

*'I must remind you that the nurse is not the doctor; that she never can be'*¹: gender and hospital nursing in 19th and 20th century England

Introduction

In the UK, nursing was and remains a gendered occupation. Within the main body of UK hospital nurses today, women make up by far the majority of the workforce, although an examination of senior roles indicates that male nurses are disproportionately represented. The assumption is made that while women fit easily into the traditional, stereotypical view of nurses as carers (emotionally and physically) they are less comfortable in 'male-type' managerial roles which require non-traditional female skills (financial acumen, decision-making and strength in character). Such explanations were put forward in a discussion on the subject in *Nursing Times* in the first decade of the twenty-first century.² To understand where these ideas come from this article will return to the nineteenth century to investigate their emergence as the professionalisation of nurses begins. It will follow their development by focussing on nursing in the voluntary hospitals of nineteenth-century Britain (which is where the 'new' nurse was born), and on the influences of contemporary ideas of gender and women's role in broader society. But it will also query whether gender alone can explain the tensions between female nurses and male doctors and managers which became obvious as the century progressed. Instead this article will suggest that some of those tensions originated as a result of the social class of the reforming nurses, who being of at least equal status in society to their male colleagues, threatened to overturn the natural order of things.

History of hospitals and nursing

Nursing does not exist in isolation of place, and in addition to the influence of nineteenth-century gender norms and ideals, it was also shaped by the places it was practised in.³ It was in the nineteenth-century hospital that the idea of the 'modern' nurse was incubated and developed. But the influence was not one-way, hospitals shaped nursing but the changes in nursing which emerged during this period also shaped hospitals.

Hospital histories are often silent on the nurses in their midst. Early histories of British hospitals, rather like early histories of nursing, tended to be Whiggish⁴ in their presentation,

¹ Charles West, *How to Nurse Sick Children* (London: Longman, Brown, Green and Longmans, 1854), 16.

² 'Why Are There So Few Men in Nursing?', *Nursing Times*, 3 March 2008. <http://www.nursingtimes.net/why-are-there-so-few-men-in-nursing/849269.fullarticle>. (Accessed online, 6 June 2016).

³ The influence of gender on nursing in the nineteenth century has not been a popular subject among gender historians. Key contributions to the debate include: Amanda Vickery, 'From Golden Age to Separate Spheres?: a review of the categories and chronology of English Women's History' in P. Sharpe, ed, *Women's Work: the English experience, 1860-1914* (London: Arnold, 1998), 294-322; Martha Vicinus, *Independent Women: work and community for single women 1850-1920* (London: Virago, 1985); Eva Gamarnikow, 'Nurse or Woman: gender and professionalism in reformed nursing, 1860-1923' in P. Holden and J. Littleworth, eds, *Anthropology and Nursing* (London: Routledge, 1991), 110-29; and Jeanne Petersen, *Family, Love and Work in the Lives of Victorian Gentlewomen* (Bloomington: Indiana University Press, 1989).

⁴ Whig history is a (pejorative) term used to describe an approach to writing history which presents the past as an inevitable progression towards the modern day. The term was coined by British historian, Herbert Butterfield in his book, *The Whig Interpretation of History* (1931).

focussed on individual institutions, often written to celebrate anniversaries and concentrating on the great and the good among the doctors who worked there.⁵ Nursing, when mentioned, was usually discussed in similar terms to the hospitals themselves, as a story of a gradual emergence from the Sairey Gamps to the enlightened Nightingales. As Lindsey Granshaw has commented, 'Hospital histories tend to focus on medical staff and it is sometimes difficult to detect that were actually were patients – or any other staff besides doctors'.⁶

Brian Abel-Smith's, *The Hospitals, 1800-1948*, published in 1964, marked a significant step-change in the history of the hospital. It was one of the first systematic analyses of the development of hospitals in Britain, from the beginning of the nineteenth century to the launch of the National Health Service (NHS) in 1948. Like his work on the history of nursing, this has become an iconic and still influential book and a required read for anyone interested in the pre-history and origins of the NHS. For the first time, a history of hospitals considered the place of nursing in this history. Improvements in nursing, he said, were the result of a subtle shift in the purpose of voluntary hospitals during the first half of the nineteenth century; a transformation from sites caring primarily for the chronically ill to a focus predominately on more acute cases.⁷ Abel-Smith considers in some depth the reasons for this significant shift in patient populations, which he assigned in part to the need for hospitals to demonstrate effective use of their supporters' money, something easier to do with short-stay acute cases.⁸ Developments in medical knowledge were also probably at play here, as physicians, and particularly surgeons, became more confident in their ability to not just manage illness but to affect cures. As Henry Burdett put it in one of his many volumes on hospital management, the best conducted hospital was one that treated 'the greatest number of patients, in the fewest possible beds, at the smallest actual cost, in the shortest possible time'.⁹ For the hospitals, while such a performance might lead to more uplifting statistics in the annual reports, it most certainly also meant more pressure on their staff. Acutely ill patients required more care than the chronically sick; and their condition, being less stable, needed more frequent monitoring by intelligent and trained observers.¹⁰ According to Abel-Smith this responsibility fell to nurses, and was one of the main incentives to improve the quality of nursing departments. He never asked why these new tasks should fall to female nurses.

⁵ Geoffrey Rivett, 'Hospital Histories', *Social History of Medicine*, 1993, 6 (3), 429-37.

⁶ Lindsay Granshaw and Roy Porter, *The Hospital in History* (London: Routledge, 1990), 1.

⁷ Brian Abel-Smith, *The Hospitals, 1800-1948* (London: Heinemann, 1964), 44-5.

⁸ Throughout the nineteenth century voluntary hospitals in Britain (with the exception of Guys, St Thomas' and St Bartholomew's which had endowments) were funded entirely through charitable donations. The 'state' hospital sector (the workhouse infirmaries and the insane asylums, and later the fever hospitals) received their funding through local poor law rates.

⁹ H.C. Burdett, *Hospitals and Asylums of the World, Vol 3.: Hospitals – History and Administration* (London: J&A Churchill, 1893), 138-9. Burdett was one of the most authoritative voices on hospital management in the latter decades of the nineteenth century (and well into the twentieth). For a brief biography of Henry Burdett see Frank Prochaska, 'Burdett, Sir Henry Charles (1847–1920)', *Oxford Dictionary of National Biography*, Oxford University Press, 2004; [<http://www.oxforddnb.com/view/article/38827>, accessed 8 July 2016].

¹⁰ Carol Helmstadter, 'Early Nursing Reform in Nineteenth-Century London: a doctor-driven phenomenon', *Medical History*, 2002, 46, 325-50.

Abel-Smith undoubtedly stimulated a number of historians to ask different questions about the development of hospitals in Britain, and although it took another thirty years, in the 1990s a number of works were published which examined nineteenth-century hospitals from different perspectives. Most prominent of these were Geoffrey Rivett's study of the development the 'London Hospital System', Frank Prochaska's investigation of philanthropy and the hospital sector and Kier Waddington's analysis of the notorious dispute at Guy's Hospital between its doctors and managers regarding a new nursing system.¹¹ This dispute is probably now overused, being selected repeatedly as a case study of the relationship between nurses, doctors and hospitals by historians of hospitals and of nursing.

