The GNC recommended in 1946 that a PTS to start nurse training;

> '*……be established as soon as possible and in any case not later than within two years of the termination of the war with Germany*' (DT 15/28, 1945).

In summary nurses played important roles in the war efforts in West Yorkshire. In Halifax and Huddersfield unqualified and qualified nurses cared for sick and wounded soldiers and civilians in military and civilian hospitals. Due to shortages of staff the definition of the term '*nurse*' changed with increased use of untrained nurses occurring. With more qualified nurses needed than were available locally women responded to meet this demand. The impact of war had varied effects on women's job

opportunities locally in both the wars but mainly reflected the national trends of increased chances for work in wartime but limited opportunities post war. Nursing changed and progressed as a profession during both wars. During and after the First World War the profession became organised and controlled nationally by the GNC. During and after the Second World War male nurses became formally accepted as part of the nursing profession and the Assistant Nurse's role emerged.

Conclusion of chapter.

Technological developments from 1870-1960 impacted upon nurses and nursing in often small but important ways. Increasing awareness of the need for hygiene and the use of antiseptics was evident. The emphasis on cleanliness within nursing locally reflected national trends. Simple and more complex equipment was made available for nurses to use as medical advances developed. Their education developed accordingly and they were trained in the use of ever increasingly more technical skills. Oral testimony from local nurses illustrated the decline in fever hospitals and some nurses recalled nursing patients in iron lungs during this time. Nurses' oral evidence was relatively matter of fact in describing what in retrospect was seen as a pivotal era in medical history, the discovery and use of antibiotics. Their unique accounts of how these drugs were introduced into Halifax and Huddersfield hospitals, and how they were administered, is an important element to the local history of nursing. The impact of war can be seen as important in changing both the nurse's role and the role of women at work. There was little mention of antiseptics, anaesthetic advances or the discovery of insulin within the archival and oral history sources. This may be explained by the nurses taking for granted antiseptics and not being directly involved in anaesthetics.

The next chapter considers the '*nurse as worker*' and examines the working lives of nurses locally in relation to their student experiences, clinical care and religion, their qualified nursing experiences, their pay and conditions and the methods used to organise nursing care.

Chapter 8 - The nurse as worker.

This chapter considers the working lives of nurses locally under four main headings. Firstly, student experiences are considered in relation to training, clinical care and religion. Secondly, qualified nurses' experiences are explored reviewing the three issues of rapid promotion, employment prospects and part-time working. Thirdly, pay and conditions are explored dealing with district nurses and working and off duty time, health and safety, pension schemes and long unsocial working hours. Fourthly, methods of organising nursing care including the use of workbooks and allocation of work are considered in both hospital and community settings. Both archival and oral history sources are used to provide the results relating to the nurse as worker.

Nursing was often seen as an occupation with nurses devoted to patients and not a profession. This culture of altruism was apparent throughout the study period. Nurses were often expected to work unpaid and have limited personal social off duty time representing a form of exploitation.

From 1870-1960 student and qualified nurses working lives improved from the very basic pay and working conditions of the late Nineteenth century through to the modern salary and benefits nurses received during the 1950s.

Demands upon nurses and the nursing '*profession*' locally in the 1870s-80s included an increasing population needing health care services as seen in appendix 8.1. Dennis (1974-5) suggested that the population growth of Halifax and Huddersfield was on a par with Leeds but not as fast as Bradford. He further clarified that Huddersfield gained municipal borough status in 1868 and that; *……by 1880, the surrounding villages had been absorbed into an urban area of over 80,000 people*' (Dennis, 1974-5, p. 46-47). As well as the growing population there was a relative shortage of women working as nurses. In West Yorkshire there were large numbers of women under twenty years old working in domestic service as illustrated by the occupational structures for local towns in appendix 8.2. Maggs (1983, p. 45) suggests these would be competing against nursing recruits. Also, the apprenticeship style of training promoted a worker-learner split which embedded the work ethic into both student and qualified nurse. Despite these restrictions nurses sought jobs locally and trained and worked in the two towns.

Student experiences.

The apprenticeship system of nurse education meant students were both learners and workers and as employees and students they were supervised by both a manager and an educationalist resulting in intense scrutiny of their working and off duty time. They were subjected to strict hierarchical lines of authority and rigid disciplinary rules and regulations. The dilemma for the students was that their work and education was entwined leaving little scope for flexibility in how they lived and worked.

At the end of the Nineteenth Century and beginning of the Twentieth Century the training of nurses locally occurred in both the voluntary hospitals and Poor Law Institutions. The Workhouses of Yorkshire were involved in a training scheme to standardise the education of nurses in 1901 (P/HU/ZZ/33, 1901) (Appendix 8.3). Probationer nurses were to be assessed in practice and be awarded a certificate if successful. Fitness to practice was important and a lot of probationers were unable to complete the training either due to physical illness or susceptibility to diseases.

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Probationers therefore needed to be; 'well educated young women of high character' (P/HU/ZZ/33, 1901).

During the early and middle decades of the Twentieth Century nurses locally had probationer contracts for a three or four year training course with an option to do a two-part midwifery course and appendix 8.4 provides further details of this issue.

At HGH during 1923-24 all eighteen probationers entering training were single women and fifteen were recruited from outside West Yorkshire (Appendix 8.5; 8.6). This compares with RHI figures where forty-six percent came from Yorkshire (Appendix 8.7). The number of probationer nurses entering the RHI from 1898-1932 was 369 (C448/5 Addnl 1898-1919; C448/6 Addnl 1920-1933) (Appendix 8.8). There were fifty-five 'educational or work related' reasons for leaving which provide a much larger proportion of the total reasons. Seven categories relating to the probationers performance either in relation to their suitability for the training, their ability to pass the examinations or their nursing practical work performance included:

> Educational
> - Did not pass examination
> - Did not pass out of school
> - Not accepted for training
> - Not suitable for training
>
> Work related
> - Poor performance
> - Not strong enough
> - Does not like nursing

Twenty-one of the educational reasons were that the probationers were not suitable for training (Appendix 8.9A). Three related to health issues while five were due to the lack of examination success or slow practical skills. These values were important to hospital staff and indicate the standards held (Appendix 8.9B). There were thirteen reasons under the two categories of 'did not pass examinations' and 'did not pass out of school' (C448/5 Addnl 1898-1919; C448/6 Addnl 1920-1933) (Appendix 8.9C). Under the 'poor performance' category there were eleven reasons for the probationers leaving relating to the lack of theoretical and practical abilities such as; 'composition and writing poor, practical work better than theory'. One other reason was insubordination linking to authority and discipline (Appendix 8.9D). Seven probationers left because they were not 'strong enough' and it was unclear if this was physical or emotional but as some entries indicated they were ill or physically weak this seems the most likely reason. Finally, three probationers left due to 'not liking nursing' which may link to their preconceived views of what nursing was (C448/5 Addnl 1898-1919; C448/6 Addnl 1920-1933) (Appendix 8.9E).

Clinical care experiences of students.

Clinical care experiences of students varied as their work was based within a hierarchical structure. The main two aspects of care that emerged from the oral history data were mouth care and pressure area care. Mrs Dyson described the practice of mouth care at HRI (Appendix 8.10A). This care was varied and at RHI Mrs Titchmarsh gave a fairly general account of mouth care; 'Mouths had to be

looked at,……and err, teeth brushed, umm, …… artificial teeth, you know,……put in,……' (HX 1, Mrs P. Titchmarsh). These examples illustrate nurses provided patients with mouth care.

An early mention of the need to care for patients pressure points was in 1895 at Huddersfield Workhouse (Hall, 1895, p. 108) (Appendix 8.10B). Pressure area care was described by Mrs Wimpenny who confirmed the Matron would check sores daily and that a variety of treatments were used (Appendix 8.10C). At HRI Mrs Beaumont described how pressure area care was integrated into daily routines and the nursing care provided (Appendix 8.10D). At HRI differing views of the occurrence of pressure sores was highlighted with Mrs Dyson claiming they were rare while Mrs France suggested they were common and there were really bad ones (Appendix 8.10E; 8.10F). At RHI Miss Sykes explained the importance and professional view of sores developing; *'…….if you got a patient with a bed sore,……umm, it was thought of as a disgrace'* (Appendix 8.10G). Mrs Bland indicated there was a blame culture at RHI with '*bad nursing*' to blame for any breakage in patients' skin; *'……so if anything went wrong, you were to blame,……cause you hadn't done your work properly'* (Appendix 8.10H). Pressure area care was therefore an important element of the student nurses work.

Religion.

Many students described how religion played a part in their lives with examples of how this materialised during childhood, family and hospital nursing experiences. Many were brought up in religious families influencing their beliefs and values. Their nurse training experiences were frequently described as powerful factors in the development of faith. There seemed to be a tradition during the Twentieth Century that Ward Sisters and other senior nurses were responsible for ensuring a Church of England service within the nurses working and off duty lives. An example of this was; *'……morning prayers' were part of the Sisters duties'* (Hargreaves, 2005, p. 152). At HGH Miss Mulligan described how senior nurses were involved at meal times; '*and the…… Home Sister or Assistant Matron said Grace,……*' (HX 7, Miss M. Mulligan) (For other examples see appendix 8.11A; 8.11B). These routines was strictly adhered to and also occurred after meals; *'……you had to sit there waiting patiently and you were not allowed to go out,……until they said Grace*' (Appendix 8.11C).

At HRI Doris Davis recalled her training experiences stating; '*I, myself, often remember with nostalgic feelings, the Bible classes,……*' (Davis, 1958, p.15) (Appendix 8.11D). These religious activities were not always popular with nurses and were also problematic in relation to the strict rules junior nurses abided by (Appendix 8.11E). Nurses were expected to attend communion with the hierarchical system continuing in church and Mrs Higginson felt this unfair and her complaint led to this practice stopping. She continued by explaining that wards with a piano held Sunday services (Appendix 8.11F). At HRI there was a Catholic Nurses Guild but the nurses had problems getting time off to go to church which was resolved by changing the Mass time (Appendix 8.11G; 8.11H).

The importance of religion may explain how they coped with the sacrifices that the altruistic nature of nursing demanded of them.

Another aspect of their motivation to complete the training and tolerate the work regimes was linked to their devotion to patients. This altruistic culture was apparent throughout the study period and the experiences of nurses at RHI best illustrate this devotion. The RHI nurse's hospital badge included

the picture of a Pelican feeding her young and the words '*Herself Unmindful of Herself*' on it (Appendix 8.12A; 8.12B). This badge and its image of self sacrifice and altruism played an important part in nurse training stressing the virtues of nursing at the time (Callander-Grant, 2001, p. 70-73) (Appendix 8.12C). A pelican sculpture was mentioned by the nurses and Miss Astley provided five comments on its origins and whereabouts (Appendix 8.12D).

Photograph 8.1 shows the RHI hospital badge with the pelican design. The image represented the philosophy of the RHI overall, not just the nurses, as its benefactors donated financial or other benefits.

Photograph 8.1 The Royal Halifax Infirmary Hospital Badge.

Source: Retired nurse.

Two examples of devotion to patients are illustrated in appendix 8.12E. Miss Astley confirmed the image was part of training and confirmed it meant a lot to her emotionally that nurses should not harm patients (Appendix 8.12F). Appendix 8.12G illustrates the official background to the pelican motto supporting the assertion that the pelican was used to represent both Christian values of charity and as an emblem of Christ. Appendix 8.12H provides three photographs with examples of the pelican image in publicity materials.

The pelican image and its motto were an important part of the probationer's induction into nursing and perhaps represented for many the altruistic philosophy that attracted them into the profession.

Qualified nurses' experiences.

Qualified nurses throughout this time period worked in a variety of settings and roles. The earlier nurses often worked alone supervising unqualified and probationer staff. As numbers increased, there was an increasing bureaucratic approach to managing nurses and ensuring suitable individuals were recruited for the increasingly important jobs they were doing.

In 1881 there were only thirteen '*nurses*' working in four of the local Workhouses caring for 1,265 inmates (Higginbotham, 2000) (Appendix 8.13A; 8.13B; 8.13C; 8.13D). In the workhouses of Huddersfield at the end of the Nineteenth Century nurses could be dismissed from work (Appendix 8.13E). Along with this there was a need for the nurses to be supervised and observed in relation to their work performance (Hall, 1895, p. 169) (Appendix 8.13F).

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In relation to record keeping, qualified nurses were from an early time in Huddersfield required to provide details of the number of inmates, admissions, discharges, births and deaths, and the Matron had a role in stock control requiring a literate nurse (Appendix 8.14).

At the end of the Nineteenth Century nurses were not only employed in Poor Law workhouses, DNAs, and voluntary hospitals, there were also groups of private nurses working in both towns. They were housed in Nurses Homes and treated patients there or in their homes. Nurses for the Huddersfield and Halifax Nurses Homes during 1897-1898 had to be; '*……good class and experienced nurses*' (Anon, 1897, p. 424; Anon 1898, p. 328; p. 368). In her autobiography Mrs Josiah Lockwood provided an insight into her sister Miss Murray, who was the Matron of the Huddersfield Nurses Home (Appendix 8.15A). Miss Murray opened the Nurses Home at 56 Westfield, Trinity Street (Census, 1910; Lockwood, 1932, p. 118) (Appendix 8.15B). Mrs Lockwood initially gave a negative view of her sisters' nurses;

> '*……whilst the nurses, wiry their parochial minds, sat silent round the table, dimly understanding and unable to appreciate the witty sallies of their matron……*' (Lockwood, 1932, p. 118-119).

However, the standard of the nurses seemed to improve; '*Then a fresh batch of more understanding nurses joined the home and times improved*' (Lockwood, 1932, p. 118-119). The nurses work included; '*……patients coming in for operation…….*' and; '*……nurses starting off hopefully to take up a case ……*' (Lockwood, 1932, p. 119) (Appendix 8.15C). When Miss Murray became ill she was nursed by her staff in the Home and her sister described two of the nurses;

> '*Nurse Susan, with steady good sense and a clear head, she chose to look after the accounts and run the house. Nurse Mary, with soft brown eyes and a sense of humour, nursed her beloved matron zealously to the end*' (Lockwood, 1932, p. 120).

In 1901 five single nurses were working with Miss Murray and described as '*hospital nurses*' (Appendix 8.15D). Jessie Murray died at the Home in 1903 aged forty-eight (Lockwood, 1932, p. 121).

Rapid promotion.

The work nurses did depended upon their job. In the earlier years a flat career structure existed illustrated by nurses going straight to Ward Sister posts after qualifying. An example of this was third year Probationer Nurse A. Newsham who was promoted to Sister at HGH in 1905 (OR/PL 41, p. 5). A later example was Nurse Elsie Harling at HRI in 1925 who had done Sister's duties even before she was promoted to this grade (Appendix 8.16). Her speed of promotion is not indicated but she completed her nurse training in May 1925 and was a qualified QN by August 1927 (KC 981/1/7).

Employment prospects.

Further illustration of the nurses employed locally included at RHI during the period 1917-1942 where sixty qualified nursing appointments occurred. These were from Sister level and above including Housekeeping trainees. Their average age was 32.33 years with a range of 24-52. Appendix 8.17 shows the types of jobs nurses were appointed to, and number appointed (C448/1 Addnl).

Local nurses during the 1940s-50s had no problems getting jobs once qualified due to high employment rates (Appendix 8.18A; 8.18B; 8.18C). Miss Mulligan explained how she got her first job as a staff nurse at HGH (Appendix 8.18D). She indicated newly qualified staff went on night duty for

three months choosing which ward they worked on (Appendix 8.18E). The working lives of qualified nurses were often no less strenuous and disciplined than students, and nurses working at Shelf Sanatorium lived in the Nurses Home and shared accommodation (DT 33/255) (Appendix 8.19). At HDVSNA there was evidence that nursing standards were monitored when Miss Hall the Superintendent was; *'……to investigate complaints about how one of the nurses performed her duties*' (KC291, 1911).

In 1941 at the HDNA it was clear nurses were controlled in relation to their job tenure as the Supervisor Miss Johnstone was likely to retire in the early 1940s. Her proposed retirement was discussed but the Committee felt a replacement would be hard to find in war-time. However, the QVJIN Inspector recommended; *'……the time had come for Miss Johnstone to give up,'* (TNA, 30/63/491, 1941) (Appendix 8.20). It is unclear what happened to her after 1941. In 1939-40 HDNA community nurses often worked in teams and provided a variety of care to different groups of patients and appendix 8.21; 8.22 illustrate the number of patients on the books and numbers of visits made. Evidence of the stability of employment prospects was available consistent with periods of nurse shortages. Long job tenures were common however, some nurses moved around the country changing jobs and gaining promotion.

Part-time working.

Early signs of changes to the tradition of full time working included Mrs Beaumont who when working as a district nurse in Huddersfield recalled unsuccessfully requesting to go part-time after completing her '*contract*' for the first year after qualifying (Appendix 8.23).

Part-time was defined as working only a few hours less than full time indicating the opportunities for flexible working to meet women's social needs were changing. In 1939 at HDVSNA there were two part-time auxiliaries which is one of the earliest records of part-time nursing staff and the role of the auxiliary nursing support worker locally in the community (30/63/495, 1939). Of sixteen nurses in 1940, two were working as part-time relief nurses (30/63/495, 1942). In 1946 there were two part-time nurses (SRN) and one assistant part-time nurse (30/63/495, 1946). By 1947 six part-time non-resident staff worked at HDVSNA reflecting changes in employment relating to working hours, contract terms and conditions, and living out restrictions (30/63/495, 1947). Mrs Galvin applied for a part-time community nurses job at HDSPDN in 1949 where she started evening duties giving out drugs allowing her to raise her family (Appendix 8.24). This increase in part-time work opportunities showed the move to more flexible employment approaches.

Experiences of qualified nurses related to the three issues of rapid promotion, employment prospects, and part-time working, and provided examples of how these influenced their working lives.

Nurses' pay and conditions.

Nurses' pay and conditions were recognised as poor and linked to factors such as gender and female work, and age and marriage bars as aspects of employment contracts. Within this area of pay and conditions the nurses working life issues related to district nurses, working and off duty time, health and safety, pension schemes and the long and social working hours. They are considered in relation to local nurses within both hospital and community settings.

Chapter 8 - The nurse as worker.

Pay.

Nurses' pay varied with a general increase over the ninety years under study (Appendix 8.25A). Pay scales locally mainly reflected national pay structures and were increasingly regulated nationally (Appendix 8.25B).

Detail of nurses' pay in the local workhouses in the Nineteenth Century was limited. James Wright started at Halifax Union Workhouse in 1879 as a Lunatic Attendant on £40 per year (£1,932.40 = 1880) and rations, washing and an apartment in the Workhouse (TNA, MH 12/14987, 1880).[4] An example of nurses' pay in 1888 was an Assistant Nurse at SRFH who earned £22-£25 (£1,317.58-£1,497.25 = 1890) with uniform (Nursing Record, 1888, p. 513). This compared favourably with the 1894 HRI probationers three year training pay of £12, £15, £20 (£718.68, £898.35, £1,197.80 = 1890) and Charge Nurses salaries of £26-£30 (£1,557.14 - £1,796.70 = 1890) (Nursing Record and Hospital World, 1894 p. 228). The first Superintendent Nurse at HDVSNA in 1897 was paid £40 (£2,285.25 = 1900) which was more than Charge Nurses (30/63/495, 1897) (Appendix 8.26). Private nurses in Huddersfield and Halifax during 1898 were paid well in comparison receiving £35 per year (£1,997.10 = 1900) increasing by £2 per annum to £41 (£2,339.46 = 1900) (Anon, 1897, p. 424; Anon 1898, p. 328; p. 368).[5]

An early example of industrial unrest related to pay was at HDVSNA when on Queen's District Nursing Institute (QDNI) recommendations Nurse Salmon was appointed as third nurse. She sent a letter asking for '*£35 like her last job*' (£1,997.10 = 1900). In October 1898 she requested not to have to share a bedroom and took a room outside at her own expense and asked for an allowance. She was granted two shillings (£5.71 = 1900) a week '*……on account of extra washing*'. During August-October 1899 the Superintendent investigated complaints about how; '*……one of the nurses performed her duties*' (KC291, 1911). Whether this was Miss Salmon is unclear but in April 1900 she was still employed and her pay had increased from £30 to £33 (£1,711.80-£1,882.98 = 1900) per year (KC291, 1911).[6] This illustrates how pay and employment conditions were tied up together and how individual nurses fought for satisfaction. Appendix 8.27 illustrates Nurse Salmon's pay in 1900 and the narrow £10 (£570.60 = 1900) grade difference which may have contributed to this incident.

Pay in hospitals went through various stages and the next section looks at some. Although comparisons of pay are not easy as many institutions were able to pay staff independently, Charge Nurses at Doncaster Royal Infirmary were paid £35 in 1913 (£1,507.10 = 1915).

In 1906 the salary of Miss Barry, Matron at HRI was unknown however, the Matron at Doncaster Royal Infirmary Miss Edith S. Chinnock was paid £60 per year with board and laundry (£3,441.00 = 1905). This salary was large compared to those at HGH in 1905 illustrating probationers and qualified nurses pay differences (Appendix 8.28). The four Sisters earned different amounts based on their experience. The probationers listed were all third years however in appendix 8.29 second years earned £1 1s 6d (£61.65) and first years £0 15s 4d (£43.97) illustrating a hierarchal pay scale. By

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4 His pay compared well with the only male of ninety-one nurses at Manchester Royal Infirmary in 1879 of £3 11s 6d a quarter (Thompson, 1989, p. 102).

5 These rates of pay compared favourably with temporary fever nurses for scarlet fever wards at the Halifax Fever Hospital who were offered £25, (£1,426.50 = 1900) with uniform (Anon, 1898, p. 328).

6 This compared favourably with the District Nurses in Doncaster as the Head Nurse Annie Wheller was paid £34 (£1,940.04 = 1900) per annum and new District Nurse Aldous £21-24 (£1,198.26-£1,369.44 = 1900) (Swann, 1973, p. 82).

Chapter 8 - The nurse as worker.

September 1910 there were eight Sisters and two had worked for different numbers of years but received the same pay (Appendix 8.30). This was not explained showing there may have been individual differences dependent on their circumstances. Even more surprising is that Sister Lawson mentioned in appendices 8.28 and 8.30 was earning the same amount of pay as five years earlier. In 1912 a 'nurse' called Ethel Wilson was being paid £0 13s 10d (Net) (£39.47 = 1910) and a year later Arthur Robinson a Male Attendant was earning £1 4s 7d (Net) (£52.93 = 1915) (OR/PL 33).[7] This was a pound less than his colleague Mr Dixon earned three years earlier.

Voluntary hospital pay scales seemed to be on a par with Poor Law and Municipal scales. During her training from 1922-25 at HRI Elsie Harling had to buy her own uniform which was expensive. She was on trial for the first three months and got free board and lodging's but no pay (Appendix 8.31). In 1924 Phyllis Bland a Children's Nurse at HGH was paid a salary of £25 (£749.25) rising to £27 10s (£824.18) and then to £30 (£899.10) in two years (OR PL/37, 1923-24). At HGH during 1923-24 probationers pay changed little during their training as illustrated in appendix 8.32.

Alongside pay nurses were offered extra provisions and appendix 8.33 illustrates these from thirteen different job advertisements during 1932. Five (38%) of the jobs offered some sort of uniform provision, one (8%) offered laundry facilities and one (8%) offered board. The Health Visiting / School Nurse job was the highest paid at £196 (£6,550.32 = 1930).[8] A similar Health Visitor salary of £200-230 with £10 uniform allowance and travelling expanses was paid in 1938 (Appendix 8.34).

At RHI in 1939 staff nurses on the medical and maternity wards and theatre were paid '£75 rising' (£2,154.00 = 1940) (Anon, 1939, p. xiii). This compared favourably with the Sister's £85 in 1938 (Appendix 8.34).

At RHI appointments to various nursing grades from 1926-1945 provide examples of pay scales (Appendix 8.35). There was a gradual small increase in pay and a clear differential between grades and pay. Sisters' pay was between £75-85 with the exception of the X-ray Sister in 1926 who earned £110 (£3,296.70 = 1925). Sisters' pay only increased significantly after 1941 rising to between £100-140. The photograph in appendix 8.36 illustrates the six month management course for House Keeping Sisters with a £12 per year salary. Data in appendices 8.35 and 8.37 indicate the Sister Tutor's pay increased from £155 (£4,451.60 = 1940) in 1941 to £230 (£5,968.50 = 1945) in 1945. The Assistant Matrons' pay of £150 in 1935 is a large amount compared to the Ward Sister's £75-85.

