COMPLEX ALLIANCE: A STUDY OF RELATIONSHIPS BETWEEN NURSING AND MEDICINE IN BRITAIN AND THE UNITED STATES OF AMERICA, 1860-1914

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And Social Work
To

David
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ABSTRACT

Nurses and doctors work together in hospitals as they provide care to patients. Nursing knowledge and practice are affected by relationships between nurses and doctors. This study sought to shed light on relationships between nurses and doctors using a broad comparative approach. Relationships between nurses and doctors in Britain and America were examined in order to shed light on the nature of the relationship between nursing and medicine in Britain and America between 1860 and 1914 and to elucidate factors which contributed to the development of this relationship. Examination of the historical roots of the relationship between nursing and medicine may help nurses to develop a deeper understanding of the situation of nursing within healthcare and the ways in which historical factors, such as societal practices and assumptions regarding class, gender, hospitals, and work have affected nursing theory, practice, and status. Studying these issues in two countries may facilitate exposure of factors which might be overlooked in a study of one country alone. This study focuses on hospitals in London and Philadelphia, which were both major centres for development in nursing and medicine during the study time period.

The time period for this thesis is 1860 to 1914. It begins with the opening of the Nightingale School at St. Thomas’s Hospital in London in 1860 which served as a model for other hospital training schools for nurses in London and Philadelphia. The bulk of the material for the study comes from the 1880s to the early years of the twentieth century as multiple formal hospital nurse training schools developed in important hospitals in both cities.

Various factors were identified which contributed to the context in which nursing developed in London and Philadelphia during the study time period. This study examines conceptualisations of nursing and nursing work in relation to medicine and doctors’ work particularly through Nightingale’s writings and the elaboration of her ideas by her friend Eva Luckes, matron of the London Hospital as well as material in nursing textbooks. The study also looks at relationships between nurses and medical staff as they worked on hospital wards, particularly the effect of the presence of many medical students on the wards of London hospitals and their absence in Philadelphia. The importance of strong nurse leaders within hospitals in regard to separation of hospital nursing and medical services is examined. Harmony and discord between nurses and doctors is examined in order to understand factors which contributed to tensions between doctors and nurses. The case of the development of physiotherapy reveals important aspects of relationships between nursing and medicine in society.
DECLARATION

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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>ANA</td>
<td>American Nurses Association</td>
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<tr>
<td>CPPHL</td>
<td>College of Physicians of Philadelphia Historical Library</td>
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<tr>
<td>CSHN</td>
<td>Center for the Study of the History of Nursing, School of Nursing, University of Pennsylvania</td>
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<tr>
<td>ICN</td>
<td>International Council of Nurses</td>
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<tr>
<td>ISTM</td>
<td>Incorporated Society of Trained Masseuses</td>
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<tr>
<td>LMA</td>
<td>London Metropolitan Archives</td>
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<td>PHHC</td>
<td>Pennsylvania Hospital Historic Collections</td>
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<td>PCA</td>
<td>Philadelphia Department of Records, Philadelphia City Archives</td>
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<td>RCNA</td>
<td>Royal College of Nursing Archives</td>
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<td>RLHA</td>
<td>Royal London Hospital Archives</td>
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<td>STM</td>
<td>Society of Trained Masseuses</td>
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THE AUTHOR

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CHAPTER I
INTRODUCTION

Rationale for the study
A mid-nineteenth century probationer nurse at St. Thomas’s Hospital wrote in her ward diary that some of the routine hospital work was tedious but that she did not mind doing it because it was necessary for ‘the comfort of the patients…’ Upon reviewing the diary, Florence Nightingale noted in red pencil, ‘This is saying nothing: of course it is to be done: but by whom?’ From the beginning of professional nursing questions have been raised about the nature of nursing, nursing work, and who should be responsible for various aspects of patient care. Many of the responsibilities for patient care rest on nurses and doctors. This thesis examines the intricate interaction between nurses and doctors in the early years of professional nursing and the ways in which this interaction affected nursing work and ideas about the nature of nursing.

Nurses and doctors work together to care for patients in hospitals, hence factors which affect the work of one half of this dyad can also affect the other. The morphology of hospital nursing is directly affected by medicine and vice versa. This thesis research seeks to shed light on the interaction between nursing and medicine during the latter part of the nineteenth century and the first years of the twentieth century. It seeks to illuminate the conditions in which nursing ontology and nursing

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1 Lady Probationer’s Record of Ward duties with remarks, Miss Carroll, emphasis in the original, HI/ST/NTS/C37/4, LMA.
practice developed in the hospital setting during this time period. Interaction between doctors and nurses affected the way that nurses perceived their purpose, their roles, and their sphere of knowledge, and it is hoped that this research will increase understanding of how this took place and help to refine the concept of nursing practice. Probing nineteenth century roots of the nursing and medicine interface helps to explain the relationship between nursing and medicine and reveal assumptions and circumstances which have not previously been made explicit. It is hoped that making these circumstances and assumptions explicit will contribute to informed discussion of how nursing developed during this time period.

A short outline of the current situation regarding the nature of nursing as opposed to medicine may help to clarify some of these issues. The majority of patient related tasks performed in hospitals are performed by nurses and medical doctors.\(^2\) Historical, socio-cultural, and economic factors have influenced the relationship between these two groups. From the emergence of modern Western medicine and nursing to the present, boundaries have been ambiguous and some work originally performed by doctors has been assumed by nurses.\(^3\) Nursing as a concept has been difficult to define. The American Nurses Association (ANA) defines nursing as:

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...the protection, promotion, and optimisation of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations.  

The ANA declares that the difference between nursing and medicine is that while medical doctors are responsible diagnosing disease, nurses are responsible for diagnosing the human response to disease or illness. Nurses assign specific nursing diagnoses to the various human responses to illness and use them to formulate plans of nursing care. While this definition is not intended to specify the tasks of nursing, it implies a clear differentiation between nursing and medicine.

Other professional nursing organisations explicitly recognise ambiguous boundaries between the work of medical doctors and nurses. In a twenty-eight page document about the definition of nursing the Royal College of Nursing (RCN) states that

Nursing is the use of clinical judgment in the provision of care to enable people to improve, maintain, or recover health, to cope with health problems, and to achieve the best possible quality of life, whatever their disease or disability, until death.

The RCN asserts that differentiation between nursing and medicine is difficult and that succinct definitions of nursing cannot supply details about how nurses interact with patients and other health care professionals. They note that boundaries between health care professions are changeable, that some tasks performed by nurses today


were performed by doctors in the past, and that some tasks which were previously thought to belong to registered nurses are now carried out by others including patients or their family members. They argue that nursing is an ‘amalgam’ or glue that holds the health care system together—rather like connective tissue in living beings. The RCN's definition of nursing, then, is not intended to delineate a specific set of nursing tasks or specify a relationship between nursing and other health care professionals.

During the process of formulating an official definition of nursing, the RCN examined numerous existing conceptualisations of nursing including what they assert to be the most famous definition, that of Virginia Henderson. Henderson stated that

The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or to peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge.

She also discussed the nature of nursing and medical tasks in terms of fluid boundaries. She stated that the boundaries between nursing and medicine are constantly changing. The role of nursing includes everything that has to do with human health and is limited only by the imagination of nurses. Not only are nursing and medical roles continually fluctuating, but other health care roles have developed which overlap nursing and medicine, such as physical therapy and occupational therapy. Henderson argued that because nurses are with patients around the clock, they must be able to perform the duties of other health care professionals, including

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‘the physician, the nutritionist, the physical therapist, or the social worker,’ who are not always available.\textsuperscript{10} Other authors have also discussed constant presence at the bedside as the unique aspect of nursing.\textsuperscript{11}

Jolley and Brykczyńska agree that nurses often do the work of doctors and other health care providers when these other providers are absent. They state that this situation is very problematic for nursing because filling in for others obscures the unique functions of nurses and forces nurses to perform as experts in areas for which they do not enjoy official responsibility.\textsuperscript{12} Lynaugh (1996) discusses these and other serious problems associated with ambiguous boundaries not only between nurses and physicians, but also among registered nurses, practical nurses, and other nursing personnel. She cites Stein’s description of the ‘doctor/ nurse game,’ a difficult and stressful method of dealing with the inconsistencies inherent in the relationship when a nurse knows more about the medical care of a patient than does a particular physician.\textsuperscript{13} Ambiguities and inconsistencies within nurse/doctor relationships are a source of stress for all involved and inhibit professional growth for nursing.\textsuperscript{14}

Extremely broad conceptions of nursing which do not differentiate between nursing,

\footnotesize
\begin{itemize}
\item \textsuperscript{10} Henderson, ‘The Concept of Nursing’ (1978), p. 126.
\item \textsuperscript{12} Maya Jolley and Gosia Brykczyńska, \textit{Nursing: Its Hidden Agendas.} (Suffolk: St Edmundsbury Press, 1993).
\item \textsuperscript{13} Joan Lynaugh, \textit{American Nursing: From Hospitals to Health Systems.} (Cambridge, Mass.: Blackwell Publishers, 1996).
\end{itemize}
medicine, and other health care providers provide little basis for the delineation of a distinct body of nursing knowledge, which is a prerequisite for professional standing.

The International Council of Nurses (ICN) provides a more specific conceptualisation of the relationship between medicine and nursing practice:

Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings.\textsuperscript{15}

Collaborative care refers to care which involves both nursing and medicine. Thus, according to the ICN definition, nursing has a dual role which entails care performed by nurses autonomously and care which involves both doctors and nurses.

For over a century, nurses in America and in Britain have practised the dual role of providing nursing care and carrying out doctors’ orders.\textsuperscript{16} However, until recently nurses in Britain have not spent as much time performing ‘medical tasks’ or devoted as much energy to developing roles in which they diagnose disease and prescribe medications.\textsuperscript{17} Studying historical factors which contributed to the development of this situation will help to explain the nature of nursing and relationships between nursing and medicine in both countries.

\textsuperscript{16} Eva Gamarnikow, ‘Nurse or Woman: Gender and Professionalism in Reformed Nursing 1860-1923,’ in Pat Holden and Jenny Littlewood (eds.) \textit{Anthropology and Nursing}. (London: Routledge, 1991); Melosh, \textit{The Physician’s Hand}.
Purpose of the study

The purpose of this study is to shed light on the nature of the relationship between nursing and medicine in the Britain and America between 1860 and 1914 and to elucidate factors which contributed to the development of this relationship. Examination of the historical roots of the relationship between nursing and medicine may help nurses to develop a deeper understanding of the situation of nursing within healthcare and the ways in which historical factors, such as societal practices and assumptions regarding class, gender, hospitals, and work have affected nursing theory, practice, and status. Studying these issues in two countries may facilitate exposure of factors which might be overlooked in a study of one country alone.

Study Questions

This study aimed to answer the following questions in regard to Britain and America between 1870 and 1914:

1. What was the work of nurses?
2. Did unique nursing knowledge and functions, separate from medicine, exist? If so, what were they?
3. How did Florence Nightingale’s ideas influence assumptions about the uniqueness of nursing?
4. How was the work of nurses similar to that of doctors? How was it different?
5. What were the working relationships between doctors and nurses?
6. What factors contributed to the development of relationships between nursing and medicine?

7. What were conditions of nursing and medical education which formed a background for the development of relationships between nurses and doctors?

In addition to answering these questions, this study aimed to produce new questions related to these concepts which will serve as springboards to further research.

**Methodology**

*Study design*

This is a qualitative, comparative historical study of the relationship between nursing and medicine in the hospital setting in the United States of America and Britain between 1860 and 1914. The study involved investigation of similarities and differences between nursing and medical work, knowledge, and education during this time period and the ways that doctors and nurses interacted with each other. Both nursing and medicine were studied, but the focus of the research was on nursing.

*Comparative history*

Historical exploration of nursing in two countries will be studied in order to expose assumptions which may otherwise be taken for granted. If a concept which is taken for granted in one location or socio-cultural context is absent or significantly
different in another, the concept is put into relief making it more accessible to examination. In regard to the benefits of this method, Arthur Marwick states that studies that involve more than one country ‘are of immense value, since in highlighting both similarities and differences they can be a source of new syntheses, new questions and, sometimes, convincing answers.’\textsuperscript{18}

Other historians have also stressed the advantage of comparative historical study for highlighting specific aspects of historical factors and making them stand out with more clarity. John Tosh asserts that comparing countries is a compelling method because no society exists in isolation and that important historical elements have existed over wide areas at the same time. Examining these features in different areas helps to ‘separate the essential from the particular…’\textsuperscript{19} Looking at nursing in more than one location helps to identify essential aspects of nursing as opposed to those which are unique or particular to one place or another. Looking at more than two locations would be still more beneficial, but practical constraints preclude the examination of more than two sites in this study.

Comparative study provides other benefits as well. According to John Gaddis, comparing historical cases helps to ‘resist reductionism while encouraging an ecological perspective.’\textsuperscript{20} If some elements of nursing are found in multiple geographical or cultural settings while others are particular to a single setting the

historian can avoid mistakes of over-generalisation of what are actually particular elements and reduction of complex issues to simplistic explanations. An ecological perspective helps the researcher recognise that any factor, however seemingly small, can have a significant effect on events and historic development. James Mahoney and Dietrich Rueschemeyer make similar arguments for the benefits of comparative historical research.\textsuperscript{21} Mahoney and Rueschemeyer also discuss drawbacks to this method, which they argue are principally associated with attempts to make universal generalisations about causal theories. The present study is a comparative study in the broad sense of ‘all studies that juxtapose historical patterns across cases,’\textsuperscript{22} and does not attempt to make universal generalisations or develop sociological theories. It addresses similarities and differences in circumstances and raises questions about relationships between circumstances and historical developments in nursing.\textsuperscript{23}

A comparative historical study by Celia Davies helps to demonstrate how comparative historical study may be effectively carried out.\textsuperscript{24} Davies compares nursing education in Britain and America from the beginning of the Nightingale School in 1860 to 1939. A specific purpose of her study was to demonstrate the usefulness of comparative historical study. She uses comparative analysis in order to highlight the perils of ignoring particularities in the history of nursing in the two countries. She argues that nurses in Britain were frustrated with their nursing

\textsuperscript{22} Mahoney and Rueschemeyer, \textit{Comparative Historical Analysis in the Social Sciences}, p. 10.
\textsuperscript{23} Mahoney and Rueschemeyer, \textit{Comparative Historical Analysis in the Social Sciences}, p. 9-10.
\textsuperscript{24} Celia Davies, ‘A Constant Casualty: Nursing Education in Britain and the USA to 1939,’ in Celia Davies (ed.) \textit{Rewriting Nursing History} (London: Croom Helm, 1980).
education, felt that there was nothing they could do about it, and were sometimes envious of nursing education in America. She concludes that comparing nursing education in the two countries is in some ways like comparing apples to oranges and that both countries had their educational disadvantages. Her study seeks to explain the differences.

Davies focuses on ‘different battles’ which nurses fought in Britain and the United States because of different circumstances relating to such factors as professional organisation and the openness of educational opportunities. She points out what the differences were between the two countries and then explains how distinct historical developments in the two countries were related to those differences. Other historical studies have used similar methodologies. This is the method which was followed in the present study. This study will point out differences which existed in American and Britain and will then outline historical developments related to those differences. When sufficient evidence for relationships between particular differences and historical developments was not found, this study will formulate questions about relationships between differences and historical developments which can be investigated in future studies.

**Selection of material to be studied**

This study focuses on nursing in hospitals, in accordance with Davies, who asserts that in order to understand the trained nurse it is important to understand the hospital,

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23 Thomas Bonner, *Becoming a Physician: Medical Education in Britain, France, Germany, and the United States, 1750-1945* (Baltimore: The Johns Hopkins University Press, 1995); Mahoney and Rueschemeyer, *Comparative Historical Analysis in the Social Sciences*. 
which was ‘the organised site in which her work took root and how her position was elaborated.’

This study focuses on nursing in hospitals in Philadelphia and London, because these two cities were in the vanguard of nursing development in the nineteenth century and because extensive historical material for several important hospitals in each city is available. The large London hospitals with associated medical schools were the centre of medical education in Britain and an important centre of medical education in the European region during the time period for this study. Nurse training schools at these London hospitals were also among the most respected and emulated. According to Carol Helmstadter and Judith Godden, there were other great hospitals in Britain outside of London, ‘but they looked to the London teaching hospitals for leadership in nursing reform.’

In America, Philadelphia was a recognised centre of hospital development and medical education and home of the first voluntary hospital, first dispensary and, according to Richard Shryock, the first ‘real’ medical library in the country. Elizabeth Blackwell, first female graduate of an American medical school, reminisced that in the middle of the nineteenth century Philadelphia was ‘considered the chief seat of medical learning in America.’

In regard to the history of nursing, Patricia D’Antonio has argued that Philadelphia was comparable to New York and Boston, but that Philadelphia is a particularly useful focus of study because it ‘provides a particularly intriguing and

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28 Carol Helmstadter and Judith Godden, Nursing Before Nightingale (Farnham, England: Ashgate, 2011).
29 Porter, The Greatest Benefit to Mankind; Bonner, Becoming a Physician; Shryock, The Development of Modern Medicine, p. 45.
exceptionally well-documented example’ of the development of nursing in America.\textsuperscript{31} Comparing nursing and medicine at large teaching hospitals in these two cities will involve a comparison between some of the most respected hospitals in Britain with some of the most respected ones in America.

Selection of specific hospitals in London and in Philadelphia for this study occurred after preliminary examination of primary data sources to determine the quality of data available. The hospitals selected for study had affiliated nurse training schools, participated in medical education, and had substantial available primary material for the time period. In London primary material was examined for three large voluntary hospitals: The London Hospital, Guy’s Hospital, and St. Thomas’s Hospital, also referred to as St. Thomas’ Hospital. When the hospital was first established it was named after St. Thomas Becket, but when it was re-opened after the dissolution of the monasteries under Henry VIII, association with Becket was considered inconsistent so the hospital was dedicated to St. Thomas the apostle, thus acceptably retaining its name. When referred to as St. Thomas’ Hospital, both saints are recognised.\textsuperscript{32}

In Philadelphia material for this study was obtained in regard to The Presbyterian Hospital, The Pennsylvania Hospital, and the Philadelphia General Hospital (PGH). All of these hospitals were voluntary hospitals except the Philadelphia General, also known as ‘Blockley.’ The PGH was a large public hospital which began as an early


eighteenth century alms-house. Nevertheless, the PGH was similar to voluntary hospitals in that patients with acute illness and injury were regularly admitted and it was an important site of medical education from its early days. A school of nursing was established there in the 1880s and the PGH became an important site for nursing education as well.33

**Time period**

The time period between 1860 and 1914 was selected because during this time modern hospital nursing was taking shape on a broad scale in Britain and America. Modern hospital nursing was rooted in nineteenth century Protestant nursing sisterhoods and subsequently in what have become known as the Nightingale reforms.34 Eighteen-sixty is a convenient starting point because this is the year that the Nightingale School of Nursing opened at St. Thomas’s Hospital, London. Most of the material for this study is derived from later decades in the nineteenth century when training schools for nurses began to proliferate in America. The first American schools organised on the ‘Nightingale model’ were established in the early 1870s, although organised nurse training had been taking place earlier at the Women’s Hospital in Philadelphia.35 ‘Nightingale iconography’ was introduced to Philadelphia

when Alice Fisher, a graduate of the Nightingale School in London arrived to head a new nurse training school at the PGH.\textsuperscript{36}

One reason for setting the end date for this study at 1914, when Britain entered the First World War, is that discussion of disruptions caused by the war would be beyond the scope of this study. Life in general and hospitals in particular were seriously disrupted by the war, particularly in Britain\textsuperscript{37}. Another reason for fixing the end date for the beginning of WWI is that nursing was entering a period of transition at that time because many of the reforms for which nurse leaders had been working had been brought to pass. According to Rosenberg, by the time the war began, ‘nursing reformers could claim that many of their educational goals had been attained.’\textsuperscript{38}

Another reason for fixing the dates of this research between 1860 and 1914 is that it was during this time that nursing as an occupation and its relationship with medicine became an important public issue. Controversies surrounding nursing during this time period came to be known as ‘the nursing question’ in Britain. Public interest in the nursing question is reflected in the popular press of the time. A review of The Times newspaper electronic archive shows that the first mention of ‘the nursing question’ in The Times appeared between 1810 and 1820. The number of articles about the nursing question increased steadily until about 1880 then peaked between

\textsuperscript{36} D’Antonio, \textit{American Nursing}, p. 23.
1890 and 1910. A marked decrease in newspaper articles about the nursing question between 1910 and 1919 particularly after 1914 suggests that public discourse about nursing had changed significantly during that time period.\(^{39}\)

**Data Collection**

Primary sources were studied in order to understand what Nightingale meant when she said that nursing was different from medicine. Archived records of nursing education and nursing textbooks during the period 1860 and 1914 were examined. These records reflected what nurses were expected to know and do within this time frame. Textbooks, syllabi, nursing exam papers, and graduation addresses were examined. Nurses’ diaries and other personal writings were also examined for references to what nurses and nursing students did during their hours on the hospital units and interaction between the nurses, doctors, and other hospital personnel. Official rules for the six hospitals selected for focused study were obtained and examined to find out about official expectations for medical and nursing staff and relationships between them. Some of these rules were found in hospital annual reports, others in free-standing publications, and one set of rules was found in handwritten minutes of the hospital governing board. Nursing journals such as *Nursing Notes* and *Trained Nurse and Hospital Review* were for the most part examined at the Royal College of Nursing Archives in Edinburgh, Scotland. *Nursing Notes* was a particularly important source of material relating to nurse masseuses. In addition, the researcher examined issues of *Nursing Notes* and other journals for more extensive evaluation of general contents.

\(^{39}\) *The Times* Electronic Archive. www.thetimes.co.uk.
Medical school syllabi and the writings of doctors and medical students were examined in order to discover attitudes and interaction with nurses and to compare the work of nurses, doctors, and students of both disciplines. Some patient medical records were examined, but access to even nineteenth century records was restricted so the use of these records was limited. Popular magazines, such as *The Nineteenth Century*, and newspapers, such as *The Times* in Britain, were examined in connection with specific issues uncovered in the research, specifically a ‘crisis’ related to nursing at Guy’s Hospital. Nursing journals were also studied for material relating to the study questions.

**Primary and Secondary Sources**

Archival material was obtained in accordance with the study questions. Primary material for this study was obtained from the following archives in Britain:

- London Metropolitan Archives (records for St. Thomas’s Hospital and Guy’s Hospital),
- Royal London Hospital Archives (records for the London Hospital),
- Royal College of Nursing Archives, Edinburgh (books and nursing journals), and
- Wellcome Library, London (nursing and medical textbooks).

Primary material was obtained from the following archives in Philadelphia: Barbara Bates Center for the Study of the History of Nursing, School of Nursing, University of Pennsylvania (records for the Presbyterian Hospital and the Philadelphia General Hospital), The Pennsylvania Hospital Historic Collections (records for the Pennsylvania Hospital).

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The College of Physicians of Philadelphia Historical Library and Wood Institute (doctors’ case notes, personal letters), and Philadelphia Department of Records, Philadelphia City Archives (records for the Philadelphia General Hospital).


Several fictional novels were also used as primary sources for this study. Joan Rockwell and Christopher Maggs argue that fiction can be useful in historical research.\(^\text{41}\) Maggs explains that novels written in a particular time period are valuable as primary sources because they ‘can tell the historian much about contemporary attitudes and values.’\(^\text{42}\) A novel written by Edward Berdoe, a nineteenth century physician who had studied medicine at the London Hospital, was

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found particularly useful for this study. His novel, *St Bernard’s: the Romance of a Medical Student*, has the advantage of being accompanied by a companion book, *Dying Scientifically: a Key to St. Bernard’s*, which explained what the author meant to accomplish with the novel and gave specific clarifications of its accuracy in reality. In *Dying Scientifically* he explained that he wrote *St. Bernard’s*, an autobiographical novel, to expose what he perceived to be common unscrupulous activities occurring in hospitals at the time. He used the pseudonym ‘Aesculapius Scalpel’ and did not identify his alma mater in his writings because he held his school and hospital in high esteem and did not want to imply that they were in any way inferior to other hospitals and medical schools. Berdoe made it clear that he believed that the activities described in his novel took place at all of the large London teaching hospitals.

**Analysis of sources**

Rules of data collection and analysis for historical research are inherently different from those for positivist science. According to D’Antonio, while historical research is a ‘disciplined mode of inquiry,’ it is not a discipline which generally adheres to strict rule based methods. Nevertheless, with Gaddis she endorses specific concepts which form a basis for historical as opposed to positivist scientific research. Of these concepts, the ones most applied in data analysis of this study are

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45 Berdoe, *Dying Scientifically*.
‘interconnectedness of variables,’ ‘contextualisation,’ and ‘ambiguity.’ Interconnectedness of variables is akin to an ecological point of view in that it is believed that each variable, or historical factor, is related to every other associated factor. The process of change is examined in light of all pertinent factors. Contextualisation focuses on finding out about ‘immediate rather than remote’ historical factors. Historical material is put into appropriate historical context and those factors which are most close in ‘time and place’ are given priority. Ambiguity as applied here refers to historians’ desire to take events which seem ‘self-evident’ and ‘complicate’ them—taking into consideration what is in reality a complex interaction of individuals and social structure.\textsuperscript{47}

The data pertaining to textbooks, curricula, and hospital policies and procedures were analysed for knowledge and tasks which students were expected to learn and which nurses were expected to know how to do. They were also analysed for relationships between nurses and doctors such as official lines of authority. Diaries, letters, other personal writings, and professional journals were analysed for comments about what the nurses did in their nursing practice and their interaction with physicians and other co-workers. Popular periodicals were analysed for public exposition of nursing issues.

The data was analysed concurrently with data collection. In this way the researcher was continuously assessing the validity and credibility of the data in regard to study

questions and directing data collection to material connected with factors which had been identified as relating to the study questions. 48

Ethical issues

This study conforms to the ethical guidelines and standards of professional conduct for nursing history research as outlined by Nettie Birnbach. 49 These include honesty, rigorous scholarship, care and preservation of archival materials, sensitivity to controversial issues, and confidentiality of individuals. Sandra Lewenson and Eleanor Herrmann discuss the importance of serious reflection in regard to publication of information which may be injurious to institutions or individuals. 50 No individuals were interviewed. Diaries and other personal writings which were examined were from nurses who are no longer living. All of the data which was collected from institutions was information about curriculum and policies which is available in archives. Records about curriculum and policies were not expected to require extraordinarily sensitive treatment.

Conclusion

Nurses and doctors frequently work together as they care for hospitalised patients. This qualitative comparative historical study aims to shed light on the nature of interaction between doctors and nurses in the last decades of the nineteenth century

and early years of the twentieth century in Britain and America. It seeks to illuminate the conditions under which nursing work and conceptualisations of the nature of nursing developed. A broad comparative method was chosen for this study in order to put into relief the particular circumstances in which nursing developed in Britain and America during this time period. The study also seeks to raise questions about the influence of the interaction between nurses and doctors on the development of nursing in these two countries.
CHAPTER II
BACKGROUND TO THE STUDY

This chapter is a review of the literature regarding nursing and medicine in the context of the last several decades of the nineteenth century and first years of the twentieth century in Britain and America. The literature review is intended to provide historical context, to discuss gaps in the research, and raise more specific questions relevant to this study. The review will discuss what is known about these topics first in regard to Britain followed by a discussion of developments in the American context. Next similarities and differences between the two countries will be discussed. Finally, the chapter will outline specific issues and questions which will be addressed by the study.