For a while hospital histories turned to focus on their finances, exemplified in Waddington's *Charity and the London Hospitals*, and perhaps not unsurprisingly given his previous interest in nursing at Guy's, he turned his attention to the role of nursing in hospital finances. By the late nineteenth-century hospital finances were under increasing pressure, partly as a result of their growth in size, but also as a result of developments in medical science. In this latter category, Waddington identified particularly the cost of anti-septic working, surgical innovations and changes in nursing systems.¹²

From an historian of nursing's point of view the Guy's dispute exemplified the opposition nursing reforms faced from the medical profession; a group whose own professional status had only relatively recently been assured through the Medical Registration Act of 1858. In fact, Arlene Young has suggested that the professionalisation of nursing held a mirror to the surgeons' progress: from rough, semi-educated practitioners in the late eighteenth century more associated with manual than cerebral dexterity, to a Royal College with the ability to award higher qualifications in 1843. Surgeons were acquiring similar status to their counterparts, the physicians; and they guarded their newly acquired status within the pantheon of the medical profession jealously. According to Young, the 'new' nurses focus on education and their fight for professional recognition, coupled with the middle-class status of the women who formed this 'new' class of nurses, could be considered by medical men as on a par with that of the surgeons before them. Before long they too would be clamouring to be considered alongside the exulted physicians.¹³

Waddington sees the dispute at Guy's as an important event in the history of the medical profession, rather than professional nursing. The incident revolved around objections by the medical staff to the introduction, without consultation, of a new system of nursing, headed by a matron trained by St John's House sisterhood. Controversially, the matron was to have

¹¹ Frank Prochaska, *Philanthropy and the Hospitals of London, 1897-1990: the King's Fund* (Oxford: Oxford University Press, 1992); Keir Waddington, 'The Nursing Dispute at Guy's Hospital, 1879-1880', *Social History of Medicine*, 1995, 8 (2), 211-30; Geoffrey Rivett, *The Development of the London Hospitals, 1823-1982* (London: The Kings Fund, 1986). Rivett's work was originally published in book form, but some years ago was made available online by the author, who reviews and updates it periodically. The most recent update was March 2015; www.nhshistory.net/Londonshospitals.htm (Accessed online, 8 July 2016).

¹² Keir Waddington, *Charity and the London Hospitals, 1850-1898* (Woodbridge, Boydell Press, 2000).

¹³ Arlene Young, 'Entirely a Woman's Question?: class, gender, and the Victorian nurse', *Journal of Victorian Culture*, 2008, 13 (1), 18-41.

full control of nursing staff, reporting directly to the Hospital management. The combination of these new powers, combined with her background in a religious nursing order (which were regarded with great suspicion in some quarters) was seen by the doctors as a direct affront to their authority. The dispute was drawn out and vindictive, fought in a blaze of publicity through the pages of newspapers and medical journals. It ended with the resignation of several of the medical staff and the vindication of the matron. This case is usually presented by historians of nursing as a victory for the new system of nursing (and for nursing sisterhoods); but Waddington takes a different perspective. Although the new system of nursing was introduced (albeit in a somewhat modified form), in return for their accommodation of the new system, the medical staff who survived were able to negotiate seats on the management board for the first time. As a result, Waddington sees this as a chapter in the history of the medical profession, one in which doctors were able to gain 'a formal role in the Hospital's management that ultimately extended their authority'.¹⁴

Certainly, arguments against the new nursing system were often about the cost of such innovations. The new matrons (or lady superintendents as most preferred to be called) set high standards, agitating for improved nurse:patient ratios and for better working conditions for their nursing staff - more time away from wards, higher wages (especially to reduce turnover in staff), more comfortable accommodation and better food, both in terms of quality and quantity.

Guy's was not the only hospital where the introduction of lady nurses raised objections. Many attempts have been made to explain what appeared to be a great antipathy towards and suspicion of lady nurses from both medical men and hospital administrators; and the over reliance by historians on the Guy's dispute to answer such questions has not helped. Some ten years earlier, a similar drama was being played out at St George's Hospital in London, although in this case without the accompanying blaze of publicity. Again, the dispute arose following the appointment of a 'lady' superintendent, Zepharina Veitch, after protracted discussions about how to improve the quality of nursing at the hospital. Miss Veitch came immediately into conflict with the Weekly Management Board, which in St George's case did include members of the medical staff. In circumstances which were to be echoed in the Guy's dispute, she was accused of trying to introduce a sisterhood into the hospital and to be 'ritualistically inclined'. The Board made it clear that such sentiment was not acceptable, using arguments employed several years earlier, when a proposal to give the nursing of the hospital to St Peter's Sisterhood was defeated.¹⁵ On that occasion the Board cited the '[doubts and apprehensions] which may exist [among its supporters] as to the

¹⁴ Waddington, 'The Nursing Dispute at Guy's', 211. For a detailed exposition of the dispute from a nursing historian's point of view, see Judith Moore, *A Zeal for Responsibility: the struggle for professional nursing in Victorian England, 1868-1883* (Athens, Georgia: University of Georgia Press, 1988). For an alternative interpretation of the dispute at Guy's and of another dispute between St John's House Nursing Sisterhood and Kings College Hospital see Judith Moore, *A Zeal for Responsibility: the struggle for professional nursing in Victorian Britain, 1868-1883* (Athens, Georgia: University of Georgia Press, 1988).

¹⁵ Given this clear distrust of nursing sisterhoods, Miss Veitch's appointment was perhaps a surprising move - as with the matron at the centre of the Guy's dispute, Miss Veitch had been trained by the St John's House Sisterhood. Sue Hawkins, *Nursing and Women's Labour in the Nineteenth Century* (Abingdon: Routledge, 2010), 61.

adoption in a Hospital supported by voluntary contributions of such an experiment ...', incidentally also illustrating the similarities between charity and business: the need to keep donors/customers happy.¹⁶ However, perhaps just as importantly as the suspicion of Veitch's religious motives, the Board was concerned about the cost of the reforms she wanted to introduce. One of the frequent charges against lady superintendents (and sisterhoods) from hospital managers was that they would push costs up, demanding superior forms of accommodation for themselves and their nurses.¹⁷ Certainly, while Miss Veitch was at the hospital (only a short nine months), she had insisted on significant improvements to her own rooms and an assistant to help her, and recommended an increase in the size of the nursing department. For her nurses she demanded more time off, better meals and a room set aside for their recreation.¹⁸ Veitch's main confrontation appeared to be with the apothecary rather than the hospital's medical staff, providing more evidence of a gendered dispute between the 'new' nurses and any men who happened to be in authority, be it male management committees, the medical staff, or in St George's case, the apothecary.