In 1938 Housemaids at Shelf Hospital needed to be; '…… experienced, clean workers' and were paid £32-£36 (£919.04- £1,033.92= 1940) with uniform and holiday allowance which compared favourably with probationers of the time (Nursing Mirror and Midwives' Journal, 1938b, p. xlv).

In 1938 probationer's annual pay varied during their first years at seven West Yorkshire hospitals (Appendix 8.38). Fever nursing probationers pay varied from £28-40 dependant on whether a one or two year course. In relation to the general hospitals there was a similar range of pay from £18-30. Two of the hospitals offered four year training courses including RHI which did not provide a pay rise for final year probationers. Probationers pay at HRI stayed at a low level until at least 1940. In 1939 at HGH probationer nurses on the three years training were offered salaries of £30 representing a

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7 It is possible they were not qualified nurses but support staff.

8 This was £46 (£1,537.32 = 1930) more than an Assistant Matron.

depreciation from 1923-4 (£861.60 = 1940), £35 (£1,005.20 = 1940), £40 (£1,148.80 = 1940) (Anon, 1939, p. xix). At HRI in 1939-40 probationers were paid even less, £20 (£574.40 =1940), £25 (£718.00 = 1940), £30 (£861.60 = 1940) (Anon, 1939, p. xv; Anon, 1940, p. xi). These figures conflict with oral history testimony which suggests probationers in 1947 got £200 (Appendix 8.39). In 1940 at Selly Oak Hospital Birmingham probationers were paid more in their third year with £30 (£861.60), £35 (£1,005.20), £47 (£1,349.84) per year (Anon, 1940, p. xii). These examples illustrate the differences in nurse's local and national pay. The differences in Municipal and Voluntary hospital pay scales may reflect the financial difficulties that Voluntary hospitals were facing.

District Nurse's pay.

To illustrate pay aspects of district nurses details of their salaries in Halifax and Huddersfield are examined. Pay scales were often based on national QDNI figures but some individual DNAs paid more or less than these.

Appendix 8.40 provides details of nurses' pay at the HDNA in 1929. This shows a hierarchical grading system except for the outside nurse (midwife) who was paid more than the Superintendent. Appendix 8.41 provides details of nurses' pay at the HDNA in 1938 when two staff earned more than the Superintendent. In 1933 Mrs Leeson a Non QN Nurse Midwife with the same qualifying date was second highest of eighteen staff paid £146 (£5,399.08 = 1935) and the third highest paid in 1936 with £140 (£5,177.20 = 1935) (30/63/491, 1933; 1936).[9] She may have been a Midwife whose job title did not reflect her position.

In 1941 the Superintendent Miss Johnstone was earning £210 per annum (£6,031.20 =1940) and her Assistant Miss Shepherd £140 (£4,020.80 = 1940) indicating Miss Johnstone's pay had increased but Miss Shepherd's had not (30/63/491, 1941).

The majority of nurses' grades were described as Sister, Staff Nurse or Nurse on 10 January 1928 (MISC: 493/10, 1941). Nurses' pay at HDVSNA between 1930 and 1947 increased gradually with various grades all receiving improved salaries. Superintendents received £150 (£5,547.00 = 1935) in 1933 rising to £385 (£9,990.75 = 1945) in 1947. Appendix 8.42 shows Superintendent pay rates at HDNA from 1929-1946 doubled over seventeen years. Appendix 8.43 shows Superintendents pay was comparable between the two towns with Halifax paying more in the earlier years but Huddersfield paying a higher rate later resulting in a £50 differential in 1946. The Nurses' pay was £70 (£2,588.60 = 1935) in 1933 and by 1946 reached £160 (£4,152.00 = 1945). This latter figure was less than the 1945 salary of £170 (£4,411.50 = 1945) indicating a pay reduction. Appendix 8.44 shows QNs pay at HDNA from 1929-1941 ranged from £63-95 illustrating pay based upon experience and incremental pay scales. Of the three years with comparable data Huddersfield nurses twice had larger salaries than their Halifax counter parts with an unexplained deficit of £15 (£430.80 = 1940) in the remaining year. HDNA and HDVSNA candidates were paid similar amounts with pay doubling from £55 in 1929 to £110 in 1946.

The Rushcliffe salary scale was universally adopted by DNAs from 1944 (Charlton, 1998). The Nurses Salary Committee recommended scales of salaries and other employment conditions for all

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9 This represents an unexplained reduction in pay.

nurses in 1944 including Ward Sisters' pay from £130 per year rising to £180 (Appendix 8.45). According to publicity materials for the RHI circa 1948 probationers received;

> '*a Salary in accordance with the Rushcliffe scale, and 28 days Annual Holidays are granted. In addition to Salary, emoluments include Uniform made by the Infirmary dressmakers, Board, Lodging and laundry*' (Anon, nd).

In the 1950s student nurses paid their Preliminary and Final Examinations fees as illustrated by appendix 8.46. Mrs Sleight who started training at HGH in April 1933 qualifying in 1936 remembered paying £2 Guineas (£77.66 = 1935) for her Preliminary exam and £3 Guineas (£116.49 = 1935) for her Final exam but got £5 Guineas back when she passed (HX 2, Mrs A. Sleight) (Anon, 1939, p. xix). Overall nurses pay remained consistent in relation to gradual increases and grade differentials. Local nurses were paid relatively poorly with no major variations from national pay scales.

Working Conditions.

Apart from their salary, nurses were also subject to terms and conditions of service and therefore contracts of employment varied. In both hospital and community settings perks included uniforms, board and lodging, housekeeping and laundry allowances.

District Nurses.

At HDVSNA the '*General Conditions*' relating to nurses were that;

> 1) '*Nurses should have at least 1 years training in approved General Hospital or Infirmary*
>
> 2) *They should have approved training in District Nursing for not less than 6 months including Monthly Nursing*
>
> 3) *Nurses in County Districts must have at least 3 months Midwifery training*' (30/63/495, 1897).

From its inception the HDVSNA engaged various nursing staff and the QDNI often recommended staff (KC291, 1911). However, not all appointments were successful illustrating nurses were able to have job choices. During its first three years an establishment of nursing staff was built up with appointments and resignations occurring (Appendix 8.47). In 1898 Miss BH. Hall was appointed Superintendent on condition she stayed for two years unless unforeseen circumstances occurred, but resigned in 1899 (30/63/495, 1898) (KC291, 1911). Miss Emily E. Abraham's from Bilston, Staffordshire was interviewed to replace her and the Committee asked the QDNI if they thought;

> '*Miss Abraham's has sufficient social standing to make her a suitable Superintendent and if not to submit other names*' (KC291, 1911).

This resulted in Miss Abraham's withdrawing her application on 7 September 1899. A; '*Miss Ross from Handsworth Birmingham and a Miss Piercy (Holiday Nurse)*' applied and via a '*Ballot vote*' Miss Piercy was appointed. This illustrates flexibility in appointments and that selection of senior nurses was important. Evidence of workload pressures at HDVSNA included in 1900; '……*work was so heavy the staff could not stand any increased strains*' and a Miss Pickering Birkenhead was appointed holiday nurse to cover (KC291, 1911).

In Halifax there were further examples of staff turnover when in 1913 Ellinor F. Williams was appointed as a Queen's Nurse at HDNA (BJN, 1913, February 22, p. 149). In 1919 it was stated that;

> 'Miss Quayle, the Assistant Matron, left to go to the Rochdale Association and Miss Ramsay was appointed in her place' (MISC: 493/3-9).

In 1923 Miss Laycock the Superintendent at HDNA for eleven years retired due to ill health. Appreciation of her services was confirmed when; 'On the 27th March, 1923, she was presented with a cheque for £62.0.0' (MISC: 493/3-9, 1936). This equates to £1,858.14 in today's money. She was replaced by Miss M. Johnstone of Rotherham on 6 April, 1923 (MISC: 493/3-9, 1936). This turnover of staff ensured new outside staff arrived.

Outside of HDNA and HDVSNA in December 1927 Nurse Currie was the first 'village nurse' at Marsden but later resigned in March 1929 illustrating nurses appointed to smaller DNAs were able to resign (RC/6/79, 1929, p. 25).

Nurses' working conditions were supported by the social facilities employers provided such as at HDNA; 'the Nurses were entertained by Lady Firth and spent a pleasant afternoon at Scriven Park' (MISC 1003/5, 1931, p. 4). Examples of benefits and working conditions nurses enjoyed included £8 (£295.84 =1935) for uniforms and laundry (30/63/491, 1933). By 1947 HDVSNA nurses were provided with uniform allowances, initially of £15 15s 6d (£409.36 = 1945), with a renewal of £14 (£363.30 = 1945) per year and fifteen shillings (£19.46 = 1945) for their board (30/63/495, 1947).

Working conditions within the community varied but there was evidence that the nurses' welfare was taken into account. Job tenure was on the whole stable and often nurses were in post for many years.

Working and off duty time.

Along with pay the number of hours and types of shift patterns nurses worked for this pay was important. During the 1930s district nurses at Halifax had a weekend off duty each month and a half day per week and there was an evening shift till 22.30hrs (30/63/491, 1933; 1936; 1938). In 1938 a QDNI Inspector suggested there should be a more liberal Sunday off duty time (30/63/491, 1938). By 1940 the nurses' off duty was increased to include a day off 'every Sunday except 1:7' and a forty-four hour week (30/63/491, 1940).[10] By 1947 nurses at HDVSNA had fifteen days annual leave every six months which had not changed significantly since the early 1930s (30/63/495, 1947).

By comparison with district nurses, probationers at SLH in 1951 worked a forty-eight hour week and night duty was ninety-six hours per fortnight from 20.30-08.30hrs. Meals were taken in the ward kitchen and they worked two weeks on and had four and a half nights off (DT 33/265, 1951). This illustrates that local nurses worked varied shift patterns and hours depending on their position and type of nursing.

Health and Safety.

As part of their employment nurses like other workers were expected to have healthy and safe conditions. An example of safety issues was when Florence Ramsden a RHI OPD nurse sustained an eye injury. In relation to the Workmen's Compensation Act 1906 (WCA) a; 'Notice of Memorandum Re: Agreement sent to Florence Ramsden' was sent to her (MISC 812/2). Correspondence dated May 1909 states she incurred a; 'Personal injury caused by accident arising out of and in the course

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10 This figure had decreased from an average fifty hours per week in 1932 (30/63/495, 1932).

of her employment' (MISC 812/2).[11] She was twenty-five years old at this time circa 1909 and her average weekly earnings were 14s 2d *(£*40.42 = 1910*)* (MISC 812/2) (Appendix 8.48). The RHI admitted liability and presumably paid compensation.

During the Twentieth Century welfare and supervision of the health of nurses became important particularly in relation to infectious diseases. An indictor of the health of nurses were the attrition rates of training schools and HRI had a lot of students with ill health or infectious diseases requiring them to leave training (SMH, 1930). At Shelf Sanatorium nurses had a medical examination and x-ray on appointment repeated six monthly and before leaving. Mantoux Tests were performed and nurses weighed monthly. They wore gowns and masks for certain dressings and cutlery was marked and crockery was of a different design for patients (DT 33/255, 1946). Health and safety was therefore an important part of working conditions.

Superannuation Pension Schemes.

An example of the wider support of nurses as workers was the operation of a Superannuation Pension Scheme at HDNA and although not unique to Halifax it shows the organisation valued its staff and it was QDNI approved. Although not unique to Halifax it shows the organisation valued its staff and the QDNI approved of it (Appendix 8.49; 8.50). In 1947 a Federated Superannuation Scheme of fifteen percent was in operation at HDVSNA (30/63/495, 1947). The only scheme offered out of thirteen jobs advertised was a Scheme for staff nurses at Dewsbury General Infirmary in 1932 (Appendix 8.33). In 1938 only eleven (20.75%) out of a sample of fifty-three advertised jobs mentioned a scheme, one at HRI, one at RHI and two at HDVSNA (Appendix 8.34). These were confirmed the following year (Anon, 1939, p. xiii; p. xv).[12] A further example of employment conditions was compassionate leave (Appendix 8.51).

The long and unsocial hours.

Local nurses worked long hours and often lived in the hospital making the work-life balance difficult. This is illustrated at SLH in 1893 when all the staff had days off allocated in a three weekly cycle (Appendix 8.52). Nurses worked longer hours at night and a Sister Hobart and Sister Costello in 1917 often did; *'……thirty or more nights without a break, and then it was usually only one night off'* (Marsh, 1975). Mrs Rushton training at RHI during the early 1920s recalled; '*Oh, it was such hard work……well we did 12 full hours……*' (HX 8, Mrs D. Rushton). Nurse Harling who trained at the same time at HRI described how she worked up to seventy-two hours per week and how '*split shifts*' were used. She also confirmed that lectures were taught in the nurses' off duty time and she had three weeks annual holiday (Appendix 8.53). In 1932 the average working week for district nurses at HDVSNA was fifty and one quarter hours per week with one weekend off per month (Appendix 4.26 in chapter 4). In 1939 HGH probationer nurses worked a forty-eight hour week including one day off weekly, a long weekend monthly, and three weeks annual leave (Anon, 1939, p. xix). In 1946 the weekly working hours at Shelf Sanatorium for both day and night shifts were fifty-three and fifty-four hours respectively (Appendix 8.54). In 1958 the average number of hours QNs worked was forty-four with one day off per week and working one weekend every six weeks which included Saturday,

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11 The injury was ; '……some foreign body or poisonous matter in her left eye while doing duty as Hospital Nurse in the OPD of the Infirmary' (MISC 812/2).

12 For trained nurses at RHI circa 1948 the Federated Superannuation Scheme required nurses to pay 5% and the Infirmary 10% of her salary (Anon, nd).

Sunday and Monday *(SA/QNI/T/1/44, 1911)*. At MHH in 1947 nurses worked ninety-six hours per fortnight, ten hours less than at Shelf (DT 33/265, 1947).

During the 1940s-50s student nurses worked long unsocial hours which they accepted as part of their training. Appendix 8.55 shows the timetable for nurses at RHI circa 1942-45 illustrating on and off duty times and night shifts confirming the nurse's work and personal time was controlled from breakfast up to bedtime. At HRI nurses were expected to use some of their coffee break to go to their rooms to tidy up and change their uniform ready to return to the wards with a clean apron on (Appendix 8.56). Another nurse recalled; '*We worked from seven-thirty in the morning until nine at night with three hours off during the day and one day off per week*' (along with four weeks holiday and three months on night duty) (Appendix 8.57). Other nurses commented that as they had little time off, little money to spend and limited social activities on offer, working unsocial hours was not a problem. Mrs Beaumont explained that they could request time off for a special event but because they did not know where they would be working this proved difficult (Appendix 8.58). However, rules and discipline still covered the nurses when off duty, resulting in limited private free time (Appendix 8.59).

After the NHS, nurses' pay and working conditions were covered increasingly by national policies and therefore local variations diminished.

The nurses were contracted to work under varied conditions and many of these linked to discipline and authority. Despite this the nurses were protected and given stability of employment.

Pay and working conditions were therefore important factors in maintaining stability in nurses' working lives. Accepting that there were many examples of nurses resigning or leaving their posts for a myriad of other reasons evidence indicates that during the 1920s-50s there was a fairly stable workforce with many nurses having a '*job for life*' and often staying in the same organisation all their careers.

Methods of organising nursing care.

Methods of organising nursing care, and nurses themselves, was a major part of the nurses' working lives as nursing work varied and was linked to the staffing levels available to provide care. Work was often '*prescribed*' and these prescriptive orders illustrate how they were autocratically directed to care for patients. In 1897 at HDVSNA nursing tasks included some of the essential personal nursing care all patients may require (Appendix 8.60). This early description of the district nurse's role illustrates their work and it was stated; '*We are glad that the nursing is being organised on such a wise basis*' (Nursing Record and Hospital World, 1897, p. 441).

Workbooks and allocation of work.

Local nurses in both hospital and community described examples of their role in record keeping describing the different sorts of documents used. They indicated only certain aspects of nursing care were documented. Nurses at HRI recalled using notes and books to record patient details and care (Appendix 8.61; 8.62; 8.63). Nursing work was usually organised with a senior-junior allocation of tasks and Miss Astley at HRI described how the hierarchy worked in relation to individual nurses' roles (Appendix 8.64). Senior nurses worked with their juniors giving supervision and direction to ensure risks were minimised and patients kept safe, and three interviewees provided accounts of this (Appendix 8.65; 8.66; 8.67; 8.68 and 8.69). The allocation of tasks was integrated within the twenty-

four hour ward routines giving a structure to the day, and ensuring accountability for particular tasks. Nursing work was also linked to the shift patterns of mornings, afternoons, evenings, and nights with '*split shifts*' commonly worked (Appendix 8.70). Nurse Harling training at HRI in the early 1920s explained the morning routine which included cleaning the brasses (Appendix 8.71). The organisation of nursing care often included the shift change handover reports and Mrs Honour mentioned these in relation to the night nurses and the morning routines (Appendix 8.72). Mrs Velma at HRI described the night staff handover there and confirmed it was both in verbal and written form and led to the allocation of tasks for the morning staff (Appendix 8.73). This was part of the night duty routine and patient nursing records were kept including a written morning report read to the nurses (Appendix 8.74; 8.75). The report seemed to involve all grades of staff but it ended with a hierarchical allocation of tasks with juniors doing the sluice work. The sorts of reports given were described as hand written with each patient receiving a progress report, usually a sentence or two on a form, which was sent to the Matron's office and a copy kept in a ward book (HUD 11, Miss M. Kirkbride). Miss Mulligan at HGH described how nurses were allocated tasks using lists of work, and how nurses were allocated tasks related to a four hourly cycle of care (Appendix 8.76; 8.77). Mrs Titchmarsh at RHI described a patient centred form of allocation caring for a small group of patients (HX 1, Mrs P. Titchmarsh). Therefore in hospitals no detailed records were kept about the patients but charts to record patient observations were used as well as books and forms.

In the community during the 1930s district nurses were allocated work in their individual districts travelling either by foot, car, bus, or bicycle. They worked from 08.30hrs until 13.30hrs then did evening visits. The HDVSNA district nurses Home housed about twenty nurses and two Matrons and was never left unattended in case of emergencies (Irving, 1937, p. 25, 27). Mrs Beaumont remembered working at Clare Hill (Appendix 8.78). Miss Herron a QDNA inspector reported to HDVSNA in 1959 that care was good, relatives appreciative, and due to high numbers of part-time nurses, more staff were needed *(*SA/QNI/T/1/44, 1911). However, the administrative part of the nurse's role was recognised as problematic; '*It is also felt that some clerical assistance for the Superintendent would enable her to give more time to nursing duties' (*SA/QNI/T/1/44, 1911). This provides an example of the dilemmas nurse managers faced for many years about their '*player-manager*' roles working as both clinician and administrator.

Overall there were various methods of organising nursing and allocating care tasks often based upon a hierarchy of staffing grades. As nursing work became more specialised and workforce numbers increased there was a need to consider how to organise nurses to ensure efficiency and effectiveness. Nurses in both hospital and community settings used verbal and written reports as methods of delegating care across a variety of shift patterns covering the twenty-four hour patient day. As more part-time working opportunities occurred nurses were able to work more flexibly and for example accommodate time for raising families.

Conclusion of chapter.

This chapter has explored the aspects of the nurse as worker within the two towns of Halifax and Huddersfield 1870-1960. The student and qualified nurses' experiences of work were similar involving

Chapter 8 - The nurse as worker.

working in strict regimes of discipline and authority. From 1870-1900 there was a change in the type of work performed and skills needed to improve to ensure satisfactory care standards as the nurse's role expanded due to technological advances. As nursing progressed during the first twenty years of the Twentieth Century attempts were made to standardise training. Nurses' pay and working conditions varied but were in common with national rates and benefits. Hierarchical scales of pay illustrated how nurses gradually diversified into different roles and grades. However, examples of nurses' pay been static meant in real terms pay was cut. Although nurses' pay was low and associated with female work rates they received additional bonuses which were often valuable assets. Following the Second World War bonuses reduced as more nurses lived out. With the introduction of the NHS nurses' pay became more critical to both the government and local health care organisations. Lower paid auxiliary grades were employed more and part-time working opportunities increased to counteract the rising nursing workforce costs. Finally, the methods of organising nursing care and nurse's work occurred within strict disciplinary regimes involving long hours and unsocial shift patterns. Nursing care was embedded in routines and practices that did not change alongside the emerging nurse's role. Nurses did not keep patient records to any great degree and the archives contained few nursing care records. Nurses did however record their daily work in workbooks or lists allowing them to allocate care ensuring the task was done and those responsible identifiable. This enforced the hierarchical allocation of tasks which was common up to 1960. However, there were hints from local nurses that in places a more patient centred style of care was delivered.

The next chapter considers the 'hospital as problematic' examining how issues like the increasing need for more complex grading hierarchies for nurses were influenced by the internal dynamics and social functions of the institutions they worked in.

Chapter 9 - The hospital as problematic.

In the previous chapter the '*nurse as worker*' was considered and therefore it is important to explore the context of the nurse's work and the institutions they worked in. Consideration of the '*concept of institutions*' allows for an understanding of the way the internal order and dynamics, social function and social universes worked in the local institutions (Rosenberg, 1987b, p. 68).

Rosenberg's account of '*the care of strangers*' illustrates the move from a family self caring model to a more organised health care model with nurses (Rosenberg, 1987a). As caring for the '*sick poor*' became a priority nursing gradually developed with an increasing demand for more nurses resulting in hospitals and other institutions opening nurse training schools. Also, societal changes related to gender, class and medicine allowed more women to train as nurses.

Examining the influence that these had on local nursing history is paramount to understanding the context within which local nurses worked. This context included the internal dynamics like the administrative and managerial structures and social functions of organising care.

The 'hospital as problematic' area of importance is related to three issues; firstly the concept of institutions, secondly, pre and post-NHS health care developments and thirdly, the role of administration / management and the emerging role of the Matron. These three issues relate to nurses working in hospital and community organisations and the evidence is presented from archival and oral history sources.

The concept of institutions.

During this study four main health care organisational structures which impacted upon nurses and nursing; the Poor Law and Workhouse system, the Voluntary Hospitals and DNAs, the Local Authority hospitals and NHS institutions. In addition to these there were smaller private institutions in both towns. Within all these institutions identified problems included the need for improvements in building stock, patient ward space, standards of care and treatment, and organisation of staff. At least twenty-five different types of institutions opened from 1870-1960 which divided nursing as nurses started specialising (Appendices 9.1; 9.2).

Nationally in 1879 discussions occurred about how to make hospitals more useful and criticism of the efficiency of hospitals led to the need for change (Fairlie Clarke, 1879, p. 91) (Appendix 9.3). However, thirty years later there was still discussion about the way hospitals should be organised (Burdett, 1909). An example of the social function of institutions included two opposing views of the Poor Law illustrating the extent of change in Huddersfield, the first in 1837;

> '*The Poor Law Amendment Act is the greatest piece of legal inhumanity ever passed, and its authors might justly be charged with speculative murder, and who ever took part in its execution was a traitor to his country. Submission to such a law involved treason to reform and country*' (Chadwick, 1937a, p.126).

This contrasts with the Chairman of the Huddersfield Board of Guardians 1930 speech;

> '*We have been face to face with the unfortunate poor. We have seen the tragedies of life, and we have tried to uplift those who were down. We have taken part in a great social work the uplifting of humanity*' (Chadwick, 1937a, p.126).

This shows how institutions provided a social function within the community.

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A general point related to institutions being problematic included the location of hospital sites. The size and geographical location of isolation hospitals built in rural areas proved problematic as urbanisation enclosed them as illustrated at SJH; '*When that building was commenced, it was quite out in the country, and there were no buildings near*' (Longbotham, 1902, p. 23). To illustrate some of the local issues six areas are discussed;

1. Poor Law (Municipal) and Voluntary institutions
2. fever hospitals
3. district nursing
4. Nurses Homes
5. overcrowding
6. hospital closures.