Hospitals and Nursing in Nineteenth century Britain

Nineteenth Century Britain was a time of optimism regarding British expansion and the spreading of ‘civilisation’ and Christianity to the world. Scientific activity was contributing to increased understanding of the world and impressive improvements to industry.¹ Industrialisation led to changes in class structure and urbanisation, and it has been argued that urbanisation contributed to increasing class awareness.² The

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² Monica Baly, Florence Nightingale and the Nursing Legacy: Building the Foundations of Modern Nursing (Philadelphia: BainBridgeBooks, 1997); Elaine Denny, The Second Missing Link: Bible
situation regarding class was complex, but great differences clearly existed between the upper classes and lower classes in nineteenth century British society. One important difference between the upper and lower classes involved the role of work in daily life. Ideally, the lower classes worked for a living while the upper classes did not. This distinction would play an important role in the development of nursing in Britain.

Gender was another factor which influenced the development of nursing during the nineteenth century. Because nursing then as now was closely associated with female gender, a general understanding of the place of women in nineteenth century society is important. Historical research suggests that in the nineteenth century women were assumed to be morally superior to men and were expected to use their moral influence to improve the conduct of men through their domestic and motherhood roles. Wealthy women were also supposed to have moral influence over their domestic servants. Ladies were used to relating to the working class as employers and supervisors and the servant was socially and economically dependent on the mistress’s patronage.


4 Cannadine, Class in Britain; Steinbach, Understanding the Victorians; Thompson, The Rise of Respectable Society.


6 Denny, 'The Second Missing Link,' pp. 1175-82; Dingwall, Rafferty, and Webster, An Introduction to the Social History of Nursing.
According to Carol Helmstadter, women were expected to be ‘religious, modest, gentle, patient, compassionate, and self-sacrificing, placing the needs of other members of their families ahead of their own needs or wishes.’ Armed with these qualities, it was the responsibility of women to improve living conditions in the face of adverse circumstances. Like other members of the upper classes, an upper or middle class lady did not work for an income, and if for some reason she were compelled to do so, she ceased to be a lady. She could do almost any kind of work as charity, but not for pay.

Among all classes, there were many more women than men in Victorian Britain. Amongst the middle and upper classes, this resulted in a significant number of more or less idle spinsters who might desire or require suitable occupation. Acceptable work for middle and upper class women who needed to work or wanted to work outside the home was generally limited to being a governess or lady companion. But the number of governess and lady companion posts was limited and not all spinsters desired these occupations. Therefore, women with the time, inclination, and moral authority to do constructive charitable work were available.

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7 Helmstadter, 'From the Private to the Public Sphere,' p. 128.
8 Denny, 'The Second Missing Link,' pp.1175-82.
Reverby asserts that members of nineteenth century British society assumed that the rich held their wealth in trust for God and that taking care of the poor was part of that trust.\textsuperscript{11} Voluntary hospitals, financed through subscriptions from wealthy patrons helped to fulfil obligations to the poor. In order to be admitted to a voluntary hospital a patient had to have a referral from someone who was a patron or donor to the hospital. Those who could not secure a referral had recourse to workhouses, public institutions supported through taxes.\textsuperscript{12}

Each hospital was under the control of lay administrators who were responsible for maintaining the medical staff and nursing staff, which included the matron, sisters, and nurses. The hospital matron was responsible for domestic matters of the hospital such as linen and cleaning and for hiring nurses, but before 1870 she was not usually a nurse and was not necessarily responsible for supervising the nurses.\textsuperscript{13} The ward sister was responsible for the day to day running of the ward under the control of the medical staff and reported not to the matron but to the doctors.\textsuperscript{14} According to Katherine Williams, sisters usually came from a background as upper servants in a household or had been promoted from the position of hospital nurse.\textsuperscript{15}

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Nick Black asserts that voluntary hospitals were sources of pride in the eighteenth century but that these hospitals and the nursing care which they provided had fallen in standards in the nineteenth century.  

According to Helmstadter, nurses in the voluntary hospitals came from the same class of women as charwomen, and many of them could not read or write. Drunkenness and slovenliness were proverbial, stealing of hospital property not uncommon; nurses often left the hospital without permission, and sexual misconduct with medical students was a continual problem. Moore asserts that when a new matron took over the nursing at Guy’s Hospital in 1879 she found that most of the nurses were disreputable and that they did not keep the patients clean. Nevertheless, reformers might be disposed to exaggerate pre-reform hospital conditions. As Monica Baly noted,

Let Nightingale be and all was light! The popular myth is that before 1860 all was Stygian gloom as the Gamps plied their drunken way, and after 1860, all was sobriety, respectability and light. History is not like that. Reformers not only overstate their case, they often overstate the results.

Other historians have also concluded that here were both able and disreputable nurses before the Nightingale reforms.


\[20\] Carol Helmstadter and Judith Godden, Nursing Before Nightingale 1815-1899 (Farnham: Ashgate, 2011); Abel-Smith, A History of the Nursing Profession; Anne Summers, ‘The Mysterious Demise of Sarah Gamp: the Domiciliary Nurse and her Detractors, c. 1830-1860,’ Victorian Studies, 32(Spring 1989), pp. 365-386.
It was generally assumed that no special training was needed to be a nurse, and doctors trained the nurses informally on the wards to their own specifications. The nurses worked on one ward and became well acquainted with the preferences of the doctors on that ward. This was known as the ‘ward system’ and is discussed thoroughly by Helmstadter and Godden.22

Brian Abel-Smith notes that doctors were most annoyed by nurses who did not follow their orders.23 Traditionally doctors were not resident in hospitals, which until the eighteenth and nineteenth centuries were more like hospices for the frail than institutions for the sick. Doctors served primarily as unpaid consultants who visited the hospital regularly and saw private paying patients outside of the hospital to earn a living. Having an appointment as a hospital consultant gave a physician or surgeon prestige in the community, consequently Doctors did hospital work out of good will and for recognition which often translated into expansion of income from private paying patients.24 Junior medical posts included clinical clerks and ‘dressers,’ the contemporary name for certain medical students who were responsible for the dressings of surgical patients.25

Some historians contend that indecorous behaviour of the doctors and medical students in early nineteenth century hospitals was nearly on a par with the nurses.

22 Helmstadter and Godden, Nursing Before Nightingale 1815-1899.
23 Abel-Smith, A History of the Nursing Profession, p. 11.
Some of the adjectives which Helmstadter found in primary sources in regard to medical students and doctors include: ‘appalling,’ ‘low,’ ‘low bred,’ ‘horrific,’ ‘childish,’ ‘licentious,’ and ‘rude.’ Arlene Young also notes that medical students were notoriously uncouth and unruly. Both doctors and nurses could be considered servants in hospitals, the doctors as head servants and the nurses as under-servants as one would see in a large household.

The general culture of the mid nineteenth century hospital, like lower class life outside the hospital, was ‘disorderly, highly disreputable, and unrestrained.’ Hospital patients were rowdy and often difficult to control. Drunkenness was a major problem among the patients as well as the nurses. Most health care took place in the home. Doctors visited the homes of the sick to provide medical services and family members or other members of the household provided nursing care. Sick persons without domestic resources had the option of entering a hospital. Paid hospital nursing was not a respectable occupation for women of higher classes. Nevertheless, upper and middle class women had the moral authority to make improvements in society, and many of them had the time, resources, and inclination to do so.

26 Helmstadter, ‘Old Nurses and New,’ p. 50.
27 Young, ‘Entirely a Woman’s Question?’ pp. 18-41.
28 Helmstadter ‘Old Nurses and New,’ p. 45.
29 Helmstadter ‘Old Nurses and New,’ p. 53.
30 Helmstadter ‘Old Nurses and New,’ pp. 43-70.
Nursing reform in Britain

Wealthy women with the obligation, resources, and desire to care for the poor often organised care for the sick poor in their vicinities. Some particularly conscientious women in the early part of the nineteenth century decided that care of the sick poor should be more organised and turned to Christian sisterhoods, an early Christian model of charity care for the sick poor. David Hempton argues that religious revivals among Protestants during the late eighteenth and early nineteenth centuries generated interest in bringing the Anglican Church closer to its early Christian roots with increased emphasis on the importance of good works. This movement led to the restoration of sisterhoods, and with the organisation of nursing orders, sisters again provided nursing care to the poor. Between 1845 and 1875 forty two Anglican sisterhoods had been formed, many to implement good works such as care of the sick among the poor. In addition to High Church Anglican sisterhoods, there were Protestant evangelical philanthropic societies and sisterhoods formed by people with a Broad Church background. Sioban Nelson notes that Elizabeth Fry, a Quaker, went to Kaiserswerth, Germany, before founding the Protestant Sisters of

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33 Helmstadter and Godden, *Nursing Before Nightingale 1815-1899*.
35 Helmstadter, 'From the Private to the Public Sphere,' pp. 127-140; Helmstadter and Godden, *Nursing Before Nightingale 1815-1899*.
36 Baly, *Florence Nightingale and the Nursing Legacy*.
Charity in London in 1840 to train women to care for the sick in their homes. The sisters of this order were systematically trained at Guy’s Hospital in London.\textsuperscript{38}

According to Jane Brooks, the work of the nursing sisterhoods was organised around social class. The deaconess movement of the Low Anglican Church, Quakers, and Methodists did not attract women with money and status to the extent that the Anglican sisterhoods did, but the sisters had to come from families that could afford to send money to support them. Novice sisters participated in heavy work, which was particularly challenging for those from aristocratic backgrounds. Wealthy sisters did manual labour alongside the paid nurses in order to give dignity to nursing work and to increase respect for nursing as an occupation.\textsuperscript{39} But in many sisterhoods lay associates, who came from lower classes, performed most of the manual labour.\textsuperscript{40}

The sisterhoods had a formal hierarchy in which sisters were members of the order while nurses were employees.\textsuperscript{41}

One of the first modern nursing sisterhoods in Britain was St. John’s House, founded in 1848. In addition to the clergymen and physician, a Lady Superintendent was also an officer of the institution.\textsuperscript{42} The ladies who formed St. John’s House were used to being in charge of their households, were used to giving orders, and were not

\textsuperscript{38} Sioban Nelson, \textit{Say Little, Do Much: Nursing, Nuns, and Hospitals in the Nineteenth Century.} (Philadelphia: University of Pennsylvania, 2001); Helmstadter and Godden, \textit{Nursing Before Nightingale 1815-1899.}

\textsuperscript{39} Brooks, ‘Structured by Class, Bound by Gender’ pp. 13-21.

\textsuperscript{40} Nelson, \textit{Say Little, Do Much}, p. 69

\textsuperscript{41} Anne Marie Rafferty, \textit{The Politics of Nursing Knowledge} (London: Routledge, 1996); Moore, \textit{A Zeal for Responsibility}; Nelson, \textit{Say Little, Do Much.}

\textsuperscript{42} Helmstadter, ‘The First Training Institution for Nurses,’ pp. 295-309.
reluctant to express their views. The Sisters and the hired nurses came from different social classes and formed a two-tiered class system within St. John’s House. The nurses were employees of the council but had their training from the sisters and took their orders from the sisters. Although the nurses were trained by the sisters, they also received ‘medical education’ from the physicians.

In the beginning the sisterhoods offered nursing services only in the homes of the poor, but the St. John’s House sisterhood were later contracted to provide the nursing services at two large London hospitals. The nurses and servants hired by St. John’s reported only to the Lady Superintendent and her ‘orders and decisions’ were final. The sisterhood made it clear that doctors associated with the hospitals would have no authority over the sisters and nurses, but the sisters and nurses would be expected to follow doctors’ orders for patient care.

According to Helmstadter, the nursing system set up by the sisterhood was not only successful but famous, and many people came to observe the new system in operation. Later on, however, the High Church tendencies of the Sisterhood (or the perception of such), their insistence on autonomy, and the high cost of their quality care led to conflict with hospital administrators. The doctors, on the other hand, appreciated the vast improvements that the Sisters had made, and seven out of eight

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44 Helmstadter, 'The First Training Institution for Nurses,' p. 299.
physicians at King’s College Hospital did not want to lose them. The Sisters refused to compromise either their autonomy or their high standards of patient care, the conflicts were not resolved, and the Sisters eventually left both hospitals.48

Nursing services under the direction of nursing sisterhoods were also implemented at other hospitals.49 According to Rafferty, hospital administrators found that the sisterhoods improved hospital milieu as well as the quality of the nursing.50 At first doctors associated with the hospitals praised nursing sisterhoods, but they later became critical of them for several reasons. One reason for their displeasure was that members of sisterhoods, and others, often assumed that religious objectives were more important than medical objectives, which put the position of the sisterhoods above that of the doctors.51 The overtly sectarian nature of the sisterhoods also contributed to tensions. There was great fear of religious fanaticism in nursing in the mid to late nineteenth century,52 and conflict between adherents of Evangelicalism and High Church Anglicanism was intense.53

Helmstadter and Moore point out that conflicts also developed over who was responsible for the nurses—the hospital or the sisterhood, and who was responsible

49 Baly, Florence Nightingale and the Nursing Legacy; Moore, A Zeal for Responsibility.
52 Moore, A Zeal for Responsibility.
53 Hempton, Religion and Political Culture in Britain and Ireland.
for the nursing of the patients—the nurses or the doctors. According to Young, doctors claimed that they were vexed by the nurses’ religiosity but, Young claims, it was really the nurses’ class superiority which worried them. In a society in which those of the higher classes were assumed to have divine authority over those of lesser classes, and where high class women managed large households, the question of who was in charge of the patients was salient. Because of controversy surrounding religious sisterhoods, medical support for them had declined by the 1880s, and by the end of the nineteenth century Sisterhoods were no longer providing nursing services in the London teaching hospitals. The nursing in all of these hospitals was subsequently controlled by hospital officials.

Helmstadter and Godden argue that Nursing sisterhoods had a significant impact on the nature of nursing work and the development of hospital nursing in the nineteenth century. Rafferty notes that sisterhoods had special status in society and in the hospital because of their high class associations and their spirituality. They were instrumental in changing the relationship of patients and the charwoman or handywoman nurse because they added an explicitly moral dimension to the relationship between nurse and patient. In addition, the sisters formed rational

54 Helmstadter, 'The First Training Institution for Nurses, Part II,’ pp.3-18; Moore, A Zeal for Responsibility.
55 Young, ‘Entirely a Woman’s Question?’ pp. 18-41.
56 Nelson, Say Little, do Much; Helmstadter, 'Old nurses and New,’ pp. 43-70.
57 Helmstadter and Godden, Nursing Before Nightingale 1815-1899; Dingwall, Rafferty, and Webster, An Introduction to the Social History of Nursing.
organisations in which traditional nurses were supervised by women who were socially superior to them.⁵⁹

As the nineteenth century evolved, Victorians came to realise that women could take their moral authority from the home and apply it to public ‘homes.’ Evangelical Protestantism emphasised the sacred nature of the home as a refuge from sin filled society and this applied to the hospital home as well. It became acceptable for women to work as nurses because they could be perceived as extending their domestic role, including the role of supervising the help, into the public sphere. Engaging women from the higher classes in nursing improved the calibre of nurses, and improving the calibre of nurses improved nursing services.⁶⁰

Lack of respect for nurses was a significant barrier to recruitment, therefore the presence of ladies in nursing would facilitate the recruitment of respectable hospital nurses. After ladies began to enter nursing, according to Baly, nurses without the requisite social status could still be thought of as ladies.⁶¹ Rafferty argues that nursing reform aimed to change the moral quality of nurses by altering the class structure of nursing as an occupation, not to change the nature of nursing work.⁶² Brooks asserts that although reformers were not particularly successful in recruiting upper class women to nursing, they were more successful at moulding respectable

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⁵⁹ Dingwall, Rafferty, and Webster, An Introduction to the Social History of Nursing.
⁶¹ Baly, Florence Nightingale and the Nursing Legacy, p. 159.
working class and lower middle class women into reputable nurses.\footnote{Brooks, 'Structured by Class, Bound by Gender.' pp. 13-21.} Competition for suitable student nurse applicants became more intense as the nineteenth century progressed. There was a great deal of competition for ‘white blouse labour’ at the end of the nineteenth century, and all of the hospitals had difficulty attracting the kinds of recruits that they most desired. More than seventy per cent of probationers had past work experience.\footnote{Dingwall, Rafferty, and Webster, An Introduction to the Social History of Nursing, p. 69.} Rafferty likens reform of nursing in the hospitals to factory work. Hospital sisters were supervisors of respectable working class labour, the class from which hospitals wanted to recruit nurses.\footnote{Rafferty, The Politics of Nursing Knowledge, pp. 17-19.}

Some nurse historians assert that another reason that respectable women were wanted in nursing was that doctors needed assistants who could be relied upon to follow increasingly complex doctor’s orders, be accurate observers of the patient’s condition, and be able to accurately report that condition to the doctors. In order to be able to do this, nurses needed to have the right kind of disposition, some medical knowledge, and a good deal of practical experience under appropriate supervision. Doctors needed better nursing for more advanced patient treatment, so nursing reform would make medical advances possible.\footnote{Abel-Smith, A History of the Nursing Profession ; Baly, Florence Nightingale and the Nursing Legacy ;Black, 'Rise and Demise of the Hospital,’ pp. 1394-6; Helmstadter, 'Old nurses and New,’ pp.43-70; Kalisch and Kalisch, The advance of American Nursing, pp. 85-105.} Rafferty challenges this assertion. She argues that because little is known about the way in which medical theory and practice affected nursing theory and practice, we cannot say that scientific advances in medicine led to the need for a better educated nurse, and that more research needs
to be done on this topic before coming to this conclusion.\textsuperscript{67} The present study addresses these issues by examining various factors which contributed to the context in which interactions between doctors and nurses took place.

According to Rafferty some physicians wanted nursing reform because they were uneasy about autonomous nurses giving independent, unsupervised care in the home, and worried about competition from them. She argues that doctors supported reform of nursing education partly because they wanted more control over the training of nurses who would then provide nursing in the home. Contemporary discussion of domiciliary nurses in the medical community was carried on in the same terms as discussion about medical quacks. Nurses needed to be taught to respect the rational scientific basis of medicine and trained to follow doctors’ orders to the letter.\textsuperscript{68} At the same time, Young asserts that most doctors were happy with the status quo in regard to hospital nursing.\textsuperscript{69}

Another impetus for nursing reform came from the explosive public reaction to deplorable conditions endured by British soldiers in the Crimean War. When the public became aware of the conditions in the army hospital in the Crimea they were appalled, and Florence Nightingale was dispatched with a group of nurses to take charge of the nursing at the military hospital in Scutari.\textsuperscript{70}

\textsuperscript{67} Rafferty, \textit{The Politics of Nursing Knowledge}, p. 24.  
\textsuperscript{68} Rafferty, \textit{The Politics of Nursing Knowledge}, p. 12.  
\textsuperscript{69} Young, ‘Entirely a woman’s question?’ pp. 18-41.  
Florence Nightingale and the Nightingale School

Some historians argue that the direct accomplishments of the Nightingale nurses in the Crimea were limited but the symbolic ramifications in regard to public perceptions of progress and enlightenment in nursing were profound. Nightingale had the tenacity, writing skills, social connections, and because of the publicity of her work in the Crimea, the fame, to effect change on a large scale.

Nightingale developed a set of definite ideas about nursing. After her return from the Crimea, she put these ideas into influential books about nursing, most famously her book *Notes on Nursing*, which was an international bestseller. She was adamant that women had too much to do as women to waste their time and effort with men’s work, such as medicine. Nightingale was not interested in nursing having parity with medicine or being based on a ‘medical model,’ rather she thought of nursing as a ‘sanitary mission.’ According to Nightingale, nursing was about putting patients in the best circumstances for nature to heal them, and putting patients in the best situation for healing involved making sure that the patient had clean water, fresh air, and clean, quiet surroundings. This was extremely important as it separated nursing from medicine. Nightingale believed that nursing was much broader than medicine and that the responsibilities of nurses included supplying optimal ventilation, clean drains and sewers, good diet, good order, and good morale. She believed that

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72 Baly, *Florence Nightingale and the Nursing Legacy*, p. 25.

73 Baly, *Florence Nightingale and the Nursing Legacy*; Bostridge, *Florence Nightingale*. 
medicine and surgery were much narrower and therefore smaller players in the health of patients in and out of hospitals.74

Because she believed that women were different from men, Nightingale believed that women had a separate role in society. Because women had a separate role, they needed to be under the control of women in a ‘female hierarchy that was equal to, but separate from, that of men.’ Under this ideology, nursing would not be a threat to the authority of physicians because it was a separate discipline ‘structured around a hierarchy of its own.’75 Although many of the innovations which Nightingale introduced in the Nightingale School at St. Thomas’s had been previously implemented by nursing sisterhoods, her insistence that nursing was separate from medicine was not an idea shared by members of the sisterhoods.76 Nevertheless, Nightingale believed that nursing should work cooperatively with medicine. Reverby notes that Nightingale was not interested in competing with doctors although she believed that nurses should be loyal and respectful to physicians.77

In regard to who should provide nursing care, Nightingale expected that the bulk of nursing work would be done by nurses of working class backgrounds—those from the upper servant class being the best—under the supervision of a lady nurse—as

77 Reverby, Ordered to Care, p. 42.
was the case in higher class households. Nightingale also had many other ideas which influenced her approach to nursing. For instance, she believed that conflict would ultimately bring about the best outcomes for patients because each side in a debate would learn from the other and the end result would be the best of both.

When a group of nurses set about to improve the status of nursing by working to implement nurse registration, eliminating lower class nurses and courting and appeasing medical men, Nightingale objected. She wanted to concentrate on clinical competence and expertise rather than prestige. What Nightingale meant when she discussed nursing competence and expertise is unclear, however. Clarifying what she meant is one aim of this thesis.

On her return to Britain from the Crimea, Nightingale was a famous heroine. Money donated by members of a thankful nation was put into a fund for the establishment of organised nurse training and a foundation, the Nightingale Fund, was set up to manage the funds. Money was donated by people of all religious denominations so it was imperative that the school be strictly non-sectarian. But as Mark Bostridge notes, after the difficulties associated with class and religion experienced by the Sisters of St. John’s House, Nightingale had already decided that the school would have to be non-sectarian. Baly explains that Nightingale wanted a nurse training system which would be religious but non-sectarian and that would combine the best

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78 Abel-Smith, A History of the Nursing Profession.
79 Moore, A Zeal for Responsibility; see also Bostridge, Florence Nightingale, p. 137.
81 Bostridge, Florence Nightingale; Baly, Florence Nightingale and the Nursing Legacy.
traits of the upper classes with the best traits of the working classes. She knew that this would be very difficult and expected that it would take an extended period of time to achieve.\textsuperscript{82} After a great deal of agonizing about how and where the school should be organised, it was determined that the new Nightingale school would be established at St. Thomas’s Hospital, London. The school opened there in 1860.\textsuperscript{83}

Before going to the Crimea Nightingale had learned about hospital management and nursing from visits to Catholic and Protestant hospitals on the continent.\textsuperscript{84} The St. John’s House sisterhood was also a key source of insight about nursing for Nightingale. Helmstadter explains that the St. John’s House Sisterhood’s nursing system was a radical shift from the traditional hospital nursing of the time and that the Nightingale system was modelled after it.\textsuperscript{85} Helmstadter and Godden argue convincingly that the sisterhoods set the pattern for nursing reform in England.\textsuperscript{86}

There were three fundamental points stressed by Nightingale and the administrators of the Nightingale Fund when setting up the school. The school must have a trained matron with complete control of the nursing service, the nurses must be well paid, and there must be servants hired to do the manual labour. Being well paid and not doing manual labour may have been compromised at schools of nursing which espoused Nightingale’s ideal, but having a trained matron with control of the nursing

\textsuperscript{82} Baly, \textit{Florence Nightingale and the Nursing Legacy}.
\textsuperscript{83} Baly, \textit{Florence Nightingale and the Nursing Legacy}; Bostridge, \textit{Florence Nightingale}.
\textsuperscript{84} Bostridge, \textit{Florence Nightingale}; Nelson, \textit{Say Little, Do Much}.
\textsuperscript{86} Helmstadter and Godden, \textit{Nursing Before Nightingale 1815-1899}.
service was sacrosanct. Nightingale was determined that the Fund would establish high quality non-sectarian nursing with the nursing of the hospital under the control of a non-sectarian high class trained woman nurse, not a doctor, clergymen, or hospital administrator. This was difficult in the beginning because very few of these women were available, and concessions had to be made. The first superintendent of the Nightingale School, Sarah Wardroper, was not a trained nurse. When trained nurses became available, Nightingale did what she could to implement her plan of having a trained nurse as matron at St. Thomas’s, but hospital authorities prevented this from happening, and Wardroper remained at St. Thomas’s for many years.

Training at St. Thomas’s had a difficult beginning. Implementation of formal nurse training under the Nightingale plan fundamentally altered the structure of authority within the hospital. With the matron in charge of all of the nursing, the status of the ward sisters, who had up until this time had no central nursing head, was diminished. As part of their training, student nurses were moved from ward to ward under the direction of the matron, which diminished loyalty to doctors which had existed under the old system. The nurses were to be loyal to ‘the occupation and to the moral vision of the class from whom the matrons were drawn’ rather than being loyal to their wards as they had been under the old system. For Nightingale, high moral character was the most important characteristic of nurses. As noted

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87 Dingwall, Rafferty, and Webster, *An Introduction to the Social History of Nursing*.  
88 Moore, *A Zeal for Responsibility*.  
89 Helmstadter,  'Old nurses and New,' pp. 43-70.  
90 Abel-Smith, *A History of the Nursing Profession*.  
91 Dingwall, Rafferty, and Webster , *An Introduction to the Social History of Nursing*, p. 56.
above, emphasis on morality over intellectual and scientific aspects of learning was in accordance with societal assumptions about the intrinsic nature of women.

From the beginning of nineteenth century nursing reform, nursing education was linked with doctors and scientific medicine. One of the foundational principles of St. John’s House had been an emphasis on the importance of advanced scientific education for nurses. According to Helmstadter, the sisters believed that if nurses did not understand scientific principles of medicine, they could not be effective nurses, and in the early days of the nursing sisterhoods, sisters paid for lectures from doctors in order to help them prepare for nursing the sick.92 Dingwall et al note that Nightingale objected to having much scientific training at St. Thomas’s. If ‘science’ was synonymous with medicine in health care, more scientific instruction would have involved more medical instruction. In light of Nightingale’s belief that nursing should be kept separate from medicine, it is not surprising that she opposed ‘scientific instruction.’93

Elaborations on how Nightingale’s ideas on unique aspects of nursing were disseminated and incorporated into hospital nursing in Britain and America are scarce. One of the aims of this study is to illuminate what Nightingale’s ideas about the unique functions of the nurse were, what impact they had on nursing knowledge, education, and practice, and how they were related to medical aspects of nursing.

93 Dingwall, Rafferty, and Webster, An Introduction to the Social History of Nursing.
Other training schools for nursing modelled on the school at St. Thomas’s became successful and the general quality of hospital nursing improved, although most nursing work at hospitals with nurse training schools was performed by student nurses. After the establishment of formal nursing schools on the Nightingale model, hospital administrators soon realised that student nurses could supply inexpensive labour for the hospitals. As time went by, it was generally assumed that having a nurse training school was an economical and effective way to supply hospital patient care services, and most of the nursing work in hospitals was done by students.94

Nursing work

According to Williams, nursing work before the nineteenth century nursing sisterhoods and the Nightingale reforms consisted of cleaning and scrubbing and ‘very loosely specified nursing tasks deriving mainly from medical theory’.95 The term ‘nurse’ was traditionally used interchangeably with ‘ward maid’.96 Historical research indicates that basic nursing included helping patients get in and out of bed, lifting and moving patients, making beds, caring for bedclothes, cleaning patients, keeping the ward clean, attending to patients’ needs, placing and emptying bedpans, giving therapeutic baths, and laying out the dead. Making poultices and putting them on less seriously ill patients was also a traditional function of the nurses. Poultices

95 Williams, 'From Sarah Gamp to Florence Nightingale,’ p. 57.
were an important part of care before the implementation of aseptic surgical techniques and antibiotics because all wounds were expected to suppurate.  