Women in society

The 'new nurses' referred to above had arrived in hospitals as a result of the work of nurse leaders such as Ethel Fenwick to improve the class of nursing.¹⁹ Fenwick and her supporters believed that if nursing was to be transformed into a profession of standing, alongside medicine, it should be undertaken by women of good character and social standing, by definition therefore, by middle-class women. As a result of their social standing, and the authority thus entrained, such women (who were often referred to as lady nurses to differentiate them from the body of working-class ward nurses) were in a position to influence the running of the hospitals they worked in.²⁰

Socially elite women were challenging accepted social roles for women in Victorian society in a variety of settings, and lady nurses were bringing such challenges directly into the hospitals, which were bastions of male authority. Although the traditional view of Victorian women was one of constraint, restricted in influence to the home and to the domestic sphere, many historians have challenged this, particularly since the late twentieth century.²¹ Amanda Vickery, for instance, claimed that the ideology of domesticity was in fact a

¹⁶ St George's Hospital Weekly Board (SGHWB)/33, 21 March 1866. The proposal to introduce a sisterhood was rejected. Hawkins, *Nursing and Women's Labour*, 58-62.

¹⁷ See Waddington, *Charity and the London Hospitals* or Janet Likeman 'Nursing at University College London, 1862-1948'. Unpublished doctoral thesis, University College London, 2002.

¹⁸ St George's Hospital Committee for Nursing (SGHCON)/1, 1 March 1869.

¹⁹ Florence Nightingale, the woman most closely associated with the introduction of 'new' nursing, was less convinced by arguments about class. She believed solid working-class 'girls' made the best nurses, but maintained that only educated middle-class women were capable of the strong leadership required in nurse managers (eg matrons). Christopher Maggs, *The Origins of General Nursing* (London: Croom Helm, 1983); Brian Abel-Smith *A History of the Nursing Profession*, (London: Heinemann, 1960).

²⁰ Much has been written about social class and nursing in the latter decades of the nineteenth century and the infiltration of nursing by middle class women. Most such work tracks the transformation of nursing into a middle class occupation, although see for instance Hawkins, *Nursing and Women's Labour* for a more nuanced investigation of the class structure of nursing at this time.

²¹ See for instance: Vickery, 'From Golden Age to Separate Spheres?'; Vicinus, *Independent Women*; Gamarnikow, 'Nurse or Woman'; and Jeanne Petersen, *Family, Love and Work*.

rhetorical device, used to counter a perceived increasing participation of women in public life.²² Eva Gamarnikow has also argued for a less constrictive interpretation of the ideology of domesticity and femininity, and used nursing as a case in point. She claims nurse leaders deliberately emphasised feminine qualities inherent in caring for the sick, to define an occupation specifically for women. Gamarnikow, unlike historians of nursing, sees this as an enabling strategy rather than a limiting or restrictive move; women using their gender and ideals of gendered spaces to create an occupation for themselves.²³

Kathryn Gleadle, however, has warned against reducing the separate spheres ideology to nothing more than proscriptive rhetoric. A much more nuanced interpretation by historians was called for, she argued, in which the rhetoric is balanced alongside lived experiences. Definitions of the various spheres into which the world was divided, in her view, were fluid and personal; hence it was possible for nineteenth-century feminists to be both campaigners for women's rights and to espouse a version of 'separate spheres'.²⁴ And the ideology has received further challenge from studies of women's engagement in the political sphere, in which the rigid gender divide between public and private is queried.²⁵ Indeed, Sarah Richardson goes so far as to argue that the 'separate spheres' construct was never as clearly delineated as historians have assumed. Rather, she argues that the dividing lines between the spheres was always vague and very permeable, and that if one looks beneath the rhetoric of the era evidence can be found of many women engaged in political activities or in civic roles.²⁶ Such studies use examples of women in wide-ranging roles, such as workhouse or school inspectors, local councillors, Poor Law guardians, in philanthropic societies and reforming associations.²⁷ It is disappointing that none have followed Gamarnikow's example of twenty years ago to include the role of nursing in the creation of another female space from which women could influence and define the public sphere.

Feminising Hospitals

Current work on middle-class women is pointing to them taking up increasingly active roles in a range of public activities, and when considered in this light their move into nursing should not be surprising. However, significant cultural barriers did exist which had to be negotiated before such women could successfully insinuate themselves into the Victorian hospital system.²⁸ The integration of middle-class women into voluntary hospitals, domains

²² Vickery, *Independent Women*, 300.

²³ Gamarnikow, 'Nurse or Woman'.

²⁴ Kathryn Gleadle, 'Our Several Spheres': middle-class women and the feminisms of early Victorian radical politics' in K. Gleadle and S. Richardson, eds, *Women in British Politics, 1780-1860: the power of the petticoat* (Basingstoke: Palgrave Macmillan, 2000), 134-52.

²⁵ See for instance, Simon Morgan, *A Victorian Woman's Place: public culture in the nineteenth century* (London: Tauris Academic, 2007) or Megan Smitley, *The Feminine Public Sphere: middle-class women and civic life in Scotland, c. 1870-1914* (Manchester and New York: Manchester University Press, 2009).

²⁶ Sarah Richardson, *The Political Worlds of Women: gender and politics in nineteenth century Britain* (London and New York: Routledge, 2013).

²⁷ Smitley, *The Feminine Public Sphere*.

²⁸ 'Insinuate' describes this process beautifully. Carol Helmstadter has argued that sisterhoods, for instance, used vocation as a convenient cloak, providing a degree of invisibility which helped to maintain respectability and reduce the threat to doctors, which the presence of middle class women in

of male power as they were, created greater challenges perhaps than their involvement in other civic institutions.²⁹ Unlike workhouse visitors or school inspectors, middle-class nurses would not only work in but live in the institutions they served. Hospitals were the epitome of everything that was dangerous in the public sphere for women, with their close association to business (they had to be run like businesses) and by the very nature of their patients (working-class and therefore morally suspect).³⁰ Visiting for brief supervised periods was one thing, working and living in them was quite another. So if this ideology was ingrained, how did middle-class women manage to break into hospitals at all?

Gamarnikow has argued that unwilling or unable to challenge the prevailing culture directly, instead nurse leaders embraced it, constructing within hospitals one of Ann Digby's borderlands - female spaces in public society created through women's charitable and philanthropic work.³¹ Such an interpretation sits comfortably alongside the reinterpretation of separate spheres discussed above. In the context of hospitals, it is therefore hardly surprising that middle-class women should seek greater involvement in these public institutions, where they could dispense both practical and spiritual care of the sick poor.

In order to facilitate this transition, and to ease themselves into the alien environment of the hospital, nurse leaders (and members of the medical profession who supported them – and this was not unanimous) used family metaphors to render the hospital a safer place for middle-class women. The doctors and (male) managers were fashioned as the father or patriarch; the matron and her nurses, the mother, providing succour, care, compassion AND obedience; while the patients were the children (who being placed in this position relative to the nurses rendered them sexless and therefore much less a threat to their modesty).³² The hospital thus became an extension of home, which was neither strictly public nor completely private.³³ Thus nurse leaders were able to create a niche in the complex world of Victorian hospitals into which women could insert themselves, creating a discrete feminine enclave at the heart of the male bastion. Jose Harris, as Carol Helmstadter above, has argued that whenever women moved into public life, be it in hospitals, local government, on school boards, or as teachers, they were obliged to cover 'themselves, to a quite exaggerated degree, with modesty, propriety and other outward trappings of femininity'.³⁴

hospitals might otherwise have caused. Carol Helmstadter 'A Real Tone: professionalizing nursing in 19th Century London' *Nursing History Review*, 2003,11, 3-30;

²⁹ Anne Witz, *Professions and Patriarchy* (London: Routledge, 1992); Anne Summers, *Angels and Citizens: British women as military nurses, 1854-1914* (London: Routledge and Kegan Paul, 1988).