Two issues relating to these institutions provide examples of problems, firstly uncoordinated service provision and secondly, increasing running costs.

Poor Law (Municipal) and Voluntary institutions.

In 1909 Poor Law and Voluntary hospital development was uncoordinated in relation to the use and number of beds and multi-agency, multi-disciplinary communication (Burdett, 1909, p. 1; 7). The function of the Poor Law, '*relief of destitution*', overlapped with the function of Voluntary Hospitals which used resources to prevent destitution of the ill or injured duplicating services (Burdett, 1909). Locally the opening of RHI and HGH within five years of each other illustrates this separation of services which affected nurses as they did not work or train together much until after 1960. One of the overriding problems for hospitals was money and during 1901-1942 there were four major categories of expenditure; provisions, salaries and wages, domestic costs, and surgery / dispensary supplies (Mohan and Gorsky, 2001, p. 44). Increasingly complex running costs of large institutions became problematic for providers. The total annual income of British Voluntary hospitals rose from £2.1 million (£119,826,000.00 = 1900) in 1901 to £15.4 million (£442,288,000.00 = 1940) in 1938 illustrating the escalating income needed to survive (Mohan and Gorsky, 2001, p. 40).

Nurses worked within this financial environment and at RHI in 1898 there were 5.3 patients per nurse (Maggs, 1983, p. 104) and by 1905 there were 4.1 patients per nurse (White, 1978, p. 228). These ratios indicate there were substantial numbers of nurses who required paying. During the 1930s HRI experienced rising costs with a total expenditure of £40,828 (£1,509,819.44 = 1935) and income of £1,113 less than this (£41,158.74 = 1935) (Johnson, 1937). These financial problems were linked to increasing demands for health care and spiraling costs as technological advances demanded more expensive equipment. The problem was not purchasing items as HRI had good equipment but their maintenance costs (Johnson, 1937). The average cost per patient per week in HRI for 1936 was reported as comparable with other hospitals and lower than most (Johnson, 1937). At HRI in 1937 running costs of the Orthopaedic Department were £2,500 a year (£92,450.00 = 1935) and;

'……*whilst patients are ready to give what they can afford, the income does not nearly approach this*

figure' (Johnson, 1937, p. 11). Johnson (1937) provided an illustration of HRI resources, many of which nurses would have used (Appendix 9.4).

In both towns nurses trained and worked in Poor Law and Voluntary hospitals and were expected to provide high standards of nursing care and to conform to the regimes in place. The issues of duplication of services and increasing financial costs, although not directly linked, were important examples of hospital problems that nurses were exposed to.

Fever Hospitals.

Fever hospitals existed in both towns from an early stage; '*……since 1867 local authorities had built publicly funded hospitals to address infectious diseases*' (Mohan and Gorsky, 2001, p. 38). During the Nineteenth Century in Huddersfield BWS provided an example of another hospital problem, cross infection. It was implied that the risk of cross infection was increased due to the hospital design preventing patients with different diseases being housed in separate wards (Eagles, 1984, p. 22) (Appendix 9.5). Young (1902) provided detailed discussion relating to the size of the hospital sites and their location for optimum infection control. There was also concern for the nurse's welfare and social needs due to the isolation of the institutions, resulting in on-site facilities (Appendix 9.6). During the 1920s-30s an example of the GNCs increasingly powerful role included recommending more or improved buildings. In 1935 it was reported that MHH should be; '*…… revisited when additional accommodation provided*' and in 1937 it was reported two new blocks were being built (DT 35/42, Film 6, 1935; 1937; Film 5, 1937).

District Nursing.

The development of DNAs in both towns at the end of the Nineteenth and beginning of the Twentieth Century illustrates how care at home was emerging as an alternative to institutional care. However, similar problems of duplication of services, institutional size, and provision of nursing accommodation existed. With a variety of DNAs in each town and surrounding villages, a patchwork provision existed with at least four DNAs in Halifax and seven in Huddersfield. In 1899 a religious form of district nursing operated in Halifax requiring; '*Earnest Christian desired (Churchwoman or Dissenter), with three years' hospital training. Salary, £65 inclusive*' (Nursing Record, 1899, p. ii).

Appendix 9.7 illustrates that the majority of district nurses work in 1928 was '*general nursing*' with a small amount of midwifery provision. Appendix 9.8 provides an amalgamated view of the number of cases by type for 1932-40 for the HDNA illustrating '*general nursing*' was still the largest activity but midwifery cases had increased. The overall number of cases remained fairly constant over these eight years with no obvious change as the war started.

The two main DNAs had training schools and in 1938 HDNA had one successful Midwife and illustrates duplication (Appendix 9.9). Nurses working in these DNAs provided care to patients in a variety of settings including patient's homes, clinics and the Nurses Home. They had similar problems to hospital institutions, particularly the building size for the Nurses Home, which is illustrated by the HDNA having to move three times.

Nurses Homes.

Nurses Homes were a major part of nurses' lives as up until the 1950s nurses were expected to '*live in*'. This further institutionalised the nurses with their working and private lives entwined. The

relaxation on '*living in*' was associated with changes after the Second World War to the age and marriage bars and the recruitment of male nurses. With more married nurses recruited they no longer had to be resident. The removal of compulsory accommodation provision meant nurses lost one of their long standing '*perks*', free board and lodgings, releasing institutions from this '*financial burden*'. Despite this burden local institutions had provided their own Nurses Homes and the increasing numbers of nurses meant the demand for accommodation increased creating problems of finding appropriate space and money. Local institutions managed to build onto existing Homes, build new ones or use existing facilities to house the nurses. In 1893 the London Hospital suggested a specifically designed Nurses Home was an essential for hospitals planning a training school (Luckes, 1949, p.202). Lett (1949, p. 138) and Rosenberg (1979a, p. 125; 134) indicated that Nightingale's ward design included a nurse's room so the nurse could observe and sleep near her patients (Appendix 9.10). This was also the recommendation of the Poor Law Board to Huddersfield Workhouse in1895 (Appendix 9.11). Locally the Nurses Homes often included practical rooms or classrooms which was reported in the 1890s; '……*remember that the home is not merely for board and lodging, it is a factor in the education of the nurses*' (Lett, 1949, p. 139). Nurses Homes were to be comfortable and clean and other criteria met (Appendix 9.12).

The nurse's life within the home was controlled by discipline and rules enforced by the Home Sister who was usually a senior qualified nurse with responsibilities for order and education; *'Each nurse is responsible to the "Home Sister" for the neatness of her own room'* (Luckes, 1949, p.202).

Evidence of other institutions having Nurses Homes is in appendix 9.13.

In Halifax and Huddersfield there were significant differences in the size and quality of the Nurses Homes. In 1902 it was recommended that for every 100 patients accommodation for twenty nurses should be provided (Young, 1902, p. 183). Finding space therefore was a recurring theme locally as the GNC requirement for single rooms was not met as nurses often shared rooms.

Nurses Homes were a common factor in nurses' experiences and they were expensive commodities for the institutions.

Overcrowding.

A major problem for hospitals locally was the increasing demand for their use eventually making them too small, or poor planning not taking into account increasing population numbers resulting in overcrowding. The opening and closing of hospitals was a common problem nurses coped with. Both towns opened several smaller '*cottage*' style hospitals during the 1870-1930 period and this move from large institutions to smaller '*cottage*' style buildings was one solution; '……*tearing down these massive cathedrals of medicine and construct small hospitals in rural areas*' (Lawrence, 1994, p. 65). The first small local dispensaries and workhouses opened before 1870 were replaced with larger institutions before the end of the century like DHH and SLH in Huddersfield. SLH was described as; *'……almost palatial in its appearance and extent, but is none too large for the requirements of the district* (Hobkirk and Curson, 1883, p. 5). Although seen as an improvement upon previous buildings it was still not adequate to meet demands and during the next fourteen years it proved to be inadequate (Walker, 1897).

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At SJH in Halifax in 1879 overcrowding was discussed and it was confirmed that having too many patients broke LGB rules, and also identified an increasing shortage of nurses (TNA, MH 12/14986, 1879) (Appendix 9.14). This overcrowding at SJH was still reported in 1901 (Longbotham, 1902, p. 23; 25). Action included moving the mentally ill patients to Menston and protecting children from admission or moving them to orphanages or places like Craigie Lea Children's Home in Ovenden (RD7 3/6/18, p. 11; Longbotham, 1902; Brompton, 1999) (Appendix 9.15). The inadequate facilities at SJH led to discussions about a new hospital and HGH opened in 1901 five years after the new RHI. The building of new institutions was itself problematic in relation to space and costs, and an example of the LGBs attempts to address this is in appendix 9.16. The original site for HGH was abandoned due to local resident's complaints (Appendix 9.17). This illustrates the problem of building new hospitals on new sites, but another site was found (Longbotham, 1902) (Appendix 9.18). The design of HGH complied with modern LGB requirements including; '*……the novel circular pavilions you see in the front were adopted owing to the peculiarities of the land.* (Longbotham, 1902, p. 23). In 1902 there were 278 patients at HGH and the staff included '*skilled nurses*' (Longbotham, 1902, p. 23) (Appendix 9.19). There was a more positive view of the sick poor patients care and outlook and the need for '*skilled nursing*' illustrates the value placed on this. Despite the opening of HGH in 1901 SJH remained constantly full with 656 inmates, 190 more than it was designed for (Appendix 9.20).

At the end of the century there were numerous changes in hospitals locally as earlier institutions became too small and newer ones with improved facilities opened, and regionally large numbers of nurses worked in them (Appendix 9.21). The number working in the community was just slightly higher than those in institutions and the majority were untrained.

Appendices 9.22; 9.23 show that twenty-three institutions opened in Halifax and Huddersfield from 1870-1929. In Halifax twelve institutions opened and in Huddersfield eleven opened. During the same period six institutions closed in Halifax including a war hospital, a DNA and a voluntary infirmary, while in Huddersfield three war hospitals closed. In comparison during 1930-1960, one fever hospital and one DNA opened in Halifax, and none opening in Huddersfield. Closures in the two towns during this time included a fever hospital and a DNA in Halifax, and four DNAs in Huddersfield. Therefore the earlier period was more active in building new institutions and in the latter period the opening and closing of institutions slowed.

Hospital problems continued and in 1945 a Ministry of Health report stated SLH was not suitable for modern chronic sick purposes (C348, 1971).This criticism was based upon the building stock and not the nursing standards. This general decline in building stock illustrates the problem of keeping them up-to-date and suitable to meet changing demands for patient care and technological advances. Overcrowding was therefore problematic for local institutions and a major reason for opening so many new institutions. Nurses were needed to staff these institutions and often became extremely loyal to them. Ensuring institutions were suitable for staff and patients was the main reason for opening and closing institutions. Another problem associated with institutions was that with the changes in infectious disease incidence alongside technological advances during the latter half of the Twentieth Century hospital closures occurred due to the demise of infectious diseases.

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Hospital Closures.

From 1870 onwards the threat of infectious disease was prevalent and despite the introduction of immunisation therapies many patients contracted untreatable diseases and were treated locally such as TB patients on Wards Three and Six at MHH (Appendix 9.24). The decline in fever nurse training became evident when GNC approval for MHH was extended for one year in 1944 (DT 35/42, 1944). During 1945-49 NHH had between twenty-two to thirty-five fever beds available (DT 35/43, 11 May 1949) (Appendix 9.25; 9.26). In MHH the number of beds varied and appendix 9.27 shows there were twenty-nine patients in 1947. Appendix 9.28 shows the number of cases per disease and the reducing numbers of fever patients allowed the elderly to be admitted. Mrs Velma worked at MHH from 1958-1960 and witnessed the end of the fever nursing era and the beginning of elderly care services provision, and there were other moves locally towards this (Appendix 9.29). Therefore the progressive decline in fever nursing due to the impact of the pharmaceutical advances of vaccinations and antibiotics created the need to close institutions and transfer services. In Halifax, Shelf Hospital eventually closed to fever patients who were transferred either to NHH or HGH along with the staff (Appendix 9.30; 9.31). As the incidence of TB declined any remaining TB patients went to HGH and the elderly patients eventually moved to NHH as did SJH patients (Appendix 9.32). During the forty-two years Shelf Sanatorium was open nurses were employed and educated there, and it was linked with other hospitals within the town as services and nurse education provision changed. This was an attempt to reduce duplication of nurse training and service provision. Its closure coincided with the decline in infectious diseases, increased use of antibiotics, and the subsequent reduced need for specialist isolated hospitals. A result of the opening and closing of hospitals was nurses had jobs, and specialities emerged. The number and type of institutions within the two towns, as well as the number that opened or closed during the earlier part of the time period under study, illustrates that all was not well with the hospitals. However, there was a distinct drop in activity in this respect during 1930-1960. The role of regulatory bodies like the LGB and the GNC illustrate how institutional changes were encouraged. The '*concept of institutions*' provides a contextualisation to nursing history because of how organisational structures and cultures impacted upon nurses. However, it can be argued that nurses and nursing contributed to and influenced these institutions.

By exploring the issues of local institutions, Nurses Homes, overcrowding and hospital closures it is argued that in relation to nursing hospitals were problematic. This was particularly the case prior to the NHS commencing, although problems still existed post-NHS.

Pre-NHS and post-NHS health developments.

The '*hospital as problematic*' as an area of importance provides opportunities to consider how health policy impacted upon the nurses working within the two towns. The introduction of the NHS in 1948 was seen by many as one of the largest changes in health care provision ever undertaken. The situation before the NHS is considered and selective aspects of the changes that occurred with the introduction of the NHS and the years following in the 1950s are examined.

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Oral history interviews for both towns provided limited mention of this major change, and those who did recall it described it in a matter of fact way. Archival sources and other publications provide some indication of how this change impacted upon both hospital and community nursing.

Pre-NHS.

Prior to the NHS nurses worked within varied systems of health provision in both hospital and community settings. Eight main institutions were in operation before 1948 in Halifax and seven in Huddersfield (Appendix 9.33; 9.34). Mrs D. Rushton who trained at RHI during the early 1920s described how as a child in the early 1900s her father had to pay doctors fees illustrating the financial burden on families and difficult choices they made (Appendix 9.35). Mrs Beaumont recalled as a child seeing her mother with the doctor and another man who may have been collecting medical expenses (Appendix 9.36). Patients and nurses had limited equipment resources, particularly for poorer patients and they both worried about getting access to services and equipment prior to the NHS. Miss Nattrass described the conditions as tough for patients and for herself when going into their homes unable to help them. Her description of bringing sheets from home illustrates the dilemma that nurses had if they could not provide patients with adequate care, and she recalled the poor social conditions lived in with a detailed story which vividly captures the deprivation families coped with (Appendix 9.37). She further explained the hard conditions; '*Yes I mean I've bathed babies in pie dishes and all sorts of things*' and described how the poorer patients coped (Appendix 9.38). Mrs Dyson explained that pre-NHS patients paid into a voluntary system at HRI and those patients unable to pay for care may have gone to SLH (Appendix 9.39).

At RHI Mrs Bland confirmed patients paid for their admission however, she further discussed the voluntary contribution scheme with patients contributing as much as they could (Appendix 9.40). Mrs Bland explains that the local paper published patient's contributions so the nurses could see how much they had donated (HX 6, Mrs W. Bland). In appendix 9.41 four extracts from Mrs Bland's transcript explain how patients paid into the Contributory Scheme. She clarified that RHI accepted patients unable to pay as benefactors provided resources, and she described how benefactors were recognised by bedside plaques, and that patient donations were voluntary (Appendix 9.42; 9.43). Following the change in 1948 all fifteen institutions were transferred into the NHS, patients no longer had to pay, and nurses within them became employees of the new system.

Post-NHS.

An example of changes occurring within the community was that the work of district nurses increased as more patients were not hospitalised for conditions previously needing inpatient treatments due to technology. In the ten years from 1919-1929 the number of WRCNA affiliated DNAs almost doubled to 107 (Barrows, 1974). From 1929-1949 the number of nurses delivering '*district nursing only*' doubled, while the two combined roles of district nursing and midwifery, and district nursing, midwifery, health visiting and school nursing both decreased (Appendix 9.44). The West Riding DNAs during 1947-48 employed 258 nurses with 100 doing home nursing, ninety-six home nursing and midwifery, and sixty-two combining home nursing, midwifery and health visiting (Barrows, 1974, p. 129). The number of nurses doing combined work went from 135 in 1948, to eighty-four in 1950,

showing the focus had shifted from combined roles to more specific specialised work (Barrows, 1974, p. 128).

Another example of NHS change was the management of DNAs. Prior to the NHS supervision of DNAs was done by the West Riding County District Nursing Association (WRCDNA) Superintendent and by QIDN officials but in 1948 the WRCDNA acted on behalf of the Huddersfield County Borough Council (C347, 1948; Barrows, 1974). Post-NHS the managerial set up for HDVSNA did not really change until 1957 when Divisional Nursing Officers were appointed (Appendix 9.45). Changes occurred to DNA funding which had been usually financed by donations, and in 1948 the DNAs received money from both the West Riding Council and the Ministry of Health (Barrows, 1974, p. 129). These illustrate the need to ensure the new system was viable and up and running effectively by pump priming.

In relation to the workload of the DNAs there was evidence that Local Councils started to run Home Nursing Services themselves indicating there were problems of adequate service provision (Appendix 9.46).

Institutions were obtained by buying previous DNA resources such as houses, cars, and nursing equipment and replacing them with new resources that were incorporated into the NHS (Barrows, 1974, p. 129). With the NHS in place local health authorities for the first time had responsibility for providing home nursing services. The West Riding County Council (WRCC) had 197 DNAs covering about eighty-five percent of the area (Barrows, 1974, p. 129). In 1948 in response to problems of increased demand for services and a need to obtain 100% coverage and aid hospitals and GPs with anticipated increases in workload, the Ministry of Health agreed an establishment of 204 home nurses, and twenty-four relief nurses so that each nurse served a population of 6,000-7,000 (Barrows, 1974). By 1950 structural changes to DNAs included new divisional areas each a self-sufficient unit as regards administration, but the nurses' professional supervision was still carried out centrally. New supervisory structures included by the creation of managerial 'Nursing Officer' roles linked to the specialisations of district nursing, midwifery, and health visiting (Barrows, 1974, p. 117).

At HDVSNA as the NHS was implemented Clare Hill the base for the district nurses was closed and moved to offices in the town. It is unclear if this included both the administration office and the Nurses Home. Nurses living in Clare Hill Nurses Home were allowed to move out into their own accommodation which was a major change from the '*living in*' regime. Also, patients not having to pay illustrated the financial changes allowing nurses to provide supplies freely. Miss Nattrass, recalling her memories of the NHS starting, described another three examples of better resources (Appendix 9.47). These community care examples illustrate changes post-NHS which were similar for hospitals.

Hospitals also changed as the NHS commenced and in 1948 the Huddersfield Hospital Management Committee took over SLH and extensively rebuilt it (C768, 1948; C348, 1971). At RHI there were minor changes highlighted including the publication of the League of Friends of Halifax Hospitals leaflet founded at the last Board of Management meeting (GLE 257, 1948-50). In relation to the RHI Ball Committee it was agreed to change its name in August 1948 to; '……*the 'Halifax Hospitals Ball Committee*' illustrating that combining the hospitals meant to some extent loosing their individuality

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(GLE 257, 1948-50). This amalgamation of institutions would have gone someway to reducing the overlapping and duplication of service provision.

Nurses' memories of the NHS starting were often mundane and Mrs Galvin commented that; '*I think that probably things were……going on pretty much as they had been*' (HUD 3, Mrs E. Galvin). However she remembered receiving a pay rise; '*We all got more pay,……we went up to £65 a year from £45 or something*' (HUD 3, Mrs E. Galvin). In contrast to this, Mrs Dyson believed her pay was reduced; '*well our salaries went down,……I think, not a lot,……but err, cause we were paid monthly,……now when I say that we are getting £45 a week I think it was, err, a month I should say.*' (HUD 5, Mrs M. Dyson).

Mrs Dyson recalled that war time rationing was still in operation in 1948-49 illustrating how it affected nurses before and after the NHS (Appendix 9.48). She clarified that at HRI the nurses' uniforms stayed the same when the NHS started. At RHI Miss Sykes was training as a midwife when the NHS was introduced and recalled how this affected her (Appendix 9.49). Senior staff may have believed the type of tasks staff did would change with the new NHS system but Miss Sykes indicated that this was not the case. She further explained how RHI used its finances up prior to the NHS; '*Because they didn't want the money to go to the Government,……*' by treating the nurses to a Lake District trip (Appendix 9.50). She also recalled little changed except in 1947 when a forty-eight hour week was started (Appendix 9.51). Mrs Bland a nurse at RHI recalled there was a big difference when the NHS started, including problems with requesting supplies of equipment which had not happened when the Matron was in charge (Appendix 9.52; 9.53; 9.54; 9.55). Mrs Honour recalled that she was in the first NHS nurse training school at RHI and that the NHS resulted in her having to work longer and harder (Appendix 9.56).

Finally, an example of a service that was not integrated into the NHS was the Clover Hill Road Clinic at RHI run by the Family Planning Association (FPA) (Appendix 9.57) (SA/FPA/A4/J113/2). This clinic was evidently an important part of FPA services for northern England and by going into the NHS it illustrated there were still independent public and private services.

The fifteen main hospitals within Halifax and Huddersfield prior to the introduction of the NHS remained in tact afterwards. There were changes that occurred when the NHS was implemented and during the twelve years up until 1960. Although nurses did not provide evidence of major changes to their working lives the examples they did give were important and illustrated they were affected. The majority of these changes related to the administration and management of the hospitals and these two issues are examined further in order to consider the hospital as problematic.

The role of administration / management.

Locally one of the problems for institutions was that as they increased in size and number they became more difficult to organise. The consequential increase in patient and staff numbers and types meant managing and organising services and employees effectively became problematic. The interaction between the Matron and other administrative and managerial staff therefore was an important aspect in the development of nursing locally. Increased numbers of institutions created the

potential for duplication of service provision and also created isolation as nurses often did not know each other and developed strong loyalties for their institutions.

Early recognition of problems with the organisation of workhouses resulted in recommendations that annual reports be published (Twinning, 1886, p. 709) (Appendix 9.58). The need to increase the calibre of Masters and Matrons was recognised as early as 1856 and seen as important because of their complete power over inmates (Appendix 9.59). Nurses were also in need of better preparation and education emphasising the importance of improving staff quality (Appendix 9.60). Training of workhouse nurses increased during the 1880s with sixty trained nurses being employed since 1879, but only three large towns Manchester, Liverpool and Leeds had separate infirmaries (Appendix 9.61 62). Lack of provision in these major conurbations suggests smaller provincial towns would also be lacking. To improve the educational background of Matrons they were provided with '*special care of the sick*' training (Appendix 9.62). This professionalisation of workhouse managers gives a sense of change occurring nationally as the need for more capable trained nurses and managers emerged. Removing power from the pauper nurses provided the need for a hierarchical employment structure giving senior staff more responsibility. The problems of monitoring and controlling the behaviour of increasing numbers of staff to ensure standards were kept high was illustrated in 1886 with five examples of cruelty by officers (Twining, 1886, p. 710-11). Other attempts to improve hospitals included Fairlie Clarke (1879) who discussed the establishment of OPDs and medical teaching schools.

By the end of the century the problems had not been solved and criticism of the quality of workhouse staff remained (Appendix 9.63).

Workhouses in Halifax and Huddersfield developed along the same lines as the national trends, nursing staff were developed, probationer training operational, and poor standards were identified and dealt with by the Masters and Matrons.

As the workhouse hospitals continued into the Twentieth Century there were further developments to improve the stock of staff. In 1913 NAWMM stated; '*I know of no other calling demanding so many qualifications.*' They listed five qualities required by the '*Master*' which included knowledge requiring a reasonable educational background (SA/AHR/B/1/1, 1913, p. 9) (Appendix 9.64). These managerial components of the Master's role compared starkly with the Matron's role; '*……the qualifications for a Matron are summed up in the derivation of the word 'Matron', so that to be 'a good Matron' means 'a good Mother' ……*' (SA/AHR/B/1/1, 1913, p. 9). This comparison clearly illustrates the gender role differences that existed, but as the Master and Matron were often married it is possible both used these skills.