According to Helmstadter, more seriously ill patients were nursed by medical students and junior house staff. Teams of medical students would sit with these patients twenty-four hours a day monitoring their status, feeding them, administering fluids by enema (before intravenous fluid administration had been instituted), and giving them medicine. Helmstadter argues that doctors wanted nurses who could do this kind of work, which even the most reliable and sober old style nurses could not handle, and that as the new nursing took hold, nurses took over much of the work of the medical students. Relationships between nurses and medical students and how these relationships may have affected the nature of nursing and the interaction of nursing and medicine will be elaborated in this study.  

Helmstadter summarises an explanation of nursing duties in the forward to Florence Lee’s 1874 *Handbook for Hospital Sisters* into three categories of work:

(1) housemaid’s work—cleaning patients, bed, furniture, and so on; (2) ministration—tending sick patients, dressings, posture, medicines, soothing tempers, and carrying out the orders of physicians and surgeons; and (3) superintendence—the work of one organizing mind ‘to superintend and regulate…several such wards.’  

The third category was for ward sisters only.
Dingwall et al restate the duties of a probationer printed on the application form from 1861 to 1871 at St. Thomas's Hospital. The list included being responsible for dressings, applying leeches, administering enemas, managing trusses, applying appropriate friction, positioning, feeding, and cleaning helpless patients, preventing and treating bedsores, making and using bandages, changing occupied beds, attending at operations, preparing special foods for the sick, keep the ward well ventilated, keep all utensils clean, maintain ‘strict observation’ of the patient’s condition including ‘the state of secretions, expectoration, pulse, skin, appetite; intelligence, as delirium or stupor; breathing, sleep, state of wounds, eruptions, fomentation of matter, effect of diet or of stimulant, and of medicines, etc.,’ and manage patients who were convalescent.\(^{101}\)

Two of the above activities which are most plainly designed to assist the physician in his work are attending at operations and observation of the patient’s condition. Dingwall et al do not elaborate on what the nurses were expected to do with the information which they gathered about the patient’s condition, but Rafferty discusses the role of nurses as the doctor’s ‘eyes and ears.’ According to Rafferty, this contributed to a division of labour in which the nurses systematically observed patients in order to collect information and the doctors used that information to do the decision making. Thus the nurse had a role which was inferior to that of the doctor in a situation which divided the work between the manual and the

Whether collecting and reporting observations is not intellectual work is debatable and will be discussed in this study.

There is no indication in the literature that anyone questioned whether or not nurses should be responsible for carrying out doctors’ orders. This was clearly thought to be in the nurses’ domain. Gamarnikow maintains that nurses perceived their autonomous decisions about how to carry out the doctors’ orders as empowering. She calls this ‘the autonomous translation of medical instructions into nursing tasks.’ Gamarnikow argues that being responsible for carrying out doctors’ orders resulted in nurses taking medical work and translating it into nursing work, ‘…the deconstruction of medical orders and their reconstitution as hierarchically structured nursing care and ward work or as pedagogically organised ward training.’ Moore discusses Williams’ ideas about how a medical task becomes a nursing task. She uses the example of the thermometer. She suggests that when a fever was one of the few objective ways of determining illness, the thermometer was an important symbol of medical knowledge. When other ways of determining disease were implemented, the thermometer was no longer as important symbolically and could be delegated to someone other than the doctor. According to Williams, doctors assumed that nursing was derived from medical knowledge and not from any new introduction of nursing principles introduced by Nightingale.

105 Williams, ‘From Sarah Gamp to Florence Nightingale.’
While some doctors may have assumed that all nursing was derived from medicine, the evidence presented by Williams and Moore is not conclusive in regard to the extent to which Nightingale’s principles were incorporated into nursing knowledge and practice. It will be argued in this thesis that Nightingale did have unique ideas about nursing work in hospitals which were expanded upon by others, most notably London Hospital matron Eva Luckes, that these ideas were incorporated into nursing education in Britain, and that members of the medical community recognised these unique nursing functions.

**Hospitals and nursing in nineteenth century America**

According to Nelson, north-eastern cities in the United States were not as different from London at the end of the nineteenth century as they had been at the beginning of that century.\(^{106}\) Nelson explains that by the end of the century cities in both areas had grown, previously rural areas had become industrialised, and societies had become more pluralised in terms of religion and politics. Echoing assumptions in Britain, Kalisch and Kalisch and Reverby assert that nineteenth century American assumptions included the concept that women were morally superior to men, served others out of moral and religious devotion, and had responsibility for the home, which was a safe retreat from the vices of the world.\(^{107}\)

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\(^{106}\) Nelson, *Say Little, Do Much*, p. 7.

According to Kalisch and Kalisch, American hospital development was influenced by French and English hospitals. Some hospitals in the United States evolved from alms-houses and pest-houses which sheltered destitute members of society in seventeenth and eighteenth century America. Most were voluntary hospitals, the first American voluntary hospital having been built in Philadelphia in 1751. Doctors held honorary positions within hospitals, and as in Britain, they were not paid for this service but increased their prestige through affiliation with a hospital. Prestigious faculty positions at medical schools were usually filled by doctors who were associated with hospitals.  

Urbanisation, industrialisation, and immigration created a considerable demand for hospitals. Most hospitals in America were voluntary institutions funded by wealthy middle and upper class philanthropists. Reverby notes that voluntary hospitals were created in order to provide a place to care for the ‘deserving poor’ as opposed to care for the ‘undeserving poor’ in public hospitals, in accordance with standard assumptions of the time. As in Britain, American hospital patients were strictly disciplined and were treated like ‘errant children’ in need of correction.

Most hospitals had fewer than 150 beds although there were a few large public hospitals such as Bellevue in New York City, which had one thousand beds. The nurses and patients in the hospital were on a par with those in British hospitals. Nurses and patients came from the same low social classes, and it was often difficult

109 Nelson, *Say Little, Do Much*.
for the trustees, doctors, and matrons to keep the patients and the nurses under control. The authority structure of hospitals was like the authority structure in the home, with trustees who were usually men. The position of trustee involved a great deal of responsibility and time. Trustees visited the hospital regularly and listened to complaints from employees and patients. The hospital superintendent was just below the trustees in authority, and was responsible for the day to day running of the hospital including ordering supplies and hiring and firing servants and nurses. Larger hospitals also had a matron who was often the wife of the superintendent. The matron was responsible for supervising the servants and nurses and for managing the cooking, washing, and cleaning.

Women employed as nurses generally came from the charwoman class. Early nineteenth century nursing staffs included ‘night watchers,’ who came from outside of the hospital to observe patients at night. When the hospital was extraordinarily busy extra nurses might be brought in from outside to care for patients during the day as well. Able bodied patients helped take care of other patients and do the work of servants, a practice which was also common in Britain. Employing inmates from an alms-house as nurses was common, and public hospitals served as workhouses for

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111 Reverby, *Ordered to Care*, pp. 22-30.
113 Reverby, *Ordered to Care*, pp. 25-6.
115 Reverby, *Ordered to Care*, p. 27; Helmsdtder, 'Doctors and Nurses in the London Teaching Hospitals, p. 163; Guy’s Hospital, Regulations for Management of the Hospital, London, 1874, London Metropolitan Archive, p. 67, H09/GY/A/053, LMA; St. Thomas’s Hospital Rules 1872, HI/ST/A28/4/1,LMA; The Charter of Incorporation, the By-Laws of the Governors, and the Standing Orders of the House-Committee of the London Hospital, London, 1874, LH/A/1/17, LHA.
the ‘marginal population’ into the twentieth century. At Bellevue Hospital, a public institution, there was no nursing staff on duty during the night and watchmen were expected to call the doctor when patients needed medical attention.117

Reverby states that the first American nurse training schools opened in 1873.118 To be more precise, the first nursing schools established on the Nightingale model opened in the 1870s, but early nurse training programmes had been implemented by doctors in the late eighteenth and early nineteenth century. The first such training school for nurses was established in 1798 by Valentine Seaman, an attending physician at New York Hospital.119 In 1839 Doctor Joseph Warrington established The Nurse Society of Philadelphia, a training school intended to teach respectable working class women to be ‘adjuncts to the physician’ in obstetrical care. Warrington persistently published leaflets to recruit students in 1839 and 1855, but few women enrolled.120 Some female physicians established medical colleges which provided formal training for nurses as well. Doctor Elizabeth Blackwell founded the Women’s Medical College of Pennsylvania in 1850, which provided nurse training. Education of nurses was one of the express purposes of the New England Female Medical College in Boston and was included in its charter in 1850. Women who were interested in becoming nurses were encouraged to attend ‘medical lectures’ at

116 Reverby, Ordered to Care, p. 27.
118 Reverby, Ordered to Care, p. 61.
In 1861 another Philadelphia physician, Ann Preston, established The Women’s Hospital with a nurse training school and gave lectures to pupil nurses. The Civil War interrupted her work, but in 1872 the school received a large endowment which allowed Preston to reorganise and fully establish the school. According to Lewenson, Blackwell might have founded the first nurse training school in America on the Nightingale model but the Civil War prevented her. Dr Marie Zakrzewska founded a hospital with a nurse training school which was chartered in 1862 but again because of the war was not in operation until 1872. Linda Richards, known as America’s first graduate nurse, graduated from Zakrzewska’s school.

In nineteenth century America, as in Britain, most nursing care was provided in the home, and families with the means to do so could hire a nurse to care for family members. In large households, the nurse was in an ambiguous position, living among people who were most often from a higher social class than she was. This was in stark contrast to hospital practice where patients usually came from the lowest social classes. In private duty nursing it was not clear whether the nurse was a professional or a servant, which made quotidian interaction complicated.

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122 Lewenson, Taking Charge: nursing, p. 23.
123 Lewenson, Taking Charge: nursing, p. 23.
124 Reverby, Ordered to Care, pp. 97-104.
Nursing reform in America

According to Reverby, nursing reform in America grew out of post-Civil War social welfare reform.\(^{125}\) In 1868 the president of the American Medical Association (AMA), Dr Samuel Gross, discussed the need for improving nursing care in hospitals at the annual meeting of the AMA. He said that it would not matter how good the doctor was if the patient did not also have a good nurse. The next year he again emphasised nurse training, cited formal nurse education in other countries, and advocated attaching nursing schools to hospitals.\(^{126}\)

Some reasons for nursing reform in America were similar to those in Britain. Historians of American nursing explain that nursing reform was needed in order to supply suitable employment for respectable women, improve conditions in hospitals, and provide the higher standard of nursing required by increasingly sophisticated medical care.\(^{127}\) Reverby argues that reform was needed in order to differentiate nurses from patients and to supply nurses who appreciated ‘order and caring.’ ‘The domestic order created by a good wife, the altruistic caring expressed by the good mother, and the self-discipline of a good soldier were to be combined in the training of the good nurse.’\(^{128}\) With the new nursing, women would have a new nursing role but retain their previous ideology of women’s work which was that women served out of moral and religious devotion. In nursing, this implied that technical expertise

\(^{125}\) Reverby, *Ordered to Care*, pp. 43-9.
\(^{128}\) Reverby, *Ordered to Care*, p. 41.
should come second to Christian humanitarian service. As Nightingale had insisted, the most important aspect of the new nurse was good character.\textsuperscript{129}

Nightingale’s work had substantial impact on American nursing. A significant number of American nurses and doctors who were instrumental in bringing about nursing reform in the United States, met with or corresponded with Nightingale.\textsuperscript{130} Nineteenth century American nurse leaders were ‘identified with Nightingale’s English hospital reforms,’\textsuperscript{131} and American nursing was based on Nightingale’s ideals, including concepts related to the sexual division of labour, sanitary principles, and the example of military and religious sisterhoods.\textsuperscript{132} Nevertheless, more recent scholarship suggests that American nurse leaders were not always accurate in their portrayals of Nightingale’s ideas. Joan Lynaugh argues that American nurse leaders sometimes adjusted them in order to foster specific trajectories for nursing development. As an example, Lynaugh cites the case of Adelaide Nutting, the first professor of nursing at a university, who praised Nightingale for promoting the cause of nursing education when in fact, Nightingale did not approve of an academic emphasis for nursing. According to Lynaugh American nurse leaders sometimes ‘put words into Nightingale’s mouth’ in order to accomplish their aims.\textsuperscript{133} In general, Americans were not overly knowledgeable about the details of Nightingale’s ideas but there is no doubt that she was well known and well respected.

\textsuperscript{129}Reverby, Ordered to Care.
\textsuperscript{130}Celia Davies, Professionalizing Strategies as Time and Culture Bound: American and British nursing, circa 1895. in Lagemann (ed.) Nursing history: New perspectives, new possibilities (New York: Teachers College Press, Columbia University, 1983).
\textsuperscript{131}Melo\textsuperscript{sh}, The Physician’s Hand, p. 4.
\textsuperscript{132}Reverby, Ordered to Care.
According to Kalisch and Kalisch, as writers of popular literature noted that nursing was developing into a respectable occupation for women, they urged women to embrace the nursing movement. In 1871 the editor of *Godoy’s Lady Book*, which had a monthly circulation of over 150,000, published an article calling upon women to develop ‘sick nursing’ as a profession. She argued that good nursing required an education equal to that of medicine and that the graduates of such educational programmes would be as superior to the nurses of the day as the present surgeons were to former barber surgeons. An essay in *Fraser’s Magazine* in 1874 also advocated hospital-based nurses training.\(^\text{134}\)

Reverby notes that toward the end of the nineteenth century domestic service came to be dominated by black and immigrant women, but nursing was still mainly the work of white, native born, poor, and older women.\(^\text{135}\) According to Melosh, however, the class of students coming into the nurse training schools was on average higher than that of the general population. She points out that in the 1890s thirty-two per cent of nursing students had graduated from high school as opposed to only two per cent of young women in the general population.\(^\text{136}\) By supplying respectable student nurses in the place of lowly attendants, hospital administrators began to entice a paying clientele while at the same time decreasing the cost of nursing

\(^\text{135}\) Reverby, *Ordered to Care.*  
services. As in Britain, administrators soon realised that nursing students could provide relatively inexpensive hospital labour. Melosh argues that while there were class differences among nurses in America, the biggest class issue was the division between nurse leaders like Adelaide Nutting and Isabel Hampton Robb and the average hospital nurse.

Nurse leaders contended that nursing involved special skills that required special training. Schools were set up on the ‘Nightingale ideal.’ Some historians argue that rather than meticulously following ‘Nightingale’s European model,’ however, American nursing developed from its ‘own domestic roots.’ The first American hospital training schools established on the Nightingale model opened in 1873.

When hospital training schools began in the United States programmes lasted for one year. Most graduate nurses went into private practice in the community, while a few would remain in hospitals as superintendents and head nurses. After a short time it became clear that many hospitals were having a difficult time staffing the head nurse positions. Louise Darche, superintendent of the Training School for nurses on Blackwell’s Island in New York City, discovered that by increasing nurse training from one to two years the hospital would have a steady supply of head nurses. Before this, first year nurses were sometimes pressed into functioning as head nurses. Training programmes were extended to two years and the second year

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137 Melosh, *The physician’s Hand*, p. 32.
139 Melosh, *The physician’s Hand*, p. 34.
140 Melosh, *The physician’s Hand*, p. 34.
students filled the role of head nurse.\textsuperscript{142} According to Kalisch and Kalisch, bedside care was the province of first year students, and second year students did administrative work.\textsuperscript{143} Davies emphasises that small numbers of graduate nurses were employed in hospitals in the United States because of the practice of placing second year students in the office of head nurse. Nurses who had graduated from a training school nearly always went into private practice. Although some graduate nurses were employed in hospitals as superintendents, supervisors, or assistant supervisors, Davies comments,

It is worth underlining how few trained nurses there were in the American hospitals. The seniority system provided head nurses from amongst the trainees themselves. On completion of their two-, later three-year course, these young women would look for nursing work in the community, free from any contractual obligations to the hospital or school. The American image of the trained nurse was thus of the individualistic, independent entrepreneur; the British image was rather of the faithful employee, with traditional loyalties to her hospital, her school and her matron.\textsuperscript{144}

According to Sandra Lewenson, before the first American professional nurses organisations were formed in 1893, nurse training school curricula had little uniformity. The first year of training was often composed of sixteen to twenty-four hours of physicians’ lectures along with bedside instruction by head nurses and physicians.\textsuperscript{145} Topics of instruction contained in a Bellevue report in 1875 are listed as: ‘Food for children and treatment of the child after birth,’ ‘The eye,’ ‘The wonderful discoveries of the ophthalmoscope,’ ‘A breath of fresh air,’ ‘What to do in emergencies,’ ‘Digestion and food,’ ‘Testing urine,’ ‘Circulation,’ ‘Surgical

\textsuperscript{142} Lewenson, \textit{Taking Charge}, p. 27.
\textsuperscript{143} Kalisch and Kalisch, \textit{The Advance of American Nursing}.
\textsuperscript{144} Davies, ‘A Constant Casualty,’ p. 106.
instruments and preparation for operation,’ ‘Bandaging,’ ‘Symptoms of diseases,’ ‘Puerperal women,’ ‘Medicines,’ ‘Inflammation,’ and ‘haemorrhage.’

Nursing work

Lewenson points out that determining what nursing skills were and how they were to be performed was not easy and was persistent problem in the nineteenth century. Nightingale believed that nursing was much more broad than medicine and included ventilation, clean drains and sewers, good diet, good order and good morale so that nature could heal the patient, which was the foundation of her ‘sanitary ideal.’ Susan Armeny discusses the sanitary ideal as the overriding value of the early American nurse reformers. Historians of both British and American nursing discuss Nightingale’s sanitary knowledge and sanitary missioner concepts, but there is less discussion of other aspects of her ideas relating to nursing. This thesis asserts that while management of the environment was a central theme of Nightingale’s work, it was not the only important aspect of her conception of nursing work, especially in regard to ‘sick nursing.’ Her ideas about details of sick nursing in homes and hospitals were a foundational aspect of nineteenth century hospital nursing especially as elaborated by Eva Luckes in Britain.

146 Lewenson, Taking Charge, p. 27.
147 Lewenson, Taking Charge.
Patricia D’Antonio situates nursing work in its relationship to nursing in the home. She explains that industrialisation, urbanisation, and immigrations changed society in the first half of the nineteenth century in ways that affected the work of women in the home. Women bought goods that had previously involved time consuming labour on their part. More and more men, especially middle class men, were employed away from home in business, politics, and other kinds of work, so that by the end of the 1860s middle class women had taken over responsibility of the home from men.¹⁵⁰

Women took this responsibility seriously and attended lectures and read books on home management, including care of the sick.¹⁵¹ By 1861 these included Nightingale’s Notes on Nursing. In addition to Nightingale’s work women read about basic anatomy and physiology, nutrition, hygiene, sexuality, and family planning.¹⁵² Several popular domestic manuals provided women with the latest particulars regarding care for the sick at home. Nursing care was thought to consist of ‘careful watching; the preparation of special foods and tonics; the changing of dressings; the application of plasters, poultices, and leeches; giving massages, as well as emotional comforting.’¹⁵³ According to D’Antonio, the new ‘trained nurse’ would do the same work in the hospital which women were doing in the home. She

¹⁵⁰ D’Antonio, ‘The Legacy of Domesticity’; See also Lewenson, Taking Charge.
¹⁵² D’Antonio, ‘The legacy of domesticity.’
¹⁵³ Reverby, Ordered to Care; See also Starr, The Social Transformation of American Medicine.
then asserts that the Nightingale reforms made nursing respectable and turned nursing into a vocation, not a job, but did not change the nature of the work. The lady was ‘extending the scope of domesticity’ to institutions.154 Lewenson notes that public institutions were considered to be ‘large houses’ for women to keep and in which they could let their unique talent, caring, shine.155 ‘The wife was the husband’s ‘non-threatening auxiliary’ in the home. The nurse was the non-threatening auxiliary of the doctor in the hospital.156 Several nursing scholars argue that the authority structure of hospitals was like the authority structure in the home with trustees and doctors playing the role of father, nurses the role of mother, and patients the role of children.157 Nurse leaders, however, felt the need to achieve greater professionalism in nursing and in the 1890s they convened to discuss how to go about realizing this goal.

Nursing organisations

Celia Davies gives an account of the nurse leadership meetings held at the World’s Fair in Chicago in 1893 that formed the first professional organisations of nurses in the United States.158 One of these organisations was composed of nurse leaders and called the American Society of Superintendents of Training Schools, later the National League for Nursing Education.159 The meetings also initiated the formation of a more egalitarian organisation called the Nurses’ Associated Alumnae, which

155 Lewenson, Taking Charge, p. 30.
156 Lewenson, Taking Charge, p. 28.
157 Ashley, Hospitals, Paternalism, and the Role of the Nurse; Reverby, Ordered to Care.
159 Davies, ‘Professionalizing Strategies as Time and Culture Bound .’
would become the American Nurses Association. A paper was presented by Louise Darche in which she said that because nursing had developed differently in the United States than in Britain, nurses in America needed different strategies from those of nurses in England. In America the great majority of graduate nurses went into independent private practice in the community while nurses in Britain generally did hospital and home nursing through the agency of the hospitals where they had trained. Darche thought it was strange that at St. Thomas’ Hospital nurses trained for a year and then promised to stay in the service of the training committee for another three years without receiving a certificate of completion and never having complete independence from the training committee. She commented that this would never be acceptable in the United States, although it served a useful purpose in Britain—ensuring the spread of the Nightingale system.  

Davies points out, however, that Darche was comparing current practice in America to practice in England from thirty years earlier. She argues that nursing leaders in the United States were purposely working to avoid the conflict that was going on between nursing factions in Britain over nurse registration—that they were seeking to work out a ‘professional ideology’ in order to maximise accord and understanding of their place in the healthcare division of labour.  

Davies points out differences between the two countries in regard to the organisation and political purposes of

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160 Davies, ‘Professionalizing Strategies as Time and Culture Bound.’
161 Davies, ‘Professionalizing Strategies as Time and Culture Bound,’ p. 56.
major nursing organisations. These distinctions are interesting, but are beyond the scope of this study.

**Religious sisterhoods and nursing in the USA**

Nursing sisterhoods played a fundamental role in the development of nursing in Britain, and the work of religious nursing organisations was also an important aspect of the development of American nursing. In a very broad sense, Sioban Nelson asserts that much of today’s health care system in America is built on the work of religious women. She argues that in the nineteenth century, the word ‘secular’ meant not ‘without religion’ but non-denominational, and that it is a mistake to assume that secular nursing reformers were a-religious. Nelson’s argument is that ‘nursing emerged as a hybrid religious and professional practice, and that its continuing ambiguous and ambivalent fit with professional models is a legacy of those origins.’ If those reformers who specified themselves to be secular were nevertheless deeply religious women, other women who were active in nursing work were devoted sectarians.

According to Nelson, women who were members of religious nursing orders had considerable impact on the development of American nursing in the nineteenth century. In addition to being overtly religious, women in nursing sisterhoods in America were nearly all immigrants, mostly from Ireland if they were Catholic, and mostly from Germany if they were Protestant. As immigrants, especially from

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162 Davies, ‘Professionalizing Strategies as Time and Culture Bound.’
Catholic Ireland, they had to deal not only with challenges common to other nurse reformers but also had to work within a context of very tenuous social status. Immigration to America swelled after the mid-nineteenth century Irish potato famine, especially in Boston, New York, and Philadelphia, which led to a widespread nativist movement in the United States. Anti-immigration unrest culminated in anti-Catholic riots, the worst of which occurred in Philadelphia in 1854. The work of Catholic nuns was accomplished in the face of serious anti-Catholic and anti-immigrant feeling. According to Nelson, their ability to develop advantageous relations with doctors was an important factor in their success. She points out that the necessity of working with male clergy helped Catholic Sisters know how to work well with those of the medical profession and working with medical men helped them to be able to deal with the clergy.\(^{164}\)

Protestant nursing sisterhoods were also established in America, but their approach to nursing was different from the Catholic orders. Protestant women assumed that they should serve God in the place that God had put them, in the home. By extending the home to the hospital, they could serve there as well. Nelson argues that Protestant sisters expected to be superintended by a pastor who was a substitute father, although the woman’s actual father did not relinquish his responsibility over her and could call her home if she was needed. In this context a woman’s relationship to God and to her parents took precedence over her loyalty to a religious sisterhood. Nelson concludes

\(^{164}\) Nelson, *Say Little, Do Much*, p. 164.
that while these Protestant women accomplished positive nursing work, their impact on American nursing was not as great as that of the Catholic sisters.¹⁶⁵

**Nursing and medicine in America**

American nursing leaders struggled to gain control over nursing and nursing education from the time that the first American schools of nursing patterned on the Nightingale system were opened in 1873. An early twentieth century report on the relationship of nursing and medicine stated that nursing and medicine gained from sharing each other’s knowledge and curricula, but that nurses had never been as interested in medical education as doctors were in nursing education. They cited the perennial concern that if nurses become too educated they might challenge medical authority.¹⁶⁶ Middle class family member nurses posed the biggest threat to the doctors’ authority because they were educated, had socially prescribed responsibility for the health of the family, and were on the same social level as the doctors. According to Kenneth Starr, nineteenth century American doctors had less social status than doctors in Britain. He claims that the quality of medical education in nineteenth century America was well below that in Europe, and medical education in America for the most part consisted of apprenticeships to practitioners who had to supplement their work as doctors with other work, usually barbering. The most notable American doctors had been educated in Europe or Britain, mostly at

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¹⁶⁵ Nelson, *Say little, Do Much.*
Edinburgh, which increased their status individually, but as a profession medicine was not of particularly high status.\textsuperscript{167}

Kalisch and Kalisch explain that the tenuous social status of doctors contributed to their anxiety about the effect which changes in nursing might have on physician authority. The discourse of American physicians surrounding the idea of theoretical education of nurses focused on angst about inadvertently turning nurses into doctors. Although there were doctors who acknowledged that patients often recovered as much because of the nurses’ work as theirs, physicians feared that if nurses knew too much about medicine they would want to make medical decisions themselves rather than following the doctors’ orders. The doctors insisted that nurses should know just enough about medicine to be able to carry out the doctors’ orders.\textsuperscript{168}

According to Kalisch and Kalisch, the carrying out of doctors’ orders was assumed to be the primary function of nurses.\textsuperscript{169} Melosh, however, argues that nurses have rarely simply carried out doctor’s orders unthinkingly or automatically, rather, they have ‘developed complex ways of negotiating, interpreting, and revising that formal relationship.’\textsuperscript{170} Melosh asserts that by carrying out doctors’ orders the nurse shared in the prestige of medicine because the nurse was responsible for ‘executing the physician’s work.’\textsuperscript{171} D’Antonio develops this idea further, arguing that it was very

\textsuperscript{167} Kalisch and Kalisch, \textit{The Advance of American Nursing}; Starr, \textit{The Social Transformation of American Medicine}.
\textsuperscript{168} Kalisch and Kalisch, \textit{The Advance of American Nursing}.
\textsuperscript{169} Kalisch and Kalisch, \textit{The Advance of American Nursing}, p. 66.
\textsuperscript{170} Melosh, \textit{The physician’s Hand}, p. 19.
\textsuperscript{171} Melosh, \textit{The physician’s Hand}, p. 4.
difficult to recruit pupil nurses until nursing became closely associated with an increasingly prestigious and influential scientific medical profession.\(^{172}\) This thesis proposes that differences in the ways that nurses and doctors interacted on hospital wards affected this aspect of the development of nursing in Britain and America.