³⁰ The resemblance of large charitable endeavours (including voluntary hospitals) to commercial enterprises has been commented on before, by historians such as Ann Borsay and Martin Gorsky in *Patterns of Philanthropy, Charity and Society in Nineteenth-Century Bristol* (Royal Historical Society Studies in History New Series, Woodbridge)

³¹ Gamarnikow, 'Nurse or Woman'; Anne Digby, 'Victorian Values and Women' in T. Smout, ed, *Victorian Values* (Oxford: Oxford University Press, 1992), 195-216. In the early days of 'lady' nurses most offered their services on a voluntary basis – thus avoiding the taint of paid work and accusations of involvement in 'business'.

³² Frank Prochaska, *Women and Philanthropy in Nineteenth-Century England* (Oxford: Clarendon Press, 1980).

³³ Digby, 'Victorian Values'.

³⁴ Jose Harris, *Private Lives, Public Spirit: Britain, 1870-1914* (London: Penguin, 1993), 26.

This strategy was effective as middle-class nurses became more common and 'ladies' began to take control of nursing departments which had previously been composed of a disorganised crew of semi-servants (albeit often very experienced), instructed and controlled by the doctors who 'owned' the wards they worked on. But in doing so did they make compromises which would have far reaching effects on future development of nursing as a profession? To Florence Nightingale (and other nurse leaders), a good nurse was first and foremost a good woman, the two becoming so intertwined as to be inseparable. According to Ann Witz, Nightingale employed such gendered discourse to create a space which could only be occupied by women. Training was overwhelmingly concerned with building good moral character and femininity; how a nurse conducted herself was more important than what a nurse did.³⁵ Thus the qualities which defined a good middle-class Victorian woman came to embody a good nurse, and because a good nurse was thus constituted as a good woman, this precluded men from nursing. In fact, according to Nightingale, men should not be permitted to interfere with the running and organisation of nursing at all:

It is quite, quite impossible (and it is not only my experience but that of all Christendom) for the discipline, the internal management of Sisters and Nurses to be in any other hands but those of one female Head. No man can or ought to interfere with it. Nothing but indiscipline can ensue.³⁶

In this she was less successful, and doctors in many hospitals infiltrated nursing committees.³⁷

But, good women were not born good nurses, and leading nurse reformers (Nightingale, Eva Luckes, Ethel Fenwick as examples) all agreed that women needed training to bring out the best nurse in them, even if they disagreed about much else. Catherine Wood (Lady Matron at the Great Ormond Street Hospital from 1869-1879) particularly stressed this need, regretting that 'unfortunately, a woman's education is not calculated to induce in her mind the power of accurate thought and of concentration on one subject'.³⁸ While training

³⁵ Ann Witz, *Professions and Patriarchy*.

³⁶ Florence Nightingale, unpublished letter to Mary Jones, 8 Jan 1867. Nightingale Training School Papers, quoted in Vicinus, *Independent Women*, 94.

³⁷ Helmstadter, 'Early Nursing Reforms'. In eight of the twelve London teaching hospitals in Helmstadter's study, doctors played a leading role in the running of their hospitals. Carmen Mangion also identified similar situation in her study of the Deaconess Hospital at Tottenham in north London, in the late nineteenth century. The management of this institution had originally been shared between the founder Michael Laseron and a Deaconess superintendant. On the death of Laseron, and under pressure from the Charity Commission, the management of the Institution was restructured. The position of Deaconess Superintendent was abolished, to be replaced by a Superintendent of Nurses who would be appointed by and reported to the Medical Committee. As a result, the superintendent of Nurses lost most of her authority, even in the running of her nursing department. As Mangion explains, the Tottenham hospital had 'transitioned to the more secular model of the medical marketplace ... gendered male'. Carmen Mangion, "'No nurses like the deaconesses?'" Protestant deaconesses and the medical marketplace in late-nineteenth-century England' in Suzanne Kreutzer and Karen Nolte (eds), *Deaconesses in Nursing Care: International Transfer of a Female Model of Life and Work in the 19th and 20th Century* (Stuttgart: Franz Steiner Verlag, 2016), p. 179.

³⁸ Catherine J. Wood, *A Handbook of Nursing for Home and Hospital* (London: Cassell & Co., c.1878), 2.

included instruction in elementary medical sciences, it also (if the nursing manuals are to be believed) focussed on teaching the nurse to understand her position in the hospital hierarchy.³⁹ Training manuals and nursing handbooks often began with a chapter on the Nurse's responsibilities to her patients and to the doctors, and included a warning to remember one's place in the institution, keep one's opinions to one's self and to conduct oneself with decorum at all times. In *A Textbook of Nursing*, the author stated, 'To the doctor, the first duty [of a nurse] is that of obedience – absolute fidelity to his orders, even if the necessity of the prescribed measures is not apparent to you'.⁴⁰ It is clear that in order to negotiate their space within the hospital walls, nurses were required to give up all claim to authority – even if socially (in class-ridden Victorian England) many of these women were the doctors' superiors.

Catherine Wood missed no opportunity to remind nurses of their place in hospital society: '[although] she must be often be tempted [as a result of her education and training] to cavil at the plan of treatment adopted, more particularly if it interferes with the comfort of her patient ... a nurse must remember that her place is to obey.'⁴¹ Dr Octavius Sturges (physician to Westminster Hospital and the Great Ormond Street Hospital) put it more bluntly: 'The nurse [should] remember that, like a soldier, her ruling characteristic should be obedience ... self reliance, however valuable a quality, should never shove obedience out of the way.'⁴² The characteristics of the ideal nurse were listed in article after article and book after book and always included a mixture of the following: sympathy, tenderness, long-suffering, serene, modest, selfless, neat, clean ... and with definitions of the ideal nurse thus ingrained with all the qualities so closely associated with the ideal woman, it was clear that a good nurse could never be male.⁴³ Furthermore, in many eyes (although in this case not necessarily Nightingale's) it also precluded large swathes of working-class women, whose characters were tainted by proximity to poverty, from becoming good nurses.⁴⁴

However, the problem of finding enough middle-class women with a strong enough vocation to undergo the privations of a nurse's life led nurse leaders to modify their objectives to a certain extent: and in many hospitals (especially the large teaching hospitals in London) women from the lower levels of society continued to be trained as nurses. In most, however, they were kept firmly in their place, never allowed to progress to positions of any authority.⁴⁵ Ann Bradshaw has argued that the many references to Christian virtue and

³⁹ Nursing manuals can provide valuable insight into the development of the 'modern' nurse in the late nineteenth century, but should be used with the same critical appraisal as applied to etiquette manuals of the period. Shaun Nichols, *Sentimental Rules: on the natural foundation of moral judgement* (Oxford: Oxford University Press, 2004), 130.