The NAWMM Yorkshire District Association had forty-nine members in 1913 and fifty-five in 1914-15 (SA/AHR/B/1/1, 1913, p. 22; SA/AHR/B.1/2, 1914-15, p. 39). West Riding members included Mr and Mrs Crockett, Deanhouse Huddersfield; Mr and Mrs Hoyle, SLH Huddersfield; and Mr and Mrs Harris, Halifax (SA/AHR/B/1/1, 1913, p. 49; SA/AHR/B.1/2, 1914-15, p. 36). An indication of the increasing demands that Masters and Matrons of Workhouses were experiencing in 1913 was the onus on them of employing nurses with increasing skills (SA/AHR/B/1/1, 1913, p. 55). With the Poor Law Institutions Order 1913 and Poor Law Institutions (Nursing) Order 1913 commencing in 1914 changes in the way

workhouses employed and used nurses occurred (SA/AHR/B.1 2, 1914-15, p. 39). The Nursing Order aimed to improve care by more efficient administration (SA/AHR/B.1 2, 1914-15, p. 45). This was aimed at solving the problems that had existed for years and resulted in the appointment of Superintendent and Head Nurses (SA/AHR/B.1 2, 1914-15, p. 45) (Appendix 9.65). These roles meant a Head Nurse having managerial responsibilities as well as care giving, a forerunner of the staff nurse's role. Demand for nurses with certain qualifications to ensure they could provide good standards of care also applied to senior nurses (Appendix 9.66). Examples of nurses working in combined clinical / managerial roles requiring qualifications is an indication of the professionalisation of nursing. These requirements meant that existing Matrons without the qualifications were employed as managers only (Appendix 9.67). This divided the nurse's accountability and line of command into two, clinical nursing care and administrative, ensuring the Matron's role developed as an administrative non-clinical one (Appendix 9.68).

The emerging Matron's role.

Within the workhouse system the Matron's role was further explained to ensure access to patients was allowed; *'…...the Matron retains the right of entry into those wards.….'* (SA/AHR/B.1 2, 1914-15, p. 46). This illustrates the way Matrons were still involved in the supervision of nurses and the care they gave. The LGB however stipulated that; '*……the Matron shall not in future occupy the joint position of Matron and Superintendent Nurse*' (SA/AHR/B.1 2, 1914-15, p. 46). The roles of Master, Matron, and Superintendent Nurses were therefore evolving and one of their roles was to maintain discipline (SA/AHR/B.1 2, 1914-15, p. 47) (Appendix 9.69). Masters and Matrons were usually married; *'……positions of Master and Matron should be held by married Couples'* (SA/AHR/B.1 2, 1914-15, p. 61). Within Halifax and Huddersfield this rule appears to have been implemented and discussion on the importance of a '*married Matron*' at this time was detailed (SA/AHR/B.1 2, 1914-15, p. 66-9) (Appendix 9.70). However, as the workhouses developed and the hospital Matron's role expanded this practice of employing married staff declined. The role of Master was subsumed into the administrative and managerial roles that evolved as the Poor Law institutions were taken over by Municipal authorities. During 1870-1930 Voluntary and Municipal hospitals which did not have Masters usually employed Matrons, senior nurses, or Superintendents indicating that this practice was isolated to the Poor Law hospitals.

During the Twentieth Century administration of hospitals in Halifax and Huddersfield was mainly performed by nurses as the Matron's role expanded. This included not only the day-to- day running of the hospital, but the discipline and education of probationer and qualified nurses as well as non nursing staff like domestic and catering employees. The Matron was responsible for the recruitment and selection of nurses and their dismissal. Within District Nursing institutions there were Superintendents who were the equivalent to Matrons. It was not until the 1960s that the Matron's role was to disappear. During the middle of the Twentieth Century nurses enjoyed relatively stable employment and some local Matrons were in post for many years like Miss Long at HRI. Nurses' views of how hospitals were managed was limited, but a positive one was Mrs Honour remembering her time at RHI which had limited bureaucracy and good team working (Appendix 9.72).

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The importance of Matrons as managers of the institutions increased as mounting bureaucracy occurred in part due to the local hospitals managerial structures and national policy implementation from professional and other authorities. Another factor was the increasingly complex nature of health care as medical and other technological advances placed more demands on institutional resources and the skills of staff.

Conclusion of chapter.

This chapter has considered Rosenberg's 'hospital as problematic' area of importance. Three issues, the concept of institutions, pre-NHS and post-NHS health developments and the role of administration / management illustrated how local nurses were affected by working in hospital and community settings. Nurses were affected by changes to institutions including hospital closures, the emergence of new hospitals and an increasing use of nurses in the community. Nursing evolved alongside the pre and post-NHS changes with local nurse's experiencing changes. However, it would appear that locally the new NHS did not affect junior nurses much. Nursing was regulated within organisations by the administrative and managerial aspects of a variety of institutions, and the moral responsibilities and obligations of these were important to nurses employed in them. The national regulating and governing bodies provided some control by conducting regular inspections. Nursing, administrative and medical leaders played powerful roles in how nurses and hospitals were organised, and nurses from different parts of the nursing hierarchy provided evidence of how their working and personal lives were influenced by this. The increasing demands upon hospital institutions meant a corresponding general increase in the work of DNAs continuing until at least 1960 involving emerging new types of roles for nurses like health visiting and public health.

The next chapter considers the importance of 'history from below' and how giving a voice to the ordinary men and women who worked as nurses in the institutions of these two provincial towns aids our understanding of the history of nursing locally.

Chapter 10 – History from below – ordinary men and women.

In Rosenberg's view this area of importance related to the voice of the patients and the account of their experiences of illness and hospitalisation. As this was not a main focus of this study there is limited scope to address this area of importance in such a way. However, in previous chapter's examples of patient care and treatment within both hospital and community settings from nurses provided indirect evidence of the patient experience. Despite this limitation there is scope to interpret this area of importance in relation to nurses and nursing. Selected archival and oral history sources provide local nurses' stories detailing specific aspects of the local nursing history of '*ordinary*' men and women.

In order to explore this eight issues are considered;

1. the '*ordinary*' nurse.
2. the Matron's role.
3. Miss Martin.
4. junior nurses' views of senior nurses.
5. photographic evidence and '*history from below*'.
6. staff movement and turnover.
7. the 1901 census.
8. the Royal Halifax Infirmary Nursing Pageant.

These allow exploration of the concept of the '*ordinary nurse*' and history from below.

The '*ordinary*' nurse.

The concept of '*history from below*' indicates that examining the archival and oral history data from the '*ordinary*' nurse's view is important to prevent historical distortion. The '*ordinary*' nurse is a difficult term to define, as is the concept of '*elite nurses*'. In this study the term '*ordinary nurse*' denotes nurses who were not national leaders of any nursing organisation and were mainly based in the provincial towns of Halifax and Huddersfield. This is not to say that '*elite*' nurses are excluded from the history of nursing in Halifax and Huddersfield, on the contrary it is important to acknowledge their contribution. Also, to describe any nurse as '*ordinary*' is obviously contentious and there is no intention to degrade the work they did or their stories. Due to the hierarchical nature of human societies there is an inevitable graded order to even the local nurses based upon their job and status. Although Matrons of Halifax and Huddersfield institutions could be seen as '*elite*' nurses locally, they were not necessarily '*elite*' nationally. Matrons of provincial hospitals were numerous across the country and therefore these Matrons although not unique were nevertheless distinctive locally. Therefore some senior local nurses can be seen as '*elite*' and their provincial stories are included to ensure their valuable narratives are considered. None of the nurses in the oral history sample were recognized nationally and although two nurses had been honored by the Queen these were not directly for nursing.

Chapter 10 – History from below – ordinary men and women.

In the Nineteenth Century none of the Nightingale School nurses arrived in Halifax and Huddersfield, although Sarah Ellen Ada Kidson who trained and worked at St Mary's Hospital London during 1866-1888 was Matron at HGH from 1905-1910 (OR/PL 41, p. 44).

Throughout the hospitals and DNAs of Halifax and Huddersfield there were numerous examples of nurses who trained locally and then worked elsewhere often having very successful careers. Also, both towns attracted many nurses from across the UK. This turnover of staff provided a '*peer assessment*' or form of audit illustrating that nursing in both towns was on a par with other parts of the country and helped maintain standards alongside the LGB and GNC. To illustrate this turnover of staff a number of examples are provided in this chapter.

Taking a history from below approach is however problematic in the sense that records relating to junior staff are often scarce or incomplete. Also, junior nurses were numerically large and staff turnover fairly frequent making it difficult to explore them. Senior nurses on the other hand were less in number and tended to remain in post for longer periods of time and have more complete records. This lack of data for junior staff creates a '*hierarchical bias*' with limited chance to identify junior staff or what jobs they did, but wherever possible a variety of examples of both are provided.

Halifax District Nursing Association.

At HDNA Miss Laycock was Superintendent from 1911-1923 having trained at Leeds Union Infirmary 1908-1911 and RHI 1918-1921 (GNC, 1931). Appendix 10.1 confirms her resignation in 1923 and appendix 10.2 shows she was replaced by Miss Johnstone who trained at Bradford Poor Law Union Hospitals in 1903-06 (GNC, 1931, p. 920). Appendix 10.3 lists staff from 1929-1936 and appendix 10.4 provides names and qualifications of nurses in 1936. Miss Johnstone may have been Superintendent for twenty-four years illustrating long employment tenure (Appendix 10.5).

Huddersfield District Sick Poor Nursing Association.

The first Superintendent Miss Annie Francis Lunn resigned after seven months in post in April 1898. There were four Superintendents appointed during the next two years illustrating a relatively unstable period. Appendix 10.6; 10.7 list the staff who worked at HDVSNA from 1897-1960. Examples of other nurses working there included Elizabeth Milner, Mabel Ryder and Lillian Ludwig (BJN, 1910, p. 132; 1912, p. 249). In 1958 there were two interesting changes, firstly that two male nurses were listed as qualified district nurses, and secondly that six nurses were listed as working part-time.

Nurses in both these institutions had a regular turnover of staff as them moved in and out of the area.

The Matron's role.

The Matron's role was important and the women who worked in these positions had varied backgrounds and in the earlier times were promoted quite quickly. This meant they often had limited nursing experience and seemed to move jobs frequently. Later, as a larger nursing hierarchy emerged, there was a longer promotional route to become Matron illustrated by the development of an Assistant Matron's role. This change, alongside improved job stability, increased their job tenure. Appendix 10.8 provides an example of the lack of data about staff at DHH Huddersfield. Only three Matrons were identified during a period of nearly seventy years with no records of less junior staff. It is important to recognise the '*gaps*' in this information as it is likely there were more Matrons than this,

and also to recognise that long job tenure meant they may have been in post for many years. A similar position existed at HVMH where from the 1920s-1960s only four Matrons were identified with no details about junior staff prior to 1960 (Appendix 10.9).

The appointment of Matrons and other nurses from larger hospitals across the country was common illustrating local hospitals were highly rated. In 1888 a Miss Nott-Bower was appointed Matron at HRI having trained and worked as a Staff Nurse and Sister at Guy's Hospital (Nursing Record, 1888, p. 164). At a British Nurses' Association meeting her apologies were recorded as Matron of HRI (Nursing Record, 1888, p. 398). The annual report of Guy's Hospital Trained Nurses' Institution for 1890 stated she had been appointed Lady Superintendent (Nursing Record, 1890, p. 176). Therefore her tenure as HRI Matron was July 1888 to circa May 1890. Demand for senior jobs was high and at SLH in 1911 Miss MJ. Holland from Liverpool was appointed Superintendent Nurse from twenty-four applicants (Nursing Record, 1911, p. 316).

Miss Eva Lillian Long.

Miss Long's career and life provide a '*history from below*' of a Matron in a non-teaching provincial hospital. She was Matron of HRI from July 1928 to November 1958. Having trained at Bristol Royal Infirmary she registered in 1922 (GNC, 1931, p. 1060; DT 35 42, 1938). She had started her career at sixteen or seventeen years of age in Fever Nursing, became a certified Midwife and held the certificate of the Chartered Society of Masseuses' and Medical Gymnasts (CSMMG) (Anon, 1928a, p. 154). Therefore she was well qualified and had been Assistant Matron at Bristol (Baines, 1979, p. 4). During thirty years as Matron she introduced a PTS at HRI (Baines, 1979). She founded the HRI Old Nurses League in circa 1937, was its Chairman and Vice-President for many years, and a regular contributor (HRIONL, 1958; 1969, p. 3; 1971, p. 2-3; 1981, p. 29; 1991-92, p. 19; Long, 1972, p. 7; Long, 1979, p. 12-13). She was also involved in the HRI Girl Guides and Rangers (Appendix 10.10). Her long reign was not uncommon during this era as Miss Janet Hunter was Matron for twenty-two years from 1939-1961 at Doncaster Royal Infirmary (Swann, 1973, p. 93). Two other nurses who had long careers were firstly Olive Guyll, who commenced training at HRI in March 1928 and became Ward Sister, Night Sister and PTS Sister Tutor. Her career spanned forty-one and a half years, twenty-one and a half years as a Matron, before retiring in 1967 (HRIONL, 1967, p. 17). Secondly, Miss EM. Bithell trained at HRI circa 1936-1938 and was appointed as Staff Nurse in February and Ward Sister in July 1939. In 1945 she became Senior Sister in the OPD until retirement in 1961 (HRIONL, 1979, p. 23).

Miss Long remembered two colleagues who where at HRI in 1928, '*Mrs Austin was here when I came, and also Miss Guyll*' (HRIONL, 1958, p. 11). Miss Guyll confirmed no PTS existed (Appendix 10.11). She wrote; '*I was at HRI 14 years, and was able to see many of the improvements in training she [Miss Long] introduced*' (HRIONL, 1981, December, p. 3). Miss Long was involved in nurse training and expected high standards of professional behaviour and nursing care, and ensured rules and regulations were strictly obeyed including dismissing nurses who failed exams twice (Appendix 10.12). Her uniform included a long cap with its length something of a mystery and its origins embedded in attempts to be different from the Ward Sisters (Appendix 10.13). Photograph 10.1 provides a portrait of her in uniform.

Chapter 10 – History from below – ordinary men and women.

Photograph 10.1 Miss E. L. Long, Matron of Huddersfield Royal Infirmary circa 1950s.

Source: Publicity materials for Huddersfield Royal Infirmary.

The character of Miss Long and her work are detailed in a series of tribute letters in the Nurses League journal surrounding her retirement and death (Appendix 10.14). Miss Long's death was reported stating; '*this sad news signifies the end of an era*' (North, 1979, p. 7). Her obituary confirmed many League members attended her funeral (Appendix 10.15). The letters represent individual's views written at a time of reflection and with a hint of nostalgia or sentiment with no critical letters published. Miss Long's tributes identified loyalty as an issue of importance;

> '*Loyalty was expected and given. Few knew of the battles that took place in the office, as Matron fought on behalf of some nurse against an irate honorary or other complainant or struggled to give them the best conditions possible under the thoughtless and hard regime often imposed on nurses*' (Baines, 1979, p. 5).

This is an important statement indicating Miss Long, although often seen by the nurses, particularly the probationers, as a stern and foreboding person, was an ambassador for nurses and nursing. She protected and supported nurses within an organisational culture that was not always advantageous. Her long reign as Matron may in part be attributed to her effective leadership and her very sociable personality (Baines, 1979; Berry, 1979) (Appendix 10.16).

This profile of Miss Long provides a review of her role and impact and not a '*nostalgic*' or '*celebratory*' account of her reign (Fealy and O'Doherty, 2005, p.23). It is important to consider whether she had a negative effect upon some young women who applied to start nursing but did not commence training, or probationers who started and then left. It is difficult to estimate the retention rate of probationers and nurses during her time as Matron but her tenure may have included nurses who could not cope with her authoritative role or the institutional discipline. However, her role is not dissimilar from other Matron's of this era both locally and nationally. Her effectiveness in this role is measured by the esteem peers held for her, as behind her '*Matron*' role she was a caring woman who did her best to support '*her nurses*'. Her career typifies the mid-Twentieth Century UK nurse, a single woman working as a nurse all her working life and employed in a job long term.

Miss Elizabeth Martin.

Miss Elizabeth Martin worked at RHI circa March 1912 to September 1913 (Appendix 10.17). She was a regular contributor to the BNJ's weekly essay competition winning it five times during 1912-1913 and she got honorary mentions in three more competitions (Appendix 10.18; 10.19) (BJN, 1912,

p. 223; 1912, p. 244; 1913, p. 104). In September 1913 she won another competition which confirmed she had left RHI (BJN, 1913, p. 187). In March 1948 while working as Matron of Wood Green and Southgate Hospital she died (BJN, 1948, p. 27). Miss Martin had joined the British College of Nurses upon its foundation in 1926 serving on its Council for several terms and was Vice-President at the time of her death (BJN, 1948, p. 27). Her career is outlined in appendices 10.20; 10.21 indicating she was Night Sister and Assistant Matron of RHI sometime before 1914. Miss Martin's long and distinguished career included two jobs at RHI and despite her brief time there, her appointment illustrates how the RHI was able to recruit high calibre nurses who were active in educational and professional issues.

Junior nurses' views of senior nurses.

To illustrate the way junior nurses viewed other staff besides the Matron a selection of narratives relating to a Sister Robinson of Appleyard Ward at RHI are used to show that nurses, particularly probationers, often had more contact with Ward Sisters than Matrons. Miss Astley suggested that Sister Robinson worked on Appleyard Ward a long time; '*Sister Robinson was here twenty-five years*' (HX 10, Miss J. Astley). She recalled Sister Robinson was strict but good (Appendix 10.22). Miss Astley, who followed Sister Robinson as Ward Sister when she left, described Sister Robinson's strict management style addressing patients by their surname which was not untypical at the time. Miss Sykes recalled her PTS experiences when allocated to Appleyard Ward and how other probationers informed her of Sister Robinson's strictness (Appendix 10.23). However, Miss Astley remembered Sister Robinson had a kind side to her nature providing socks for a homeless man (Appendix 10.24). Mrs Bland, whose maiden name was Robinson, described how her letters got mixed up with Sister Robinson's and how she was told to ensure they were clearly labelled to differentiate them (Appendix 10.25). Mrs Bland although unhappy with the situation felt Sister Robinson was a good role model (Appendix 10.26). So Sister Robinson, although having a reputation of strictness, was able to make some good relationships with probationers and some enjoyed working on her ward.

Photographic evidence and '*history from below*'.

Photographic evidence proved a powerful source to support '*history from below*' and its use in this study is defended. However, the scarcity of photographic evidence for the earlier times increased the importance of and reliance on the survival of written archival sources. An early example of written records related to Elsie May Harling (Nee Hallas) who trained at HRI, was Silver medallist in 1924 and received a Certificate from Matron GE. Parsons in 1925 (KC981/1/2) (Appendix 10.27). Personal written accounts of nursing were rare but her memoirs of working at HRI in the 1920s provide a valuable insight into nursing then (KC981/2/1).

Two categories of photographs, formal official and informal casual images, provide insight into nursing in both towns considering '*history from below*' and the ordinary nurses' experiences. These two categories are not without contention as depending on the content of the images some could be classed under both headings, particularly when groups of nurses are included. However, it is possible that photographs could look formal even though taken for informal reasons.

Official photographs.

At NHH the value of formal photographic evidence is shown in photograph 10.2. The date is unknown but there are seventeen nurses with five males who may have been attendants. In 1956 there were ten male qualified nurses so it could be a group of nurses from that era (DT 35/43, 1956). This could be a group photograph of all NHH nurses, or of those from a particular ward, and it is difficult to judge who took it. The image appears old but may be misleading and could have been as late as 1956. Analysing the female uniforms, the five nurses in the centre row all seem to have a similar collar on their dresses which is different from the six on the front row. As these nurses are behind the others it may be that these are probationers doing fever nurse training. The six nurses on the front row either side of the Matron may be staff nurses (SRN) or fever nurses (SRN, SFN) and one may be the Assistant Nurse. This speculation, although logically based, cannot confirm the year of the photograph nor the nurses' details.

Photograph 10.2

Nurses at Northowram Hall Hospital, Halifax. Date unknown.

Source: Courtesy of Mike Barnes, Archivist, Royal Halifax Infirmary, Calderdale and Huddersfield NHS Trust.

Photograph 10.3 shows a formal image of the dining hall at Halifax Sanatorium Shelf. This gives an impression of order with the tables set out ready. It is unclear if the woman in uniform is a nurse or maid as they often wore similar uniforms.

Chapter 10 – History from below – ordinary men and women.

Photograph 10.3

The Dining Hall at the Halifax Sanatorium, Shelf.

Dining Hall, Halifax Sanatorium.

Source: Postcard from author's personal collection (Date unknown).

Another example of the formal images nurses collected is photograph 10.4 showing Miss Sykes as a RHI probationer nurse in 1945 with uniform, apron and cap clearly visible. Formal portraits like this were often taken at the beginning of training or on qualification. They can provide details of the types of uniforms worn but do not illustrate anything about the nurse's role or practice.

Photograph 10.4

A portrait of Miss Mary Sykes as probationer nurse at the Royal Halifax Infirmary 1945.

Source: Miss M. Sykes, retired nurse.

There is a similar formal portrait in photograph 10.5 of Mrs Velma as a Staff Nurse at HRI in 1956 illustrating her pale lilac striped dress, cap and apron. The image on its own has limited value, but when linked to the oral history interview transcripts provided a personal aspect to the stories told.

Photograph 10.5

Staff Nurse Janet Velma, Huddersfield Royal Infirmary, 1956.

Source: Information about the uniform and photograph courtesy of Mrs J. Velma, retired nurse, and her husband.

This formal image can be compared with photograph 10.6 showing an informal off duty image of her in 1953. This gives a different image to the one the nurses often gave of the disciplined regimes within the Nurses Home, and with her cap removed there is a sense of her actually being '*off duty*'. The wearing of wrist watches was prohibited on duty but she has one on.

Photograph 10.6

Nurse Janet E. Velma (Nee Firth) off duty in the lounge at Huddersfield Royal Infirmary in 1953.

Source: Photograph courtesy of Mrs JE. Velma, retired nurse and her husband.

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Informal photographs.

History from below can be seen in relation to the '*unique*' informal photographic images that nurses collected during their careers. Examples of these were numerous with many nurses' having their own collections and selected examples are used here for brevity. Mrs Dyson who trained at HRI provided photograph 10.7 of the operating theatres showing her in uniform on the operating theatre table which must have been against the rules. This '*history from below*' shows what nurses did when not officially on duty or being supervised. It is unclear why this was taken or by whom.

Photograph 10.7

Mrs Dyson in uniform on operating theatre table at Huddersfield Royal Infirmary.

Source: Mrs M. Dyson, retired nurse.

An example of an institutional image is in appendix 10.28 showing Mrs A. Sleight on the steps outside HGH Nurses Home in Rhodesia Avenue. This is one of the only pictures of this building found and although Mrs Sleight started her nursing career in 1933 the date the image was taken is unknown. She has knitting needles in her hands illustrating some of the pastimes nurses enjoyed and is wearing a full uniform. Rhodesia Avenue was a road opposite the main hospital entrance. The actual house number or whereabouts is not known and there was no archival evidence to confirm this.

Photograph 10.8 provides another rare image showing the types of uniform senior RHI nurses Miss A. Ford and Sr Embleton wore in 1945 and how the hierarchal nature of uniform was displayed. Taken in the ground in front of a ward it shows Miss Ford who was Sister Tutor there wearing a completely different type of uniform. Black and white images like this one do not provide the colour details of the uniforms but often they were blue. Images with two nurses in like this would have been informal and the reason for taking unknown.

Photograph 10.8

Miss A. Ford and Sister Embleton two of the senior nursing staff at Royal Halifax Infirmary in 1945.

Source: Miss M. Sykes, retired nurse.

Photograph 10.9 shows another informal image of a group of five uniformed '*nurses*' on Crossley Ward RHI in the 1940s.

Photograph 10.9

Nurses on Crossley Ward at the Royal Halifax Infirmary circa 1940s.

Source: Miss M. Sykes, retired nurse.