According to Melosh, doctors in America, like doctors in Britain, insisted that nursing was part of medical care.\(^{173}\) If medical care encompasses everything that has to do with the health of patients, then nursing would indeed be part of medical care. Thetis Group and Joan Roberts reverse this concept and argue that nursing encompasses medicine and has been usurped by doctors. They claim that

> The blurred lines between the present functions of nurses and physicians today are in part a result of the exclusion of women from their previous healing functions...The present overlap of many functions of nursing and medicine exists because of the increasing medicalization of all healing tasks and the renaming of all health domains as belonging to physicians.\(^{174}\)

Other scholars including Ivan Illich and Peter Conrad have elaborated on ‘medicalization’ in society, and this issue has become a cause célèbre among anthropologists and sociologists.\(^{175}\) Group and Roberts apply the concept of medicalisation to nursing in America. They argue that doctors deliberately repressed nursing by claiming that nursing care was part of medicine. According to Group and Roberts, before nineteenth century medical and nursing reform, most health care was provided by women who functioned as both doctor and nurse, and therefore it is

\(^{173}\) Melosh, *The physician’s Hand*.
women (nurses) who have the right to be in charge of health care, not men (doctors).

Melosh asserts that because doctors determine the division of labour in all of health care, nurses cannot be autonomous. She does not question the authority of doctors to be in charge of health care as Group and Roberts do. There is very little evidence in the literature that nineteenth century nurses questioned the doctors’ right to formulate medical instructions which the nurses would then carry out. Still, Lewenson suggests that at least some early twentieth century nurses believed that when doctors took charge of nursing, they were assuming a right that did not belong to them.

Organisation of the thesis

The body of this thesis has been organised into five chapters. Chapter three discusses the work of nursing and how nurses conceived of nursing as related to medicine and distinct from medicine. How nursing work was related to doctors and medicine is emphasised. It will be argued that nurses had two principal roles. One of these roles consisted of unique nursing knowledge and practice which was explained by Florence Nightingale and elaborated by her friend Eva Luckes. Nursing work had been carried out in hospitals by nurses and medical students before Nightingale, but Nightingale explicitly outlined what constituted ‘good nursing,’ her explanations

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176 Group and Roberts, Nursing, Physician Control, and the Medical Monopoly.
became widely disseminated, and through the efforts of Eva Luckes and other expert nurses, unique nursing concepts and practice were developed. In addition to their unique nursing role, nurses also functioned as assistants to doctors. In this role nurses had to know enough about medicine to administer treatments prescribed by doctors ‘intelligently.’ Intelligent nursing involved knowing why treatments were given so that they could ensure that treatments were administered effectively and that they could notify doctors about complications or needs for changes in treatment. Nurses also needed to be able to observe patients accurately so that they could give accurate reports about the patient’s condition to the doctor. In this chapter nursing textbooks are examined in order to understand what nurses were expected to know in Britain and America. It will be argued that there was more emphasis on the unique role of nursing as opposed to the doctor’s assistant role in Britain than in the United States.

Chapter four discusses the interaction between doctors and nurses in the hospital setting, particularly focusing on residents, interns, and medical students, together comprising the medical staff with whom nurses had most interaction in the hospital setting. London teaching hospitals had various official positions for resident doctors and medical students and there were often many medical students caring for patients on the wards. In Philadelphia hospitals, however, medical students were rarely on the hospital wards. Therefore, while nurses in large London hospitals had frequent interaction with medical students, nurses in Philadelphia did not. Primary material relating to personal experiences of nurses working with residents and medical
students tend to focus on patients’ dressing changes. London teaching hospitals had many medical student ‘dressers’ whose responsibility and privilege was to change patients’ dressings. In the absence of medical student dressers in Philadelphia, this responsibility would have fallen more often to nurses. The situation in London contributed to more clearly defined separation between nursing and medicine while the situation in Philadelphia did not.

Chapter five covers the importance of hospital matrons and superintendents of nursing and ward head nurses in regard to interaction between nurses and doctors. Nightingale believed that one of the most important requirements for good hospital nursing was that the nurses should be under the control of a trained nurse head, not doctors or clergymen. The head of the nursing service should be answerable only to hospital administrators and not to heads of the medical staff. A strong nursing head was essential in order to maintain the separation of the nursing and medical services, especially in the early days of hospital based nurse training schools. Special programmes were established in London hospital nurse training schools to recruit and train strong nursing leaders. Recruitment and training were more homogeneous in Philadelphia hospital training schools, but a programme was set up to educate graduate nurses in hospital management and nurse training at Columbia University in New York. Graduates of special programmes in Britain were recruited to help establish nurse training schools at several large Philadelphia hospitals. At London teaching hospitals nursing services were separate from medical services with nurse heads who reported directly to hospital governors. In America, hospital nursing
services were generally under the control of the head of the medical service. Thus, nursing services were more separate from medical services in London than in Philadelphia, and the nursing hierarchy in London hospitals was more separate from the medical hierarchy.

In chapter six the discussion turns to harmony and conflict between doctors and nurses. While relations were often harmonious, conflicts also occurred. Examination of the case of a widely publicised dispute between doctors and nurses at Guy’s Hospital in London helps to identify factors contributing to tensions between doctors and nurses. This case also helps to understand the process of instituting a nursing service separate from the medical service of a large London teaching hospital and the transition from previous relationships between doctors and nurses to relationships under the ‘new nursing.’ Conversations between nurses and doctors involved in the dispute also help to illuminate nurses’ conceptions of unique aspects of nursing knowledge and work. Evidence of major conflict between doctors and nurses was not found in the data pertaining to Philadelphia hospitals.

Chapter seven examines relationships between nurses and doctors in regard to the development of a specific aspect of patient care, namely therapeutic massage and exercise. Massage was an important part of patient care and nurse training in the late nineteenth century in both Britain and America. Several nurses who trained in London hospitals, particularly the London Hospital, and subsequently specialised in therapeutic massage were motivated by certain circumstances to form a society to
ensure quality and respectability in their chosen field. Their experience helps to understand the importance of doctors’ endorsement for any kind of health related endeavour while at the same time indicating that it was possible to maintain institutional autonomy as nurses. The role which these nurses developed eventually became the role of physiotherapist, and the organisation formed by these nurses became the Chartered Society of Physiotherapy. The development of physiotherapy, later known as physical therapy, in the United States happened along very different lines. Examination of this process in America reveals other aspects of relationships between nurses and doctors.

**Conclusion**

The work of the nursing sisterhoods in nineteenth century Britain lent a strong moral dimension to nursing care at a time when reform and purification of the working classes was a social priority. In a social context in which morality and spirituality were very important and were the specialist domain of high class women but where sectarian religious strife was a problem, the introduction of higher class non-sectarian lady nurses in the hospital was workable and improved hospital conditions and nursing care. These women, respected in society because of their class and voluntary Christian dedication, often became ward sisters, superintendents, and matrons in Britain. They clashed with doctors who saw them as a threat to their authority and who understandably missed the advantages of the old system of nursing. The presence of ladies in nursing, though their numbers were not large, increased the status of nursing enough to attract respectable recruits and those
wishing to be respectable. Separate training programmes for ladies laid the foundation for a hierarchy in nursing in which graduates from the same schools occupied separate rungs, ladies who became sisters and matrons and other probationers who for the most part did not.

While Nightingale conceived of nurses as ‘sanitary missioners’ with important work very different from that of doctors, actual nursing work in hospitals and the community had ambiguous boundaries with medical work. Some nursing leaders believed that doctors did not know everything about nursing and therefore could not be competent nurses. Some doctors believed that any competent doctor knew everything there was to know about nursing. Some nurse historians agree with the doctors. Various factors affected the development of ambiguous boundaries between medical and nursing work. Medical lecturing by doctors in schools of nursing was one of the most salient of these factors. There is little evidence that anyone questioned the assumption that nurses should be responsible for carrying out doctors’ orders. For the most part, doctors assumed that nurses existed first and foremost to see that medical orders were implemented.

Nursing work and the relationship between nursing and medicine in nineteenth century America were similar to those in Britain, but important differences also existed. In both countries the work of nurses and doctors overlapped and boundaries were blurred. Physicians were dealing with changes within the medical profession, developing professional prestige, and consolidating authority over medical care.
Doctors in the America had less prestige than those in Britain and did not have comparable educational resources until late in the century, but the literature indicates that physicians in both countries experienced angst in regard to the appearance of respectable, authoritative nurses. In Britain the first of these were members of religious sisterhoods. In the United States they were middle class home managers. The literature suggests that emergence of nursing as a respectable occupation for women was threatening to the nascent authority of medical doctors and many felt vulnerable.

In the late eighteenth century through the first part of the nineteenth century some doctors devised formal nurse training programmes, but these programmes did not survive the introduction of nurse training under the direction of trained nurses as advocated by Nightingale. Nevertheless, in both Britain and the United States doctors gave formal lectures to nursing students and insisted that nursing was part of medicine. As far as the doctors were concerned, the primary work of nurses was to carry out doctor’s orders. In both countries nurses took the mandate to implement doctors’ orders and made this work their own. In addition, nurses in America and Britain did the work of doctors when doctors were unavailable. In both countries the work of women in hospitals was to some extent believed to be an extension of their work in the home and most hospital nursing care was provided by students. Upon graduation from nurse training school, nurses in America nearly always went into private practice. Some were employed as head nurses and matrons in hospitals, but
some research indicates that many head nurse positions were filled by second year nursing students.

Formal nurse training in America came later than in Britain, not least because of the Civil War. Because American nursing leaders started formal nurse training later than in Britain, American nursing leaders took notice of the experiences of nurse leaders in Britain and attempted to avoid the conflicts within nursing which had taken place in Britain. Nursing in America developed in distinct ways within the context of American culture, but was influenced to a great extent by British nursing.

As in Britain, nursing leaders in America were determined, intelligent women, who worked to establish formal training for nurses. Catholic nursing sisterhoods in America built hospitals in which they had indisputable authority over hospital operations, including medical services. Upper class philanthropic women were involved in the establishment of nursing schools, contributing time, intelligence, monetary resources, and encouragement, but they were not nurses. There were no separate nursing programmes for the training of upper class lady nurses in America. Nevertheless, there is evidence that nursing leaders and upper class philanthropic women involved in the establishment of formal nurse training were united by a shared devotion to the ‘sanitary ideal.’
CHAPTER III

NURSING WORK, A ‘THOUSAND LITTLE THINGS’

Alice Fitzgerald, an American nurse caring for wounded soldiers in Europe during the First World War, observed differences in the way that American and British nurses thought about and behaved in regard to working relationships between nurses and doctors. She stated that it seemed to her that American nurses worked with the doctors while British nurses worked for them.\(^1\) She did not elaborate on this cryptic statement, but the salient point for the purposes of this thesis is that she noticed a difference.

As ‘trained nursing’ took shape in the latter half of the nineteenth century, nursing in Britain and America developed two main functions. One of these functions was to assist the doctors by carrying out their orders and reporting on changes in patient status. The other function was what will be called here ‘core’ nursing work. It will be argued in this chapter that the emphasis that was put on these two functions differed in Britain and America. It will be argued that in Britain the uniqueness of nursing in relation to medicine was more strongly emphasised while in America there was less emphasis on the separation of nursing and medicine, and the integration of nursing and medical care was more taken for granted. Nineteenth century British nurses worked more consciously to develop a body of knowledge and practice distinct from medicine. American nursing was more medically focused.

\(^{1}\) Alice Fitzgerald, Unpublished Memoirs incorporating War Diary, c 1936; Alice Fitzgerald Papers; Md HR M 2633; Md HR M 2634 The Maryland Historical Society Archives, Baltimore, Maryland, USA
Core Nursing: ‘little things’

Writing in 1889 ‘M.D.’ stated in a nursing journal that the nurse had ‘two duties—first to her patient, and second to the doctor…’² The nurse’s responsibilities to the doctor were to make sure that his plan of treatment was carried out and to avoid undermining the patient’s confidence in him. M.D. acknowledged that few doctors were perfect which might make it difficult for nurses to give the great majority of imperfect doctors the nurses’ full support, but that a patient’s confidence in his treatment was necessary. The responsibility to see that the doctors’ treatments were carried out was of the utmost importance. There is very little evidence that anyone disputed the idea that one of the nurse’s most important duties was to see that the treatments prescribed by the doctor were carried out. But in addition to implementing medical treatment, nurses fulfilled their duty to patients by administering ‘real,’ ‘true,’ or ‘core’ nursing care.

The term ‘core nursing’ is used by Margarete Sandelowski, who explains that while medical interventions are constantly changing, there has been ‘a natural and unchanging core to nursing.’ She quotes a late nineteenth century nurse who stated that ‘fashions in treatments come and fashions in treatment go, but nursing goes on forever.’³ Sandelowski’s core nursing is the ‘bed and body work of nursing’⁴ which

⁴ Sandelowski. Devices & Desires, p. 103.
includes bathing, toileting, and feeding, and which she also refers to as ‘true’ nursing.\(^5\) Core nursing as used in this thesis pertains to the bed and body work of nursing including what late nineteenth century nurses understood as a myriad of details which needed to be employed in the work of making patients as comfortable as possible in body and mind, decreasing demands on exhausted energies, and performing life-saving activities such as coaxing a patient to take food and fluids.

In order to understand the nature of core nursing work in the nineteenth century, it is useful to take a close look at Florence Nightingale’s writings. Nightingale’s widely circulated, *Notes on Nursing: What it is and what it is not*, focused on ‘sanitary knowledge’ which was knowledge every woman should have about how to maintain a healthy environment and put people in the best conditions to maintain health or recover from illness. The work of nurses was to put patients in the best conditions for nature to heal them. Only nature could heal, but a nurse could put the sick in the best conditions for healing to take place.\(^6\) At the time she wrote *Notes on Nursing* Nightingale was nationally celebrated as an expert nurse and her ideas about sanitary knowledge were considered to be highly significant.\(^7\)

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In her book, Nightingale discussed ways to help keep the sick in a state which would put them in the best position for nature to heal them. The book covered various aspects of environmental health and ways to maintain a positive emotional climate. She specifically stated that the book was not intended to be used as a textbook of nursing rather it was to give ‘hints for thought to women who have personal charge of the health of others.’ Nightingale’s definition of a nurse was anyone who was in charge of the health of another person, which would include most women.\(^8\) D’Antonio has elaborated on nursing’s roots in familial care of individuals in the home, and historians have discussed the prevalent nineteenth century concept of the ‘born nurse,’ women with innate talent for nursing.\(^9\)

Womanly care of the sick is well illustrated by a passage in Leo Tolstoy’s *Anna Karenina* in which two of the novel’s characters, Levin and his wife, were visiting Levin’s brother who was seriously ill. Levin saw the ‘dirt and disorder’ of the sick room and the agony, suffering, and abject misery of his brother. He smelled the ‘foul air,’ and heard his brother’s groans but he is sure that there was nothing that he can do about any of it:

> It never entered his head to consider all these details and imagine how that body was lying under the blanket, how the emaciated, doubled-up shins, loins, and back were placed, and whether it would not be possible to place them more comfortably or…make his condition …more tolerable…

\(^8\) Nightingale, *Notes on Nursing*, p. 33.

His wife, Kitty, on the other hand, went into action:

…Kitty felt and acted quite differently… Those very details, the thought of which alone filled her husband with horror, at once arrested her attention… When Levin returned… he found the invalid arranged in bed and everything around him quite altered. Instead of the foul smell there was an odour of vinegar and of scent… There was no trace of dust left about; there was a mat beside the bed; on the table medicine bottles and a bottle of water were neatly placed, also a pile of folded linen… On another table by the bedside were a glass of some refreshing drink and some powders. The invalid himself, washed and with his hair brushed, lay between clean sheets in a clean shirt, its white collar round his abnormally thin neck, gazing with a new look of hope…

Levin’s brother was not only in an improved physical state as a result of Kitty’s ministrations, he was in a new and therapeutic emotional state. Tolstoy’s novel takes place in Russia, but it has been argued that Anna Karenina demonstrates a significant amount of English influence. It is probably not possible to say whether or not Tolstoy was familiar with Nightingale’s writing, but the development of nursing was very much in the public eye in England in the late 1870s when the novel was being written and Tolstoy captures the essence of what Nightingale hoped to teach. Nightingale’s purpose in writing the book was to help all women to provide good nursing care in the home.

All women would not necessarily do the actual work of nursing, however. Notes on Nursing was written for women who would be supervising other people who would perform the actual ‘body work of sick nursing.’ Nightingale produced another

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edition of the book, *Notes on Nursing for the Labouring Classes*, which specifically addressed details of performing body work and provides important insight into the specifics of what Nightingale considered to be good nursing.¹³

The first thirteen chapters of both *Notes on Nursing* and *Notes on Nursing for the Labouring Classes* have the same titles covering topics from ‘ventilation and warming,’ to ‘health of houses,’ ‘petty management,’ ‘noise,’ ‘variety,’ ‘taking food,’ ‘what food,’ ‘bed and bedding,’ ‘cleanliness of the rooms and walls,’ ‘personal cleanliness,’ ‘chattering hopes and advices,’ (which were detrimental to people who are sick), and finally ‘observation of the sick.’ *Notes on Nursing* ends with a conclusion and appendix containing charts of the ages of nurses in Great Britain (508 of whom were ‘domestic servants’ between the ages of 5 and 10 years old and 311 of whom were ‘not domestic servants’ over 80 years of age) and a short note about the ‘number of women employed as nurses’ in Britain.¹⁴

In *Notes on Nursing for the Labouring Classes*, several of the chapters contain additional information about caring for the sick and there are three additional chapters on ‘convalescence,’ ‘minding baby,’ and ‘what is a nurse?’ The additional material in this book includes important information in regard to understanding what constituted good core nursing. In both books the chapter on ‘Observation of the Sick’ included discussion of the importance of nurses’ making accurate observations in order to be able to tell the patient’s doctor exactly what was happening with the

patient. But in the additional material included in this chapter of *Notes on Nursing for the Labouring Classes*, Nightingale explained what makes a good nurse more clearly and in more detail. She explained that a good nurse had the ability to observe ‘little things which are common to all sick, and those which are particular to each sick individual’ and then to implement nursing care in accordance with those observation. This was a type of observation which was different from the observation necessary to accurately report changes in patient status to physicians—and just as important. Nightingale argued that it was the implementation of ‘all these little things…which enables one woman to save life…it is the want of such observation…which prevents another from finding the means to do so.’

When Nightingale wrote of sanitary knowledge she meant cleanliness, diet, and quiet, but she also meant careful observation of a patient’s physical and emotional idiosyncrasies in order to provide a kind of nursing care which is completely dependent on the expertise and initiative of the nurse. While Nightingale clearly believed in the importance of cleanliness of various kinds, the most obvious aspects of sanitation, her elaboration of specific, detailed care of the sick also deserves close scrutiny.

In her discussion of this kind of observation and implementation of vital ‘little things,’ Nightingale used the example of helping patients to take food. A good nurse observed what helped a particular patient to be able to eat and then implemented nursing care which would take these observations into consideration:

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15 Nightingale. *Notes on Nursing for the Labouring Classes*, p. 79.
It is the...way she pillows his head, so that he can swallow comfortably. Opening the window will enable one patient to take his food; washing his face and hands another; merely passing a wet towel over the back of the neck, a third; a fourth, who is...depressed..., requires a little cheering to give him spirit to eat. The nurse amuses him with giving some variety to his ideas...  

Each patient had specific needs that only an observant nurse could assess and take into consideration in direct care. Nightingale explained that ‘the very alphabet of a nurse is to be able to read every change which comes over a patient’s countenance, without causing him the exertion of saying what he feels.’ She noted that ‘a patient is not merely a piece of furniture, to be kept clean and ranged against the wall, and saved from injury or breakage,’ but that

...a nurse ought to understand...every change of her patient’s face, every change of his attitude, every change of his voice...She may make mistakes, but she is on the way to being a good nurse. Whereas the nurse who never observes her patient’s countenance at all and never expects to see any variation, any more than if she had the charge of delicate china, is on the way to nothing at all. She never will be a nurse.  

Nightingale elaborated on many categories of little things including the ambiance of the sick room including among others the position of the bed in the room, noise, positive occupation of the patient’s mind, light, bedding, the manner and content of communication with the patient and others in the sick room and just outside the door.

This was nursing care which required the attention of an expert nurse. In the above example of feeding patients, all of the life-saving care that the nurse was doing for each of the four theoretical patients was care done on the initiative of the nurse. These interventions were not ordered by the doctor. It was important not to violate the doctor’s plan of care while providing this care to patients, but the care itself was

16 Nightingale. Notes on Nursing for the Labouring Classes., p. 79.
17 Nightingale. Notes on Nursing for the Labouring Classes, p. 83, emphasis in the original.
given under the nurse’s expertise. According to this approach, the crux of good nursing involved expert attention to many small details, the sum total of which could maintain life or not. The way that a nurse addressed these issues had the potential for enormous impact on the physiological and emotional state of patients and thus their ability to overcome the weakness and debility of serious illness. Nightingale’s sanitary knowledge, then, was much more than cleanliness and quiet.

In addition to sanitary knowledge, Nightingale discussed another kind of nursing which she called the ‘handicraft of nursing.’ In her brief explanation of the handicraft of nursing, or what she also called ‘surgical nursing,’ she used two examples of what constituted this type of nursing. These examples consisted of not allowing a patient to bleed to death and preventing the formation of bedsores. She explained that she would not elaborate on the handicraft of nursing for three reasons: practical work in hospital wards was the only way to learn them, her notes about nursing were not intended to be a ‘manual of nursing,’ and while thousands of people died from inadequate implementation of all that she considered to be sanitary knowledge, comparatively few died from lack of surgical nursing. In other words, while surgical nursing was important for seriously ill patients, she considered the work that nurses did on their own initiative and with their own expertise to be more useful because it impacted many more people.

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Ironically, in spite of her belief in the priority of sanitary knowledge over the handicraft of nursing, or surgical nursing, one of Nightingale’s most well-known projects was the founding of the Nightingale School for the training of nurses at St. Thomas’s Hospital in London in 1860. The nursing done in the hospital included the implementation of sanitary knowledge but a great deal of time was spent on nursing handicraft, working with doctors to implement increasingly complex medical regimens. Nurses initially had one year of training, which later developed into a three year programme as the training became more theoretical and specialised. Katherine Williams suggests that some observers, including Nightingale, thought this kind of training was producing a ‘bad’ kind of nurse who was more concerned with medical matters than nursing matters.\(^{20}\) Williams asserts that Nightingale believed that in their role of diagnosing and treating illness doctors needed to know about the functioning of the different parts of the body, while the nurse needed to know about the ‘laws of life and health.’ Laws of life and health, not medicine, were the basis of Nightingale’s nursing ideology.\(^{21}\) Nevertheless, Nightingale and the members of the Nightingale Fund decided together that the student nurses at the school at St. Thomas’s would learn the handicraft of nursing by receiving lectures from physicians, and the Fund paid for them.\(^{22}\) In spite of her willingness to sanction physician lectures, Nightingale did not like the idea of nurses being taught by

\(^{20}\) Williams, ‘From Sarah Gamp to Florence Nightingale.’


\(^{22}\) Baly, *Florence Nightingale and the Nursing Legacy.*
doctors. She was afraid that doctors would make the nurses into ‘medical women’ and ‘deflect them from their proper task of being sanitary missioners.’\textsuperscript{23}

Surgeon Richard Whitfield was chosen to be the first doctor to give lectures to nurses at St. Thomas’s. Whitfield set to work to make specific guidelines for probationer education by writing a comprehensive set of instructions for training nurses to take notes on medical and surgical cases. In this work he explained in detail how nurses should obtain a patient’s medical history and conduct a physical examination. The instructions included details about the proper way to do auscultation and percussion and writing case notes. Baly states that when Nightingale saw the result of this teaching she commented that the work was ‘a medical student’s paper rather than a nurse’s.’ The practice of having probationers take case notes was discontinued but doctors continued to lecture to probationers.\textsuperscript{24}

Nightingale responded to Whitfield that she wanted to see what the nurses were doing in regard to nursing skills. According to Baly, Whitfield did not recognise a fundamental difference between nursing and medicine, and Nightingale believed that doctors did not know what a good nurse was.\textsuperscript{25}

Nightingale insisted that nursing was different than medicine and that the two should be kept separate. For Nightingale, medicine was about pathology while nursing was

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\textsuperscript{21} Baly, \textit{Florence Nightingale and the Nursing Legacy}, p. 26; see also Helmstadter, ‘Doctors and Nurses in the London Teaching Hospitals,’ pp. 161-197. \\
\textsuperscript{24} Baly, \textit{Florence Nightingale and the Nursing legacy} , p. 58. \\
\textsuperscript{25} Baly, \textit{Florence Nightingale and the Nursing Legacy} .
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about the promotion of health.\(^{26}\) This was the crux of being a sanitary missioner. Medicine had different work to accomplish and if nurses acquired too much medical knowledge it could distract them from their sanitary mission.\(^{27}\) Helmsdadter and Moore suggest that other nineteenth century nursing leaders also maintained that nursing was different from medicine, with a separate body of knowledge and practice that physicians did not know.\(^{28}\) On the other hand, Helmstadter asserts that some doctors, including the eminent Dr Gull of Guy’s Hospital, believed that competent doctors understood every detail of nursing care. Helmstadter states that while doctors did not do the cleaning that the nurses did, they often performed ‘the more important aspects of nursing care’ and knew all there was to know about nursing.\(^{29}\) She illustrates this point with an example of medical students taking turns sitting up with a seriously ill patient, making observations of the patient’s condition, feeding him, and administering medicine and foods by mouth and fluids by enema.\(^{30}\) Abel-Smith points out that medical students had done nursing care in pre-Nightingale reform hospitals, noting that those occupying junior medical posts could be found fluffing pillows and generally making the patients comfortable.\(^{31}\) Helmstadter adds that in the teaching hospitals, medical students or residents performed some of the tasks for which nurses are now responsible. She argues that critically ill patients had long been nursed by medical students, and as late as 1890 it was not beyond the pale to


\(^{27}\) Baly, *Florence Nightingale and the nursing legacy*.


\(^{29}\) Helmsdadter, ‘Doctors and Nurses in the London Teaching Hospitals,’ p. 188.


consider cutting costs by having medical students do nursing care in place of paid nurses. In addition, Helmstadter points out that although a nurse leader claimed that boundaries between nursing and medicine had been plainly marked out by 1890, the 1891 census put thousands of men and women described as medical students and assistants under the category, ‘sick nurse.’ Helmstadter argues that in general doctors defined nursing expertise as ‘physical skills in handling the patient,’ which required a great deal of physical strength, ‘experience and familiarity with the new medical therapeutics’ and ‘…clinical knowledge of symptomatology.’ She also cites a doctor who defined nursing as ‘continuously caring for a patient who is dangerously ill,’ thus reinforcing the medical view of nursing as the ‘ability to recognise clinical symptoms.’ According to Helmstadter, nursing leaders did not agree with this definition but never devised one of their own which would establish a unique body of nursing knowledge and skill.