⁴⁰ Clara Weeks-Shaw, *A Text-book of Nursing* (London and New York: Edward Arnold, 1897), 6.

⁴¹ Wood, *A Handbook of Nursing*, 2.

⁴² 'Nursing Echoes', *Nursing Record*, 29 January 1891, 53.

⁴³ See for instance: Robert Dingwall, Anne Marie Rafferty and Charles Webster, *An Introduction to the Social History of Nursing* (London: Routledge, 1988).

⁴⁴ Noel Parry and Jose Parry, *The Rise of the Medical Profession: a study of collective social mobility* (London: Croom Helm, 1976), Chapter 8, 162-85.

⁴⁵ For instance at King's the matron stated, 'No woman can be a sister here who is not a 'gentlewoman born'', Charles Booth Archive B153, 82, and at St Thomas', 'All the sisters ... are 'specials' [ie paying probationers] ... Gentlewomen keep up the tone of the ward'. Charles Booth Archive B153, 178.

religiosity which she found in the nursing textbooks is evidence of a strong Christian vocation underpinning nursing in the second half of the nineteenth century.⁴⁶ But it is also plausible to interpret this as a reflection of the need to instil middle-class virtues into raw recruits who lacked such character on entry to the hospital: that nurse training existed not only to inculcate skills and techniques, and a basic understanding of medicine, but also served to teach working-class women how to behave more like their middle-class sisters.

Having established nursing as being synonymous with middle-class womanhood, and the relationship of a nurse to the doctor (and also to the male hospital managers) as equivalent to a good middle-class wife's relationship to her husband, nurses also had to accept the constraints on her authority which accompanied it.

Doctor-imposed boundaries of nursing

Why were hospital managers and doctors even interested in admitting educated middle-class women into their hospitals? There was an obvious need for women in hospitals to do 'women's work', such as washing (patients and linen), scrubbing, making beds, cooking, keeping the place tidy and 'tending' to the patients. The 'old style' rough and ready nurse-cum-housemaid already occupied this role. Why imagine that a new kind of 'higher' nurse was required?

In the early days of reform, such tasks as above constituted the sum of a nurse's job; a nurse did not handle equipment, or make close observation of a patient's condition, this was the role of the dressers and medical clerks (trainee doctors) who roamed the wards when their superiors were absent.⁴⁷ As Arlene Young has argued, 'medical students gained practical experience in patient care working as clinical clerks or dressers', taking temperatures, administering medicines and changing dressings.⁴⁸ This work, recognised as a type of 'higher' nursing care, was within the medical students' realm, and on surgical wards a medical student learned 'in great measure how to nurse' through difficult surgical cases which tested his 'ingenuity and nursing skill'.⁴⁹ At Guy's, Dr Moxon argued that such tasks should never be given to nurses as it was a critical part of medical training.⁵⁰ Historians (and contemporary commentators) have argued that it was the increasing demands of scientific and technical medicine which led doctors to call for a new body of well educated nurses, and that women responded to this need because the role now offered something more than simple nursing.⁵¹ But if such work was regarded as good grounding for medical students, why was the response to this demand not to increase the number of medical students on the wards?

⁴⁶ Anne E Bradshaw, 'Gadamer's Two Horizons: listening to the voices in nursing history', *Nursing Inquiry*, 2013, 20 (1), pp.82-92.

⁴⁷ Young, 'Class, Gender and the Victorian Nurse'.

⁴⁸ *Ibid.*, 20.

⁴⁹ 'Leader', *Guy's Hospital Gazette*, July 1877, 78, quoted in Arlene Young, 'Entirely a Woman's Question?', 20.

⁵⁰ Young, 'Entirely a Woman's Question?'

⁵¹ See for instance, Helmstadter, 'Early Nursing Reform'.

Anne Marie Rafferty and Mary Poovey have both suggested that the reason behind this willingness to permit women to take on work previously the domain of student doctors lay in the medical profession's inbred fear of competition.⁵² One of the characteristics of any profession is the practice of controlling access to its specialist knowledge by limiting the numbers allowed to qualify.⁵³ Medicine in the second half of the nineteenth century was no different. If the demand for more intensive (or 'high') nursing was growing, to respond by increasing the number of medical students was a recipe for disaster. More students meant more qualified doctors, and an excess of practitioners would place pressure on the market, generating competition for the lucrative patients. Rafferty and Poovey postulate that female 'non-medical' attendants were the more attractive option as they were much less of a threat and, if well trained in skills and obedience, could actually bring great benefits, without threatening the status quo.⁵⁴

While these arguments are powerful, perhaps there are also other influences at play. The science of medicine was developing alongside the Victorian obsession with measuring and recording. Hospitals, according to Foucault among others, became vast observatories of disease, where every detail and nuance was observed and recorded.⁵⁵ Surgery, from being performed in only dire need, was becoming common place, and surgeons were now able to open up the body cavity to perform complex internal surgery. Recipients of such procedures required special care in the immediate post-operative period, especially in wound dressing and constant monitoring in the critical first hours. When such surgery was in its infancy, these tasks were undertaken by the dressers and medical clerks, as discussed above. But as operation lists grew, and with medical schools reluctant to take on more students, the presence of a well-trained but subordinate and obedient non-medical assistant began to appear attractive. It seems likely that doctors were quite relieved to transfer some of the more routine tasks to these new 'helpmeets'.

Dr Charles West summed up doctors' views on the ideal nurse, linking their characteristics inseparably to those of an ideal woman, but he then continued, 'the nurse [also] needs an amount of technical skill which is gained by long practice, and which the doctor has no leisure to acquire ... and lastly the knowledge enough of disease to carry out intelligently the directions received'.⁵⁶ Note the clear categorisation here of nursing as a skill, which can be learnt through practice alone, rather than an intellectual (or male) activity, which needs years of study. He continued in the same tone: '[Nursing] is routine and somewhat dull ... it calls for nimbleness of hand ... gentleness and patience, implicit obedience, but it does not give scope for the higher powers of the mind'.⁵⁷ Perhaps in this short sentence he sums up why doctors were willing to permit these women a limited access into their world.

⁵² Mary Poovey, *Uneven Developments: ideological work of gender in mid-Victorian England* (London: Virago, 1989); Anne Marie Rafferty, *The Politics of Nursing Knowledge* (London: Routledge, 1996).

⁵³ Ann Witz, *Professions and Patriarchy*.

⁵⁴ Anne Marie Rafferty, *Politics of Nursing Knowledge*; Mary Poovey, *Uneven Developments*.

⁵⁵ Michel Foucault (trans A.M. Sheridan Smith), *The Birth of the Clinic: an archaeology of medical perception* (New York: Vintage Books, 1994).