The inclusion of a male nurse in the 1940s is an early example of how men were becoming more frequent in number. The old style beds and bedside lockers can be seen behind the nurses. It is unknown who they were, who took the photograph or the reason for taking it. Appendix 10.29 illustrates a similar scene with nurses on Holt Open Air Ward RHI showing how patients were nursed

in fresh air. Views of nurses working inside the ward areas were relatively rare prior to 1940 making it difficult to see images of this.

However, several photographs provided unique insights into the nurses' experiences and helped to visually show '*history from below*'. One example is photograph 10.10 showing an informal picture of the HRI March 1950 PTS nurses with the Sister in Charge and the Housekeeper in the centre wearing an overall outside Trinity Street Nurses Home. Appendix 10.30 shows another view of this building. These informal images are important as they show nurses in more relaxed poses and are helpful in showing the way nurses behaved. Wearing uniform was compulsory for most days so there are few pictures of nurses wearing everyday clothes. Identification of individuals makes the images even more valuable and allows triangulation of data.

Photograph 10.10

Huddersfield Royal Infirmary Preliminary Training School Nurses at the Home in Trinity Street during March - June 1950.

Back left – right: Nurse Thelma Percival, Nurse Margaret Kirkbride, Nurse Armstrong (from SLH), Nurse Mary Marshall, Nurse Hall (SLH), unknown, Nurse Constance Ward, Nurse Janet Hanson (Nee Edgar), Nurse Schiendorfer, Nurse Holbrook, Nurse B. Horrocks, House keeper, Sr. Harrison.

Source: Photograph and information courtesy of Miss M. Kirkbride, retired nurse.

Photograph 10.11 shows Sister V.D. Lewis who was in charge of Pre-nursing courses (PNC) at HRI circa 1949-1950 on the balcony of Ward 12. The HRI Sister's uniform was described in detail by a retired nurse (Appendix 10.31). The main source of recruitment during the 1950s was the PNC (Appendix 10.32). This photograph does not look professional with shadows behind, and therefore might be informal, and the reason for it and who took it, unknown.

Photograph 10.11

Sister VD. Lewis who was in charge of the Pre-Nursing Course at Huddersfield Royal Infirmary from September 1949 and March 1950 on the balcony of Ward 12.

Source: Photograph and information courtesy of Miss M Kirkbride, retired nurse.

In Photograph 10.12 there is a more formal picture of PTS nurses at HRI in 1952. Sister Wignall the PTS Sister was mentioned by several nurses in the oral histories.

Photograph 10.12

Huddersfield Royal Infirmary Preliminary Training School at Ellerslie in 1952.

Left to right: Clifford Speight, Margaret Thurman, Pauline Howgate, Sister Wignall, Janet Velma, Betty Hickey, Margaret I'Anson.

Source: Photograph and information courtesy of Mrs JE. Velma, retired nurse and her husband.

The male nurse's role is unknown but provides further evidence of them. These six nurses illustrate that intakes were small although they may not represent the whole cohort.

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Photograph 10.13 shows dinner being served on Ward 12A in 1952 by Sister Parry with Student Nurse K. Boydell. Patients are in bed with Sister plating the food and the nurse waiting to serve it. Appendix 10.33 shows a similar photograph of a rare glimpse of how nurses worked in the 1950s at HRI. Analysis suggests the ward looks light and airy, very clean and tidy with the majority of patients in bed even though it was a convalescent ward. These images were professionally taken but their purpose is unclear.

Photograph 10.13

Dinner being served on the female convalescent ward 12A, Huddersfield Royal Infirmary in 1952.

Source: Photograph and information courtesy of Mrs M. Dyson, retired nurse.

Photograph 10.14 shows an informal group of PNC students in front of the Nurses Home at HRI in 1957. Appendix 10.34 shows a similar image in 1959.

Photograph 10.14

Pre-Nursing Course Students at Huddersfield Royal Infirmary in 1957.

Left to right: Margaret Francis (nee Nalson), Janet Bradley, Dorothy Rowlands, Margaret Garside, Dorothy Lumley, Janice Collins.

Source: Photograph and information courtesy of Mr and Mrs R. Francis, retired nurses.

Chapter 10 – History from below – ordinary men and women.

Mrs Francis a HRI Gold Medallist is in both photographs providing testament to the success of PNCs (Appendix 10.35; 10.36). Triangulation of data from the oral histories supports the existence of the PNC and one of the first nurses to start was Miss Kirkbride in 1949;

> 'So in September forty-nine I went……to Huddersfield on the pre-nursing course. And the following March, err, when I was err, seventeen I went into…the err, PTS as it was then, ……upon Trinity Street' (HUD 11, Miss M. Kirkbride).

This typical scenario prepared nurses too young to start the nursing course ensuring their enthusiasm was capitalised upon. Mrs Beaumont was another PNC nurse who provides two interesting stories giving a clear sense of the way nursing was viewed by some. The formal style of recruitment and interview also took into account age of entry to nursing and length of training (Appendix 10.37). Photograph 10.15 shows an informal image of Nurse Anna Foster at MHH circa 1951-53. Here the rural aspect can be seen illustrating the 'isolation' of the hospital. The children are very young illustrating the type of patients nursed.

Photograph 10.15

Nurse Anna Foster with two patients on a lawn behind Ward 5 or 6 of Mill Hill Hospital Dalton, looking towards Waterloo, circa 1951-3.

Source: Photograph and information courtesy of Mrs B. Lukash, retired nurse.

The final two photographs provide images of nurses' reunion meetings. Photograph 10.16 shows the annual re-union dinner of the HRI Nurses League at Ellerslie Nurse Training School in 1959. This provides a rare internal view of the Ellerslie building and shows many of the nurses who were actively involved in the League.

Photograph 10.16

Annual Re-union Dinner of the Huddersfield Royal Infirmary Nurses League at Ellerslie in 1959.

Source: Mrs E. Galvin, retired nurse.

There was a similar reunion picture at RHI with nurses sitting in groups in Whitworth Hall in photograph 10.17. There are also nurses in uniform within this image.

Photograph 10.17

A Nurses' Reunion at Royal Halifax Infirmary in Whitworth Hall (date unknown).

Source: Mrs M. Sykes, retired nurse.

These two images show the importance placed upon allowing the nurses an organisational identity and ensuring comradeship was maintained.

All these formal and informal photographs provide images showing how nurses worked and dressed and give a visual account of '*history from below*'.

Mr. Jack Trepte.

Photographs proved useful as owners could identify individuals in them thereby putting names to faces. One such example was Mr Jack Trepte seen in photograph 10.18 at the Prize Giving Ceremony at HRI OPD Waiting Area in 1961. Two retired nurses provided names helping to identify individuals and to make links with other pictures.

Photograph 10.18

Prize Giving Ceremony at Huddersfield Royal Infirmary Out-patients Waiting Area in 1961.

Back row left to right: Miss Hickman, Senior Tutor, Catherine Greenwood, Dorothy Rowlands, Dympra? Murphy, unknown, unknown, Leslie Storer, Eileen Webster, Christine Stone, Shirley Wood, Ann Mostyn, Mr Jack Trepte, Tutor.

Front row left to right: Margaret Francis (Nee Nalson) Gold Medallist, two Hospital Committee members, Kathleen Raven who presented the prizes, a GNC / RCN Official, Miss CA. Nicholson, Matron, Helena Thornhill, Silver Medallist.

Source: Mr and Mrs R. Francis, retired nurses.

In the photograph Mr Trepte is last on the right of the back row. He was wearing a nursing uniform with shoulder epaulettes and described as a Nurse Tutor helping place him in the next two photographs. Photograph 10.19 shows him teaching wearing the same type of uniform as in photograph 10.18. The venue for these photographs is unknown and is either HRI or Ellerslie. If the latter these would are rare images of the building and classrooms. In 1966 Mr Trepte was an Associate Member of the HRIONL (Anon, 1966, p. 26). A colleague remembered; '*……I would also like to send my greetings to Miss Hickman and Mr Trepte, who were our tutors at Ellerslie*' (Shrivastava, 1980, p. 24).

He was mentioned by eight oral history interviewees from Halifax indicating he was based there most of his teaching career and by 1968 he was the Principal Tutor at RHI (DT 33/258 GNC, 1968, p. 7). He may have been a Principal Tutor earlier as Miss Marsden indicates he became Principal Tutor possibly in 1965 when she left the role (Appendix 10.38). She suggested he was in post until at least 1970; '*……and Mr Trepte'd been running……this for three or four years anyway, I would have said it was getting on for 1970,……*' However she was not certain and continued; '*but you might find……it was sixty-eight or something*' (HX 3, Miss D. Marsden). Miss Johnston who worked at RHI as a nurse

educator arranged for him to go to London for teacher training before returning to RHI (Appendix 10.39). Miss Mulligan indicated that when the RHI and HGH schools amalgamated Mr Trepte was part of this (Appendix 10.40). She indicates he was in charge at the RHI School but unclear for how long. Mrs Honour recalled that Mr Trepte was instrumental in getting her into nurse education (Appendix 10.41). This was a good example of how senior staff could aid nurse's personal development (Appendix 10.42).

Photograph 10.19

Mr Trepte, Nurse Tutor at Huddersfield Royal Infirmary circa 1962.

Source: Courtesy of Calderdale and Huddersfield NHS Trust.

His previous nursing career prior to teaching is not known although Miss Johnston indicated he may have trained at HGH and Miss Mulligan further explained this (Appendix 10.43).
He was fondly thought of by many of the nurses who recalled he died suddenly and that his memorial garden seat was in the grounds of the Willows (HX 1, Mrs P. Titchmarsh) (Appendix 10.44).
These testimonies indicate that Mr Trepte was a Nurse Educator in both Halifax and Huddersfield circa the late 1950s until possibly 1970. The use of photographs therefore assists in providing a visual image of this individual and his career.
Photographs therefore provide valuable information about local nurses and illustrate '*history from below*'.

Staff movement and turnover.
Locally nursing was structured in a hierarchical manner inevitably creating groups of local '*elite*' and '*rank and file*' nurses. The relative stable employment conditions during the first five decades of the Twentieth Century allowed nurses to work, should they wish, in the same organisation for many years and enjoy the benefits of a '*job for life*'. However, despite this there was evidence that many nurses changed jobs fairly frequently and this allowed a healthy turnover of staff. This was supported by rigorous government and professional body inspections ensuring national standards were met. As we

saw earlier nurses working in the local DNAs provided a rich source of data illustrating staff turnover as nurses commonly moved in and out of the towns, and here eight hospital examples are provided. At RHI the first of four examples was Annie Cross a Sister circa 1908-1914 who was appointed Home Sister at Victoria Hospital Blackpool in 1914 (BJN, 1914, p. 269). The Home Sister's role was a promotion and often led to an Assistant Matron's job. The same year Sarah Agnes Kaye was appointed Matron of the Infectious Diseases Hospital, Mastin Moor Derby having trained at RHI in 1901-1904 and being Sister at MHH (BJN, 1914, p. 228; GNC, 1931, p. 955). By 1931 she was working at the Isolation Hospital Bilston Staffordshire showing how staff moved around the country (GNC, 1931, p. 955). In 1943 Agnes Steedman was appointed Sister Tutor and Home Sister at Kendray Isolation Hospital Barnsley having trained and being a Staff Midwife circa 1930s at RHI and a Health Visitor and School Nurse at Brighouse (BJN, 1943, p. 143). The fourth example was Miss ET. Smith who was appointed Matron of the Midland Counties Institution Knowle near Birmingham in 1948 having trained at RHI circa the late 1930s early 1940s (BJN, 1948, p. 31).

Three examples of HGH trained nurses who were successful included Ellen Geldart who was Assistant Matron of the Cambridgeshire Mental Hospital in 1930 (BJN, 1930, p. 274). Secondly, in 1933 A.E. Fletcher was appointed Matron of the Broughton Institution for Mental Defectives near Chester (BJN, 1933, p. 131). Thirdly, an example of progress in nursing education is found with Miss Dorothy Wood who completed her nurse training circa 1924-5 at HGH (KC853/3). She worked for HDNA gaining her Midwifery and QN Certificates and in 1928 started a Health Visiting course at Leeds University (MISC: 493/10). Then in 1929 she became a School Nurse / Health Visitor in Marsden remaining there until retirement in 1956 (C381/11/11, 1956). This is another example of the long term employment nurses enjoyed.

An example in Huddersfield included in 1929 D.M. Lowe being appointed Assistant Matron and Housekeeping Sister of the Royal United Hospital Bath having previously being a Ward and Theatre Sister at BWS (BJN, 1929, p. 80).

Therefore individual local nurses worked successfully nationally and this turnover and movement of staff created a healthy nursing environment.

1901 Census.

'*History from below*' can also be considered by use of Census records which as they become available each decade can open up riches of data that nurses can use to expand the historiography of the profession. An example of this is found in the 1901 Census which lists the staff of RHI (Appendix 10.45). There were three senior nurses, Matron, Assistant Matron and Night Superintendent, and six Ward Sisters with an average age of 29.83 years ranging from twenty-seven to thirty-two years of age. Of these nine staff only two (22.22%) were born in West Yorkshire. There were nine staff nurses providing an early example of this role. Their ages ranged from twenty-five to thirty years with an average of 26.89 years. Of these nine staff nurses only two (22.22%) were born in West Yorkshire. Interestingly there was a district nurse living in the Infirmary illustrating that there were nurses in this role in the town prior to the HDNA opening in 1911. The eighteen probationer's average age was 25.06 years with a range of twenty-two to thirty-five years of age. Only four (22.22%) of the eighteen

Chapter 10 – History from below – ordinary men and women.

were born in West Yorkshire. There were fifteen qualified nurses excluding the three senior nurses giving a high Nurse: Probationer ration of 1:1.2. In total the nursing staff listed totalled thirty-seven however, according to the Census there were in total forty. The ones missing off this list were the three (7.5%) male staff who may have lived outside the Infirmary. In addition to the nurses listed there were twenty-eight servants including five men (17.85%). These staff will have contributed to the nursing of patients or some of the nursing tasks as a form of support worker. There were 124 patients, sixty-nine males (55.65%) and fifty-five females (44.35%). Excluding senior staff and probationers the Qualified Nurse: Patient ratio was 1:8.26, and with probationers included the ratio was 1:3.75.

Royal Halifax Infirmary Nursing Pageant.
The final illustration of '*history from below*' considers the 1946 Nursing Pageant to celebrate the RHI Golden Jubilee. It was not the only hospital to conduct a pageant as in 1939 there was a; '*Pageant of Nursing representing the progress of nursing since 1087 in aid of the London Hospital'* (Anon, 1939, p. 632). The RHI pageant was attributed to Sister Tutor Miss A. Ford (HX 5, Miss M. Sykes) (Appendix 10.46). She had written and produced the Pageant of Nursing which presented a history of nursing from 410 B.C. in ten scenes (Anon, nd) (Appendix 10.47). Miss Sykes provided thirteen photographs of the pageant with one example in appendix 10.48 illustrating a scene showing costumes and production. The pageant programme listed the scenes and appendix 10.49 shows its front page. Names of nurses involved included, '*……and a background of gramophone music was played by Nurse M. Sykes*' (Anon, nd). Miss Sykes recalled;

> '*I put on the incidental music between the scenes, and on a seventy-eight record trying to get the right bit, I'd a chalk mark (Laughter), I had to get the needle (Laughter) for the right bit, (Laughter) it was very difficult,……but we managed it*' (HX 5, Miss M. Sykes).

The pageant script first page and those taking part are listed in appendix 10.50; 10.51. The twenty-five nurses listed did not represent everyone as over forty people were involved (HX 5, Miss M. Sykes). The pageant was performed during an afternoon and two or three evenings ensuring all the nurses could attend (Anon, nd) (Appendix 10.52; 10.53).

Conclusion of chapter.
Examining '*history from below*' in relation to the occupational and professional aspects of local nurses provides accounts and images of how they lived and worked. Both archival and oral history sources provide a selection of stories and visual images that illustrate how nurses were involved in many work and social activities. These '*ordinary*' men and women who worked as nurses locally provide a unique picture of nurses and nursing that hitherto remained dormant.
Nine issues related to the concept of the '*ordinary*' nurse included nurses who worked for local DNAs, the emerging Matron's role illustrated by Miss Long at HRI, other selected case study examples like Miss Martin at RHI, junior nurses' views of senior colleagues, case studies of individual nurses and official and unofficial photographs like the case of Mr Jack Trepte, the movement and turnover of staff, the importance of archival sources like the 1901 census, and finally the RHI Pageant. These nine issues allow exploration of the concept of the '*ordinary nurse*' and history from below.

Chapter 10 – History from below – ordinary men and women.

The next chapter examines Rosenberg's final area of importance, '*History as meaning.*' This considers four issues in relation to recognising the importance of the past to nursing, the history of nursing locally and nationally, of local nurses as resources to local nursing history, and links to present day developments.

Chapter 11 – History as meaning

'*History as meaning*' is the final area of importance reviewed. To evaluate the importance of local nursing history the following four issues are considered:

- recognition of the importance of the past to nursing.

- recognition of the importance of the history of nursing locally and nationally.

- recognition of the importance of local nurses as resources to local nursing history with the case study of Annie Elizabeth Healey (Nee Haynes).

- links to present day developments including seven issues; the Matron's role, nurse education, nursing care, pay and working conditions, Assistant Nurses, coping with change and human resource management.

Rosenberg discussed historians becoming more concerned with the past experiences; '*as felt and interpreted by past actors*' (Rosenberg, 1987b, p. 68). He suggested that; '*death, birth and illness are emotionally central aspects of human life*' that have been neglected by past historians (Rosenberg, 1987b, p. 68). He stated by considering the; '*texture of life as perceived by ordinary folk in the past*' this can be addressed (Rosenberg, 1987b, p. 68). Although this study did not explore patient experiences directly a number of examples existed in archival and oral history evidence which illustrated nurses caring for vulnerable patients, and how this affected the nurse and patient. These examples of '*human experience*' give important historical meanings to explain how nurses, nursing, and the health care organisations that employed them, operated. These '*meanings*' provide a rich source of data that aids our understanding of the social, political, professional and managerial aspects of nursing. This allows nursing history to be interpreted within wider social and cultural considerations that ensure historical '*facts*' are not just considered chronologically but also within the nurse researchers own experience. Where the investigating nurse is '*coming from*', and why they are exploring nursing history are important factors in the interpretation of historical facts.

So what do all the historical '*facts*' tell us about the history of nursing in Halifax and Huddersfield 1870-1960? What happened and how can these '*facts*' be interpreted to give history meaning.

Recognition of the importance of the past to nursing.

The premise here is that having recognition of the importance of the past to nursing may be useful for both individual nurses and the profession. This can be challenged by suggesting that the study of nursing's past is irrelevant to today's nurse. The nurse today has to learn many subjects and a plethora of skills in order to work in the modern health service. Many nurses have no interest in history and many seem surprised when it is raised as an issue. There seems to be a trend to exclude the subject as a study area in an already overcrowded nursing curriculum therefore preventing novice student nurses from being exposed to the historical context of both nursing and the historiographical research methods they could explore. Anecdotal evidence provides examples of applicants to nursing not knowing who Florence Nightingale was and this lack of awareness of the professions history would seem to be a poor reflection upon their general education and their preparation for the application process. It may be that individual nurses may have a natural historical interest but that

many without this are not encouraged or given opportunities to be exposed to nursing history. There also seems to be a possible argument that individual interest in nursing history only becomes popular on maturity when nurses' have their own experiences to compare. Needless to say, the study of the local history of nursing was found to be an interesting subject by many local nurses.

It was surprising to note that locally there were only two nurse educationalists researching nursing history in any significant way, although it is acknowledged that others may have reviewed historical events related to their subjects. There were no major historical studies done by nurse practitioners within the two towns, although many nurses had been involved in preparing and presenting commemorative hospital events that included elements of nursing history.

When reflecting upon this study it was easy to review the historical facts and then ask, so what? Knowing about the different institutions in the two towns and how they involved nurses in the past does not help a nurse on the wards today to provide a better standard of care for their patients. However, knowing about the problems that nurses faced in the past working in difficult or even inadequate circumstances with limited technological support may aid their understanding of how they themselves may be able to ensure they survive in the present day '*crisis*' within health care. Understanding how nurses cared for patients with highly infectious diseases without the back up of antibiotics may be important to help today's nurse understand principles of asepsis and infection control. Giving novice nurses' opportunities to explore the history of nursing can provide them with both a rich source of data with which to apply to current day practice, and give them a sense of the professions identity and history. Ensuring nurses of the future understand their past is an important part of allowing the profession to develop its identity and allowing nurses the chance to contribute to further historical studies. This becomes even more important when applied to local nurses within provincial towns where the '*ordinary*' nurses are often not allowed a voice and become the anonymous '*rank and file*' and therefore their stories are important to document.

Recognition of the importance of the history of nursing locally and nationally.

The importance of local and national nursing history can be suggested as being linked to the '*elite*' and '*history from below*' concepts. It is obvious that historically significant nurses who had major influences upon nursing nationally would be placed high within the nursing hierarchy and this would seem to be appropriate to recognise their important contributions. However, it is equally important to tell the story of the '*rank and file*' nurses who were part of the nursing workforce and delivered the care to patients. In fact in Halifax and Huddersfield there were some interesting examples of senior nurses having involvement in, and contributing to, national nursing agendas. These included Workhouse Matrons on national committees and individual nurses contributing at conferences or publishing in the nursing press. On the other hand no locally trained nurses became GNC inspectors. Despite this there were various links between nurses in these two provincial towns and national organisations. Nurse training school affiliations allowed hospitals to have links with other local hospitals and there was a healthy turnover of nursing staff.

The historical stories of nurses in provincial towns, particularly in the north of England, are limited. This is understandable as the larger '*teaching*' hospitals in the bigger cities would have a larger

population of nurses wanting to explore their local histories and perhaps have more complete collections of archival materials, and more prominent individual nurses. However, it has been shown that a number of senior nursing positions in the two towns were held by nurses who had worked in other larger institutions, and continued their careers elsewhere later.

It is argued here that recognition of the importance of the history of nursing locally and nationally is an important factor and that each one compliments the other. The trend locally was that nurses and nursing followed national policies particularly in the 1940s-50s. How nurses were trained and employed locally was often decided by local nurses prior to this, and followed the organisational initiatives of the various health care schemes such as the Poor Law, municipal and voluntary hospitals.

Recognition of the importance of local nurses as resources to local nursing history.

A history of nursing in West Yorkshire gives a unique view of how nursing developed in this region with its particular industrial, geographic, cultural and social nuances. It also provides examples of how nurses worked there and allows their contribution to nursing and health care locally to be recognised. This study demonstrates that local nurses have themselves proved to be valuable historical resources providing a rich collection of data of both a personal and institutional nature. Nurses who started training during the 1920s-1950s enabled valuable information to be collected by their generosity in sharing memories and memorabilia. However, it must be remembered that the historical data collected is not necessarily representative of what happened as the nurses involved in the informal and formal interviews, and others contacted by post, do not represent the total population. Therefore, other nurses who did not want to participate, or have the opportunity to contribute, or did not survive to be sampled, did not have their stories told. However, the vast amount of data collected from local nurses and surviving archival sources illustrates the value that local nurses, and the institutions they worked in, have in contributing to nursing history. It was clear when talking to local nurses, that should they die they had made no provisions for their resources to be saved or donated to archival collections. The loss of these sources therefore is of some concern for future nurse researchers who may find this data lacking. It is therefore argued that the recognition of the importance of local nurses as resources to local nursing history has been demonstrated as they provided valuable rich historical varied data.

Annie Elizabeth Healey (Nee Haynes).

A specific example of the valuable resource local nurses can be was meeting a local retired Health Visitor, Miss Mary Healey, who possessed detailed information about her mother Annie Elizabeth Healey (Nee Haynes) 1907-1981. This unexpected discovery illustrated the ad hoc nature of exploring local nurses. Using Annie Elizabeth Healey as a case study allowed comparisons to be made between her experiences and local nurses. Born in India in 1907 she came to the UK aged fifteen years old and started a two and a half year children's nurse training course in 1924 at the Children's Infirmary, Elder Road West Norwood in London completing this in October 1927. Appendix 11.1 provides a picture of her. She then started her SRN training at Mile End Hospital, Stepney London qualifying on 21 October 1930. After qualifying as a Midwife in 1932 she worked as a Health Visitor.