Nightingale had defined nursing work in terms of ‘sanitary’ work and ‘surgical’ work. The nursing work which medical students were doing in Helmstadter’s discussion included activities from both categories. Feeding patients and making them comfortable are sanitary nursing. Continuously watching for and recognizing clinical symptoms is surgical work. In other words medical students were doing both kinds of nursing work; medical students were doing it but it was nursing work.

33 Helmstadter, , 'Doctors and Nurses in the London Teaching Hospitals,' p. 188.
34 Helmstadter, , 'Doctors and Nurses in the London Teaching Hospitals,' p. 165.
35 Helmstadter, , 'Doctors and Nurses in the London Teaching Hospitals,' p. 190.
Regardless of who was doing the work, those who were doing it recognised that what they were doing was nursing. This is the work that trained nurses developed. Nurses did not develop this work from the ground up rather they took what was being done and refined and expanded it.

Decades later Nightingale gave a more simplified conceptualisation of nursing and explained with more clarity what she meant by sanitary knowledge and care of the sick. In 1893 she wrote a paper on the differences between health nursing and sick nursing which was presented at the World’s Fair Congress on Hospitals, Dispensaries and Nursing in Chicago. The paper was entitled ‘Sick nursing and health nursing,’ and in it Nightingale outlined the difference between the two. Sick nursing or ‘nursing proper’ was practiced ‘under’ doctors and had to be learned in hospital wards, while health nursing was to be taught and practiced in the home. Health nursing encompassed activities in which all women should be engaged because ‘God did not mean mothers to be always accompanied by doctors.’ Sick nursing was the servant of medicine, but health nursing was not. Nightingale reiterated that a new practitioner should be developed, one which she called the ‘sanitary missioner.’ A syllabus of proposed lectures for sanitary missioners was included at the end of the paper which outlined lectures on care of homes, keeping the body clean, circulation and keeping the body warm with proper clothing, digestion and proper food, care of children, and what to do before and after visits from the doctor. Nightingale made it clear that in her view the health missioner role

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was considerably more important than the sick nurse role. The paper was short and did not have room for more information even if Nightingale had been inclined to include more about the details of good nursing. Her major works after *Notes on Nursing* focused on hospital management, particularly in regard to military hospitals, and sanitation in India, \(^{38}\) not on further discussion of the many little things that comprised good nursing.

The concept of good autonomous nursing as many small things recurs, however. One context for this recurrence involved a much publicised series of events at Guy’s Hospital in 1880. Controversy at Guy’s developed between the medical staff and nursing staff over the appointment of a new matron who was thought to have been given too much authority. One of the staff nurses wrote an article about the controversy which was published in a popular magazine. In the article she asserted that although some doctors claimed to know everything about nursing, there was actually nursing work and knowledge which was unique to nursing and which doctors did not know.\(^{39}\) In a subsequent article she clarified what she meant by the nursing which doctors did not know about in a way that emphasised the fundamental nature of the concept that good nursing involved skilled management of numerous details.\(^{40}\) She used an example of a patient for whom the doctor has left an order stating that the patient must not be moved. She argued that the nurse would not then ask the doctor how she would change the patient’s sheets, and that if she did ask such

\(^{38}\) Bostridge, *Florence Nightingale*.

\(^{39}\) Margaret Lonsdale, ‘The Present Crisis at Guy’s Hospital,’ *The Nineteenth Century*7 (1880), pp. 677-683.

\(^{40}\) Margaret Lonsdale, ‘Doctors and Nurses III’ *The Nineteenth Century* (June 1880), p. 1105.
a question, the doctor could ‘reasonably reply, ‘that is your business.’ She then stated that ‘In this, and in a thousand other little ways, small, no doubt, but of infinite importance to the comfort and well-being of the patient, the nurse’s and not the doctor’s ingenuity is taxed.’

This brief description of good nursing as a thousand little things echoed that of Nightingale. Extensive elaboration of the concept was carried out by Nightingale’s friend, London Hospital matron Eva Luckes. In her popular nursing textbook Luckes stated that a ‘trustworthy’ nurse had to be able to be ‘very patient and painstaking over all the innumerable ‘little things.’ Her directions for how to help a patient with a bedpan are instructive regarding the meaning of little things,

For patients who are able to raise themselves a little, a nurse should take the utensil in her left hand, and put her right hand gently and firmly under the patient’s back, with the palm next to the patient’s skin. If the patient is weak, it will give a sensation of support, and with a little practice this alone will enable a nurse to know whether the vessel is in its proper position. It is so hard upon the patients, in their weakness, to be left in a damp, uncomfortable condition... If patients cannot raise themselves in the least, a nurse must always ask another person to help her...and not attempt to push it in or to drag it out by main force. In the delicate condition in which the skin of such patients is certain to be, this alone is sufficient to induce a bed-sore...The fact of being dependent on a nurse for attentions of this kind must always be a source of distress to a patient, ...Nurses should grasp this fact, and take special pains to make the patient feel as easy as possible over these little matters...however trying the patient may be, the nurse must remember that his condition justly claims her utmost sympathy.

Again, the actions that Luckes described were activities which the nurse would implement using her own ‘ingenuity,’ on her own initiative without doctor’s orders,

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although the nurse would need to be careful to observe all doctor’s orders in the process.

Although Nightingale did not elaborate on her discussion of little things in *Notes on Nursing for the Labouring Classes*, she reinforced the importance of attention to little things in introductory lectures to probationers at St. Thomas’s Hospital. The concept of nursing as many little things appears in more limited contexts as well, such as an account of a nurse’s home visit in the journal *Nursing Notes* which stated that a nurse had performed ‘various little offices.’ In an address at the opening of the Johns Hopkins Hospital one of the organisers of the hospital, Dr John Billings, discussed the ‘art of nursing the sick, with all its thousand details.’ It was said that at the Philadelphia General Hospital many small things for patients had not been done well or not done at all before the arrival of British nurse Alice Fisher. All of these examples were associated with British nursing. They were found in a British nursing journal or associated with Alice Fisher, a British nurse, and Billings, who had recently returned from a fact finding tour of Britain at the time of the opening of Johns Hopkins Hospital.

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46 John Billings. ‘Address at Opening of Johns Hopkins Hospital, Baltimore’ *Trained Nurse and Hospital Supplement.* 2 (Jan-July 1889), p. 245.
47 Alice Fisher Alumnae Club Booklet circa 1893. MC 71, IV, 6, f.1, CSHN.
Notes on Nursing was widely read in Britain. It was also enthusiastically received in the United States. It was serialised in a popular American magazine and an American edition of the book was published in 1860. 49 Notes on Nursing for the Labouring Classes, with its explanations of good nursing as many little things separate from care given under the direction of doctors, was Nightingale’s favourite version of the book, 50 but it was not brought out in an American edition nor given coverage in American magazines. 51 American audiences were not exposed to Nightingale’s writings about nursing as unique little things which were essential to core nursing to the extent that audiences in Britain were.

In addition to core nursing, nurses were expected to be able to assist doctors with implementation of medical treatments and monitoring of patient status. In order to do this effectively, nurses needed to have some knowledge of what the doctors were doing.

Assisting doctors: ‘intelligent nursing’ and ‘stupid nursing’

According to Luckes, the work of doctors was to decide what was wrong with patients and devise plans of medical care for them. The work of the nurse was to ‘consider the methods of administering relief’ and to implement the doctors’ plan of care. 52 She repeated, in this context, that nurses had greater familiarity with many details with which it would be impossible for the doctor to be aware—the work that

49 D’Antonio, American Nursing, p. 5.
51 D’Antonio, American Nursing, p. 7.
nurses knew better than doctors. Luckes stressed that it was in implementing the plan of care and making doctors aware of what was happening with patients that doctors needed the help of nurses.\textsuperscript{53} She placed further emphasis on this topic and the two-way nature of the relationship between nursing and medicine,

...Doctors can often do so little without nurses that they are frequently the first to acknowledge that ‘nearly everything depends upon the nursing.’ This is a familiar phrase in reference to many cases. On the other hand, it is only right, in deference to the...different range of studies of doctors, that nurses should help them to carry out whatever means they may think fit to adopt, by prompt and intelligent obedience.\textsuperscript{54}

Nurses’ unique knowledge was necessary for the good of the patient, but the doctors’ unique knowledge was also, of course, indispensable. And in their special work, doctors needed the help of nurses.

The meaning of ‘intelligent nursing’ is explicitly stated in a journal article about nursing patients with typhoid fever. The anonymous author stated that, ‘the more a nurse is able to appreciate the “why and wherefore” of the medical attendant’s directions, the more intelligently will she be able to carry them out...’\textsuperscript{55} The author then gave an explanation about the organisms that caused typhoid and how they were spread. After this she asked the reader to imagine the multitude of deadly organisms floating in the utensil containing stool and the terrifying consequences of pouring them untreated into the drains. Knowing this, she explained, the nurse would intelligently disinfect the stool, according to the doctor’s directions, with a great deal of conscientiousness because she understood why it was so important. At the end of

\textsuperscript{54} Eva Luckes. \textit{General Nursing, Sixth Edition}, p. 34.
\textsuperscript{55} Anonymous, ‘Typhoid Fever’ \textit{Nursing Notes} (June 1\textsuperscript{st}, 1891), p. 77
the day rather than being ‘haunted’ by a vision of rampant multiplication of typhoid horror, the nurse could rest assured that ‘not one of the organisms has survived your attack.’

Authors of late nineteenth and early twentieth century nursing literature repeatedly wrote about intelligent nursing. Nightingale famously stated that being ‘devoted and obedient’ would do as well for a horse as it would for a nurse. The rest of that statement is that a good nurse would be capable of ‘intelligent obedience.’ To illustrate, she used an example of a nurse who could not be trusted to use her intelligence to light a small fire for a patient who, according to the doctor’s instructions, was not supposed to be in a room that was too warm. The patient was cold because this nurse understood having a large fire or no fire but did not possess the intelligence to make a small fire for the patient. Nightingale would later refer to this concept as the ‘obedience of intelligence, not the obedience of slavery,’ the obedience of the slave being ‘stupid obedience.’

Zepherina Veitch also referred to the difference between intelligent and stupid obedience. The ‘stupid nurse’ would ‘go on doggedly’ carrying on with doctor’s orders even if changes in patient condition warranted calling the doctor to report the new symptoms and to ask whether he wanted to change the treatment. Luckes

56 Anonymous, ‘Typhoid Fever’ Nursing Notes (June 1st, 1891), p. 77
57 Nightingale. Notes on Nursing for the Labouring Classes, p. 86.
58 Nightingale. Notes on Nursing for the Labouring Classes. p. 86.
59 Nightingale. Florence Nightingale to her Nurses, p. 11.
stressed the importance of such ‘prompt and intelligent obedience.’\textsuperscript{61} She forcefully
stated that the consequences of ‘ignorant’ nursing could be ‘cruelly increased
suffering’ or loss of life.\textsuperscript{62} Other writers also emphasised the importance of
intelligent nursing.\textsuperscript{63}

The ability to notice changes in patient status was an important part of intelligent
nursing. Luckes’ explained that nurses must be able to accurately notice what is
going on with patients and that in order to do this a nurse must possess a certain
amount of intelligence.\textsuperscript{64} In her widely used nursing textbook, Clara Weeks-Shaw
also pointed out the importance of this concept. Although she did not use the term
‘intelligent nursing,’ she emphasised the importance of the nurse knowing what to do
about her observations. In her textbook chapter on observation of symptoms Weeks-
Shaw noted that not only must the nurse be able to accurately observe patients, she
must also be able to make decisions about what to do with that information,

Shall she send for the doctor in the middle of the night, or apply her own
resources? Shall she give or withhold the medicine left to be used only in
emergency? Shall she alter or let alone an arrangement which has proved
unexpectedly uncomfortable? Are questions constantly arising.\textsuperscript{65}

Nurses needed to be able to consider various factors in regard to the patient’s care
then implement the doctors’ orders and make decisions based on sound reasoning.

\textsuperscript{61} Luckes. \textit{General Nursing, Sixth Edition}, pp. 15, 34.
\textsuperscript{63} Edward Domville. \textit{A Manual for Hospital Nurses and Others Engaged in Attending the Sick.}
(London: J. & A. Churchill, 1875); Isla Stewart and Herbert Cuff, \textit{Practical Nursing} (Edinburgh and
\textsuperscript{64} Luckes. \textit{General Nursing, Sixth Edition}, p. 199.
\textsuperscript{65} Clara Weeks-Shaw. \textit{A Text-Book of Nursing, Second Edition} (New York: D. Appleton and
Company, 1894).

p. 85; Clara Weeks-Shaw. Edited by William J. Radford. \textit{A Text-Book of Nursing.} (London: Edward
Intelligently assisting doctors and effective core nursing were proficiencies which all trained nurses needed. As nurse training schools became established a need was felt to supply textbooks specifically intended for instruction of pupil nurses. Nightingale insisted that nursing had to be learned at the bedside, and nineteenth century pupil nurses spent a great deal of time doing work on hospital wards, but nursing textbooks were produced and became an important resource in training schools. Nineteenth century nursing texts are a useful resource for understanding what nurses were expected to know. Textbooks will be examined here especially to compare expectations in Britain and America.

**Textbooks, Nursing, and Medicine**

Analysis of nursing textbooks helps to shed light on differences in emphasis regarding nursing work and the relationship between nursing and medicine in America and Britain. Reading lists provide information about which books nursing students were expected to read. One of the earliest reading lists for nurses is the 1873 reading list for St. Thomas’s Hospital included in the syllabus of lectures delivered by Dr John Croft, medical lecturer to the probationer nurses. The list began with an ‘Introductory Address, by Miss Nightingale.’ Students were expected to read *Notes on Nursing* ‘at least four times.’ The list also included two other short nursing texts, *Handbook for Nurses* by Z. Veitch and *A Manual for Hospital Nurses* by E. J. Domville, along with Berkeley Hill’s *Essentials of Bandaging*. Medical books on the

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list include three chapters in Dr Sir T. Watson’s *Lectures on Physic* and material on 28 medical conditions in Tanner’s *Index of Disease*. Reading on surgical subjects included several chapters in Druitt’s *Surgeon’s Vade Mecum*. ‘Additional Subjects for more Advanced Probationers’ included six more medical textbooks. The list was signed with Croft’s name.⁶⁷

Several of the books on the list were medical textbooks. From the beginning of the Nightingale School pupil nurses had read medical books. According to Baly, in the early days of formal nurse training, students had only medical books to read and would borrow these from doctors. Nightingale believed that reading medical textbooks created serious problems for pupil nurses. She believed that intelligent pupils would realise that they could not know very much without further instruction and become discouraged. Those who were not so intelligent would think that they knew the material, which would make them dangerous.⁶⁸

What nurses should read was enough of an issue that when the editorial board of the journal *Nursing Notes* decided to hold a writing contest in 1893 they chose to ask readers to write about the topic of what nurses should read. The author of the winning article, ‘Hospital Sister,’ reminisced that when she had been at her training school (she did not say which one) she and the other probationers had been left up to themselves to read whichever books they thought suitable. Because of that, she said that they read medical books which were too advanced for them and became

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⁶⁷ John Croft, ‘Syllabus of Mr Croft’s Lectures for 1873.’ HI/ST/NTS/C13/1, LMA.
confused. She then explained that probationers in 1893 had the opposite problem; they were told exactly what to read and so never learned to ‘stand on their own feet.’ She hoped that she could tell prospective probationers how to go about reading before and during their nurse’s training and so avoid either extreme.\(^6^9\)

The author recommended reading Eva Luckes’ *Lectures on General Nursing* before entering the school. Upon entering their school probationers would need a medical dictionary, an elementary physiology book, and a manual on nursing (whatever was recommended by the training school). If a school did not recommend a certain nursing manual the author of the article endorsed Humphrey’s *A Manual of Nursing: Medical and Surgical*. She recommended having a ‘small elementary’ book on diseases and therapeutics to use as a reference but cautioned against reading advanced medical books found in hospital libraries and to avoid medical papers. A book on materia medica (medications), bandaging, antiseptics, urine testing for nurses, and gynaecology would be useful. For surgical information Bell’s *Lectures on Surgery to Nurses* was advised. If a nurse were planning on working in a hospital after graduation she would be teaching others and would find Luckes’ *Hospital Sisters and their Duties* helpful. She suggested that those who would be developing curricula for schools of nursing might benefit from Isabel Hampton’s *Nursing: Its Principles and Practice*.

\(^6^9\) Hospital Sister, ‘Prize Competition: When, How and What Should a Nurse Read?’ *Nursing Notes* (Nov 1\(^\text{st}\), 1893), p. 145, (continued Dec 1\(^\text{st}\), 1893), p. 159.
It can be seen from these lists that British probationers read both nursing and medical texts but that by the 1890s they were enthusiastically advised to avoid advanced medical books and to read books specifically written for nurses. Even at St. Thomas’s in 1873 only ‘advanced’ probationers—probably special probationers—were advised to read more advanced medical texts.\textsuperscript{70} Special probationers made up a small proportion of total probationers in London schools of nursing, so most of the probationers would not have been advised to read them.\textsuperscript{71}

‘Hospital Sister’ mentioned Isabel Hampton’s textbook, \textit{Nursing: Its Principles and Practice}. Hospital Sister did not recommend this book for general reading rather she advised that nurses who would be formulating curricula for nurse training schools might find it helpful. This volume provided a list of books which Hampton recommended for a good nursing reference library. In the 1902 second edition, which Hampton noted had not changed significantly from the first edition, the recommended books included \textit{Principles and Practice of Medicine} by Osler, \textit{Materia Medica and Therapeutics} by Wood or Hare, \textit{Textbook of General Therapeutics} by Hale White, \textit{An American Textbook of Surgery} by Keen and White, and Tyson’s \textit{Practical Examination of Urine}. Several other medical books were also included. Nursing books were \textit{Notes on Nursing}, \textit{Guide to District Nursing} by Mrs Dacre Craven, Clara Weeks’ \textit{Textbook of Nursing}, and Luckes’ \textit{Duties of Hospital Sisters}. Other books to be used included an anatomy and physiology book for nurses, a book

\textsuperscript{70} John Croft, ‘Syllabus of Mr Croft’s Lectures for 1873.’ HI/ST/NTS/C13/1, LMA.  
on materia medica by nurse Lavinia Dock, and a handbook of cooking.\textsuperscript{72} In the third edition of Hampton’s book, published in 1907, Hampton stated that she had changed a great many things. One change was that the list of books for a nursing reference library was smaller. The medical books were the same but the only nursing books mentioned were \textit{Notes on Nursing}, \textit{Guide to District Nursing}, and \textit{Duties of Hospital Sisters}.\textsuperscript{73}

Hampton did not go into specific instructions about how the books should be used, but she did recommend several advanced medical books, and in the later edition of her book she included fewer nursing books than the earlier edition. Again, it is not known why, and it is possible she wanted students to obtain specific books required by individual schools of nursing. She did include nursing textbooks and other books specifically written for nurses. Dock’s book on materia medica was specifically tailored for the needs of nurses, for instance, by leaving out material included in books on materia medica written for doctors that did not pertain to nurses.\textsuperscript{74} But Hampton assumed that advanced medical books should also be included. Her recommendations include more medical books than those of ‘Hospital Sister.’ This suggests that American nurses were expected to have more medical knowledge than British nurses.


What was the material which was included in the medical textbooks? Examination of medical textbooks reveals a pattern of organisation of material which doctors were expected to know. All of the medical texts examined for this study were organised into sections devoted to individual diseases. Each disease was discussed in regard to some combination of the following: general description, aetiology, symptoms, diagnosis, prognosis, and treatment. William Osler’s *Principles and Practice of Medicine* included all of these. Thomas Tanner’s *Index of Diseases and Their Treatment* was more succinct and included descriptions, symptoms, and treatment. The surgical textbook, Robert Druitt’s *Surgeon’s Vade Mecum* included descriptions, causes, consequences (symptoms), and treatments. Other medical texts had similar combinations of these components. Medical textbooks consisted of factual descriptions of diseases and their medical and surgical treatments conforming to medical and surgical functions of diagnosis and treatment of disease. Treatments consisted of medications, diet, various baths, poultices, leeches, and other applications as well as various levels of physical activity and surgical interventions.

The nursing textbooks examined for this study contained components which were not included in the medical texts. Components of nursing texts not included in medical textbooks included specific instructions for carrying out personal care of

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patients, details regarding how to give emotional support, brief histories of nursing, explanations of the roles of nurses, and explanations of the relation of nursing to medicine. These aspects of nursing texts for the most part correspond to core nursing work. In order to be able to intelligently assist doctors, nurses were also expected to understand why patients were receiving medical treatments which were administered by nurses such as patient activity, diet, and medicines. An examination of specific nursing textbooks suggests that American nursing textbooks put more emphasis on these medical aspects of care while British nursing textbooks put more emphasis on core nursing.

Specific nursing textbooks from Britain and America will be compared here. Two widely used American nursing textbooks and three widely used British textbooks will be most closely examined. The American textbooks are Isabel Hampton’s Nursing and Clara Weeks-Shaw’s Textbook of Nursing, which was included on Hampton’s list of recommended texts. The British textbooks which are examined are Eva Luckes’ General Nursing, Laurence Humphry’s A Manual of Nursing, Rachel Williams and Alice Fisher’s Hints for Hospital Nurses, and Isla Stewart and Herbert Cuff’s Practical Nursing. All of these books were published by large reputable publishers and went into multiple editions. Other British nursing texts which will be discussed here are Angelique Pringle’s A Study in Nursing, and Zepherina

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Veitch’s *Handbook for Nurses for the Sick*. Another American text, Bellevue Hospital’s *A Manual of Nursing*, will also be discussed.\(^{80}\) A comparison will be made between the second edition of Weeks-Shaw’s textbook and a British edition of the book which was adapted from it.\(^{81}\)

Nurse training schools in both Britain and America recommended Nightingale’s *Notes on Nursing* as a standard work and nursing textbooks in both countries referred to concepts discussed by Nightingale. But *Notes on Nursing* was not written as a textbook for nursing students, so it cannot be directly compared with books written for that purpose.

One of the earliest nursing textbooks was Veitch’s *Handbook for Nurses for the Sick*, published in 1870. Veitch wrote her handbook in order to give ‘hints’ to help new nurses to be able to learn their work faster and with less trouble. She stated that her most important objective was to provide basic hints on various topics in a volume that almost any nurse could afford to buy. She ended her preface with the statement that if she had

> entered more fully into these subjects, it would have made the work more expensive, and at the same time have rendered it very difficult for me to avoid interfering with subjects not strictly within the province of a nurse…\(^{82}\)


She thus stressed the importance of keeping nursing and medicine separate and made it clear that a longer book would have been inappropriate because it would have included material outside of the nursing domain. Veitch’s book is small, comprising a total of fifty-six pages. But despite the small size of the book, she devoted four pages to general remarks—resembling Nightingale’s thoughts—about moral responsibilities, the importance of ‘studying her patient first in everything,’ and becoming familiar with ‘every detail of nurses’ work.’ She also warned prospective nurses that they should not be surprised to find that they are ‘always a hard-worked, often a weary, worn, and sorely harassed woman.’ True to her purpose she devoted the next thirty-five pages to brief hints about such topics as beds, bedpans, undressing patients, giving enemas, and preparing for operations and finished with a glossary and lists of weights and measures.

Rachel Williams and Alice Fisher’s *Hints for Hospital Nurses*, was a 170 page text published in 1877 with the express purpose of acquainting new probationers with expectations, terminology, and work encountered by new nurses in the hospital setting. Williams and Fisher were both respected superintendents of nurse training schools. Williams had been instrumental in establishing the nurse training school at the Edinburgh Royal Infirmary, and Alice Fisher had been a successful matron at two British hospitals, the General Hospital in Birmingham and Addenbrooke’s

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84 Rachel Williams and Alice Fisher, *Hints for Hospital Nurses* (Edinburgh: Maclachlan and Stewart, 1877). The second edition of this book was published in 1891 after the death of Alice Fisher and the marriage of Rachel Williams and was entitled *Norris’s Nursing Notes: Being a Manual of Medical and Surgical Information for the Use of Hospital Nurses and Others* (Marston: Sampson Low, 1891).
Hospital in Cambridge, before going to Philadelphia to establish the nurse training school at the Philadelphia General Hospital. They advised readers that the material in their book was very basic and that if a reader wished to read more complex material they would have to look elsewhere. The authors specifically wished to provide simple explanations regarding the material which they would hear in doctor’s lectures noting that they had heard various comments from probationers as they left doctor’s lectures, from those who felt the doctors spoke to them as if they were children to others who remarked that ‘It would have been beautiful, if I could but have followed him.’ It was to this ‘latter class of listeners’ that the authors directed their book. The book addressed the various body systems including some detailed descriptions of anatomy. Practical instructions for various ‘ward duties’ which nurses would be expected to perform such as applying leeches and using the catheter were given, but information about treatment was general with little discussion of specific physical assessment, diagnostic tests, or medications. The authors discussed symptoms which nurses were expected to report to doctors, occasionally advising readers to obtain more detailed instructions from the ward sister or staff nurse. The stated purpose of Williams and Fisher’s book was to clarify doctor’s lectures for probationers. If they intended to reinforce what every nurse should understand from those lectures, their text suggests that nurses were expected to know how to intelligently implement treatments and recognise dangerous symptoms but had no need for theoretical details about diagnosis and treatment.

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87 Williams and Fisher, Hints for Hospital Nurses, p. 7.
Because this book was intended to clarify doctor’s lectures, it is not surprising that Williams and Fisher did not dwell on topics related to core nursing care.

A nursing text which emphasised perhaps more than any other the various aspects of Nightingale’s ‘little things’ associated with ‘sanitary knowledge’ was authored by Eva Luckes, matron of The London Hospital and friend of Nightingale. Luckes’ nursing textbook *Lectures on General Nursing*, later shortened to *General Nursing*, was a compilation of lectures which she gave to probationers at The London Hospital.88 These lectures were devoted to nursing, while medical and surgical content was presented in two subsequent series of lectures from members of the medical staff.89 As a friend of Florence Nightingale and one who adamantly agreed with Nightingale’s ideas about unique aspects of nursing work and making nursing as distinct as possible from medicine, it is not surprising that Luckes would take the time and effort to write a nursing textbook devoted to core nursing. Luckes explicitly stated that her purpose was to elaborate on unique aspects of nursing, and she had much to say about this topic. The sixth edition published in 1906 had over 350 pages. *General Nursing* will be examined closely in this thesis in order to shed light on what Luckes meant when she discussed unique aspects of nursing and differences between nursing and medicine.