⁵⁶ Charles West, *Medical Women: a statement and an argument* (London: Churchill, 1878), 22.

⁵⁷ *Ibid.*

In the nineteenth century, the status of skilled work in any field was influenced by perceptions of its complexity which in turn influenced gendered preconceptions. Skilled male work required an 'education' (whether in a formal institution or through very long apprenticeships), but women's work required only training.⁵⁸ Men's minds were expanded and developed through education but women's minds were to be moulded to a specific purpose. As a result women's work was devalued. A good example can be found in the garment manufacturing industry. Male tailors went through a long and arduous apprenticeship and as a result were highly skilled, achieving status as a result; female seamstresses did not. Their ability to sew was regarded as natural (nimble fingers), needed no specific training and therefore was invested with no particular status.⁵⁹ Echoes of this gendered interpretation of work can be seen in the gendering of medicine and nursing: nurses learn on the job, medical men must undertake years of study. According to Deborah Simonton, 'As the doctor's role became more clearly diagnostic, nurses undertook more duties which by virtue of their transfer to women became devalued.' She continues, 'Thus despite the aims of nursing to establish a single stratified profession ... the subordination of nursing to medicine and its gendered character left nurses in a devalued, low-status and poorly paid profession.'⁶⁰ From the hospital managers point of view though, it left them with a highly skilled, responsible and cheap workforce.

Dr Octavius Sturges shed some light on the transfer of certain tasks from the doctor to the nurse, to relieve his burden. On taking temperatures he said: '[It is now] left by doctors completely in her hands. It is a work of which she never tires. Six times, twelve times a day, even 24 times ... is the thermometer applied. If that work were done by men I think we should hear more of the trouble and weariness of it'.⁶¹ From Sturges' declaration it seems highly likely that doctors were glad to be relieved of this tedious task; quite happy to delegate it to nurses, whose female minds were more suited to repetitive tasks than creative thinking. At St George's Hospital by 1877, it was even becoming a distracting chore for the Head Nurses, and the task of regular temperature taking was delegated to probationers. The move was facilitated by the rapid decline in the cost of a thermometer, symbolising its fall from grace from a precious instrument which conferred status to a mundane everyday object conferring no status at all.⁶²

Other tasks were handed down from doctor to nurse, in a similar manner. Taking the pulse, like temperature, had to be conducted several times a day or more depending on the patient's condition. It too was transferred from doctor to nurse as pressure on medical staff increased. This transfer, however, was not quite as straightforward as temperature, and there were some very important boundaries to be drawn. Dr Sturges described the careful

⁵⁸ Deborah Simonton, *A History of European Women's Work, 1700 to the Present* (London: Routledge, 1998).

⁵⁹ See Sonya O Rose, *Limited Livelihoods: gender and class in nineteenth-century England* (London: Routledge, 1992); Angela John, ed, *Unequal Opportunities: women's employment in England, 1800-1918* (Oxford: Blackwell, 1986).

⁶⁰ Simonton, *European Women's Work*, 244.

⁶¹ Octavius Sturges, 'Nurses and Doctors', *The Nursing Record*, 28 March 1889, 198.

⁶² SGHCON/1, 12 February 1877.

division of labour in regard to taking the pulse: 'It is made part of a Nurse's duty to count the pulse – a wise and necessary requirement, which, nevertheless, would have surprised the old physician. But while you are trusted so far, yet with the *character* of the pulse, its length, quality, and tension, you have nothing to do'.⁶³ To assess a pulse's character would be to stray into the realms of diagnosis, a territory jealously guarded by doctors and to be defended to the last. As one author put it, 'The doctor finds out what is the matter with the patient and lays down a plan of treatment; the nurse carries this plan of treatment out, and makes the patient as comfortable as possible, thereby helping, assisting, and working with the doctor to relieve or cure the patient.'⁶⁴ Nurses were constantly reminded that diagnosis was the preserve of the doctor only, and while they may be 'allowed' to count pulses on no account should they interpret what they feel.

A final example also demonstrates the boundaries in place which controlled and restricted nurses' sphere of activity. This case involved the use of hypodermic injections, and offers a glimpse into the gendered assumptions of the time. Hypodermics were used to deliver drugs, including the powerful painkiller morphine, and there was a strong voice of opinion that this task should not be left to nurses. According to Sturges the danger lay in a woman's inherent desire to make her patient as comfortable as possible, a feeling which might override her sense of professional duty:

Hypodermic injection (which means ... administration of morphia) is left to the Doctor out of consideration both for the Nurse and patient. Once the injection-syringe is in the keeping of the Nurse, and she becomes liable to continual harass and importunity on the part of the patient, tempted, [she] may be to make use of this potent agent for pain-killing against her better judgement. It is in her own interest therefore, the instrument is kept out of reach.⁶⁵

This view was not limited to doctors. Catherine Wood also believed that, 'A nurse would do best if she had nothing whatever to do with the hypodermic injections, but left it to the Doctor'.⁶⁶ Not everyone agreed. In *Nursing Notes* the previous year, a list of questions to which a probationer should be able to reply 'Yes' included, 'Have you given a hypodermic?', and 'Have you given a hypodermic of morphia?'⁶⁷ At Edinburgh Infirmary, Lister clearly agreed with Duckworth and Wood, as only on his departure to King's were the rules changed and head nurses were deemed competent enough to administer the injections, albeit under close supervision of the medical officers.⁶⁸ Clearly, although there was not a consensus, the main argument was not about competence, but about a woman's emotional resilience: reflecting the commonly held view of women's inability to control their emotions.

⁶³ Sturges, 'Nurses and Doctors', 197.

⁶⁴ R. Lawton Roberts, *Nursing and Hygiene*, 10.

⁶⁵ Sturges, 'Nurses and Doctors', 198.

⁶⁶ 'Nursing Echoes', *The Nursing Record*, 4 April 1889, 219.

⁶⁷ 'List of questions a probationer ought to be able to answer positively by end of year 1', *Nursing Notes*, 1 August 1888.

⁶⁸ Risse, *Mending Bodies, Saving Souls: a history of hospitals* (Oxford: Oxford University Press, 1999)

This tension over the defining of boundaries of responsibility is illustrated in a quote from another nursing manual which had originally been written for the American market. In the foreword for the British edition, by the same Sir Dyce Duckworth, he explained that several changes to the original text had been necessary, to render the book suitable for use by British nurses. Most particularly, it had been necessary to remove any sections which encouraged nurses to 'prescribe for patients, and to undertake other serious responsibilities which should never be allowed to devolve upon them. Such instruction has ... no part in the training of sick-nurses.'⁶⁹ This same book starts with a justification for the education of nurses to counter any criticism levelled at it from the editor's fellow doctors. In particular, it appears to be attempting to ease doctors' fears that educated nurses would compete with them for business in the private sector, 'if they were taught to know one drug from another, [they] would immediately proceed to the practice of therapeutics on their own account'.⁷⁰ Once again the argument against lady nurses did not question their ability to acquire the knowledge of drugs, but instead warned that in doing so they would pose a serious threat to the doctor's own territory.