Chapter 11 – History as meaning.

Surviving personal records from her probationer nurse training included 'Matrons' Lecture Notes' dated 2 November 1927 - 4 April 1928. This documentary evidence contained approximately 400 sides of well-written detailed notes which provided a fascinating insight into how she managed note taking and studying, the nature of the probationer / Matron relationship, and the Matron's educational role. It also provided valuable insights into the practice of nursing in the late 1920s through the words of a novice nurse. Appendix 11.2 shows the first page of these lecture notes dealing with the subject of hygiene, ventilation and respiration. Her notes included an explanation of how to prepare a Turpentine Stupe;

> *'Sprinkle 3T - 3iv of turpentine on flannel or lint before boiling water is poured on, so that turpentine can be easily distributed. Used in treatment of distension in Typhoid Fever. Opium and Belladonna Fomentations may be ordered to relieve pain. 30 minims are sprinkled on lint after fomentation is wrung out. The quantity to be measured out carefully in a minim measure glass'.*

The latter part demonstrates the measurement and dosage scales used and how water was added and appendix 11.3 shows the original notes. This written description provides evidence of this nursing practice, however, what fruitful additional information would have been gained if Annie Haynes had been interviewed and provided with the opportunity to explain in more detail what it was like to be in the classroom, and how the lectures were applied to practice. Also, there could have been a chance to explore further the types of nursing practices, equipment, and treatments Annie recorded. Without this opportunity it is difficult to imagine how and why the procedures and pieces of equipment she recorded were used, such as '*ice cradling*'? (Appendix 11.4). Of course we can check these out in old nursing textbooks, but to have captured her answers to these sorts of questions would have provided first hand personal information to go with the documentary evidence provided in the lecture notes. The potential richness of hearing Annie describe how she was actually taught or performed these tasks is lost, as are the answers to many other questions about her experiences. Missed opportunities like this to collect nurses' memories can never be replaced. Appendix 11.5 shows a page from the Matron's notes illustrating the importance of preventing and treating bedsores, and the role of pressure in their causation. However, by comparing her experiences with nurses at RHI and HRI in the 1920s similarities are found in relation to the Matron's role in education and the types of nursing care and treatments provided by nurses at this time. The use of lectures to provide the nurses with details of the care and treatment of patients was a common practice and these methodical and neat notes illustrate the emphasis placed on order and detail. Of course, it is not known if this standard of note taking was the norm, or whether other nurses were as thorough.

This case study illustrates the scope of source materials that are available from local nurses and how using this material can add context to the local and national history of nursing.

Local history of nursing studies therefore can contribute to the national story of nursing providing useful comparisons with other towns and areas that help to contribute to the patchwork approach of seeing the holistic picture of the history of nursing nationally.

Links to present day developments.

Within Rosenberg's eight areas of importance there were many issues that have links to current day developments. For brevity however, only seven specific examples are addressed here.

The Matron's role.

The Matron's role disappeared during the 1960s as nursing was restructured within the wider hospital administrative and managerial changes that occurred. However, during the 1990s with increasing criticism of the NHS, and poor standards of care such as hospital food, infection control, and hygiene, there were calls within the media and general public for the Matron's role to return. Since this role was re-introduced nurses have explored its usefulness and questioned the philosophy of resurrecting a '*ghost from the past*' to solve current day problems (Anon, 2001; Hewison, 2001; Read and Scott, 2004, Shanley, 2004, Bufton, 2005; Scott et al, 2005). Others have looked at the merits of returning the Matron to the hospitals (Coombes, 2001; Castledine, 2003; Dept of Health, 2003; Gallagher, 2003). As seen within this study the Matrons and Supervisors of Halifax and Huddersfield's institutions were working in particular social, organisational, and professional arenas that were time specific to that era. The political aspects of gender, and in particular the roles of male and female nurses, were unique to these time periods and influenced by the societal changes during 1870-1960. To now have '*Modern Matrons*' working in the towns institutions indicates that this nursing role has come full circle. The effectiveness of this is unknown currently, but the fact that the Matron's role was seen as an '*answer*' to modern problems is testimony to the power of the belief by many that this role was important. However, it is possible that the respect and authority that these '*old matrons*' had, and the discipline and conformity they demanded of their nurses, are not now appropriate or even compatible with the modern values of both health care institutions and society. Having '*rose tinted*' views of this role may cloud these issues and allow '*nostalgia*' to drive policy instead of evidence based practice. During the oral history interviews the '*Modern Matron's*' role was emerging and many of the interviewees felt this was good, and that their views of the Matron's role were on the whole positive. This link to the present is an important example of how nursing history can provide evidence to allow analysis of contemporary nursing issues.

Nurse education.

A second example of a link to the present relates to nurse education and in particular the Workhouse Training Scheme of 1901 between the Yorkshire College in Leeds and the Poor Law Unions of Yorkshire. The Yorkshire College was to gain university status and offer local nurses higher education from the 1920s onwards. Since the mid 1990s local nurse education has moved into the higher education sector showing the early links with Leeds have come to fruition. The move to standardise nurse training between Workhouses in Yorkshire in 1901 was an early example of how localised health care organisations were trying to work together. This involved a joint approach to the nurse probationer's theoretical and practical assessment. Related to this initiative recently within West Yorkshire have been moves to create a combined joint clinical assessment document to be used by all local university students on their placements. These two examples have strong links with the activities occurring 107 years ago and illustrate again the '*full circle*' aspect of history. Knowing this

illustrates how often '*nothing is new*' and that changes occurring now are possibly the same or similar to previous historical events.

Nursing care.

In relation to nursing care the general view is that the care that was provided in the Nineteenth Century was at least basic and at times poor. However locally there were nursing and other groups that ensured standards rose over time. The changes in the treatments of infectious diseases during the next century provided examples of technology impacting upon nurses and nursing. Links to the present in relation to nursing care however are found with old treatments like the use of leeches coming back into vogue. Also, with the increasing return of infectious diseases once believed to have been eradicated, or at least for the main part minimised, such as TB, the modern nurse has to care for patients with these conditions again. Principles of infection control are therefore important with these patients as well as in the care of other conditions such as HIV patients. This disease provides an example of how new forms of illness ensure the nurse has to adapt over time and perhaps be able to use history as a resource to ensure practices are based upon previous generations of nurses' experiences. Other more recent problems of infection control include the spread of the so called '*super bugs*' Methicillin-resistant Staphylococcus Aureus (MRSA), and Clostridium Difficile (C. Diff). When comparing the types of patients nurses cared for during the Poor Law times the patients were often poor and malnourished because of want for food. However, modern day nursing has to cope with issues of malnutrition in hospitalised patients who are not fed appropriately or assessed for their nutritional needs. Nurses also have to adapt to patient needs in relation to the side effects of the '*obesity epidemic*'.

Pay and working conditions.

Nurses' pay and working conditions are also topical issues currently causing concerns with today's nurses. Within the professionalisation of nursing there have been major developments since 1960 in relation to the nurse as a worker and nurse education. Nursing has had at least two major pay and grading reviews which have affected nurses in both financial and job role terms. There have been changes to the relationships nurses have with doctors as well as changes to the lower end of the nursing task spectrum between nurses and support workers. Throughout the period 1870-1960 nursing had to cope with recruitment and retention issues similar to those prevalent today. McKenna et al (2007, p. 1283) discussed the '*global shortage of registered nurses*' and how there was '*role drift*' related to the nurses' duties and workload manifesting itself in tasks moving from doctors to nurses, and from nurses to health care assistants (HCAs). They argued this process was not new and there is clear evidence in Halifax and Huddersfield that '*role drift*' occurred throughout 1870-1960. Examples included the roles of '*Lunatic Assistant*', '*Staff Nurse*', '*Junior Sister*', '*Assistant Matron*' and '*Assistant Nurses*'. Miss Wharton, Matron of RHI in 1897, had attended a meeting where Matrons who were registered nurses had protested against admitting '*Asylum Attendant*s' as registered nurses (Nursing Record and Hospital World, 1897). Moving tasks from doctors to nurses can be illustrated with the development of different branches of nursing. Specialties like Mental Health, Learning Disabilities, Paediatrics, Midwifery, Health Visiting, District Nursing, and School Nursing provide

examples of how nurses' roles evolved. The emergence of '*specialist nurses*' like Diabetic and Stoma nurses in the 1950s were examples of '*role drift*'.

Assistant Nurses.

The delegation of tasks from nurses to HCAs as a form of '*role drift*' can be linked to the Assistant Nurse's role which developed after the Second World War. These nurses were described as assistants and eventually became second level nurses called State Enrolled Nurses (SENs) working with and supporting their SRN colleagues. Prior to this probationer nurses were the main providers of nursing care on the wards supervised by qualified staff. During the 1990s the SENs role was diminished and many given the opportunity to qualify as SRNs. With natural wastage the number of nurses in this role dwindled. However, with re-grading of nurses and the issue of skill mix there was financial pressure to find alternatives to paying large salaries to nurses on the lower skill grades. This resulted in employers recruiting HCAs and the dilemma that these grades were then seen to be delivering many of the tasks nursing had traditionally performed. McKenna et al (2007) therefore ask;

> '*Is one solution to such 'role drift' and intensification the re-introduction of a second level in the nursing register?*' (McKenna et al, 2007, p. 1284).

This re-introduction of a second level nurse would therefore have a direct link to the SEN role and again illustrate the importance of recognising historical events, and how they link to the present. Paquay et al (2007) discuss the roles of qualified nurses and support staff illustrating that they often vary in their task allocation and that the registered nurses did not delegate tasks to support staff. Therefore the nurse's role in relation to the technical and medical aspects which overlap with doctors' roles and the caring aspects which overlap with unqualified support staff are important elements of today's nursing practice.

Coping with change.

Throughout the 1870-1960 period nurses had to cope with a variety of changes whether, social, political, technological, or professional. In Halifax the town had a proud history of industrial textile manufacturing and had seen major changes in social, working, and living conditions, with consequential changes in health needs. At the turn of the Nineteenth Century and first part of the Twentieth Century it was known as the '*town of a hundred trades'* because of its industrial diversity (Hargreaves, 1999, p. 121). An example of the impact of the changes in social conditions was the creation of the Halifax Citizens Guild in 1905 that helped school children and the unemployed during the winter economic depressions of 1905 and 1908. The Guild also encouraged the local authority to appoint health visitors (Hargreaves, 1999, p. 154). Another example is that Halifax only had a quarter of its houses with water closets in 1911 (Hargreaves, 1999, p. 147). Although it could be argued the pace of change was slower than today, the changes were as stressful.

Other examples of change included the opening and closing of hospitals and institutions, dealing with war time, and the introduction of new technology, and nursing and medical practices. Contemporary nurses have the added problems of rapid daily change, high levels of uncertainty, and increases in technology that their predecessors perhaps did not have. In this era of '*new build*' hospitals, many nurses in Halifax and Huddersfield have felt a personal sadness at the loss of hospitals they have

spent significant parts of their careers in. In the last twenty years many mental health nurses have experienced these sorts of changes with the closure of large psychiatric hospitals, which often had strong institutional affiliations for both patients and staff (Massey, 1991).

Reviewing the past can help when adapting to, and analysing, the challenges of the future and dealing with complex major changes. It is important however to challenge the assumption that all change is for the good and that history confirms that progress is continuously improving (Herdman, 2001). When faced with change, it is easy to understand why nurses may resist it, as there may be an awful lot of truth in the saying '*the good old days*'. Exploring and demystifying the '*good old days*' allows nurses to identify how current changes relate to historical events locally.

Human resource management.

Finally, examples of how nurses met the problem of ensuring adequate numbers of nurses were on duty in the past are useful to consider in relation to modern day practices of using nurses from nursing '*banks, pools and agencies*'. Within Halifax and Huddersfield there were examples of how to accommodate nurses' holidays by employers creating the '*holiday nurse*' role. This person was used as a temporary replacement for the nurses while they had their holidays and is perhaps similar to the pool or bank nurse of today. The main way employers seemed to ensure staff had their holidays was to employ all staff as full time and in enough numbers. This was in combination with offering staff limited holiday entitlements. However, the financial consequences of this were to prove too costly and by the Second World War this practice was less common and part-time nurses were on the increase giving employers more flexibility to cover annual leave. There was little mention in the oral histories of sickness and absence being a problem on the wards. Nurses did not often discuss having to cover for colleagues who were sick, or to move wards to help out other staff due to absence. These aspects of staffing illustrate that in the past it was less of a problem than currently. This may have been due to either the number of staff, skill mix or patient dependency, and length of stay affecting the nurse's workload. It may also have been due to the nature of their employment, the discipline regimes, and the Matron's role.

Conclusion of chapter.

Evaluation of the importance of local nursing history using the four issues stated has provided arguments that this area of importance is initially a difficult one to interpret from Rosenberg's original idea. However, by exploring it further there were suggestions that recognising the importance of the past to nursing is linked to individual nurses' views and interests, and that if novice nurses are not allowed or encouraged to explore history they will miss opportunities to help them understand it and develop an interest. Recognising the importance of the history of nursing locally and nationally is central to this study, and it is argued that the study of the history of nursing in provincial towns and cities supports the national historical development of nursing and allows comparison with other provincial areas. This study has recognised the importance of local nurses as resources to local nursing history by using a '*history from below*' approach. Life stories and case studies of various local nurses allow an insight into the personal world of men and women who worked as nurses in Halifax and Huddersfield. Selected examples of how the nursing history in the two towns links to present day

developments are argued to be supportive of the way knowledge of the past can enhance our understanding of the present.

So '*history as meaning*' as an area of importance addresses the four areas of recognizing the importance of the past to nursing, importance of the history of nursing locally and nationally, importance of local nurses as resources to local nursing history, and links to present day developments. These ensure that the history of nursing is embedded within a historical framework that gives it credibility, reliability, and validity.

The next chapter provides a discussion of the overall findings of the study and a review of the methods used. Local nursing is discussed to illustrate the changes for the nurse from 1870-1960, and the two towns are compared to illustrate their similarities and differences.

Chapter 12 – Discussion.

This chapter considers that general and district nursing in Halifax and Huddersfield from 1870-1960 changed enormously in a variety of ways. As this study covered a ninety year period discussion includes consideration of three arbitrary time periods;

- The reform of nursing - 1870-1900.
- Social class, the fight for registration, the war and the GNC - 1900-30.
- The GNC, Second World War, gender, the new NHS, and the motivation to nurse - 1930-60.

This allows the issues of the origins of local general and district nursing relating to the reform of nursing during 1870-1900 to be considered. There is discussion of the fight for registration, war, and the GNC, followed by examination of the professional development, and the introduction of the NHS from 1930-1960.

There is also a review of how the studies methods met the research aims and the limitations of the methods used. Finally, Halifax and Huddersfield are compared as are the nurse of 1870 and 1960.

Background.

The history of nursing in Halifax and Huddersfield provides a unique picture of one region of the UK. This is not to say they were dissimilar from other northern industrial towns, but their uniqueness stems from the individualism of the two towns in respect of their particular geographical and industrial setting. The lack of research into the history of nursing in other northern towns hinders any comparative analysis and identifies an area for future study. There were differences even between the towns Pennine locations and industrial textile bases which made them unique. Regional cultural variations during the time under study show that provincial towns countrywide were relatively isolated from the larger cities and that particularly in the earlier time period transport and communication systems were a little limited. It is therefore possible that the nursing history of towns in the UK would to some degree all be unique. The importance of investigating towns is an important consideration as they usually did not have medical teaching hospitals and therefore are not easily comparable with cities. Also, the development of the hospital movement often meant the cities with more financial backing and medical school prestige opened institutions earlier. Halifax and Huddersfield are located within West Yorkshire and surrounded by major cities like Sheffield, Leeds, Bradford and Manchester all in relatively close proximity therefore occupying a unique place geographically and professionally. There was an indication that both towns developed various nursing services either prior to, at the same time, or after other parts of the country. This indicates that they complied with LGB and later GNC directives for general nursing and the QIDN / QVJIN for district nursing. Their reports suggest that on the whole the nurses, nurse training, and nursing care provided locally was on a par with other areas of the country. The way nursing developed in the two towns reflected the national developments in relation to government policy, health and social care initiatives, professional developments and the social and cultural aspects of women's labour.

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The uniqueness of the history of nursing locally is mainly linked to the institutions they were employed by and the individual nurses who worked there. This is not to say that the towns had unique hospitals as they followed the national picture, however the actual buildings and the cultures they developed are unique to them.

The reform of nursing - 1870-1900.

To discuss the 1870-1900 period there is a need to consider to what extent local nurses were a part of the wider debates and developments in the process of nursing reform in the late Nineteenth Century. This will include discussion of national issues with local examples for both general and district nursing. The majority of local nurses were not involved to any great degree in the wider national process of nursing reform in the late Nineteenth Century. However, there were indications that individual local nurses did play a part and that the effects of these national developments were felt by local nurses.

The origins of general nursing.

Maggs (1983a) provided a convincing argument for the origins of general nursing and a number of issues he raised are considered here. Maggs (1983a) confirmed that the emergence of general nursing and nurses from the 1880s onwards was due to various factors, but in particular the increase in the number and type of hospitals. From 1870 to the start of the First World War Huddersfield opened three new hospitals and two DNAs and the HRI was developed to accommodate more patients. During the same period Halifax opened eight new hospitals and a DNA. This activity illustrates the increasing number of institutions and hospital beds, and the corresponding increase in demand for nurses. Locally there was evidence at HRI of the increasing number of nurses when in 1872-73 a new storey was added to the main building for nurse's accommodation (Tomlinson, nd). The Halifax Poor Law Union Board of Governors recorded that patient numbers had doubled, however, nursing numbers had not increased and they recommended an increase in nursing staff in October 1879 (MH 12/14986b, 1879). At HRI in 1886 average bed numbers occupied, patients treated, and an average length of stay of thirty-four days, indicated more nurses were needed (Johnson, 1937, p.10).

In the 1890s at Huddersfield Workhouse (Hall, 1895) paints a serious picture of the nature of the nurses' roles and responsibilities and the need to ensure quality of care. There are indications of the increasingly technical aspects of care such as the administration of medicines, medical applications and record keeping with the proviso that; '*no person shall hold the office of Nurse who is not able to read written directions upon medicines*' (Hall, 1895). This indicates the change in quality of nurse, with them requiring increased educational ability and skills. This change is documented by Maggs (1983a, p. 8-9) who estimated there were less than 1,000 women employed as hospital nurses in 1861 rising to 12,500 by 1900. By 1880 there was a large body of trained nurses and the number was increasing rapidly (Cope, 1955, p. 17). After the 1880s nursing found itself in the;

> '*unenviable and somewhat contradictory position of having to complete for its recruits with other expanding and developing areas of women's work*' (Maggs, 1983a, p. 45).

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During 1881-1901 about twenty-five percent of the female population was occupied in work (Maggs, 1983a, p. 49). By 1897 Halifax was the centre of the worsted dress goods trade employing women (Collett, 1898, p. 4). Despite this there was no evidence of an impact upon nurse recruitment and in fact local hospitals often employed the majority of their nurses from outside of West Yorkshire. Whether this was because of the local demand for women to work in industrial jobs is unclear. It was certainly a proactive tactic at HGH from 1900 where it was policy not to employ local women in order to aide hospital discipline (BJN, 1915, p. 371). Another consideration related to nursing and the textile industry was that there was no other job except nursing where women were required to '*live in*'. This would have been attractive to some young girls and less so for others. So even though there was some competition between nursing and local industry for recruits women would have had to make this choice.

Locally in 1900 Barrows (1974, p. 19) suggested there were, '*69,000 persons engaged in some form of nursing*' almost equally distributed between hospitals and other sectors like private nursing, domiciliary midwifery and district nursing. She identified that only 25,000 of these were qualified or had taken any training (Appendix 9.23). These figures conflict with the 12,500 hospital nurses that Maggs identified above, and this discrepancy remains unexplained, but the accuracy of figures is an important element and as Maggs identified the term '*nurse*' was used in various ways during this era. According to Baly (1995, p.125) in 1901 the estimated number of qualified nurses was still low and most care was delivered by unqualified older married or widowed women. The lack of any local evidence to confirm this makes it difficult to comment on as many data sources only included qualified staff.

By 1905 Maggs (1983a) suggested less than half of all nurses worked in hospitals and that of these only twenty-five percent were qualified, the rest working as probationers. However, at RHI in 1901 there were eighteen qualified nurses and eighteen probationers reported in the census (Appendix 10.45). The qualified nurses included the Matron and her Assistant and the Night Superintendent. This seems to conflict with Maggs' findings and if accurate illustrates at least one example of an exception to the rule of having a nursing workforce made up mainly of probationers. However, Maggs alerts us to the reliability of census data and it is possible some of the probationers listed at RHI may have lived there but actually working in either other institutions or as district nurses. The former would seem unlikely though as there was little cooperative working between institutions at this time. However, as there was a district nurse listed as living at the RHI there is a possibility some of the probationers were training in district nursing although they were usually called '*candidates*' and the HDNA was still ten years from forming.

Maggs (1983a, p.11) reported that the need for more nurses was also linked to the increasingly technical role nurses were required to play in the evolving healthcare system. He argued that this role was mainly done by probationers as qualified nurses '*did not work at the bedside*'. Therefore to increase the numbers of nurses, Maggs (1983a) suggested that recruitment to nurse training became important after 1881 and that this coincided with increased employment opportunities for women. An early local example was Adelaide Chalker who was a probationer nurse at RHI from 1886-87 (Maggs, 1983a, p. 150). Also in relation to the reform of nursing education the Lady Superintendent of Halifax

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Workhouse Infirmary, Miss Wilkie, wrote a letter to the *Times* in 1897 related to a paper she had presented at the Central Poor Law Conference in London that year. She described a scheme for a Central Poor Law Nursing Department that would include a nursing inspectorate, training schools for nurses, central recruitment, and standard conditions of examination and service. She wanted to raise the level of the Poor Law nursing service, improve the status of the nurses, and raise the whole tone of the profession (White, 1978, p. 97-98). This was a model not dissimilar from the eventual GNC structure.

By 1901 Halifax had three hospitals training general nurses and one training fever nurses, while in 1898 Huddersfield had two hospitals training general nurses, two training fever nurses, and one training district nurses. In 1901 at a Conference of Yorkshire Unions, Huddersfield participated in a scheme to approve the Training and Certification of Workhouse Nursing in Yorkshire resulting in the creation of the Yorkshire Poor Law Nursing Board (P/HU/zz/33, 1901). It is unclear if this was linked to Miss Wilkie's initiative as the Poor Law authorities had been thinking of a national scheme for possibly twenty-years before this (Dingwall et al, 1988, p. 81).

Cheap labour.

The recruitment by hospitals of increasing numbers of probationer nurses was also linked to their use as a form of cheap labour (Baly, 1995, p. 125). During this period the number of nurses and their pay increased and hospitals found this a financial burden. By opening schools of nursing they could recruit probationers who could then deliver care more cost effectively. There was also a suggestion that elongating the length of training benefited the hospital further, and allowing nurses to perform cleaning tasks reduced domestic expenditure (Dingwall et al, 1988, p. 59; Baly, 1995, p. 125). Locally there appear to have been increases in probationer numbers across the hospitals of the two towns. However, locally there was no indication of extended training in the archival sources with most of the earlier general nurse training schemes appearing to be for three years. The performance of cleaning within the local hospitals was a consistent feature of the nurse's role in both voluntary and Poor Law institutions but there was no indication that this was a cost saving exercise. The use of probationers as a form of cheap labour arguably continued for a number of years to come.

National policies.

Another issue that influenced local nursing was the need for authorities to comply with national healthcare policies such as the Isolation Hospitals Act of 1901. This and other directives created the institutions and specialist areas that nurses worked in. It is likely that in this circumstance these two towns would be in a similar position to most others in having little choice of the type of nursing done or institution it was done in. Rafferty (1996, p. 183) identified policy as an underestimated historical factor in the development of nursing and here it is recognised as having a major impact upon the local history of nursing. This suggests that in both towns government policy was one of the main drivers for change in nursing.

Gender – female nurses.