Luckes devoted the first chapter of *General Nursing* to what she called ‘real’ and ‘true’ nursing and to explaining how nursing was different from medicine. In this

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regard she echoed Nightingale’s emphatic insistence that nursing and medicine were fundamentally different.\textsuperscript{90} According to Baly, only Nightingale knew what was meant by a ‘nursing model’ as opposed to medicine, \textsuperscript{91} but Luckes believed that nursing was different from medicine, and went into detail about differences between the two. She emphasised that prospective nurses must realise that they were training to become ‘skilled’ nurses and not doctors. She continued,

Training schools for nurses are not established with the object of supplying second or third-rate doctors, but to produce first-rate nurses, which is quite a different thing. A trained nurse of average ability will be able to perform many little offices for the sick infinitely better than a doctor of average ability could, and doctors themselves are the first to acknowledge this.\textsuperscript{92}

Here Luckes included the concept of nursing encompassing numerous small details and pointed out that this is nursing and not medical knowledge and skill. She elaborated on the difference,

Nurses have to consider the methods of administering relief, not how to direct treatment; that is essentially the doctor’s business. For instance…It is for the doctor to decide whether a patient must be kept in bed, and how long he must remain there; it is for the nurse to know how a patient may best be made comfortable in bed, and how that bed should be made. These simple examples serve to show the respective duties and position of doctor and nurse and also illustrate how utterly dependent the patient’s welfare is on the skill and efficiency of both.\textsuperscript{93}

After this discussion Luckes stated that many people in the general public did not understand the difference between nursing and medicine and sometimes meant to compliment a good nurse by saying that she was ‘almost a doctor.’ According to Luckes, even though doubtless said with good intentions, a good nurse would not

\textsuperscript{90} Florence Nightingale letter to Dr W. Gill Wylie at Bellevue Hospital reprinted in Anonymous, ‘On Trained Nurses, A Forgotten Letter from Florence Nightingale,’ \textit{The Century Illustrated Monthly Magazine} 81, new series: 59 (November 1910 to April 1911), p. 159-60.
\textsuperscript{91} Baly, \textit{Florence Nightingale and the Nursing Legacy}, p. 58.
\textsuperscript{93} Luckes, \textit{General Nursing, Sixth Edition}, pp. 6-7.
find the comment agreeable. No well-educated nurse would want to do anything that would be akin to ‘amateur doctoring.’ While there might be occasions when a nurse would have to take a doctor’s place in his absence in order to help a patient in an emergency or occasions when a doctor would have to do the same in the absence of a nurse, it would be unjustifiable under any other circumstances.\(^94\) She did not discuss specifically how much medical knowledge a nurse should have in order to take the place of the doctor in an emergency, but the implication was that she would not be equal to the doctor in such circumstances, just as the doctor would not be expected to perform a nurse’s duties as well as a nurse could.

Like Nightingale, Luckes discussed the importance of certain personal qualities necessary for good nurses and nursing as art. Nightingale had emphasised that nursing was perhaps the finest art in the sense that like painting and sculpting it involved taking materials and changing them into new, pleasing forms. But instead of using ‘dead canvas or cold marble’ a nurse transformed living human beings.\(^95\) In her turn, Luckes made a salient analogy with musicians. Regardless of how much someone wanted to be a singer, if the person did not have a pleasing voice, she would never be particularly successful.\(^96\)

Luckes also wrote about hospital etiquette, such as standing while visitors, including patients’ friends, hospital officials, and doctors, were in the wards, and while giving and receiving patient related information to and from the sister. After her discussion


\(^{95}\) Florence Nightingale, ‘Una and the Lion,’ in *Good Works*, 9 (June 1\(^{st}\) 1868), p. 362.

of etiquette, Luckes went into some detail about the actual work that nurses were expected to do, continually focusing on the little things. She elaborated on housekeeping, patient hygiene, and toileting. She devoted a page and a half to details involved in helping a patient with a bedpan. Methods of feeding patients (not including specific foods they should be fed) took six pages; details associated with sleep took eight. Undressing accident patients required five pages of instructions. In regard to carrying out medical treatment plans, she gave short simple explanations about splints, strapping, bandaging, cold and heat, baths, fomentations, poultices, counter-irritation, blisters, surgical dressings, taking temperatures, giving enemata, and placing urinary catheters. Hypodermic injection was explained, but she noted that in the London Hospital, where she was matron, the sisters gave any hypodermic injections ordered for the patients.97

Haemorrhage, delirium tremens, drunkenness, fainting, drowning, burns, and erysipelas were discussed with few details, which were mostly about how to keep patients safe. A chapter was devoted to observation of symptoms and how to report them to the doctor, including some instructions concerning collection and examination of urine. In regard to observation of urine Luckes gave details about how to evaluate whether patients were urinating normally, how to collect urine, and how to ascertain whether or not the urine was normal. She gave some information about abnormalities, but informed her readers that because ‘in ordinary circumstances, the testing of urine does not come within the nurse’s province, it

would not be suitable to enter into further details on this subject…'⁹⁸ In the early
days of the Nightingale School at St. Thomas’s, when one of the most pressing
problems was to determine what nurses should do, probationers began to take on
tasks such as urine testing which Nightingale did not consider to be proper nursing.⁹⁹
Luckes agreed and made a point of saying so. Again nurses were reminded of the
separate spheres of medicine and nursing. The inclusion of a special book on urine
testing on ‘Hospital Sister’s’ list of recommended books for nurses suggests that not
everyone agreed that nurses should not be doing urine testing. It is likely that in large
teaching hospitals such as the London where Luckes was matron resident medical
staff did the urine testing, but in smaller hospitals and in private duty nursing there
would have been few or no resident medical staff. Williams and Fisher stated that
nurses might be called upon to test urine for sugar and albumin but advised
probationers that they would have little use for knowing about other kinds of urine
testing.¹⁰⁰

In one of the last chapters, of General Nursing in which Luckes discussed care of
the terminally ill patient, she remarked that ‘It would not be suitable in a book on
‘General Nursing’ to enter scientifically and minutely into the physiological aspects
of ‘life’ and ‘death’…’¹⁰¹ She did, however, use over three pages to give details
about how the nurse should lay out the expired patient and six more pages to discuss
details regarding how the nurse should interact with the patient’s friends. A chapter

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⁹⁹ Baly, Florence Nightingale and the Nursing Legacy, p. 172.
¹⁰⁰ Williams and Fisher, Hints for Hospital Nurses, p. 160.
on operations included three pages on how to sympathise with a patient undergoing surgery while directions for care of a patient with a haemorrhaging stump stated only, ‘…the nurse must raise it whilst waiting for the surgeon’ and be careful of her facial expression so as to be sure not to alarm the patient.\textsuperscript{102} The next chapter deals with care of patients after various kinds of surgery and included instructions for positioning, watching for haemorrhage, tracheotomy tents and cleaning, et cetera. A sample of these instructions illustrates their cursory nature,

\begin{quote}
The only point to which special attention need be called in cases of lithotrity is that the surgeon will expect all the urine to be carefully measured and strained, and all the fragments of stone reserved for his inspection.\textsuperscript{103}
\end{quote}

When a nurse has charge of a case of stricture she must guard against chills, see that the bed and body linen of the patient is supplied warm, and watch carefully for rigors.\textsuperscript{104}

\begin{quote}
In most uterine operations the special point a nurse has to keep in remembrance is that the patient must not be allowed to stand or sit up for some days, though in other respects she may feel and be quite well.\textsuperscript{105}
\end{quote}

These explanations are short and contain little specific information about the medical functions of diagnosis and treatment. Luckes did not include information about which medications doctors would use for specific medical conditions and kept discussion of other medical treatments and diagnostics very brief. A similar type of instruction was given in the next chapter for various medical conditions followed by a chapter on care of the patient with typhoid fever and a chapter for care of the patient with diphtheria. Luckes kept information related to medical diagnosis and treatment to a minimum.

\textsuperscript{102} Luckes. \textit{General Nursing, Sixth Edition}, p. 239.
\textsuperscript{103} Luckes. \textit{General Nursing, Sixth Edition}, p. 250.
Luckes made it clear that her book was a compilation of the nursing lectures which she gave to probationers at the London Hospital. She also explained that in addition to lectures on true nursing, probationers at the London received lectures from doctors. These doctors’ lectures helped pupil nurses to understand medical interventions enough to enable them to practice intelligent nursing. ‘Hospital Sister’s’ recommended reading list included a popular nursing textbook which was a compilation of doctors’ lectures to nurses, Laurence Humphry’s *A Manual of Nursing: Medical and Surgical*, first published in 1889. Humphry was a fellow of the Royal College of Physicians and had given lectures to probationers at Addenbrooke’s Hospital in Cambridge where he was an influential member of the medical staff. He based his book on those lectures. Although he apparently was not associated with the large London teaching hospitals, Addenbrooke’s was an important hospital with a respected medical school, and it was the first hospital in Britain in which general anaesthesia was used during surgery. In a preface to the book Humphry thanked Sir Dyce Duckworth, a member of the medical staff St. Bartholomew’s Hospital, for the use of notes on the lectures which Duckworth gave to probationers there. Humphry also noted that he appreciated hints he had received from John Croft of St. Thomas’s Hospital regarding surgical nursing. St. Bartholomew’s and St. Thomas’s were two of the most prestigious London teaching hospitals.

hospitals and lend further credence to Humphry’s work. It is difficult to know if this book was used in London nurse training schools, since ‘Hospital Sister’s’ recommendations were given in a nursing journal and not associated with any school, unlike Hampton’s recommendations which she had probably implemented at Johns Hopkins and intended other superintendents to use when setting up nurse training school libraries. Nevertheless, Addenbrooke’s Hospital did have a nurse training school, established by prominent Nightingale School graduate Alice Fisher in the late 1870s, and Humphry gave lectures to nurse probationers there. His textbook was a compilation of lectures to nurses at a reputable nurse training school established by a capable and respected matron.

Humphry’s nursing manual began with a chapter on ‘general management of the sick room’ which included extensive instructions about ventilation and short instructions about keeping the room clean and providing personal care of the patient. ‘Prevention of bed-sores’ took two sentences. Five lines were sufficient for use of bedpans. A paragraph on ‘feeding in states of exhaustion’ noted that in difficult cases the nurse would need to ‘use her discretion and her tact.’ A page on ‘observation of the sick’ was devoted to the importance of observation of symptoms so that an accurate report could be made to the doctor. The chapter on general management was fourteen pages long with the bulk of the 248 page book organised by body system with instructions for specific diseases related to each system. Humphry’s was the only nursing textbook examined for this study to be organised in this way, which is similar to the

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organisation of medical books of the day. He included several pages of anatomy and physiology for each body system, described symptoms of disease in detail, and discussed some pathophysiology, but did not go into detail about pathophysiology or medical treatment. In regard to inflammation, for example, he simply described symptoms of inflammation, the appearance of pus, and the reason for leaving deep wounds open—to prevent formation of an abscess. In a footnote he did go into some detail on urine testing. Thus, the book was organised in a similar way to medical textbooks but focused on material with would help nurses to recognise important symptoms and have a general understanding of why certain treatments were used without divulging details about diagnosis and treatment.

Another popular British nursing textbook, *Practical Nursing* by Isla Stewart, matron of St. Bartholomew’s Hospital and Herbert Cuff, medical superintendent of a London fever hospital, began as two volumes. The first volume was published in 1899 and covered ‘the nurse’s work from a general point of view.’ The second volume, which would be published at a later date, was to cover the nursing of specific diseases. Thus, nursing content and medical content were separated into two different volumes. The purpose of the set of books was to give more detailed instructions for various patient interventions, such as vapour baths, than were included in other nursing textbooks. The authors stated that they recognised that such ‘operations’ could really only be taught at the bedside but that some pupil nurses did not have the opportunity to have a great deal of experience with every procedure and

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might benefit from detailed instructions in a book. In all of their instructions they wanted to help the nurse to understand the reasons for what she was doing in order to ‘increase her interest in the work, and lead to a more intelligent performance of it.’

The first volume of the first edition of this text contains a one page history of nursing followed by a discussion of the role of the nurse. This discussion focuses on the nurses’ role in assisting doctors and does not discuss differences between doctors and nurses. The remainder of the book consists of general directions for hygiene of the ward, observation of patients, personal care of patients, medication administration, and details of enemata and various kinds of baths. This information is similar to that in the other British nursing textbooks. A copy of the second edition of Stewart and Cuff’s book was not found, but the third edition published in 1910 combined both volumes in one. In the preface to this edition Cuff apologised for the delay in its publication which had resulted from the illness and death of Isla Stewart. The first three quarters of the book was the same as the first volume of the first edition. The remaining portion was made up of descriptions of various diseases and their treatment, including some detail of medical treatment such as specific drugs which were commonly used. This kind of information is not found in the other British nursing textbooks. In other words, this nursing textbook had more medical material than the others.

Unlike Luckes and Nightingale, Stewart was a staunch proponent of nurse registration. Many British nurses during this time period were divided into two

\footnote{Stewart and Cuff, \textit{Practical Nursing}, pp. v-vi.}
camps, those who supported registration and those who opposed it. Under the leadership of prominent nurse Ethel Fenwick and other renowned nurses such as Stewart, pro-registrationists organised themselves and courted the support of medical men. Registrationists hoped that support from the medical profession would increase nursing prestige and believed that making nurse training more scientific, like medicine, would help to achieve this goal. In addition, Helmstadter notes that registrationists emphasised that although nursing was a ‘distinct profession,’ nursing should be an ‘inseparable part’ of medicine. Stewart’s association with nurses who wanted to make nursing more scientific and who wanted to emphasise nursing’s connection with medicine are consistent with a nursing textbook which includes details of medical science, and which was co-authored with a doctor. Nevertheless, the authors did separate what they considered to be medical material from what they considered to be nursing material into two separate volumes.

Stewart and Cuff’s book was first published at the turn of the century while Luckes’ book was first published a decade and a half earlier. While the later publication of Stewart and Cuff’s book could suggest a trend toward medicalisation of nursing in Britain, the new sixth edition of Luckes’ book published in 1904 had not changed substantially in this regard. This suggests that her focus on core nursing was still in demand.

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There is little evidence that a textbook similar to Luckes,’ which was devoted to nursing content as separate from medical content, was published in America. That such a book was produced in Britain and that it became one of the most widely disseminated nursing books in that country indicates that a book devoted to core nursing was considered important there. Luckes’ textbook about hospital sisters was included on Isabel Hampton’s list of recommended books, but her book on general nursing was not.

Isabel Hampton’s, *Nursing: Its Principles and Practice*, became ‘Isabel Hampton Robb’s’ after she married Dr Hunter Robb between publication of the first and third editions of the book.\(^{116}\) Robb’s textbook contained material which was different from the above British textbooks. It included a chapter with an outline of the course of study at Johns Hopkins Hospital nurse training school and chapters on gynaecology, obstetrics, insanity, and the administration of anaesthetics. None of the British textbooks examined for this study mentioned nurse administration of anaesthetics.

Unlike Luckes, Robb did not include a chapter on how being a nurse was different from being a doctor. Luckes had included three entries in her book’s index under ‘Doctors.’ They were ‘Doctors, distinction between work and nurses,’ ‘Doctors, manner of reporting to,’ and ‘Doctors, relation of, to nurses.’\(^{117}\) Robb did not have an entry for doctors in the index of her book. This does not mean that Robb did not mention doctors, but she did not devote specific sections of her book to distinctions

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between doctors and nurses. She did, like all of the British authors, discuss the importance of implementing the doctors’ treatment plans and she devoted a section of a chapter to details about giving information about patients to doctors. She devoted considerable space to housekeeping, patient hygiene, and observation of symptoms. In regard to other aspects of patient care to which Luckes gave considerable treatment, Robb’s coverage was less comprehensive. For example, Robb included two paragraphs about helping patients to sleep, and her discussion of care of the dying patient consisted of advising nurses that, ‘Everything should be done for the peace and comfort of the dying patient,’ but excessive attention might be distressing, and stimulants should not be given by mouth after swallowing becomes difficult. Robb did not give details about interacting with the patients’ friends.118 Stewart and Cuff gave more attention to details of core nursing than Robb did, although not so much as Luckes.

In contrast, Luckes gave urine testing cursory coverage, insisting that urine testing was not a nursing function, while Robb devoted an entire chapter to this topic. Robb’s treatment of urine testing included details about how to prepare the urine and testing equipment and how to conduct various tests, including several tests for albumin, three for sugar, and some tests for urates. Robb noted that in order for nurses to be able to carry out these procedures, nursing students should learn ‘in the laboratory under a teacher, each member of the class actually making the tests and observing the results.’119 She also reviewed specific diseases associated with

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abnormalities of the urine. Humphry and Stewart and Cuff discussed procedures for doing specific tests on urine, but not in as much detail as did Robb.

Robb also went into significantly more detail in regard to taking the temperature and pulse than did Luckes. The chapter which dealt with feeding patients had one and a half pages of details regarding the feeding of helpless patients and those not inclined to eat compared with six pages in Luckes.’ Robb’s discussions of medical and surgical conditions often included more scientifically technical information. For example, on the topic of inflammation Robb wrote,

…Inflammation comprises those changes in the tissues which result from the action of certain irritants. The causes are 1. Mechanical…2. Physical…3. Infectious…The phenomena of inflammation are dilatation of the blood-vessels, an increased flow of blood to the part, the appearance in the tissues of leucocytes or white blood-corpuscles…An inflammation is said to be fibrinous, serous, or purulent according to the nature of the exudate…

On the same topic, Luckes wrote only, ‘The early application of moist heat has a tendency to cut short inflammation, as many people may have noticed when a poultice has been applied to a bad finger directly it becomes painful.’ Robb’s book was substantially more medically focused than Luckes.’ It was more similar to Stewart and Cuff’s textbook, but Robb included more information on pathophysiology. Robb’s textbook also had more information about pathophysiology and medicines than Humphry’s book. Humphry’s discussion of inflammation is very simple compared to that of Robb.

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121 Luckes. *General Nursing, Sixth Edition*, p. 120.
Another American nursing textbook, Bellevue Hospital’s *Manual of Nursing* also surpassed Veitch, Humphry, and Luckes for medical content. *Bellevue’s Manual* went into more detail than Veitch or Luckes in regard to specific procedures and crossed into areas such as which medications should be used for which medical conditions. For example, in the section on emergencies the authors instruct nurses to give a solution of carbonate of soda or magnesia to patients who have swallowed an acid,\(^\text{123}\) and to put a mixture of carron oil, equal parts linseed oil and lime-water, on serious burns.\(^\text{124}\) Giving directions for these kinds of activities in a book, even for emergencies, was not done in any of the British texts. Stewart and Cuff’s textbook did mention drugs commonly used for certain diseases, but did not specify precisely when and how to formulate and use them.

While comparing the above American and British textbooks is useful, idiosyncratic characteristics of the various authors may complicate the comparison. Fortunately, it is possible to avoid this issue somewhat by comparing a British edition and an American edition of a highly regarded nursing textbook by American nurse Clara Weeks-Shaw. The first edition of the book was written under the name Clara Weeks, and the second edition, which was used as the basis of the British edition was published after her marriage under the name Clara Weeks-Shaw. The first edition of Weeks’ widely used *A Textbook of Nursing* was published in 1886, one of the first

\(^\text{123}\) Committee of Bellevue Hospital, *A Manual of Nursing*, p. 91.
\(^\text{124}\) Committee of Bellevue Hospital, *A Manual of Nursing*, p. 86.
nursing textbooks published in America. In the preface Weeks explained that she had used ‘all authorities’ on the subject she presented, with the hope that other nurses would not have to go ‘through a mass of extraneous and over-technical matter’ to find what they wanted to know. Like Luckes, Weeks began her book with a chapter on what nursing was and the nurse’s relationship to the doctor. Her definition of nursing was, after Nightingale, to keep patients in the best conditions for nature to heal them. Her description of nursing work included

…executing physicians’ orders, administration of food and medicine, and the more personal care of the patient, attention to the condition of the sick-room, its warmth, cleanliness, and ventilation, the careful observation and reporting of symptoms, and the prevention of contagion.

In this chapter Weeks also gave details about how to help keep patients in an emotional state conducive to healing. Her discussion about doctors focused on how to keep the needs of patients paramount while obediently carrying out the doctors’ treatment plans. She gave a short history of nursing and nursing education with some emphasis on resistance on the part of some in the ‘medical profession’ who had at first worried that ‘educated nurses would trench upon their own province, and...immediately proceed to the practice of therapeutics on their own account.’ She gratefully explained that not many doctors had that attitude at the time of writing as they had come to realise that untrained nurses were much more likely to behave in that manner than trained nurses. She enjoined each nurse to prove her good education by ‘showing how completely and exclusively she can mind her own


126 Weeks. A Text-Book of Nursing.

business.' 128 Weeks stressed that nursing was of the highest importance and that, ‘in many cases the recovery of the patient will depend more upon the care he receives than upon medical skill.’ 129

Weeks then devoted three chapters to housekeeping and general care of the sick room and hospital ward, beds, bed-making, and bedsores. The following chapters dealt with the same kinds of topics which were covered by Luckes and Robb. They contained physiological and other scientific detail similar to Robb including a chapter on urine testing. The chapter on food included cursory material on how to feed helpless patients and a great deal of material about the chemical make-up of food and the physiological processes of digestion. Some of these chapters included detailed illustrations of such subjects as anatomy and microscopic blood cells. 130

The second edition of Weeks’ book was published in 1894 under Weeks’ married name, Clara Weeks-Shaw. 131 A third, ‘thoroughly revised and enlarged’ edition was copyrighted in 1902. 132 In the third edition the author left out some of the material which focused on the nature of nursing. For example, the first two pages of the introductory chapter on nursing were omitted. But the third edition was longer than the second. When material had to be cut, it was material about unique aspects of nursing that were deleted.

130 Weeks. A Text-Book of Nursing.
The British edition of Weeks-Shaw’s text was a revision of the second American edition. Published in 1894, the British edition was edited by William Radford, M.R.C.S., senior medical officer of the Poplar Hospital, and had an introduction by Sir Dyce Duckworth, eminent physician at St. Bartholomew’s Hospital in London. In order to produce a book that would conform to British ideas of separation of nursing and medicine, Radford diligently removed portions that were considered too medical. He explained that great care had ‘been taken to expunge from the text such references as related to treatment on the part of nurses independently of medical supervision.’ He pointed out that only ‘matters of importance’ for nurses had been kept and that anyone who was interested in knowing more about anatomy, physiology, and other topics beyond the scope of nursing could consult other sources.¹³³ Duckworth’s introduction also emphasised that British ideas about what was appropriate to put in a nursing textbook were different from those in America. He commented on the popularity of Weeks-Shaw’s book in America and then explained that parts of the book had to be ‘adapted’ to the ‘customs and arrangements which prevail in…this country,’ adding,

Some of the instruction in the original lectures appeared to be designed with the object of training an irregular order of medical and surgical practitioners; it was certainly calculated to encourage nurses to prescribe for patients, and to undertake other serious responsibilities which should never be allowed to devolve upon them. Such instruction has been rigidly excluded from this volume as forming no part of the training of a sick-nurse.¹³⁴

One example of such adaptation had to do with treatment using a tannic acid poultice. In the American edition the passage read that this poulticing was frequently delegated to the nurse and detailed instructions followed for how to make and apply

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¹³³ Weeks-Shaw, Edited by Radford. A Text-Book of Nursing.
In the British edition the reader was told that the treatment was ‘often delegated to the nurse, under his orders’ and omitted the instructions.\textsuperscript{135} Another example of differences between the two editions relates to passages regarding operations. Passages of material considered unnecessary for nurses were deleted and an extensive discussion about emotional support of the patients undergoing surgery was added. Luckes’ extensive attention to emotional support of patients indicates that it was an important part of core nursing. The American edition of Weeks-Shaw’s book included a substantial section on how to administer anaesthesia which was completely excluded from the British edition, suggesting that in America administration of anaesthesia by nurses was common enough to warrant general teaching of this topic while in Britain this was presumed to be an exclusively medical function.\textsuperscript{136}

Differences in the chapter on circulation, pulse, and temperature are also illustrative of what was considered appropriate for a nursing text in America but not in Britain. For example, in the discussion of temperature the following passage from the American edition was omitted from the British edition:

\begin{quote}
Inflammation sometimes gives a local rise of temperature, without affecting the general heat of the body. To test this, a surface thermometer is used, one with the reservoir flattened…It is to be applied alternately over the seat of inflammation, and over some corresponding part known to be isothermal with it in health…This, like the general temperature, will be found to fluctuate, exhibiting periods of exacerbation and defervescence.\textsuperscript{137}
\end{quote}


Another passage left out of the British edition related to treatment of elevated temperature,

   Some of the recently discovered antipyretics—notably antifebrin—may bring the temperature down in two or three hours...to a subnormal point...This is not alarming, unless the patient becomes cyanotic and the pulse feeble, but stimulants and hot bottles are indicated.138

Eight passages in the chapter on ‘observation of symptoms’ were also excluded from the British edition. Some of the omitted passages were short such as, ‘The facial expression in sepsis is very marked and characteristic, although difficult to describe.’139 Other excluded material was more extensive, such as a passage dealing with different kinds of pain which covered most of one page.140 There were similar kinds of differences in the chapters on medications and other treatments. Weeks-Shaw included more allusions to Nightingale’s works on core nursing and the difference between medicine and nursing than some other American authors, more in the first edition than in later ones, but significant amounts of material related to the diagnosis and treatment of disease was removed from the American text in order to make it acceptable in Britain.

It might be argued that the British version of Weeks-Shaw’s book contained less medical material than the American edition because it was edited by doctors, who were protecting their interests from nurse interlopers. However, the American edition of the book was also reviewed by doctors. In the preface to the first and second American editions Weeks-Shaw expressed gratitude to one of them, Dr J. S. Hawley,

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for his ‘valuable criticisms’ and ‘careful revision’ of the book.\textsuperscript{141} Little evidence was found regarding how widely the British edition was used, but according to Duckworth the American edition was widely used in America, and to the present day it is not difficult to find original copies of Weeks-Shaw’s book.\textsuperscript{142} That it was so widely used testifies to the acceptability of its contents, even though there was considerable controversy about how much medical information should be included in nursing textbooks—American nurse Charlotte Aiken called the issue of what and how much material nurses needed to know a ‘vexed question.’\textsuperscript{143}

A comparison of the American and British versions of Weeks-Shaw’s book also sheds light on differences regarding the nurse’s role of assisting doctors. One difference related to the idea that sometimes doctors’ orders needed to be conditional upon circumstances surrounding individual patients. The American edition of Weeks-Shaw’s book contained the comment, ‘…It is true that nearly all orders are conditional…’\textsuperscript{144} whereas in the British edition the same sentence was rendered, ‘…that some orders are conditional…’\textsuperscript{145} This suggests that nurses in America assumed more latitude in adjusting doctors’ orders to individual circumstances. The difference was apparently quantitative rather than qualitative as nurses in both countries were expected to make adjustments to doctors’ treatment plans based on various patient and situational factors.

\textsuperscript{142} Weeks-Shaw, \textit{A Text-Book of Nursing}, Edited by Radford, p. vii, an internet search produces several copies of Weeks-Shaw’s text book for sale and it is currently available as a photo copied re-print.
\textsuperscript{143} Aikens, \textit{Clinical Studies for Nurses}, p. 5.
\textsuperscript{144} Weeks-Shaw, \textit{A Text-Book of Nursing. Second Edition}, p. 16.
\textsuperscript{145} Weeks-Shaw, Edited by Radford, \textit{A Text-Book of Nursing}. 
It may also be argued that Weeks-Shaw and other authors of nursing textbooks which did not give detailed instructions about core nursing work such as feeding patients because they assumed that the ways of correctly performing these offices was obvious. If this was the case, it would suggest that some nurses did not perceive the importance of developing expert details and standardizing the performance of core nursing work. Luckes’ *General Nursing* is unique in its detailed treatment of core nursing work. That it was widely used in Britain suggests that standardisation of core nursing work was considered to be important and useful there. That *General Nursing*, or a similar book, was not published in the United States does not mean that core nursing was not important in America but does indicate that the necessity for this material to be developed and disseminated in textbook form, for whatever reason, was not recognised, and the influence of such a book was not felt in the United States.

In addition to implementing core nursing, intelligently assisting doctors was an important nursing function. Implementation of doctors’ orders, observation of patients, and reporting information to doctors were important ways that nurses assisted doctors. Luckes stated that ‘The work of nurses is neither to rival nor interfere with that of doctors, but in every sense to help them…’ She then explained that women (and hence, nurses), were uniquely qualified to help men (doctors), because women’s work was helping work.\(^\text{146}\) Much has been written about nursing,

gender, and ‘women’s work’ in the nineteenth century. Further discussion of that issue is beyond the scope of this paper, but Luckes’ statement raises an interesting question about whether it was a nineteenth century assumption that as men, doctors were incapable of getting along without the help of women.