Many arguments were used against the 'over-education' of nurses, and invoked pseudo-science to 'prove' that women were incapable of detailed learning – claiming that such education would lead to serious overstimulation of their brains, which were not constructed for such work. However, at the root of these arguments were the professional insecurities and protectionism to which medical men returned time and again. Gender differences were invoked, but in reality gender was a smokescreen, this was about protecting the profession from intruders.

Nursing was becoming a repository for the tasks doctors did not want to do, and in the process evolved into something more than purely providing bedside care. Their education came to resemble (albeit on a basic level) the curriculum for medical students; and in a way the nurse became a sexually ambivalent figure, combining male traits of education, observation and practical knowledge with feminine caring and nurturing. However, the strong tie between nursing and domesticity, which had enabled nurse leaders to create their own space within the hospital, also functioned to radically limit the scope for these activities. Having placed so much emphasis on the conflation of good nurse:good woman, nursing was naturally bound by the same constraints which governed middle-class women in society as a whole, occupying a place subordinate to the patriarch, in this case the doctors or hospital managers.

Male nurse – a contradiction in terms?

In one respect at least the early reformers were very successful. The tie between nursing and female traits led to an occupation run for women (and to a certain extent) by women. Maggs has argued that the ubiquity of the nurses' home, which offered a place of respectable sanctuary to hospital nurses, also served a physical barrier to further exclude

⁶⁹ Dyce Duckworth, 'Introduction' in Clara Weeks-Shaw, *A Textbook of Nursing*, ed. William A. Radford (London and New York: Edward Arnold, 1897), vii-viii.

⁷⁰ Radford, *A Textbook of Nursing*, 2.

males from the profession.⁷¹ Although male nurses (often referred to as charge hands or commissionaires) existed on the periphery of the medical world (in asylums and the armed services), they were almost completely absent from the mainstream.⁷² While female nurse leaders poured scorn and approbation on the quality of training these few male nurses received, they also successfully blocked their access to training in civilian hospitals.⁷³ As one witness (the managing director of the Male Nurses' Temperance Co-operation) reported to the 1904 Select Committee on Nursing, '[there is] nothing in the nature of a test or examination [for would-be male nurses] ... [and] little or no means of training them. moreover, in most hospitals, there is great prejudice against male nurses, and this is one of the great difficulties they had to contend with.'⁷⁴

Most hospitals had to use male nurses to deal with special cases, often where there was a threat of violence, such as delirium tremens. They were hired on a case by case basis, sometimes (as in St George's case) through the auspices of an agency which specialised in male nurses, such as The Hamilton Association for Trained Male Nurses or the Male Nurses' Temperance Co-operation mentioned above. The Hamilton Agency from the start was at pains to stress that it had no desire to compete with female nurses; rather its nurses could be used in cases where, 'Hospital Surgeons ... know too well that ... females ought to be spared from painful scenes and duties for which they are unfitted on account of their decorum or of inferior physical strength.'⁷⁵ Their rules stressed that male nurses should never be used to care for female patients. In 1889, the Association had fifty men on its books, illustrating the 'not inconsiderable demand for Male Nurses', and had placed them in several major hospitals in London, including St George's, Guy's, The Westminster, The National Hospital for the Paralysed and Epileptic, and The Seaman's Hospital at Greenwich.⁷⁶ In addition, the Association provided private male nurses to 'gentlemen resident in chambers' and 'to travel with invalids of their own sex'. It also supplied male nurses to visit the poor, 'in the same manner as female "District Nurses"'.⁷⁷

The Association planned to offer systematic nurse training to men, to place them in hospitals and other institutions, and to form a body of trained male nurses for private work. However, it found great difficulty in persuading hospitals to receive men for training, and proposed instead to establish male training schools, associated with large hospitals, 'on as adequate a scale as has been done in New York'.⁷⁸ This objective was never fulfilled. General hospitals resolutely refused to accept male probationers, citing lack of suitable accommodation as the

⁷¹ Christopher Maggs, *Origins of General Nursing* (London: Croom Helm, 1983).

⁷² For a discussion of the history of male nurses see Joan Evans, 'Men Nurses: a historical and feminist perspective', *Journal of Advanced Nursing*, 2004, 47, 321-28; B. Brown, Peter Nolan and Paul Crawford, 'Men in Nursing: ambivalence in care, gender and masculinity', *International History of Nursing Journal*, 2000, 5 (3), 4-13; Carolyn Mackintosh, 'A Historical Study of Men in Nursing', *Journal of Advanced Nursing*, 1997, 26, 232-36.

⁷³ 'The Select Committee on Nursing', *The British Journal of Nursing*, 30 July 1904, 87-80.

⁷⁴ *Ibid.*, 87.

⁷⁵ 'The Hamilton Association for Providing Trained Male Nurses', *The Nursing Record*, 7 November 1889, 265.

⁷⁶ *Ibid.*

⁷⁷ *Ibid.*, 266.

⁷⁸ *Ibid.*, 265.

main reason, there being barely enough to house the female probationers without adding the complexity of housing males into the mix. Matrons also declared that it was impossible to find male recruits with the same level of education as their female probationers.⁷⁹ This latter excuse was in no doubt: it is difficult to imagine a Victorian middle-class man (the only males likely to be as well-educated as their female counterparts) being willing to put their respectability and masculinity to public test by undertaking a role so closely associated with feminine qualities.

A report in *The Hospital* in 1887 made its position on male nurses very clear, 'No doubt cases exist where the strength of a man is required to control a violent patient, and others where the nature of the complaint must be objectionable to women', but the writer doubts whether men could ever be able to be half as good as women at the work. 'Men have not, as a rule, the tact, patience, and endurance which are essential qualities of a good nurse'.⁸⁰ Arlene Young has concluded that the existence of such agencies (and the undertaking of 'high' nursing duties by medical students) is evidence that nursing was not seen as an exclusively female occupation and that male nurses had support of the public and the hospitals: but if this was the case why did agencies such as the Hamilton Association struggle financially and encounter such barriers to training their staff? Hospitals certainly used the male nurses, but from the experience at St George's it seemed to be a grudging use, in cases where no other alternative was available.⁸¹ Complaints appear in the Management Board minutes regarding the cost of male nurses and in 1892, when the male attendants petitioned the Committee of Nursing for relief to cover their meal times, the Committee replied that it was, 'impossible to have a nurse watch the patient and no one else [was] available'.⁸² Presumably the male nurses had to take their meals on the wards, a practice which had been discontinued for their female counterparts over twenty years previously.

The experience of male nurses did not improve rapidly. When the Nurse Registration Act came into law in 1919, it provided for the central registration of all nurses employed in general hospitals, with some telling exceptions: children's nurses and male nurses were excluded from the main register on the basis that they did not undergo the same breadth of training as nurses in general hospitals. Instead they were placed in a supplementary section.⁸³ Nursing was now officially a female occupation.