Prior to 1870 the Nightingale reforms alongside the technological medical changes such as antisepsis and anaesthesia challenged the need for a more '*scientific*' nurse (Baly, 1995, p. 124). Baly argued that the need for more nurses linked to class and was aided by issues such as late marriage, a lower

birth rate, an economic depression in the 1870s, and high male emigration. These resulted in a; '*large pool of middle class spinsters*' (Baly, 1995, p. 124). The increasing respectability that nursing was to receive allowed these women to consider nursing as an occupation aiding them to fulfil their '*Christian duty*' (Baly, 1995, p. 124). It is unclear if this occurred locally but from 1870 onwards the female orientation of nursing was an important factor in the national development of nursing, nurses, and women's occupational work, and did not change to any great degree locally until the 1940s.

In the earlier part of the time period under study male nurses were fairly common and often worked in workhouses locally as '*assistants*' caring for patients. Before 1900 there was evidence of male nurses working in general nursing scenarios such as Poor Law institutions. However, again their status, trained or not, and branch of nursing, was unclear, so some will have been working as the equivalent of mental health nurses. However, even in the late 1800s there seemed to be a different rule for the male '*nurses*' like the lunatic attendants, who seemed to be able to marry while the female '*nurses*' could not. By 1901 male nurses made up just 1.7% of the nursing population and they were restricted to an adult male only training syllabus (Rafferty, 1996, p. 82). This illustrates a form of reverse discrimination with lack of equal opportunities for men during a time of emancipation for women which is discussed later.

Whether these sorts of gender-based working relationships were exclusive to nursing is unclear as it was perhaps a unique situation. A woman working closely with men was an unusual occurrence due to the social norms of the day and strict working regulations.

The use of age and marriage bars.

Maggs (1983a, p. 19; p. 157-8) described the use of age and marriage bars up to 1914. This indicated that these bars were used by institutions and the Matrons in charge for recruiting, selecting and employing nurses. Locally they were both commonly used in Halifax and Huddersfield institutions until at least 1950 and were often supported by GNC regulations. During 1898-1933 at RHI and 1923-24 at HGH, probationer ages ranged from 19-26 years of age with the majority unmarried. The use of the age bar was suggested to prevent younger women being recruited who may not conform. It was believed that older more experienced women who had worked elsewhere would be more mature and amenable to the authoritarian regimes. Maggs (1983) suggested that the age bar was imposed for a number of reasons, one to prevent young girls being exposed to hospital life too early. As the crisis in recruitment occurred during the middle of the Twentieth Century this rule was relaxed in order to allow younger applicants into nursing. By the 1950s schools of nursing like HRI were recruiting students onto PNC to ensure they were not lost to the profession before they met the age entry requirements. It is unclear if a similar course was available at Halifax but none of the interviewees mentioned it.

The fast nurse.

Within the area of authority and discipline Maggs (1983a) described the importance of time within nursing and how it was used within the routines and practices of nursing to ensure nurses were controlled and performed efficiently. Probationers during training were identified as susceptible to dismissal if they were perceived as '*slow*' or unpunctual (Maggs, 1983a, p. 126). This approach continued in both general and district nursing confirmed in oral history testimony. The speed nurses worked at was seen as important and at RHI during 1898-1934 probationers left due to poor

performance being described as; '*Very slow does not seem able to get her work done*,' and '*Very slow and needs much supervision*' (C448/5 Addnl 1898-1919; C448/6 Addnl 1920-1933) (Appendix 8.9A). An initial probationary period allowed the hospitals to dismiss the probationers early once they had identified their potential. This process was to later be formalized by the GNC with the introduction of PTS. Another reason for dismissal listed was insubordination linked to authority and discipline. Maggs' discussion of the retention of probationer nurses once trained, and the methods hospitals used to keep them, particularly the best, were mirrored in Halifax and Huddersfield with both offering post qualifying additional training, mainly in midwifery. In 1899 Miss Wilkie, Lady Superintendent of Halifax Workhouse Infirmary, suggested it was important to have prizes and proficiency medals in theoretical and practical work (Wilkie, 1899, p. 151). HRI established an award system of medallists in 1904 agreeing with (Maggs, 1983a, p. 143) that these were used to identify and retain the best most efficient nurses. The HRI gold medal for efficiency was continued until the 1980s illustrating efficiency was still important then.

In relation to the nursing careers Maggs[13] discussed, there were examples locally of fast promotion with several nurses seemingly very quickly rising through the ranks, and at the RHI the average age of Sisters appointed during 1917-1942 was 32.33 years with a range of 24-52 years of age (C448/1 Addnl).

The concept of the '*fast nurse*' seemed to relate to '*scientific management'* philosophies of working efficiently and effectively. To be productive the nurse must be seen to be working all the time. Also, a slow nurse was seen as inefficient and they either improved upon their performance or were dismissed. Measuring nurse performance on the ability to work quickly and hard was to be a benchmark at least until 1960, and perhaps beyond locally.

Discipline.

The issue of discipline was a prominent aspect of the training and education chapter of Maggs' work describing the routines and control nurses were subjected to in order for authority and command to be maintained. He described the hierarchical nature of nursing and how this spilt over into harassment and bullying, particularly of juniors, and nurses being thrown in at the deep end (Maggs, 1983a, p. 105-6). This study confirms that within general nursing locally these behaviours continued. The content of many of the biographical extracts that Maggs used was similar to the Twentieth Century oral history extracts here. His account of the importance of etiquette and that nurses had to be of good moral character was also evident locally throughout the 1900-1960 period in both general and district nursing (Maggs, 1983a, p. 121). Also, as Maggs described, the extension of this authority into the Nurses Home and nurses' off duty prior to 1914 continued to be common practice locally until the 1950s. Furthermore, much of his accounts of the experience of probationers in the early training schools was replicated within the history of nurse education in Halifax and Huddersfield right up until 1960. Rafferty (1996, p. 4) outlines a political aspect suggesting that addressing the moral conduct of nurses related to '*reforming the moral condition of the working classes*'. She continued by stating training in hospitals was the ideal place to do this. Overall the issue of discipline was a prominent

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13 Chapter 4 in Maggs (1983a).

feature of nursing locally and it is unclear whether these institutional regimes got played out in other non-healthcare organizations in the period under review. There was no evidence found that suggested local office or mill workers were controlled in a similar way, but due to the social, cultural and managerial values of the period these workers could have been subjected to similar regimes. As the disciplinary and control elements were specific to nurses and they were one of the only groups of employees that had to '*live in*' and live under the regime for much of their off duty time, this is an important factor. There was no evidence that this was required in any other areas of work such as department stores, mills or factories in Halifax and Huddersfield. However, a different form of this was found within the textile areas where mill owners provided nearby housing for families to live in similar to the mining communities. Nurses therefore seem to have had a unique experience in relation to having some of their off duty time under the same conditions as their work time by living in.

Domestic service.

During the Nineteenth Century an example of social, political and cultural reforms that impacted on nursing and nurses was the '*ideology of domesticity*' that presupposed woman and men were naturally members of distinct spheres of society: women in the private sphere of families and men in the public world of work and business (Fitzgerald, 2000e). Nursing may therefore be seen as a way that Victorian women began to gain access to paid work. However, during this period men as well as women were providing nursing care locally. At this time the concepts of nursing and the nurse were different and issues like gender, education and the professionalisation of nursing were key issues. In West Yorkshire the percentage of females less than twenty years old working in domestic service in 1871 varied from 8.8%-10.6% and both Halifax and Huddersfield employed more women than Bradford and Leeds (Dennis, 1974-5, p. 56) (Appendix 8.2).

During 1870-1900 general nursing in Halifax and Huddersfield developed from an unstructured uncoordinated system with a workforce of mainly untrained nurses, into a more cohesive professional service provided by increasing numbers of trained nurses. This increase in local nurses seemed to support the views of Maggs that it was due in part to the increasing number of institutions and resultant beds, and the need for better trained nurses to perform the increasingly more technical care they were required to do. The increased numbers of qualified nurses was a result of the increase in training schools and numbers of probationers recruited. The increase in probationers was partly in response to the financial crisis hospitals found themselves in.

Miss Wilkie was an example of a local individual nurse who was involved in the national debate about nursing's reform, but it is unclear if she was alone or whether other unidentified nurses participated. Nursing locally reflected the majority of Maggs' theory on the origins of the general nurse, and although nursing locally was not a major player in the reform of nursing, there was evidence of improvements in the management and delivery of nursing services reflecting the national changes occurring.

District nursing.

With no studies of local district nursing available there was a need to investigate this gap in literature. The origins of district nursing in the two towns are unclear but the earliest evidence of district nurses caring for patients at home in Huddersfield was in 1885 when '*free*' nurses were valued by the poor.

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This was a long time after the first ever district nurse in 1859 (Trees, 2008). By 1890 Huddersfield had started to plan a DNA although it is unclear why it took a further seven years for HDVSNA to open. In 1891 the CNA formed binding together DNAs in rural areas and smaller towns. In Halifax in 1897 there were advertisements for '……*thoroughly well trained nurses*' for the West Riding Nurses' Association in Rhodes Street Halifax, but it is unclear what this organisation was (Nursing Record, 1897a, p. 240; 1897b, p. 404; 1897c, p. 424). In Halifax the HDNA was one of the later DNAs to form and was not the first or only one in Halifax, as in 1898 Warley Jubilee DNA had formed (D54, 1898, 6/1-7; 6/2). In fact the HDNA did not open until 1911, fourteen years after Huddersfield, and it is unclear why this was the case and needs further exploration. Within Halifax there were smaller DNAs in existence as well as the HDNA until 1948. Although the HDNA and HDVSNA were affiliated with the QNI it is unclear if the other smaller local DNAs were. Nationally there was some opposition to QNI affiliation and the use of village nurses, but these two factors do not seem to have been major issues locally (Dingwall, 1988, p. 182).

The work of the local district nurses was varied and this was similar to the work described by Baly (1987). There was an indication in 1897 that district nurses at HDVSNA assisted in operations possibly in the patient's home as described by Baly (1987. p 66).

From 1870-1900 district nursing in both towns was limited with small localized DNAs or individual free nurses providing nursing care at home. There were no examples of nursing or nurses locally contributing to the national aspects of the evolution of DNAs although the development of district nursing, albeit slowly, seemed to mirror the national scene.

Social class, the fight for registration, the war and the GNC - 1900-30.

During this period in nursing history there were four main issues that affected nursing and nurses. These were social class, the movement for state registration, the First World War and the impact of the GNC. General and district nursing will be discussed with examples of all three factors included.

Social class.

During this time period social class seemed to be an important element for nursing. Baly (1995, p. 124-25) suggested that from 1870 onwards, with the increased status of nursing and the abundant availability of middle class women willing to enter the occupation, they were to be the main stay of nursing recruitment for the '*reformed schools*' until the 1950s. This was partly because these women had no other major options for employment except teaching and the civil service (Baly, 1995, p. 124-25). This was illustrated in the way recruits increasingly began to come from the middle classes and it was often linked to the financial ability to travel. To be able to travel like this presumably meant middle class women had adequate educational and financial standing. An early example was Miss Jessie Murray who had trained at Plymouth and became the Matron of a Nurses Home in Huddersfield. This example of recruitment travelling meant local nurses were often not local women as illustrated in 1901 when the majority of the thirty-six qualified and probationer nurses at RHI had not been born locally. At HGH during 1923-24 eighty-three percent of the eighteen probationers recruited came from outside West Yorkshire illustrating a tendency not to recruit local women Appendix 8.5; 8.6). This compares with RHI figures for 1922-32 where fifty-four percent came from outside Yorkshire (Appendix 8.7).

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During the first three decades of the Twentieth Century it was clear that locally women were travelling from across the country to train or work as nurses in the hospitals and the community. During 1920-33 at RHI probationers were recruited from seven broad geographical regions;

- North East
- North West
- Scotland
- South
- Wales
- Ireland
- Yorkshire

Forty-six percent came from the Yorkshire region with thirty-seven percent coming from the other six regions with the remaining seventeen percent unknown (C448/6 Addnl). This wide recruitment net illustrates that nurses were able to travel long distances to train or work locally. It also suggests that women were able to find vacancies by methods such as newspapers, nursing journals, family connections or word of mouth. Nationally the nurse was faced with finding adequate work and there were numerous examples in the nursing press of advertisements for nursing posts locally exposing a structured recruitment strategy in operation. On the whole employment prospects for local nurses were good aided by the recruitment problems in the middle of the Twentieth Century when qualified nurses were much in need. Linked to this aspect was the eventual introduction of structured part-time jobs that allowed women in particular to combine both nursing and child rearing in the post-war era. There was no apparent need for them to attract recruits away from the large cities surrounding them with additional enticements. This suggests that recruitment was relatively stable most of the time, but it may have also been that some of the recruits had tried to get into the larger teaching hospitals and having failed tried the smaller provincial ones. Nevertheless students and qualified staff were paid hierarchical scales of pay based upon their roles and grades, and in common with national trends male nurses were often paid at different rates of pay.

Close examination of the records locally makes it difficult to ascertain the social class of the women recruited into the local institutions. But on the whole the picture that emerges is perhaps a combined recruitment sample of both low and middle class women, although the majority appear to have come from the latter based upon the limited educational and social background information available.

The fight for registration.

The debate relating to the professionalisation of nursing had been developing since the 1860s based upon the rising power of the hospitals and the gender issue of women's work, but in relation to general and district nursing there was little evidence of this in either town. The invisibility of local nurses voicing opinions on the fight for registration was an interesting and important point. Of course this does not mean they were not involved in this, but that the evidence is lacking. However, as early as 1896 there was support from Dr Dolan at Halifax Workhouse for the registration of nurses in his quest to improve patient care (Nursing Record and Hospital World, 1896, p. 170) (Appendix 5.33). It may have been that some of the unrest within nursing was because of the registration argument such as the clashes between nurses and hospital authorities in the 1870s at Birkby Fever Hospital in Huddersfield, and the resignation of five senior nurses at HGH in 1901 (Brompton, 1999, p. 6).

However, this is unclear and would need further investigation. Apart from these skirmishes there were no other examples of dissent. During the First World War the use of untrained and partially trained women as VADs to meet the short fall of nurses needed, reinforced the registration argument (Beddoe, 1989, p. 79). This was further exacerbated by the VADs being called '*Sisters*' (Abel-Smith, 1960, p. 84). Also, other conflicts between the trained nurses and VADs occurred as the pattern of duties performed by VADs evolved during the course of the war (Summers, 2000a, p. 231). As the VADs undercut the trained nurses' wages by working gratuitously or for small grants, which the trained nurses resented, they could hardly be unpatriotic or impractical and refuse to have them in the hospitals (Summers, 2000a, p. 231). But there was no evidence of these feelings locally and this needs further investigation, although the formation of the College of Nursing in 1916 was discussed at HDNA (BJN, 1916, p. 492). Views of women and work in society shifted due to the war opening up new opportunities for them to become involved in nursing. All these issues would have occurred locally as both towns played important roles in military hospital provision, however there was no evidence supporting this. Yet, there were suggested to be other factors that fuelled the registration debate such as the political and administrative post-war developments that occurred. These included sorting out the large numbers of nurses resulting from the war in relation to their grading and pay (Dingwall et al, 1988, p. 84-5). Therefore, overall there is little direct archival evidence that local nurses were involved in the registration debate to any great extent. The relative invisibility of the registration debate locally is an interesting issue and it would be useful to know if this was the case elsewhere.

The First World War.

As well as contributing to the registration debate, the First World War impacted upon nursing in other ways such as the increasing opportunities it gave some women to work in employment sectors like the textile industries which they had not been exposed to previously. It also gave opportunities for women who had never worked previously to gain employment experience. Both these opportunities allowed them to replace the men who had done the work previously.

During the war the demand for nurses meant many local women were able to work as untrained nurses stimulating some of them into full time nursing careers after the war therefore aiding local recruitment. As nurses were predominately women at this time the problem of recruiting them locally was exacerbated by competition from the worsted industry. The war also allowed some qualified nurses' frontline experiences creating turnover of staff that locally seemed to be advantageous in opening up promotion opportunities.

Signs of technological changes included in 1927 the Halifax district nurses having a car which Huddersfield nurses did not seem to obtain until the 1940s. Women driving cars at this time was uncommon giving them added experience, particularly as they were often taught how to drive for free. During the 1920s a national shortage of district nurses did not seem to be reflected in the local DNAs as no records indicated this directly. However, to counteract this shortage the College of Nursing recommended £85-120 a year for resident district nurses in 1932 but at the HDVSNA in 1939 they were still only paid £75-90 annually (Appendix 4.28).

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Both towns played important roles in the support of military casualties during the war and there was evidence of many women working as qualified or unqualified nurses making an important contribution to the war effort with some receiving military awards.

The GNC.

Following the introduction of the Nurses Registration Act in 1919 the GNC was established which was responsible for setting up a nurses register and inspecting and approving training schools (TNA, Civilian Nurses, nd). In relation to the register there was some hostility nationally about the exclusion of male nurses but this was not evidenced locally (Nursing Times, 1921, p. 508; Thompson, 1989, p. 126). However, the lack of male nurses in the records may indicate its effect and it was not until the 1930s that isolated examples of men as qualified nurses were found in West Yorkshire. After registration the continuing development of nursing locally included both towns having well established DNAs governed by the QDNI. The local hospitals started to abide by GNC directives such as establishing a PTS, employing a Sister Tutor, and applying for GNC approval for affiliated training courses. The nationalization of training courses may have improved the transferability of nurses between institutions although locally nurses still had strong institutional ties to their training hospital. After the GNC was formed the economy in Halifax was poor and the industries were in a slump (Smithies, 1973, p. 34). Evidence of the impact of this within the nursing records was limited, but it did not seem to affect nursing greatly as in 1926 the X-ray Sister at RHI earned £110 (£3,296.70 = 1925) per year, which compared favourably against the average 1924 wage for female woollen and worsted workers of £78 (Smithies, 1973, p. 140). Although comparing a qualified job with an untrained job may be questionable it does illustrate there was a difference. Women employed in the textile industries in low-income low status jobs therefore found nursing an attractive alternative. The next section describes the development of the GNC until 1960.

The GNC, Second World War, gender, the new NHS, and the motivation to nurse - 1930-60.

Local nursing history during this period was dominated by five main themes, the increasing impact of the GNC, the Second World War, gender, the introduction of the NHS, and the motivation to nurse. Baly (1987, p. 94) discussed the implications of the national economic depression upon district nursing during the 1930s but there was no evidence of this in the local DNAs. In Halifax the economic situation was poor and during 1932-38 sixty-one factories closed with a net loss of thirty-six (Smithies, 1973, p. 49). However, DNAs during this difficult financial backdrop were able to provide the district nurses with superannuation schemes in both towns, and in 1936 HGH nurses' wages were increased to match those working in similar institutions illustrating that nursing was relatively unaffected by this (County Borough of Halifax, 1973, p. 171). By 1939 in Halifax 13,680 (35%) of women were in employment illustrating the increasing reliance upon them in the workplace (Smithies, 1973, p. 143). It is unclear how many of these were nurses, but it could have been a large proportion.

There was evidence nationally that by 1939 nursing was concerned that the disciplinary regimes nurses worked under were deterring potential recruits to the profession, and that there was a need to '*relax*' some of the more petty rules and regulations. Despite this concern many of these regimes continued until at least the 1960s.

From the 1930s onwards the GNC became influential in both inspecting local hospitals, and approving or discontinuing the various nurse training schemes. Their inspection reports were powerful in ensuring the relevant hospital authorities made right any deficiencies in the provision of both nursing education and service delivery. The threat of removing a training scheme would have important financial implications for the institutions in relation to the loss of a steady stream of new recruits. The detail of these inspection reports provides an insight into how thorough the inspectors were, and that they were mainly concerned with the nurse having both suitable places to live, and adequate equipment to learn and care for patients. For district nursing the QNI played a similar role to the GNC by inspecting DNAs and producing reports. These QNI reports reflected the examples provided by Baly (1987, p. 67-8) which recorded the nurse's performance as a DNA/QNI representative both on and off duty. As Baly illustrated the local reports often commented upon the district nurse's appearance and self-management skills which were important as DNAs were voluntary organisations reliant on funds from local people and so image was vital.

The increasingly important and influential QNI/GNC inspections illustrate that during the 1930-50s there were many initiatives and changes locally. These included the opening and closing of training schools and their hospitals, affiliated training schemes, pre-nursing courses, the introduction of male nurses, and part-time working. The QNI/GNC therefore played an important part in the development of nursing during this time and reacted to governmental and professional initiatives in relation to the changes that occurred.

The Second World War.

The war coincided with a national shortage of nurses due to unattractive pay and working conditions, and this was reflected locally with nurses working hard to provide existing and emergency services. As in the First World War the profession utilized unqualified staff to support the qualified nurses. Technological breakthroughs occurred, the most important for nurses being, the introduction of penicillin and other antibiotics. The GNC curtailed some of their inspection visits and made concessions during the conflict due to the exceptional conditions. The nurses of both towns were less involved in the provision of services for military casualties than during the First World War.

The most important impact of the war upon nurses locally were the changes that occurred in the post-war period. The introduction of the Assistant Nurse role and the opportunity for part-time working were two of these. Also, removal of the age and marriage bars freed nurses and nursing from these restrictions. Baly (1987, p. 105) identified that prior to the NHS most district nurses were single, but that afterwards most were married, indicating a clear change. The other big post-war development was the increase in male nurses to the profession.

Gender – male nurses.

The emergence of male nurses into general and district nursing locally was a major change and was reflected nationally after the war. A move to support the male nurse's lot had occurred in 1937 when the Society of Registered Male Nurses was founded (Thompson, 1989, p. 143). It was reported that the Society established a; '……*Chief Male Nurses Association within the society (1948), a Nurse Tutor's Section (1948), and a Public Health Section (1950)*'. Edwards (1989) stated the Society's Student Nurses' Association had 800 members by 1949, but the eventual opening of the RCN to male

nurses in 1960 meant that the Society was gradually less used. During the 1940s male nurses were offered increasing opportunities for training in general nursing, and by 1947, district nursing (Baly, 1987, p. 105; 149). Oral history evidence suggests that far from being welcomed into the profession local male nurses were resisted and given a difficult time. The nurses' feelings towards the individual men, and the idea of male nurses, were initially hostile, although once the men had settled in (perhaps over a period of months) the female nurses seemed to accept them. This acceptance may have been due to '*having no choice*', or overcoming any fear or resentment of men doing nursing. There was certainly some evidence that the men had to '*prove*' themselves and that some of the female nurses were more than impressed with the nursing care the men delivered. The paradox of men caring, and the gender issues this creates within nursing history, is an important element. Elliott (1995) maintained that this was mainly a cultural aspect of gender based roles within society and had emerged from history as the culturally accepted role of women. The powerful caring female role made male carers a mismatch. The ingrained notion within society and nursing of the feminisation of caring as described by Elliot (1995) is perhaps one of the reasons for the resistance to male nurses locally. An interesting element of the emergence of male nurses was the concept of '*reverse discrimination*' where men found themselves a minority. The lack of training opportunities before the war, and the gender based image of the female nurse sometimes used in recruitment advertisements, tended to discourage or exclude men from entering nursing. They were also initially subjected to various forms of '*discrimination*' including limited promotional opportunities, although by the 1950s male nurses were employed in various senior posts. However, some female nurses felt the introduction of male nurses locally created some inequalities as the men were allowed to live out, get married and were sometimes paid more than them. One single example illustrates the two different gender views of the introduction of male nurses. At HGH the male nurses were seated at their own table at meal times and served first. The female nurse's felt this was unfair and that the men were given preferential treatment. The male nurses, on the other hand, could have complained of segregation from other female cohort peers.

Overall the issue of gender played an important part in the post-war era and the male nurse was apparent in the majority of the female nurses' oral history evidence. Recollections of the '*male nurse*' were initially negative, but on the whole eventually became more positive. The lack of a male voice in the oral histories is a disappointing element of the study.

The introduction of the NHS.

The changes that occurred locally relating to pre-NHS and post-NHS health developments locally were mainly found within the nurses' oral testimonies. Considering the NHS was one of the largest changes in the healthcare structure of the UK, there was little evidence of it having any major impact upon local nurses. This was surprising as it was expected to have stimulated a lot of discussion within the interviews. It perhaps reflects the point that the change did not affect the '*rank and file*' nurses as much. There were some administration and managerial changes such as opening and closing buildings, but these did not seem to affect the majority of nurses.