Conclusion

Nineteenth century nurses developed a body of knowledge and practice which was different from medicine. This knowledge and practice, which can be termed ‘true’ or ‘core’ nursing was based on many little things which nurses did for the comfort and care of patients which were the business of nurses, not doctors. These little things were discussed by Florence Nightingale. Nightingale’s general ideas about nursing were widely disseminated to nurses in Britain and America via her book Notes on Nursing. Her more in depth discussion of the details of nursing were included in a later edition of this book, Notes on Nursing for the Labouring Classes, which was not published in America. The details of specialised nursing work were elaborated by Nightingale’s friend and ally Eva Luckes, matron of the London Hospital. Luckes’ Lectures on General Nursing was a unique nursing textbook which focused on the details of expert nursing, ‘little things’ which expert nurses developed and which doctors did not know. Luckes’ textbook was a recommended standard work in Britain, but there is little evidence that it was used in America. Nightingale’s direct influence and the amplification of her work through Luckes helped to explicitly

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147 Jo Ann Ashley, Hospitals, Paternalism, and the Role of the Nurse. (New York: Teachers College Press, 1976); Reverby, Ordered to Care ; Thetis Group and Joan Roberts, Nursing, Physician Control, and the Medical Monopoly: Historical Perspectives on Gendered Inequality in Roles, Rights, and Range of Practice. (Bloomington: Indiana University Press, 2001).
focus British nursing on core nursing. Nightingale was also revered in America but her ideas about core nursing were not expounded in that country to the extent that they were in Britain.

In addition to unique nursing functions, nurses in both Britain and America assisted doctors with their work. In order to help doctors, nurses needed to have enough knowledge of medical work to carry out doctors’ plans of care intelligently. They needed to know why the doctor ordered certain treatments in order to be able to monitor the treatment, report changes in patient condition to the doctor, and most importantly to know when adjustments to treatments might be necessary. An examination of nursing textbooks indicates that in both countries nurses were expected to understand why certain medical interventions were done, but the British textbooks generally contained less material regarding the diagnosis and treatment of disease than the American textbooks. Luckes’ explanations in this regard were general and brief in keeping with her belief that nursing and medicine should be kept as separate as possible. Luckes’ book was a compilation of lectures which she gave to pupil nurses at the London Hospital. Doctors also gave lectures to probationer nurses, and a compilation of doctors’ lectures to nurses are found in a nursing textbook by Laurence Humphry. Humphry’s book contains less medical material than was found in the American nursing textbooks.

Comparison of American and British editions of the same nursing textbook by American nurse Clara Weeks-Shaw also indicates that in Britain there was more of
an emphasis on keeping nursing and medicine separate by keeping medical information to a minimum. One British textbook, however, did include more medical material than the other British texts. This book was written by Isla Stewart and physician Herbert Cuff. Stewart was not an ally of Nightingale and was supportive of a British nursing movement which sought closer ties between nursing and medicine. This suggests that while more resources related to details of core nursing were available in Britain and there was more emphasis on the separation of nursing and medicine in that country, like the question of nurse registration the issue of how much medical information nurses needed was unsettled. Even in the case of Stewart and Cuff, however, the core nursing material and the medical material were put into separate volumes. British nurses Stewart and Luckes’ both assumed that the essence of nursing could be and should be separated from medicine.
CHAPTER IV
NURSES AND DOCTORS ON THE WARDS

Helping doctors by monitoring and reporting patient status and implementing doctors’ orders was an important part of nursing work. Close working relationships between doctors and nurses ensured that nurses worked out their place in the hospital in juxtaposition with medicine. For example, what the doctors were ordering made an impact on the work that nurses did, and as scientific medicine developed and diagnostic and treatment interventions became more complicated, the work of nurses also became more complex. Other factors related to the interface between nursing and medicine also affected the development of nursing work. One of these factors was the presence of large numbers of medical students on the wards in London hospitals and the work that they did. The relative absence of medical students on wards in American hospitals puts into relief the effect that medical students had on nursing work in Britain and raises questions about how their absence affected the development of nursing in America.

Both British and American hospitals employed fully qualified resident doctors, and nurses regularly worked with them. Patricia D’Antonio argues that the prospect of working with doctors during a period of intense interest in rapidly developing scientific medicine contributed significantly to the growth of nursing in the United States in the nineteenth century. She asserts that applying domestic skills to nurse the sick did not provide the allure needed to draw large numbers of women into professional nursing, but participating in and learning about scientific medicine was
exciting and appealing to many prospective nurses.\(^1\) The ‘site of this learning’ was the hospital.\(^2\) Other sources indicate that nurses in Britain were also interested in scientific medicine.\(^3\) While nurses in both Britain and America were interested in learning about scientific medicine, it will be argued here that nurses in American hospitals had more opportunities to implement medical treatments than did nurses in comparable British hospitals. Consequently, there was a stronger basis upon which to assume that this medical work was part of nursing in America while in Britain there was a stronger basis upon which to assume that this work properly belonged to doctors.

**Medical students in Britain and America**

Before the nineteenth century, medical education in Britain and America was based on an apprenticeship model.\(^4\) In Britain a few men from the higher classes studied theoretical medicine at the older, established universities at Oxford and Cambridge, but all learned their art by working with practicing doctors. At the London Hospital and the Pennsylvania Hospital physicians and surgeons associated with the hospital could have several students who would follow them on their hospital rounds and do whatever work their mentors gave to them. Because each student was only connected

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\(^3\) Barbara Melosh, *The physician’s Hand: Work Culture and Conflict in American Nursing*, p. 4; See also, Monica Baly, *Florence Nightingale and the Nursing Legacy: Building the Foundations of Modern Nursing* (Philadelphia: BainBridgeBooks, 1997), Mary Cadbury letters, HI/ST/NTS/Y16/1, LMA.

with one medical staff member, he would only work with that physician or surgeon and had no obligation toward any of the other medical staff. Medical students were accountable to their mentors, who spent little time at the hospital, but not to the hospital. According to Morris, the typical medical student at the London Hospital often ‘lounged about the Hospital, doing nothing in particular, and was a nuisance rather than a help’.\(^5\) When the apprentice system was phased out in the nineteenth century, medical students in Britain were given official hospital responsibilities. This was an important part of the development of the great teaching hospitals in London.\(^6\)

At the London Hospital, for instance, the work of medical students was considered to be an important and economical way to provide medical care to patients. In addition to the work supplied by medical students, hospitals gained income from them because students paid substantial amounts of tuition for the privilege of having hands-on experience at the bedside.\(^7\)

Large numbers of students were working directly with patients on the hospital wards at the large London teaching hospitals. Standing orders for the three London hospitals in this study included rules for numerous official positions for medical students. For example, of fifty-six official positions at Guy’s Hospital in 1874, seventeen were ‘appointments in connection with the sick…made from amongst the Students.’\(^8\)

At about the same time, St. Thomas’s Hospital also provided many

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\(^6\) Bonner, *Becoming a Physician*; Rosenberg, *The Care of Strangers*.
\(^8\) Guy’s Hospital, Regulations for Management of the Hospital, London, 1874, London Metropolitan Archive, p. 67, H09/GY/A/053, LMA.
official appointments for medical students. In 1912 when the result of Abraham Flexner’s ambitious study of medical schools in Europe was published, Flexner reported that at The London Hospital alone over 500 medical student appointments were made each year.

Conditions were different in America. Medical students were not given official positions in hospitals and medical schools were not generally hospital based such as those in London. In general, American medical schools were integrated within colleges and universities. Bonner notes that even in the first decade of the twentieth century most British medical students trained at medical schools located in hospitals and only ‘a fraction’ of doctors in Britain had university degrees. According to Rosenberg, in America, medical students were admitted to a programme of medical study at a college or university and had little hands-on training at the bedside until after graduation. That doctors caring for hospital patients were all graduates rather than medical students was considered beneficial. By the latter half of the nineteenth century in America

…resident house officers were all holders of the medical degree…The older system in which it was assumed that house officers would in many cases be undergraduate medical students and attend lectures in hours snatched from their hospital duties was no longer a viable means of providing day-to-day care…The situation was already quite different from the one that prevailed at the beginning

9 St. Thomas’s Hospital Rules 1872, HI/ST/A28/4/1, LMA.
10 The Charter of Incorporation, the By-Laws of the Governors, and the Standing Orders of the House-Committee of the London Hospital, London, 1874, LH/A/1/17, LHA.
12 Rosenberg, The Care of Strangers.
13 Bonner, Becoming a Physician, p. 295.
of the nineteenth century, when a few partially trained students and intermittently available senior physicians cared for...patients.\(^{14}\)

At the Pennsylvania Hospital in Philadelphia it was stipulated that all residents were to be qualified MDs.\(^{15}\) Hospital rules at the Pennsylvania and Presbyterian Hospitals during this time period did not include official positions for medical students, except for a reference to ‘Hospital Walkers’ at the Presbyterian Hospital.\(^{16}\) The rules stated only that these were to accompany the medical staff on their visits to the wards and keep a record of cases. Philadelphia General Hospital rules for 1902 included ‘interne’ as an official position.\(^{17}\) A separate book of rules for interns from about the same year stipulated that they serve for fifteen months under the direction of the resident physicians.\(^{18}\) Philadelphia General Hospital rules for 1868, 1870, 1883, and 1887 did not include official rules for the position of interne,\(^{19}\) but in his memoirs Barton Hirst stated that he was a prospective interne in the 1880s.\(^{20}\) The rules did not comment on whether or not the internes must have graduated from medical

\(^{14}\) Rosenberg, *The Care of Strangers*, p. 68.

\(^{15}\) Rules and Regulations of the Pennsylvania Hospital on Pine Street, Board of Managers Minutes, Eleventh Mo. 28\(^{th}\) '87, Philadelphia, 1887, Section I, Series 1, Board of Managers, 1751-1975, Minutes, v.11, PHHC.


\(^{19}\) Guardians of the Poor, *Rules for the Government of the Medical Board of the Philadelphia Hospital*, 1870, A-5431, 35-3-7,27, PCA; Guardians of the Poor, *Rules for the Government of the Board of Guardians of the Poor in the City of Philadelphia*, 1887, A-5431, 35-3-1.4, PCA.

\(^{20}\) Barton Cooke Hirst, ‘Some Reminiscences of the Philadelphia Hospital as a Prospective Interne, and as a Member of the Staff for 20 years,’ in Various Contributors, *Old Blockley*: *Proceedings of the Bi-Centenary Celebration of the building of the Philadelphia Almshouse*. (New York: Froben Press, 1933) MC 71/III/5, CSHN.
school, but according to Hirst, internes were medical school graduates.\textsuperscript{21} The rules stated that the duties of the internes involved admitting and caring for patients in the various wards of the hospital.

Like the Pennsylvania Hospital, the Philadelphia General had a proud history of medical education and medical staff were pleased to comment on the wealth of its ‘clinical material,’ the late nineteenth century term for medically interesting patients.\textsuperscript{22} Medical students did not do hands-on care of patients on the wards of the hospitals, however. Clinical teaching of medical students generally consisted of presentation of cases in the clinic room.\textsuperscript{23} Teachers would select interesting ‘cases’ from among the patients who would be displayed while the teacher explained what the medical condition was, the treatment, and course of the case. Hospital administrators refused to allow medical students to have contact with patients beyond ‘clinical lectures’ in which patients were exhibited one by one to an amphitheatre full of medical students.\textsuperscript{24} Rosenberg notes that, ‘Medical schools lacked access to hospital wards…Even the most privileged medical students had to contend with a formal curriculum frustratingly devoid of clinical experience.’\textsuperscript{25}

\begin{itemize}
\item \textsuperscript{21} Hirst, ‘Some Reminiscences of the Philadelphia Hospital’ MC 71/III/5, CSHN.
\item \textsuperscript{22} Rosenberg, \textit{The Care of Strangers}, p. 53; Richard Shryock, \textit{The Development of Modern Medicine} (Madison: University of Wisconsin Press, 1974), p. 45.
\item \textsuperscript{24} Rosenberg, \textit{The Care of Strangers}, Thomas Bonner, \textit{Becoming a Physician: Medical Education in Britain, France, Germany, and the United States, 1750-1945} (Baltimore: The Johns Hopkins University Press, 1995); Flexner, \textit{Medical Education in the United States and Canada}.
\item \textsuperscript{25} Rosenberg, \textit{The Care of Strangers}, p. 201.
\end{itemize}
At the end of the nineteenth century, Dr William Osler lamented the absence of medical students in American hospitals. He stated, ‘The radical reform needed is in the introduction into this country of the system of clinical clerks and surgical dressers, who should be just as much a part of the machinery of the wards as the nurses or the house physicians.’ Osler did work at the Philadelphia General Hospital where he is said to have introduced medical students to the wards in 1884. The rules of the Philadelphia hospital from the 1870s through the first decade of the twentieth century do not mention official positions for medical students, however.

And there is little evidence that medical students worked routinely with patients on the wards in histories and memoirs left by physicians and surgeons who worked in the hospital during this time period.

According to Harvey Cushing, after five years Osler left Philadelphia to go to Johns Hopkins Hospital in Baltimore where he felt that he would be better able to implement changes in medical education. He introduced medical students to the wards of Johns Hopkins Hospital when the medical school associated with the hospital opened in 1893 with a first class of 18 students, 15 men and 3 women. Johns Hopkins was a special case in that from its founding the medical school was an

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28 Guardians of the Poor, Rules for the Philadelphia Hospital, 1870, A-5431, 35-3-7,27, PCA; Guardians of the Poor, Rules for the Government of the Board of Guardians of the Poor in the City of Philadelphia, 1887, A-5431, 35-3-1,4, PCA; Guardians of the Poor, Rules of the Department of Charities and Correction, Philadelphia, 1902, A-5431, 65.3 PCA.
29 Agnew, ‘The Medical history of the Philadelphia Almshouse.’ MC 71/III/5, CSHN.
integral part not only of the university but also of the hospital.\textsuperscript{30} This was a small beginning compared to the hundreds of medical students working in London hospital wards during the same time period. The fact that Osler left the Philadelphia Hospital to go to Johns Hopkins, which was thought to be revolutionary in introducing medical students to hospital work, may suggest that he did not implement the kind of clinical teaching that he considered to be optimal bedside experience while he was in Philadelphia.

After completing his study of medical schools in Europe, Flexner studied American medical schools. After visiting schools in forty states, Flexner reported in 1910 that the only medical school in the country which provided clinical experience for medical students which was comparable to the excellent experience of medical students in Britain was at Johns Hopkins.\textsuperscript{31} Flexner noted, however, that three medical schools in Philadelphia, the University of Pennsylvania, the Jefferson Medical College, and the Medico-Chirurgical College, were among only a few other schools in the country which were in ‘sole and complete control of excellent hospitals, more or less adequate in size’ which they could use for clinical instruction of medical students similar to that already established at Johns Hopkins. He did not see any ‘insuperable reason’ why they should not implement the kind of clinical training for medical students that was available at Johns Hopkins.\textsuperscript{32} This statement indicates that although these Philadelphia schools were closely associated with

\textsuperscript{30} Cushing, \textit{The Life of Sir William Osler}.
\textsuperscript{31} Flexner, \textit{Medical Education in the United States and Canada}, p. 107.
\textsuperscript{32} Flexner, \textit{Medical Education in the United States and Canada}, p. 107.
excellent hospitals, even they had not implemented bedside teaching for medical students at the time that Flexner made his report.

In addition to clinical experience, medical students in both Britain and America received didactic instruction and did laboratory work. Series of lectures for medical students, which were an established part of medical education in the nineteenth century, were presented by members of hospital medical staffs or full time medical school faculty.  

The work of medical students

In order to understand how the presence and absence of medical students on hospital wards affected the development of nursing, it is helpful to know what the medical students were doing on the wards. In the London hospitals medical students were given specific patient assignments, each student being responsible for approximately four or five patients. The work that the medical students did in London hospitals is reflected in descriptions of various student positions described in the standing orders and regulations of the London hospitals.  

At Guy’s Hospital official regulations included a section of rules for ‘The Students,’ and students who demonstrated the necessary qualities were selected for appointment to official hospital positions. The hospital ‘appointments…made from amongst the

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35 Guy’s Hospital, ‘Regulations for Management of the Hospital, 1874,’ H09/GY/A/053, LMA.
Students’ were ‘house physicians, house surgeons, assistant surgeons’ dressers, assistant surgeons’ clerks, post mortem clerks, assistant physicians’ clerks, dressers in the surgery, aural surgeon’s dressers, surgical clinical clerks, obstetric residents, surgeons’ dressers, clinical assistants, dressers in the eye wards, obstetric out-patient clerks, extern obstetric assistants, dental surgeons’ dressers, and medical clinical clerks.’ Rules were outlined for nine of these positions. While specific regulations were not included for medical clerks, detailed rules were given for surgical dressers.\(^{36}\)

Twelve resident dressers were attached to the Surgical Department.\(^{37}\) Fourth year pupils were chosen for the position of resident dresser, each being attached to a specific staff surgeon. Dressers boarded at the hospital for two weeks at a time, the first week as ‘Dresser for the week’ and the second week as ‘Ex-Dresser.’ The Dresser of the week was to assist the surgeon in the out-patient department and become familiar with patients on the hospital wards, always referred to as ‘cases.’ He was in charge of patients admitted under the surgeon under whom he worked in the out-patient department and also of all ‘casualties’ admitted during the week, caring for them after their admission to the wards. The dresser of the week cared for patients injured in accidents that came to the hospital during the night but was expected to consult with the House Surgeon if he had doubts about proper treatment. He independently prescribed medicines. Dressers accompanied their surgeons on their daily visits and whenever the surgeons wanted their help, giving information to

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\(^{36}\) Guy’s Hospital, ‘Regulations for Management of the Hospital, 1874,’ H09/GY/A/053, LMA.

\(^{37}\) Guy’s Hospital, ‘Regulations for Management of the Hospital, 1874,’ H09/GY/A/053, LMA.
the surgeons about the patients’ progress. The Ex-Dresser was to help the Dresser for the week in the out-patient department and be responsible for attending to patients in the medical wards who needed surgical treatment. If the House Surgeon and the Dresser for the week were unavailable, the Ex-Dresser was to attend to patients admitted to the out-patient department. If a Dresser were unable to perform his duties, another Pupil would be selected and approved by the Treasurer to take his place. Students served as dressers for six months and were required to perform all routine dressings on the wards. The rules specifically stated that dressers were not permitted to delegate this responsibility to the nursing staff without special permission from the surgeons.\(^{38}\) Before the advent of strict asepsis wounds were expected to suppurate and required a great deal of regular dressing and re-dressing.\(^{39}\)

Various grades of physicians and surgeons, including house physicians, registrars, house surgeons, and assistant physicians and surgeons were responsible for working with the students. House physicians, house surgeons, and registrars had to be qualified medical doctors or surgeons, but the rules did not specify whether assistant physicians and assistant surgeons were or were not required to be formally qualified. Assistant physicians, who were each attached to one or more of the physicians, were responsible for giving cards and letters to patients in the outpatient department entitling them to come to the outpatient department weekly for eight weeks. They

\(^{38}\) Guy’s Hospital, ‘Regulations for Management of the Hospital, 1874,’ H09/GY/A/053, LMA.  
could delegate this responsibility to ‘their’ clerks. The same could be done by the
assistant surgeons in regard to their dressers.  

The House Surgeons were provided living accommodation in the hospital ‘along
with the Resident Dressers.’ The House Surgeons were responsible for supervising
the behaviour of the dressers and making sure that the dressers received every
opportunity for ‘obtaining practical information.’ They were required to visit the
surgical wards daily and to take care of any dressings which had been neglected by
the dressers. They would then report this neglect to the surgeon. In addition to
supervising the dressers, they were to ‘be responsible for the general good order of
the residents in the Dressers Rooms.’

Similar rules were stipulated at the London Hospital. Standing orders for 1868
specified that one Physician to the hospital and one Surgeon to the hospital would
‘attend the hospital daily,’ which was changed in the 1874 standing orders to being
required to visit the hospital at least twice a week. They were required to be
members of the Royal College of Physicians in London and the Royal College of
Surgeons of England respectively. After twenty years in this position the physician
and surgeon were eligible for the position of consultant. It is not difficult to
appreciate why consultants were highly respected considering that they had to

40 Guy’s Hospital, ‘Regulations for Management of the Hospital, 1874,’ H09/GY/A/053, LMA.
41 Guy’s Hospital, ‘Regulations for Management of the Hospital, 1874,’ H09/GY/A/053, LMA.
42 The Charter of Incorporation, the By-Laws of the Governors, and the Standing Orders of the House-
    Committee of the London Hospital, London, 1868, LH/A/1/17, RLHA; The Charter, By-Laws, and
    Standing Orders of the London Hospital, 1874, LH/A/1/17, RLHA.
successfully occupy the position of Physician or Surgeon to the hospital for twenty years before obtaining a consultant position.

The Resident Medical Officer’s qualification was the Licentiate’s Diploma from the Royal College of Physicians, the Membership of the Royal College of Surgeons, or the Diploma from the Apothecaries’ Company. He was to be in ‘constant attendance’ at the hospital with a term of 12 months. No house-surgeon or pupil could substitute for him. The fact that this was specifically stipulated may indicate that pupils had substituted for residents in the past. In the 1874 bylaws two Assistant Physicians and Surgeons were completely responsible for the out-patient department ‘with the assistance of the paid Clinical Assistants.’ They were to report any ‘misconduct on the part of the nurses, assistant, or night nurses’ to the Matron.43

Regulations for ‘Medical Assistants’ and ‘Pupils’ at the London Hospital were similar to those for clinical clerks and dressers at Guy’s Hospital. Two of the pupils lived in the hospital in weekly rotation and would continue to dress those patients who had been admitted during their rotation.44 If a resident pupil had to be absent, he was required to find an approved substitute. This suggests that the pupils provided important service to the hospital. Senior resident pupils performed clerical duties, but they also performed direct patient care. The resident pupils were required to attend the wards every evening between the hours of six and nine to ‘dress or visit’ all patients who needed attention. They also dressed patients after the Surgeon of the

43 The Charter, By-Laws, and Standing Orders of the London Hospital, 1874, LH/A/1/17, RLHA.
44 The Charter, By-Laws, and Standing Orders of the London Hospital, 1874, LH/A/1/17, RLHA.
day finished his visits. The rules stated that students who ‘misconducted themselves’ were to be expelled or suspended according to the decision of the House Committee. Any dressing pupil who refused to live in the hospital as required or failed to ‘dress and attend to his patients’ would no longer be a dresser and would not be allowed to become one in the future. In order to be appointed House Surgeon, students must have served in the ‘office of In-patient Dresser’ at least 12 months. All past pupils who qualified were eligible for appointment as Clinical Assistant in the Out-Patient Department. According to Clark-Kennedy, the work of medical students at the London Hospital was considered to be essential, economical labour for the hospital.

This was not the case in Philadelphia, where medical students did not provide patient care services and all members of the hospital medical staffs were qualified doctors. Resident physicians’ duties were outlined in the official regulations of the hospitals. At the Presbyterian Hospital the number of resident physicians was not specified but the rules stated that their tenure was one year. They were required to be graduates of a ‘regular Medical School,’ must have passed an examination given by the Medical Board, and had to provide ‘testimonials of good moral character’ to the Board of Trustees. They were required to visit their patients twice a day and they accompanied the attending medical staff on their visits, reporting on any new patients. The residents would then ‘regulate the practice according to’ the attending physicians’ and surgeons ‘orders.’ The rules of the Pennsylvania Hospital also stated that the resident physicians must be graduates of medicine. They were required to personally

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examine anyone asking to be admitted to the hospital with an accidental injury as soon as possible and were ‘in no case to act on the representation of a nurse or other subordinate.’ Other rules indicate that the ‘other subordinates’ spoken of here may have been referring to the Gatekeeper and messengers. At the Presbyterian Hospital, the by-laws went further in regard to supervision of nurses and specifically stated that the resident physicians were to ‘have general superintendence of the nurses.’ In addition to being responsible for supervising the nurses, they were to report any ‘neglect of duty’ on the part of the nurses to the attending medical officer. At the Philadelphia General Hospital, if internes had any difficulty controlling the nurses, the situation was to be resolved by the Chief Resident Physician.

In contrast, the rules and standing orders of the London hospitals, St. Thomas’s, Guy’s, and the London, do not mention physicians or surgeons supervising nurses. They do stipulate for each official position of the medical and nursing staffs that all are to report dereliction on the part of any other staff member to the hospital administrators, but the language is very general and is identical for both medical and nursing staff. At the London the medical staff were instructed to notify the matron to report any misconduct of the nursing staff. It is important to note that misconduct was to be reported to the matron, not the medical officers. At St. Thomas’s, the sisters were specifically charged with reporting any ‘disobedience, or irregularity’ by

47 Rules and Regulations of the Pennsylvania Hospital, 1887, I/1, PHHC.
48 Fifteenth Annual Report of the Presbyterian Hospital in Philadelphia, 1886, MC 35, I, 77, CSHN.
any medical student to the resident assistant physician or surgeon and the steward.\textsuperscript{50}

The nursing hierarchy was separate from that of the medical hierarchy and medical students were under the surveillance of the nursing staff as much as the nursing staff, made up mostly of probationers, was under the surveillance of the medical staff.

\textbf{Medical students and nurses’ work}

Medical students working on hospital wards influenced the work of the nurses. Because medical students did not perform routine hands on patient care at the Pennsylvania and Presbyterian Hospitals, the work that was done by clerks and dressers in large London teaching hospitals would have been the responsibility of the resident physicians. In the absence of medical students, Philadelphia nurses would have been more involved with this work. One indication that the presence of medical students influenced the work of nurses and nursing students is contained in the four volume nursing reference \textit{Cassell’s Art and Science of Nursing}. In a chapter entitled ‘Nursing as a Vocation,’ Amy Hughes stated that, ‘…the absence of a medical school makes a considerable difference in the routine work of the nursing staff, who have also in this case much more personal responsibility for the prescribed treatment of patients.’\textsuperscript{51} Hughes also pointed out that ‘in many small or cottage hospitals there

\textsuperscript{50} St. Thomas’s Hospital Rules 1872, 104, HI/ST/A28/4/1, LMA.