Conclusion

A survey of hospital histories suggests that nursing and its relationship with Britain's hospitals, how it was shaped by hospitals, and how it in turn shaped them, is an under-represented theme in the history of hospitals. The International Network for the History of Hospitals has yet to select nursing as a subject for its biennial conferences, and the

⁷⁹ The editor of *The Hospital* showed his lack of sympathy for male nurses, commenting on their higher wages thus; 'If men aspire to the popularity of their sisters in the profession they must content themselves with a reasonable rate of pay.' *The Hospital*, 2 July 1892, xcvi.

⁸⁰ *The Hospital*, 3 December 1887, 167.

⁸¹ Young, 'Entirely a Woman's Question?'

⁸² SGHCON/2, 13 June 1892.

⁸³ Brown, 'Men in Nursing'.

publications it has produced contain only two articles relating to nursing. This is surprising given that nursing forms the largest part of a hospital's workforce and, for anyone who has studied nursing history, the hospital figures large and influential in the development of the profession. Their absence suggests that, to most historians, nurses are invisible, perhaps as a result of lazy assumptions about women's lack of power in the nineteenth century - although as discussed above, gender historians have discussed the occupation of other parts of the public sphere by nineteenth-century women. Nurses are simply 'there': the 'docile bodies' who serve doctors and who 'operate as one wishes, with the techniques, the speed and the efficiency that one determines', as Foucault would have it; or the 'mere machines' that served at the Women's Hospital in Birmingham, whose comforts and ambitions went unrecognised by their contemporary managers.⁸⁴

Helen Sweet has observed that nursing history has occupied what she describes as a 'menial position' with respect to the history of medicine and as she challenges historians of gender to 'rethink their neglect of a significant area of women's history' so too historians of hospitals could be equally challenged.⁸⁵ To ignore the largest sector of the workforce of the institutions under study is surely to construct at best a most incomplete view of their history. If the stereotypes of Victorian women are accepted at face value, the possibility of nurses playing any role in shaping the institutions in which they worked, either deliberately or merely through their presence in such numbers, appears unlikely and unworthy of study. When nurses are mentioned in histories of hospitals (especially the older ones), they are brushed aside as 'nurses and domestic servants ...'. The writers may have easily substituted these words for 'female employees ...' and have done with it: all of them invisible and irrelevant in the bigger [male] scheme of things.

In this article, nurses have been studied in terms of their interactions with both the medical staff and the male administrators they worked with and it is clear to see how gender became a defining feature of the role. The 'new' nurse was a creature born and bred in the hospitals, shaped to sit efficiently within a complex web of competing male authorities. Nurse leaders used the contemporary ideal of femininity to carve out for themselves a semi-autonomous space within the hospitals, where they could develop a satisfying occupation and wield a degree of authority. While some historians have claimed they were successful in this, the level of authority they gained must be questioned. If the objective was to develop a discipline which worked in parallel with but independently of medicine, they really failed in this by the use of the ideology of domesticity. Any gains they made in carving out a position in the public sphere, were constrained by the tightly knit association with domesticity, which condemned them to be always the 'mother' to the doctors' (and the male managers') father. Doctors used cultural interpretations of gender to achieve their own ends; that is to develop a source of highly reliable assistants while protecting their own territory at all costs, tantalising nurses with the use of equipment such as thermometers, while at the same time

⁸⁴ Foucault, *Discipline and Punish: the birth of a prison* (London: Penguin, 1991), 138; Jonathan Reinartz, *Healthcare in Birmingham: the Birmingham teaching hospitals, 1779-1939* (Woodbridge: Boydell Press, 2009).

⁸⁵ Helen Sweet, 'Establishing connections, Restoring Relationships: exploring the historiography of nursing in Britain', *Gender and History*, 2007, 19 (3), 565-580.

jealously guarding their ownership of diagnosis. In aligning themselves so firmly with the ideology of domesticity, the nineteenth-century nurse leaders left a legacy in which nursing was, continues to be, so closely associated with female traits that this is what defines it first and foremost. One of the unfortunate outcomes as a result of this success has been, until quite recently, the almost complete closure of the profession to men. The implications of these decisions are still felt by the nurses today, as every expansion of their role is gained at the expense of hard battles against resistance from the medical profession.

If, then, hospitals were a mixed blessing for the development of nursing as a profession, how did new nursing affect the development of hospitals? The influence of middle-class nurses in transforming hospitals, once places of dread and fear, into institutions which offered care, cure and hope, has been described by Alison Bashford, '[O]rdering, cleansing, purifying and moralising ...had come to be so firmly the territory of the middle-class women' that the role of nurse became synonymous with them, and, in turn, their presence became a necessity for the modernisation of hospitals.⁸⁶ The 'new' nurse provided hospitals with a 'new' public face. According to Clinton Dent, for instance, nursing was the public face of a hospital and its reputation and finances depended particularly on the performance of its Nursing Department: 'Nurses', he said, 'represent their hospital for good or the reverse, and ... its credit is largely delivered into their hands'.⁸⁷

The costs of nursing certainly increased, which put a strain on vulnerable hospital finances, although the costs were offset to certain extent by the introduction of large numbers of probationers, who by the end of the nineteenth century provided most of the bedside care, for either no wages at all or for very small amounts. In fact in many cases, these same probationers rather than drawing a wage were actually paying for the privilege of providing the majority of the nursing care. Added to this, most large hospitals found other ways to make money from their 'new' nurses through private nursing institutes which enabled them to extend the benefits of new nursing to the outside world, for a fee.

Throughout the course of this study, gender has been an ever present: assumptions about women's capabilities based on contemporary understanding of their intellectual ability, assumptions about their place in society and their assumed subordination to male colleagues. However, a closer inspection reveals something in addition to gender may be at play, that doctors' objections to lady nurses was not just a gender issue but was much more about class and therefore power. In the doctors' view, historically nurses had been drawn from the working classes, and were therefore naturally their inferiors with a concomitant duty of obedience. The new 'lady' nurses presented a very different proposition. Of equal (and often of higher) social standing than the doctors, the natural power relationships were ambiguous, the direction in which obligation and duty flowed less clear. As Dr Sturges wrote, 'I venture to think that the relationship of Nurse and Doctor is not without complexity; nor is it made any easier, but rather more difficult, now that the two callings are supplied very

⁸⁶ Alison Bashford, *Purity and Pollution: gender, embodiment and Victorian medicine* (Basingstoke: Macmillan Press, 1998).

⁸⁷ Clinton T Dent, 'Lectures at St George's Hospital', *The Hospital (Nursing Mirror Supplement)* 3 March 1894, pccxv.

much from the same class.’⁸⁸ While gender may have been to the fore, status and authority inherent in class were also defining characteristics of the relationship between the new ‘lady’ nurses and their male colleagues.

⁸⁸ Sturges, ‘Nurses and Doctors’, 197.

You must (be) thrilled when the doctor said it wasn't serious. Have been. Colin's got to stay in bed for 8 weeks. I'd hate to do that. Have to. The doctor the cut on my knee. Examined. Dr Parker gave my mum a lovely for spaghetti carbonara. I think you need to your ideas more clearly so that the reader doesn't get confused. A dawn on B get in with C set out D give in. Set out.