Following the change in 1948 most of the nurses in the fifteen local institutions were transferred into the NHS. Prior to the NHS the number of West Riding DNAs doubled with a similar increase in district

nurses, although Baly (1987, p. 105), reckoned fifty percent of them were untrained which is partly illustrated by the local DNAs who often had high proportions of candidates in training. However, the integration of DNAs into the NHS was slow as they continued with difficulty under their voluntary status, supported by financial top-ups until at least 1957 (Baly, 1987, p. 104).

The absence of any great attention to this change locally therefore must be due to the interviewee's hierarchy position confirming local general and district nurses witnessed very little change in their daily work experiences. Their matter of fact descriptions of its introduction were similar to their descriptions of antibiotics, and perhaps this is similar to nurses today who have worked through major changes, but when asked to discuss them, have no real knowledge or understanding of them. Certainly, junior nurses today sometimes have limited knowledge of the ways healthcare systems and structures function, and this may have been the case in the past. Also, it must be remembered that the NHS was not a major focus of the interview schedule and within the life story approach was just one aspect. Therefore, there could be further specific research into this area where retired nurses could be asked more specific questions about their experiences during this time.

After the implementation of the NHS there were more developments with other healthcare professions, and in 1954 a rehabilitation team with physiotherapists was created in Huddersfield (Mrs E. Galvin, Pre-interview meeting notes).

Motivation to nurse.

Individual's motivation to nurse in the earlier time understudy is difficult to prove as archival data is limited. An interesting aspect of this study in relation to the oral history interviews identified that the motivation for young women to become a nurse was often quite strong. All the interviewees described how and why they had become nurses in relation to three factors; firstly, their childhood experiences of illness and healthcare; or secondly their '*feeling*' of always wanting to be a nurse from an early age; or thirdly, playing with dolls as patients. The use of dolls was described by school children recently when discussing their perceptions of nursing (Coombs et al, 2003, p. 35; 37). These issues provide interesting aspects of gender related to nursing recruitment and the powerful impact of the stereotypical image of the female nurse. Whether these powerful motivational factors are current in today's nursing students is debatable, but Bradshaw (2001, p.93) reported that in a study of 490 student nurses, half had become nurses because of a longstanding wish, a smaller number because of a desire to help humanity and relieve suffering or, as a career that offered opportunities for '*getting on*'. The motivational factors of religion and altruism were not particularly strong reasons locally for becoming a nurse, but many nurses reported that they had a '*calling*' to become a nurse, or they had '*always wanted to be a nurse*', and wanted to devote their lives to others. Nursing therefore provided them with a vocation that fulfilled their personal needs. This '*self sacrifice*' was most powerfully demonstrated with the Pelican image on the RHI nurses badge with many nurses giving examples of its importance. Therefore, based upon the values of society during this time religion was a powerful aspect of life which was reflected within the institutions nurses worked in. Certainly during the early Twentieth Century religion seemed to be a main part of a nurse's experience, both as a student and qualified nurse, only declining during the 1950s. Senior nurses were involved in saying '*grace*' at meal times and often the Ward Sister would conduct prayers before and during a shift. This link to religion

may stem from the earlier origins of nursing in monasteries and also reflect the middle class values of society at this time. The Victorian culture would have been very strong in the first half of the 1900s and this may have been a major factor. Again, it is unclear if nurses left their training courses because of these practices, but it is possible, and some oral testimony provided examples of the strength of feeling this provoked. There was some animosity between Catholic and Church of England nurses at HRI with the former feeling marginalised and disadvantaged by not being able to attend services.

Review of how the studies methods met the research aims.

When considering the effectiveness of the study methods capacity to meet the research aims and objectives the whole methodology is important in ensuring all the aspects are covered. Within the literature review and methodology chapters there was a critique of the methods illustrating that archival and oral history sources have been used effectively within nursing history previously, particularly for local history studies. However, many studies have concentrated upon using either one or the other depending on the time period under investigation. However, using both is not unique to this study, but by doing so it raises important issues about how the researcher blends together both sets of data. It also indicates that for a large proportion of the era under study only archival data was available. Relying on available archival records was both restrictive and illuminating, but using surviving documents allowed a history of local nursing to be written with the proviso to take into account that the gaps in the stories are important omissions. Bias in hospital records could also be problematic as complaints or unusual events would generate more paperwork than the unreported daily routine events (Dingwall et al, 1988, p. 18). Therefore, when relying on one data source it was important to try to substantiate the information within individual documents by cross referencing with other documents and literature, and accurate data coding. However, the extent of records found was a surprise and led to exciting discoveries about local nurses and nursing. The duel data sets were very useful for triangulation of data and aided the authenticity and reliability of the archival and oral history elements of the study. Using both methods allowed the ninety years time period to be investigated. However, other methods could have been considered like the nurse's image in general contemporary fiction (Maggs, 1983a, p. 33).

Additional opportunistic methods were used in conjunction with the two main methods including the use of biographical and autobiographical data, and nurse's personal memorabilia like photographs.

Research aims and objectives.

The main aim of the study was to chart the general and district nurses' contribution to health care provision, and how this related to the organisation of health care facilities in Halifax and Huddersfield. The methods used allowed this aim to be met overall, although the oral history method was restricted to only part of the study, and some archival documents were closed for security reasons, leaving gaps in the data.

The seven specific objectives were met and are discussed and reviewed in relation to the methods used. Firstly, this thesis has successfully synthesized an account of the development of nursing within the two West Yorkshire towns of Halifax and Huddersfield. This would not have been possible without reference to archival sources, and the oral history component of the story was an additional source

that allowed for an individual insight into local nurses' experiences of, not just their working, but also their personal lives during the middle of the Twentieth Century. On reflection the richness and detail of this data provided an '*added value*' to the latter part of the time under study that it is believed using archival data alone would not have. For example, finding details of the interviewees in archival sources brought the documents to life and illustrated how much records do not tell us about individuals.

The second and third objectives were similar on reflection and so are addressed together to provide an analysis of the major developments and changes within local nursing, addressing the Poor Law, Municipal, voluntary and private sectors of health care provision. As these changes mainly mirrored national events relevant governing body, and regional and local authority documents, helped to see how these changes impacted upon nurses and nursing. Critical analysis of these changes has enabled a clearer understanding of the nurses' roles within these sectors and their corresponding individual institutions. The oral history source was less useful for this aspect as they were not involved in the earlier changes, and were either not aware of the changes they had lived through or decided not to talk about them. Records provided evidence of the gender issues of nursing and society linking the labour history of women and nursing. The interviewees provided firsthand accounts of their experiences of living as women and nurses during the middle of the Twentieth Century. The impact of war and technological advances were other factors which were captured within the archival records, and to a certain extent, the oral history evidence. Local retired nurses provided vivid stories of the effects of the Second World War which supplemented the archival accounts. Retired nurses who were not interviewed formally provided a great deal of data that contributed to identifying individual nurses who made important contributions to nursing locally. Other archival and oral history data allowed for cross checking of individuals details to verify names, roles and work places. Interviewees remembered not only their peers, but also senior members of the nursing, medical and administrative hierarchy allowing biographical pictures of them to be reconstructed.

The fourth objective distinguished many factors which influenced nursing and nurses including issues of gender, authority, education, technology and war, nurses' work, employment, and the institutions themselves. Rosenberg's eight areas of importance provided a framework to structure these factors allowing each one to be considered in detail. The use of Rosenberg's framework was on the whole helpful, although its strengths and weaknesses indicate it is not perfect. Within this study it was found to be flexible enough for adaptation to be made so that its use in respect of local nursing history improved. From this adaptation a new version was developed which may be of use to others in the future (Appendix 12.1).

The fifth objective was achieved by identifying individual nurses who made important contributions to nursing locally. This raised the issue of '*rank and file*' and '*elite*' nurses, and what constitutes an important contribution. Within both of these categories there were nurses who contributed greatly to the local nursing services and ultimately to patient care. Sources that aided the identification of nurses included the archives, and in particular, nursing journals. The oral history accounts also provided evidence of the important local nurses allowing biographical accounts of them to be created.

Chapter 12 – Discussion.

The sixth objective was achieved by comparing and contrasting the development of nursing in the two towns. It was important to try to ensure similar types and amounts of data sources were available, however, this was not always possible as archival documents varied because of institutional and regional factors, and document survival rates were an obvious uncontrollable factor. The oral history data was more consistent, however these also varied considerably despite using the same interview schedule. This framework allowed them to tell the stories they felt important capturing their individual thoughts and experiences. Details of institutions and individuals locally were able to be presented allowing for a detailed comparison contrasting the events and people to ensure their uniqueness was recognised. Overall the two towns had many similarities as well as having their own unique aspects, and these are discussed below.

The final objective was to evaluate oral history interviewing as a method of recording the working lives of local nurses, and this worked well providing a valuable oral history collection. The use of the life story approach intentionally captured additional data that was not used for this study and archiving this ensured it was not wasted. Examples of those areas not directly used within the study were early childhood experiences, working experiences after 1960, or their retirement. It could be argued that without the life story data there would have been a more focused approach to recording their working lives simplifying data collection, transcription and analysis. However, the opportunity to interview individuals was a 'one off' event, and because, since interviewing them, several have become ill or died, it is argued that dealing with the whole oral history data was worth the effort in order to be able to offer future nurse historians the potential to interrogate the data further. With current concerns about the 'work-life balance' for nurses it is important to consider how this was managed in the past and therefore collecting life stories allows this to happen. The oral history data provided details of the nurses' working and personal life experiences illustrating their work-life balance was poorly differentiated, which they accepted as 'how it was'. The resultant audio tapes and transcripts therefore provide a unique insight into the lives of local nurses, and as the importance of nurses as resources to nursing history has not really been capitalized upon locally, this is important. Despite numerous authors writing about the past and promoting historiographical research methods like oral history, little has been done by nurses to study the history of nursing in either Halifax or Huddersfield. The importance of utilizing nurses as resources is emphasized by the numbers of retired nurses who are now surviving longer and healthier than ever before, resulting in potentially valuable memories that may provide insights into nursing in the past. As time goes by, the age of nurses who may have the oldest memories of nursing locally increases.

The oral history method complemented the documentary evidence and helped to reduce research bias, ensured reliability and validity, and cancelled out the criticisms and disadvantages of each method (Maggs, 1983; 1996a). Data triangulation was also used for this purpose (Burns and Grove, 1993; 1995). Harrison (1973) also identified oral history data as a means of validating other data, but also that it never stands alone and must be weighed against evidence from other sources such as manuscripts (cited in Maggs, 1983).

Feminist methodology as discussed by Stanley (1993) was considered important in this research. Recognising the male interviewer may have affected the interviewer / interviewee relationship was

important (Farraday and Plummer, 1979; Hammersley, 1992; 1994; Gelsthorpe, 1992; Rickard (1998, p. 40; Grbich, 1999) all suggested interviewer/interviewee gender was an important factor. Efforts to reduce any impact of this were made by emphasising verbally, and in any written correspondence, that the interviewer was a qualified nurse. None of the interviewees explicitly objected to being interviewed by a male and the resultant interview recordings and transcripts provide evidence of the interviews friendly and open nature. It is therefore suggested that this factor was dealt with adequately and did not impede the interview process. Using an oral history approach brought three special advantages; it enabled the creation of more complex and rounded pictures of the past by documenting the lives of different people; secondly, it allowed exploration of the crucial areas of life written records scarcely touch, private family memories and life time influences which shaped the professionals lives; and thirdly, it provided opportunities to re-examine well documented historical events or activities. This emphasised the ethical responsibility of ensuring history is given back to the people whose words described it (Thompson, 2000). Placing audio tapes and transcripts in archives allows others access to the data in the future (Yow, 1994). Options related to recording, transcribing and archiving are in appendix 12.2. The interview tapes and transcripts were to be preserved for future use in the University Archives as it seemed wasteful to record retired nurses' memories and then destroy this irreplaceable data. Their important contribution was a vital underpinning philosophy of this study and they were seen as a unique historical resource holding vital information to be captured and recorded before it is lost forever. Oral history interviewing and transcription was time consuming but resulted in detailed accounts of individual nurses' experiences of local nursing. It is important however to realize that the sample was relatively small and therefore other retired nurses who were not interviewed may have provided different stories. Despite this reservation the value of oral history in reconstructing local nursing history is supported.

It is therefore argued that all the seven objectives have been met and that this thesis has achieved its aim of constructing a history of nursing in Halifax and Huddersfield and creating a unique record of this. The research questions posed on page 20 have also been addressed to fill the literature review gap in knowledge of how and why local hospital / district nursing developed within West Yorkshire.

Limitations in the methods used.

In relation to limitations of the study, on reflection there were six issues that need to be discussed. Firstly, the amount of data available was underestimated and therefore this was problematic in ensuring the study was manageable within time and assessment restrictions. Taking a ninety year span from 1870-1960 was ambitious, and although this was aimed at providing a holistic approach to local nursing the depth of study for some areas was limited. Alternative options on reflection included, focusing on shorter more specific time periods such as 1930-60 in order to generate less data and allow a more in-depth study of relevant issues. Also, investigating two towns was ambitious in relation to the amount of data available, and because nursing developments in both towns were similar this increased the chance of duplication. However, in retrospect taking two towns was advantageous as it allowed comparisons to be made. Studying two towns also duplicated the archival searching task resulting in a non exhaustive sample due to the number and size of the archives. Another ambitious

aspect of the study was the choice to study both general and district nursing. As a general nurse it was easy to defend excluding mental health, learning disability, paediatric nursing, and midwifery from the study. However, possessing qualifications in both general and district nursing, they were felt appropriate to investigate. But again on reflection this created additional data that complicated the history and duplicated some aspects of data collection and analysis.

In relation to oral history the main limitation was the lack of male nurses interviewed. This reflects the absence of men in nursing history generally, and is significant as the role of the male nurse became an important theme. This deficit should be quickly rectified if possible while individuals may still be alive.

Another limitation was data saturation as the oral history data became overwhelming, and perhaps the number of interviews conducted could have been halved, reducing transcription time and making data analysis easier, but producing the same results.

Abel-Smith (1975, p. 1) identified a lack of research into nursing techniques, skills, education, teaching and assessment of nurses, and the experience of nurses in different times, and it is suggested that this study has to an extent addressed the latter four quite well. However, the nursing techniques and skills were not covered so well and this relates to the final limitation, that of clinical care experiences which from the oral history testimonies were limited. Also, it was difficult to distinguish within the interview transcripts if some were describing the care from a student or qualified nurse's perspective. In reality it may have been a mixture because of memory problems, but it was clear only seven main 'care' themes emerged that were common to more than two interviewees. The two mentioned the most were mouth and pressure area care. These were described in detail by some and illustrate the type of care the nurses were taught at an early stage, the importance of them in relation to patient length of stay and bed rest regimes, and also, because of task allocation, they did them a lot. The methods they described were consistent with the procedures of the time and are found in old textbooks and nursing journal articles, and the pressure area care regimes were to remain similar from 1940-1960. Two other common experiences mentioned were working in operating theatre and giving out of meals. Despite these limitations it is argued the studies aim and objectives were met by a comparison of the two towns and the 1870 and 1960 local nurse.

Halifax and Huddersfield compared.

Overall comparing and contrasting the development of nursing in the two towns was relatively easy as they both had similar types of institutions and training schools. Both towns had a strong philanthropic base which allowed healthcare services to develop. Oral history testimonies described very similar stories of living in Nurses Homes, working under the strict discipline regimes, and the Matron's role. Community nursing also developed along similar lines in the two towns, although Huddersfield had a Nursing Association fourteen years earlier, and Halifax used cars first.

Both towns had affiliated training schemes between their own hospitals and with external hospitals with the affiliation between HRI and SMH being the most notable. The fever hospitals of both towns were closed over the same period eventually changing into care of the elderly units.

Chapter 12 – Discussion.

One difference was the HRIONL newsletter which the RHI appeared not to have. Also, at HRI there was a long standing Matron, whereas at RHI Matrons did not stay as long in post. Huddersfield had the main war hospital with Halifax providing auxiliary institutions. Also in Huddersfield there was a Pre-Nursing Course that was not in evidence at Halifax. Overall, in relation to the development of nursing in the two towns they had more in common than not.

The nurse of 1870 and 1960.

From 1870-1960 nursing as a profession in Halifax and Huddersfield developed considerably. The nurse of 1870 was mainly an unmarried, untrained, older woman who was unskilled and her role was akin to a domestic servant. The number of nurses, either qualified or unqualified was small, and there were a few male nurses who mainly worked as mental health attendants. The typical female nurse worked in an unorganized and unregulated health care system looking after the poor who suffered from infectious diseases or illnesses of want due to scarcity of healthy shelter, food and water. She worked in Poor Law workhouses, voluntary hospitals or in private nursing, and there was no structured district nursing provision. Her role was supervised by non-nursing managers and medical staff and she was involved in the delivery of low skilled and unscientific care. Within the workhouses she was employed by the LGB and abided by their regulations. She was mostly an uneducated woman working in an era where nursing care was vital due to the lack of vaccinations, antiseptics and antibiotics. Her working conditions and pay were poor and discipline was strict and often she had to live in hospital accommodation. There were limited if any superannuation schemes for her and limited health and safety work regulations.

Her 1960 counterpart was either a woman or man aged over twenty-one years of age who was an educated, trained and skilled nurse who had benefited from a nationally regulated scheme of training taught mainly by nurses. She was registered on the professional Nurses Register and worked in a nationally organised healthcare system. She cared for patients who still suffered from some infectious diseases although, with technological advances, she was able to administer vaccinations, antibiotics and other pharmacological treatments. Diseases of affluence and longevity of living were starting to emerge and she was involved in health educational work in relation to these. Her role was supervised by nurse managers and she was involved in the delivery of skilled and semi-scientific care. Professional post-registration developmental opportunities were available to her and some nurses worked in specialist roles such as diabetes. Her working conditions were relatively good with working hours reduced during the time period, pay increased and superannuation schemes in place. She could start a PNC at sixteen years of age and was allowed to start nurse training at eighteen. She could get married during and after training, work part-time and live out, although there were still elements of the previous disciplinary regimes. A complex professional district nursing service including multi-disciplinary members like school nurses, health visitors and midwives was in operation.

Both nurses provided services for the poor, but in 1960 other social classes were also catered for via the NHS. The nurse in 1960 was more likely to have some contact with peers from the other town as the schools of nursing started to merge.

Chapter 12 – Discussion.

Conclusion of chapter.

Many issues warranted discussion in relation to both the history of nursing locally and nationally, and the methodology. As Maggs (1983a, p.3) stated;

> '*local studies of nurse training schools and hospitals need not be antiquarian but important case-studies for the history of nursing and healthcare provisions and for the history of women in general.*'

This was based upon his premise that micro-historical events contribute to macro-historical explanations. It is asserted that this study is important as it provides the first detailed account of how nursing developed in the two towns which contributes to the body of knowledge of both local and national history of nursing. This contribution to local nursing history includes details of the social, political, cultural and professional aspects of nursing. The '*history from below*' concept was crucial as it allowed the '*rank and file*' local nurses' stories to be told. This was important as their role as part of the nursing workforce that delivered patient care in these provincial towns had been under investigated.

Throughout this study it has been argued the resources identified were rich in detail although by no means comprehensive. Archival sources were detailed and provided important documents complimented by local nurses who gave unique data about otherwise unknown perspectives. Nursing in Halifax and Huddersfield during 1870-1960 reflected many of the national political, professional, and social initiatives and changes that occurred. The reform of nursing and the fight for registration during 1870-1930, although not explicitly obvious locally, was reflected in the way nursing developed. The origins of general and district nursing occurred alongside national developments and supported many of Maggs (1983a) findings. The impact of technology and the two World Wars influenced gender issues such as male nurse and recruitment. There was evidence of probationers being used as cheap labour and that discipline and employment bars had a significant effect upon the types of women employed, and their working and private lives. Social class and motivation to nurse were two other factors that impacted upon nursing. The roles of governing bodies like the LGB, QNI and GNC were important prior to the NHS and all impacted upon nursing.

The methods used allowed the aim and objectives to be met despite the limitations of the study. Nurses received training in their institutions which was overall comparable with others around the country. There were some issues related to the employment of nurses and local textile industries, and the role of district nurses within the local geographic environment. Comparing and contrasting the development of nursing in the two towns was important to illustrate their uniqueness and how the nurse, and nursing, had changed during 1870-1960.

Overall this study of the history of nursing in Halifax and Huddersfield contributes to an understanding of nursing history as labour, and women's history.

The last chapter presents some conclusions and recommendations for future study.

Chapter 13 – Conclusion.

This study has explored the historical development of nursing and nurses in the two towns of Halifax and Huddersfield West Yorkshire. Previously there had not been much written about the nurse's role in the period 1870-1960 within the geographical boundaries and surrounding areas of Halifax and Huddersfield. Therefore this thesis provides an account of the historical development of nursing locally. The ninety year scope of this study was large and therefore by necessity some areas were considered in less detail then perhaps they would have warranted if a narrower time period had been studied. The context to the study involved a specific focus on the origins and development of general nursing. This included hospital and community / district nursing, but in order to narrow the focus the professions of midwifery, health visiting, mental health, and learning disability nursing were not directly explored. However, they were considered as required in relation to aspects of professional development and changes in nursing practice and education. It was recognized that during the time period studied major changes and developments in the roles of health care practitioners occurred and this required exploration of some of these other forms of nursing.

The contribution of ordinary men and women towards the development and delivery of nursing services within local hospitals and in the community in Halifax and Huddersfield has been addressed, and for the period under study it is argued that nurses contributed in many ways to the nursing and social history of the towns.

With the increase in the number of nurses came the need to increase the hierarchical nature of the nursing team. More grades emerged creating a complex hierarchy. Nursing was organised and delivered locally via the institutions provided and also in the community. Most institutions had Matrons or Supervisors in charge of them and issues related to pay and working conditions became more pertinent. In 1870 district nursing services were limited but by 1960 both towns had an extensive array of provision including community midwifes, school nurses, health visitors and specialist district nurses. The hospital nurse's role involved mainly providing nursing care within a highly structured disciplined environment with training courses in place to allow for a continuous supply of new nurses. Nurses were involved in, and affected by the two World Wars, and changes occurred in the 1940s including a more flexible approach to employment contracts, removal of age and marriage bars, and an increase in male qualified nurses. This latter point would have been in stark contrast to the 1870-90 period where most men had roles as unqualified nurses. Also there was an inverse role discrimination aspect of the male nurse where during the majority of the time period under study there were examples of men not being able to obtain entry into nurse training which only improved during 1930-60. The impact of the introduction of the NHS on local nurses in 1948 appears to have been relatively limited, but there were subsequent changes to both the hospital and community nurses' roles.

These factors all contribute to a greater understanding of how nursing developed and what nurses did. It also assisted in illustrating who the nurses were by providing biographical data. The use of photographic evidence enhanced this by providing visual images of not just individuals, but their surroundings and the institutions they worked in.

Chapter 13 – Conclusion.

Recommendations.

As with any study there are always issues that emerge that are unexpected, or that lead to other avenues of investigation, and this study makes eight recommendations which may be of use to future researchers studying local history of nursing. These are to;

- explore the archival sources opened for viewing since those accessed for this study.

- consider conducting further oral history interviews with other local retired nurses to investigate in more detail some of the issues addressed here.

- check the feasibility of identifying and possibly interviewing other local health care staff such as doctors to collect their stories to see what they can offer in relation to nursing history.

- contemplate the possibility of interviewing patients from the past to obtain another perspective on the nurse's view of local institutions.

- review and re-analyse the oral history audio tapes and transcripts for further data that remains untouched by this study.

- encourage others to use Rosenberg's eight areas of importance, or an adapted version, in future research so they can comment on its usefulness.

- implement aspects of nursing history into the nursing curriculum.

- explore the possibility of using the expertise of local retired nurses in teaching and learning strategies.

- investigate the history of nursing in Halifax and Huddersfield from 1960 onwards.

To conclude, this thesis is presented as an honest and comprehensive study of the history of nursing in Halifax and Huddersfield 1870-1960. It is hoped that it contributes to the body of knowledge of both the local and national history of nursing, and to wider social and political audiences.

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