\textsuperscript{51} Amy Hughes, ‘Nursing as a Vocation,’ in \textit{Cassell’s Science and Art of Nursing: A Guide to the Various Branches of Nursing, Theoretical and Practical by Medical and Nursing Authorities, Vol. 1} (London: The Waverley Book Company, Limited, ND), p. 100. No year of publication is stated, but the volumes are generously illustrated with photographs of nurses wearing dresses which are floor length and have leg of mutton sleeves. The chapter entitled ‘Nursing, Past and Present’ ends with the year 1909.
is no resident doctor, and therefore the Matron and nurses have to render first aid, and immediate emergency treatment if need arises.\(^{52}\)

This point is also illustrated in the practice of Sister Dora, a famous nurse who worked in a small provincial hospital in central England.\(^{53}\) Born Dorothy Pattison, Sister Dora joined an Anglican nursing sisterhood and was placed in charge of the nursing in a small cottage hospital in Walsall, an industrial town near Birmingham. Because there was no resident medical staff, Sister Dora carried out many procedures which were considered to be in the domain of doctors, such as setting bones, pulling teeth, saving injured limbs, and training in aseptic surgical techniques. She conducted daily outpatient clinics in which she treated patients with medical problems. At least one of the doctors with whom she worked encouraged her to go to medical school but she said that she did not want to leave her people in Walsall and felt that her work as sister-in-charge was more important than the work of a physician.\(^{54}\)

According to Moore, members of religious nursing orders frequently provided physician services when doctors were not available.\(^{55}\) Nurses who worked in Poor Law institutions which did not have resident medical staff also ‘had to’ perform

\(^{52}\) Hughes, Nursing as a Vocation, p. 100.
\(^{54}\) Manton, *Sister Dora*.
more medical tasks.\textsuperscript{56} The nurse was expected to ‘be there’ continuously and to fill in for the doctor in his absence, which created a challenging situation in which to define the boundaries of nursing. Even Florence Nightingale, who strongly believed that nursing and medicine should be separate spheres of work, once commented that the district nurse must be even more talented than the hospital nurse because the district nurse would be the only person reporting to the doctor on how the patient was doing and would function as his staff of clinical clerks and dressers.\textsuperscript{57}

In Philadelphia there are data to support the concept that nurses performed medical tasks in the absence of medical students on hospital wards. The working diary of Mary Clymer, a nurse in a Philadelphia hospital suggests that this was the case. Clymer kept a daily diary of her work as a pupil nurse at the Hospital of the University of Pennsylvania in 1888.\textsuperscript{58} Her diary is particularly instructive in regard to the work of dressing wounds on a surgical ward. She recorded that she sometimes helped doctors with dressings and regularly helped a nurse to do them as well as doing them on her own in the hospital wards.\textsuperscript{59} She also cut and prepared antiseptic dressings for wounds in the operating room. Some of the dressings were quite complex, as when she ‘dressed a foot twice with lead water and laudanum on lint, covered it with wax paper and bandaged it.’ \textsuperscript{60} Clymer recorded performing dressing changes for both simple and complex wounds on a nearly daily basis.

\textsuperscript{57} Baly, \textit{Florence Nightingale and the Nursing Legacy}, p. 126.
\textsuperscript{58} Mary V. Clymer Papers 1888-1889, transcript, MC 16, CSNH.
\textsuperscript{59} Mary V. Clymer Papers 1888-1889, transcript, MC 16, CSNH.
\textsuperscript{60} Mary V. Clymer Papers 1888-1889, transcript, p. 4, MC 16, CSNH.
Another example of the expectation for nurses to be responsible for dressing wounds in American hospitals is found in a doctor’s account recorded in the American Journal of Nursing. Dr Angell, who was describing the benefits of the modern hospital in 1901, stated that when two patients with severe burns had been admitted to the hospital, the attending physician at the hospital ‘properly ordered the house surgeon to do the dressings.’ These dressings were so extensive and complicated that it took the house surgeon six and a half hours to do them. Angell continued, ‘The day following the physician very properly…arranged to have one special nurse, day and night, between the two cases, thus relieving the house surgeon from the expenditure of so much time.’ This account indicates that the nurse would be responsible for doing the very complex and time consuming dressings for these two patients, and that it was considered appropriate to assign this task to a nurse.

Doing regular dressing changes at any of the Philadelphia hospitals would have taken up a significant amount of time, time that could not be used for other nursing activities. In a large London teaching hospital this work would have been done principally by the house surgeon’s dressers. In addition to the dressers, other staff also assisted in this work. At St. Thomas’s Hospital, for instance, the rules stipulated that the surgeryman was responsible for preparing the ‘dressings requisite for the

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daily use of the Dressers…’ While some of the staff positions were phased out over time, London hospitals still had a large number of medical students employed as clerks and dressers in the twentieth century.

That dressers spent their time doing patient dressings does not mean, however, that nurses never helped with dressings at the London hospitals. Daily ‘horaries’ or diaries of nursing work kept by special probationers at St. Thomas’s also included references to nurses dealing with dressings. Miss Alladice, who entered St. Thomas’s in 1891, wrote about going ‘round’ with Mr McKellar and the house surgeons and also wrote about helping the dressers. Miss Lumby, a probationer in 1890, stated that she ‘set’ dressings for the dressers and ‘was shown how’ to do some of the dressings. She also participated in doing dressings, but it is sometimes unclear in the record whether she was doing them herself or helping others. She specifically stated once that she helped the Sister do a dressing. She also mentioned that while she was working on a particularly odorous dressing on a patient’s arm, the dressers were busy doing other dressings. Miss Haig-Brown, a special probationer who later became the Home Sister at St. Thomas’s, described helping a Sister to re-dress a wound and replace a splint on the limb. Several probationers mentioned ‘setting dressings’ for the dressers, watching dressings being done and ‘helping’ the dressers. As a whole, the horaries suggest that the sisters and other nursing staff occasionally

63 St. Thomas’s Hospital Rules 1872, p. 62, HI/ST/A28/4/1, LMA.
64 Flexner, Medical Education in Europe.
65 Horaries of special probationers at St. Thomas’s Hospital, HI/ST/NTS/C39, LMA.
66 Horary of Miss Alladice at St. Thomas’s Hospital, HI/ST/NTS/C39/13, LMA.
67 Horary of Miss Lumby at St. Thomas’s Hospital, HI/ST/NTS/C39/15, LMA.
68 Horary of Miss Haig-Brown at St. Thomas’s Hospital, HI/ST/NTS/C39/14a, LMA.
did dressings, but that the most common dressing related activities for the nursing staff involved probationers preparing dressings for the dressers and otherwise assisting them when needed.

Another description of nurses’ involvement in the work of doing dressings is found in two letters written by a St. Thomas’s probationer named Laura Wilson. One of the letters was written from the Nightingale Home on 13th May 1876 when Wilson had been at the hospital for three months and was beginning to feel like ‘an old hand.’ She had been working on the men’s surgical ward and had just been moved to the women’s surgical ward. She found working with women patients more difficult than working with men but was happy to be learning more, ‘as all the cases we have the dressing of which we don’t in male, screened cases we do not meddle with in men, such as stricture of urine, disease of testes, etc.’ In her other letter Wilson had written that after a few weeks of working on the ward she had started helping with the patients’ dressings. She explained that she assisted the dressers with morning dressing changes and had to pay close attention to what they did because she would have to ‘exactly’ repeat the process at night. She described several dressings that she had done as her ‘special dressings for the week.’ What was meant by special dressings for the week was not elaborated. Another graduate of the Nightingale School, Jane Deeble, specifically stated that at St. Thomas’s Hospital it was the dressers who did the dressings at that hospital. According to Deeble, when she was sent from Netley military hospital to obtain training at St. Thomas’s, the dressers did

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69 Laura Wilson letters from St. Thomas’s Hospital 1876, HI/ST/NTS/Y17/2, LMA.
70 Laura Wilson letters from St. Thomas’s Hospital 1876, HI/ST/NTS/Y17/1, LMA.
the dressings—with the assistance of the surgeryman and under the supervision of
the resident surgical staff.71

Even if nurses were considered capable of doing dressing changes, this was not
regarded as their proper work. In a book of helpful hints for new doctors which went
into several editions Christopher Heath, surgeon at Kings College Hospital where he
had been a dresser and house surgeon, suggested that while nurses did sometimes do
dressing changes, this was due to lack of diligence on the part of the dresser and a
desire to get on with the daily routine on the part of the nurses. He advised dressers
to avoid a certain ‘difficulty’ with nurses: ‘…the tendency they have (in order to
save trouble) to do all the dressing themselves, instead of leaving them for the proper
dressers…the dresser must be careful to attend in proper time, so that the general
business of the ward is not delayed.’72 This advice had not changed since an earlier
edition of Heath’s book which was published two decades before.73 Heath’s
comments indicate that regardless of whether the nurses were thought capable of
doing the dressings, it was not considered to be their proper work. In their textbook
of nursing Williams and Fisher commented that pupil nurses and dressers sometimes
had disagreements about who had the ‘privilege’ of doing dressings. They explained

71 Baly, Florence Nightingale and the Nursing Legacy, p. 115.
72 Christopher Heath. A Manual of Minor Surgery and Bandaging: For the Use of House-Surgeons,
73 Christopher Heath, A Manual of Minor Surgery and Bandaging: For the Use of House-Surgeons,
Library, London.
that although pupil nurses might want to do the dressings, they must let the dressers do that work because it rightly belonged to them.\(^{74}\)

**Conclusion**

The presence of medical students on the wards of London teaching hospitals affected the work that nurses did. Because medical students were performing medical work at the patients’ bedsides, nurses did not have this work to do and could spend their time in other activities. The case of doing dressing changes exemplifies this factor in the development of nursing work. Dressers, who were medical students in official positions of responsibility, provided important patient care services in nineteenth century London teaching hospitals. Late nineteenth century nurses spent some of their time assisting the dressers as well as doing some of the dressings themselves. The most important point here, however, is that while nursing staff in London hospitals sometimes did dressing work and may have felt that learning to do dressings was beneficial, it was understood that this aspect of patient care belonged to the dressers. In Philadelphia, nurses and doctors even in large teaching hospitals could assume that this task would be given to nurses. There were no dressers there.

\(^{74}\) Rachel Williams and Alice Fisher, *Hints for Hospital Nurses* (Edinburgh: MacLachlan and Stewart, 1877), pp. 143-5.
CHAPTER V
MATRONS, SUPERINTENDENTS, AND THE SEPARATION OF NURSING AND MEDICINE

Florence Nightingale insisted that the most important aspect of nursing reform was that any nursing service must be under the supervision of a trained nurse.¹ This was a radical departure from previous situations in which matrons had not been trained nurses and doctors had taught and supervised nurses on the wards. According to Carol Helmstadter and Judith Godden, the previously prevalent ‘ward system’ developed in the first half of the nineteenth century as doctors became more involved in improving the nursing in teaching hospitals. Under the ward system, sometimes called the ‘sister system,’ matrons replaced ward sisters who had come up through the ranks of working class nursing assistants with women from the higher ranks of shopkeepers and upper household servants. After being oriented to hospital work, these women of higher rank were more capable of effectively assisting the doctors, who taught them to carry out medical orders. Within the ward system doctors had control over the ward sisters who in turn supervised the staff nurses and domestics. Helmstadter notes that the ward system, ‘made the ward sister its lynch pin, changing her role from that of domestic servant to doctor’s assistant.’²

While their medical care may have been excellent, however, under the doctors’ direction the nursing care was often of low quality. Certainly one of the reasons for the low quality of much of the nursing care was related to the low calibre of many of the nurses caring for patients in hospitals before the advent of nurse training schools. Some of these nurses were reliable, capable, caring individuals, but more of them were not. The old nursing left much room for improvement and the new nursing aimed to make improvements under the direction of women trained for that purpose.\(^3\) The assumption was that a strong, morally sound woman to oversee the nursing service was required to enforce change.\(^4\) This chapter will argue that the chief nurses in charge of the new nursing services in major teaching hospitals had to be strong enough, self-assured enough, and tactful enough to successfully separate the nursing service from the medical service, and that the British matron of a large teaching hospital, who had been a hospital ward sister and prior to that often a ‘special probationer,’ was a key factor in the process both in Britain and America. The American nurse training school superintendent was also a key player in the development of nursing in America, but separation of nursing and medicine in American hospitals did not take place to the same extent that it did in Britain. Again, this chapter will focus on hospital nursing in London and Philadelphia.

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\(^4\) Margaret Lonsdale, “The Present Crisis at Guy’s Hospital,” *The Nineteenth Century* 7 (1880): 677-683. See also discussion in chapter five.
Ward sisters, head nurses, staff nurses and nurse training

Nineteenth century nurse training programs in Britain and America offered a variety of curricula, but by the end of the century general patterns had emerged. In the large London teaching hospitals, pupil nurses generally trained for one or two years as ‘probationers’ after which each nurse was assigned to work on a specific hospital ward as an assistant nurse or as a ward sister.\(^5\) According to Amy Hughes, the normal progression in London hospitals for nurses who desired top hospital positions was from probationer to staff or charge nurse to ward sister, night superintendent, home sister, and matron’s assistant. At the top of the hierarchy, of course, was the matron, who was ‘the keystone of the whole system’.\(^6\) The ward sister was in charge of the ward and was responsible for all patient care, order, cleanliness, and teaching of probationers.\(^7\) In American nurse training schools prospective nurses generally went through a probationary period of about three months after which they became first year pupil nurses. They would then pass through one or two more years of training. In their last year the senior pupils were often appointed to the position of head nurse.\(^8\) Therefore, in both Britain and America, women in their second or third year of hospital work could become responsible for an entire hospital ward. One important difference between the situations in Britain and America, however, was


that in Britain nurses who were appointed as ward sisters usually served as staff nurses before their appointment as ward sisters and they were recognised as graduate nurses in a permanent position.

In America, many head nurses were still nursing students who would graduate after the end of their senior year and usually leave the hospital to work in private duty nursing. In her nursing textbook, Isabel Hampton Robb explained that in American hospitals head nurses at that time were, for the most part, senior nursing students.9

This practice was explained in more detail by Louise Darche at a conference in 1893,

At first, of necessity, the undergraduates were obliged to act as head-nurses of the wards; the importation of head-nurses or ‘sisters’ from abroad being too expensive to be contemplated, and as yet there were no graduate nurses here. But by degrees, what was at first regarded as a misfortune came to be considered a part of the system, and it was found that by extending the course of training from one year to two, the services of the nurses after they had obtained the practical training of the first year could be retained and utilised as head-nurses.10

Nevertheless, the desirability of trained nurses in permanent head nurse positions was recognised and according to Susan Reverby, in ‘the better hospitals’ of America graduate nurses filled the head nurse positions while in the smaller hospitals head nurses were senior nursing students. Reverby notes that many senior students who were appointed as head nurses were intimidated and ‘frightened’ by the tremendous responsibility of serving in this position while still in training.11 Taking on day to day accountability for the lives of seriously ill patients and the training of new pupil

11 Reverby, Ordered to Care, p. 67.
nurses was a heavy burden. Even in cases where head nurses were graduates, nurses in American hospitals took over the role without having had the opportunity to serve as staff nurses before moving into the head nurse role. As late as the nineteen twenties 73 per cent of American hospitals with nurse training schools had no graduate staff nurses and only 15 per cent of hospitals had four or more. The Pennsylvania Hospital was one of those hospitals which did have graduate head nurses. By 1899 the nurse superintendent had filled all of the head nurse positions with the hospital’s own graduates. But even this large, progressive hospital had no graduate staff nurses at the turn of the twentieth century. Lack of graduate nurses in permanent positions in American hospitals meant that pupil nurses would routinely be interacting with the fully qualified medical staff. As neophytes the pupils would have reason to be very impressed with the scientific medicine practiced by the doctors.

In contrast, sisters in London hospitals were in ‘permanent’ positions and did not leave except, as one doctor explained, through promotion to a matronship, marriage, or death. Ward registers from St. Thomas’s Hospital corroborate the longevity of many ward sisters there. For example, E. Hatcher became ward sister on the ophthalmic ward on 24 September 1872 at the age of 33 and remained in that position.

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12 Reverby, *Ordered to Care*, p. 188.
position until she retired in September of 1890. According to Nightingale, a permanent ward sister was ‘the key to the whole situation’ in regard to training nurses because it was through the ward sister that the matron would ‘influence’ the nurses, probationers, and patients. Staff or ‘assistant’ nurses were either graduate nurses or senior probationers. At St. Thomas’s Hospital the wards had one or two graduate staff nurses and these sometimes remained in their positions as staff nurses for many years. According to Maggs, however, most nurses considered the staff nurse position as a stepping stone to a ward sister position. Eva Luckes believed that ‘the best preparation for a Sister’s post, whether on a large or a small scale, is undoubtedly the experience that can be gained as a Staff Nurse.’

**Hospital leadership and social class**

The pivotal positions of matron and sister called for nurses of the highest calibre. A two tiered training system developed in Britain in order to maximise the preparation of hospital and ward nursing managers. Women who came from a background in which they would have had careful moral training and opportunities to direct other members of the household were thought to be more ready to assume leadership roles in the hospital and could enter special nurse training tracks leading to positions as sisters and matrons. In America, some differentiation was made between nursing students who showed leadership ability in regard to hospital and ward management.

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16 St. Thomas’s Hospital Ward Register 1871-1892, HI/ST/C2/3, LMA.
19 St. Thomas’s Hospital Ward Register 1871-1892, HI/ST/C2/3, LMA.
21 Luckes, *Hospital Sisters and Their Duties*, p. 55.
and those who did not, but according to Louise Darche, the American way of organizing hospitals was proudly based on ‘very democratic principles’ under which all student nurses were on the same level regardless of their previous station in life. Social class was consciously and overtly embedded in London nurse training programmes in concert with assumptions about suitability for hospital leadership positions. In America class was an issue in nurse training, but a more muted one. As components of their respective cultures, nursing in these countries was influenced by societal assumptions about class.

Differences regarding the importance of social class in America and Britain is a complex subject, and one that has been the subject of a great deal of debate, though social class has generally been thought to have had more impact in Britain than in America. Fiona Divine argues that although differences between the two countries have been exaggerated, differences do exist. David Cannadine makes a similar argument in regard to England and colonial America. He asserts that differences have been exaggerated but that significant differences did make America distinct from England. In America the founders deliberately set out to eliminate a fixed

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22 Pamphlet, ‘Information for applicants for admission into Philadelphia Hospital Training School for Nurses’ (Philadelphia, 1890), MC 71, II, 4, f.1, CSHN. First, second and third class pupils were categorized according to how long they planned to stay at the hospital for training; Rules and Regulations of the Pennsylvania Hospital on Pine Street, Board of Managers Minutes, Eleventh Mo. 28th ’87, Philadelphia, 1887, Section I, Series 1, Board of Managers, 1751-1975, Minutes, v.11, PHHC. At the Pennsylvania Hospital pupils could do a one year course and leave or could stay on in a leadership position for a second year.
23 Darche, ‘Proper organisation of training schools in America,’ p. 96.
25 Divine, Social Class in America and Britain.
social hierarchy by prohibiting primogeniture and formal titles. According to Cannadine,

To be sure, the American Revolution did not abolish distinctions between rich and poor and, during the nineteenth century, these economic inequalities would become greater than those in Britain itself. But it did assault political dependency, did undermine social inequality, did outlaw formal distinctions of status, and by so doing, it did create a new sort of society and a new way of looking at society, increasingly unlike that in England... As anyone knows who has crossed the Atlantic, the Americans are more independent and less deferential than the English... Of all the communities that the British have created across the seas and around the world, the Americans are unique in having so explicitly rejected the hierarchical social structure... and... the languages both of ranks and of class as the prevailing forms of social description.26

In nineteenth century Britain a social hierarchy made up of many gradations of class was an important factor in determining one’s place in society, and it was taken for granted that members of the upper classes were fundamentally different from those of the working classes.27

Assumptions about class are reflected in British and American nursing. For example, Florence Nightingale wrote two versions of Notes on Nursing, one for women who supervised other workers in the home and one for members of the ‘labouring classes.’28 Only the first version was published in America and reviewed in

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American magazines, suggesting that one version should be sufficient for all members of society in that country. Class assumptions are also reflected in arguments about nursing registration in Britain. Two major factions arose among British nurses in the latter part of the nineteenth century over the issue of nurse registration. Those who believed that nurses should be professionals and have uniform standards evaluated by standardised testing promoted nurse registration while those who believed that nursing should be a vocation and that whether or not one was a good nurse could not be evaluated by standardised testing were opposed to registration. The issue of social class was a salient part of the discussion.

Some nurse leaders believed that in order to promote nursing professionalism and safeguard the safety of the public, particularly those who hired trained nurses for private cases in the home, all trained nurses should be of the higher classes. Ethel Fenwick, a forceful proponent of the latter view, maintained that nurse registration would eliminate women of the lower classes from professional nursing. According to Abel-Smith, Fenwick felt that it was inappropriate for lower class women to call themselves nurses and care for people in their homes. She and other registrationists were looking to increase the status of nursing by keeping lower class women out of nursing and by increasing the emphasis on intellectual, scientific education while decreasing focus on moral character. The registrationists believed that focusing on moral character development promoted the anti-intellectualism that kept women out

29 D’Antonio, American Nursing.
30 Abel-Smith, A History of the Nursing Profession.
of the professions. By adopting the scientific approach of medicine, they could promote nursing as a profession. In addition to their other goals, the registrationists aimed to increase the prestige of nursing as an end in itself. They made significant progress toward this goal when their professional organisation, the British Nurses Association, secured the sponsorship of Queen Victoria’s daughter, Princess Christian. As a member of the highest social class, Princess Christian was at the pinnacle of British society, and the BNA could have received more prestige only if they had been sponsored by the Queen herself.

On the other side of the debate, Florence Nightingale believed that working class women could be good nurses and should not be excluded from nurse training. Nightingale insisted that patient care was hard work and should be done by women of good character who were used to hard work. She strongly believed that character needed to be an essential focus in nursing and that standardised tests for registration could not evaluate a nurse’s character or her nursing practice. These could only be accurately evaluated by direct observation of probationers by competent ward sisters. Nightingale wanted to concentrate on clinical competence and expertise rather than prestige. The training of probationers was meant to

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32 Rafferty, The Politics of Nursing Knowledge.
produce a competent nurse who could handle the day to day care of the patients and was geared toward the teaching of the country girl.36

Although she believed that working class women made good bedside nurses, Nightingale had decided even before the registration debate that the Nightingale School would need to recruit higher class nurses in order to train nurses for leadership positions. Baly explains that Nightingale disliked the idea of separate lady probationer schemes, believing that ‘the lady should be educated with her cook,’ and that in the beginning the Nightingale Fund programme had recruited women from artisan and working class backgrounds. But in 1867, after seven years in operation, only one of the graduates of the St. Thomas’s school could be considered a nurse of high enough quality to be a successful matron.37 Women from the higher classes would begin their work as nurses with social authority to supervise others. In addition to a need for leaders with social authority, nursing needed women with impeccable moral training. Morally pure middle and upper class women were needed to supervise less morally pure working class recruits.38 Nightingale repeatedly emphasised the importance of moral training of the highest order for nurses. Other schools had already implemented programmes to train ladies of higher classes for leadership positions, and beginning in 1867 women from higher classes were also recruited for a separate programme at St. Thomas’s.39

36 Abel-Smith, A History of the Nursing Profession , p. 21.
37 Baly, Florence Nightingale and the Nursing Legacy, p. 172.
39 Baly, Florence Nightingale and the Nursing Legacy ; Brooks, ‘Structured by Class, Bound by Gender,’ pp. 13-21.
The entry of ladies into nursing posed serious problems. Two of the problems were that the ladies would have to take orders from doctors, many of whom would be their social inferiors, and they would be doing work that would be seen as being unsuitable for women of their social standing.\textsuperscript{40} There were two solutions to the problem of ladies doing unsuitable work. The ladies supervised underlings who did the manual labour of nursing, and the ladies did nursing work in the spirit of Christian charity, which was considered the proper work of a lady, as exemplified by early Christian deaconesses.\textsuperscript{41}

In order to circumvent the problem of ladies taking orders from doctors who might be their social inferiors, it was important for the nursing elite to be in a different hierarchical structure than the doctors. If the nursing staff were in a different hierarchy from the medical staff with a nurse matron at its head, the nursing elite would be subordinate only to a woman with a background like their own.\textsuperscript{42} Nightingale believed that because women were different from men, they had a separate role in society. Because women were different from men and had a separate role, they needed to be under the control of women on a ‘female hierarchy that was equal to, but separate from, that of men.’ Under this ideology, nursing should not be a threat to the authority of physicians because it was a separate discipline ‘structured around a hierarchy of its own.’\textsuperscript{43}

\textsuperscript{40} Brooks, ‘Structured by Class, Bound by Gender,’ p. 14.
\textsuperscript{41} Brooks, ‘Structured by Class, Bound by Gender,’ pp. 13-21.
\textsuperscript{42} Brooks, ‘Structured by Class, Bound by Gender,’ p. 14.
\textsuperscript{43} Reverby, \textit{Ordered to Care}, p. 42.
Another problem for lady probationers was that of remuneration for their work. From the beginnings of the training schools probationers had been given room and board, washing, uniforms, and often a small stipend, but being paid would have unacceptably diminished the status of higher class women. This problem was addressed by having ladies pay for their room and board and other services and forgoing the stipend. If the higher class woman paid for her room and board her status as a volunteer doing charity work was maintained. Having overcome philosophical and social barriers to the entry of ladies into nursing, separate programmes for ‘special probationers’ were established in prestigious hospital nurse training schools in London and other parts of Britain.

**Special probationers**

Training schools with special probationer programmes had various categories of nurses in training. The two general categories were ‘ordinary’ or ‘regular’ probationers, and ‘special,’ ‘paying,’ or ‘lady’ probationers. Special probationers paid for their living expenses in the hospital, a source of income for financially strapped charitable hospitals, and an indication of superior social status for the probationer. Regular probationers received room, board, washing, and a small stipend during their term of training. In order to pay for their living expenses during training, special probationers had to have a source of income outside of the hospital and generally came from higher class backgrounds than the regular probationers, although some regular probationers were downwardly mobile women from the
middle classes and not all special probationers were ladies. Sometimes applicants for special probationer programmes had social backgrounds that were similar to those of applicants for ordinary probationer programmes, but they were willing to pay in order to gain status as special probationers.\textsuperscript{44}

All probationers, special and regular learned to make beds, keep the ward clean and orderly, wash patients, and perform other aspects of patient care. Even if a probationer were to expect to be placed in a supervisory role upon graduation she would need to know how to do the work in order to supervise others. Sisters had to be able to teach the probationers every detail of patient care and matrons had to be able to see that everything was done correctly.\textsuperscript{45} Of Eva Luckes, matron of the London Hospital, it was said that as ‘the Commander-in-chief of an army of over five hundred…there is nothing of importance concerning her army that she ignores—no point that she cannot put her finger on…no night scrubber whose portion of the work she does not know…”\textsuperscript{46} This does not mean, however, that special probationers had the same training experiences as ordinary probationers.

Christopher Maggs argues that lady or paying pupil nurses had a much less ‘unnerving’ training experience than ordinary probationers. He states that lady probationers were trained as ‘sister’s assistants’ and that as such they were not required to do strenuous work, although they did all the bedside care for a few

\textsuperscript{44} Brooks, “Structured by Class, Bound by Gender,” pp. 13-21; Abel-Smith, A History of the Nursing Profession.
\textsuperscript{45} Luckes, Hospital Sisters and their Duties.
\textsuperscript{46} Anonymous, ‘Chats with Matrons, Miss Eva C. E. Luckes, of the London Hospital,’ Our Hospitals and Charities (April 1904), pp. 21-22.
assigned patients. In addition to this bedside care the special probationer accompanied the sister on doctors’ rounds and gave the medications, activities which the ordinary probationer did not do. 47 Helmstadter notes that special probationers wore different uniforms and did not have to do cleaning work, and that whenever the ward sister was not on the ward, a special probationer would take her place.48 Working directly with the ward sister the special probationer learned to maintain ‘order and method’ on the ward by keeping everyone on a precise schedule. Order was not easy to maintain because patients came into the hospital largely because of accidents and other events which were impossible to schedule in advance. Before the advent of nurse training schools, nurses had also often arrived and left the wards according to very loose parameters which detracted significantly from orderly ward management. Bringing order to the wards was the goal, as much as anything else, of the new nursing and the person responsible for this essential work was the ward sister.49

In some hospitals only special probationers received doctors’ lectures. For instance, an ordinary probationer who finished her training at St. Thomas’s Hospital in 1903 did not attend doctors’ lectures.50 Where both regular and special probationers received doctors’ lectures, special probationers often had an advantage of educational background which put them well ahead of the regulars. 51 Special

50 Miss Wills, ‘Recollection of a St. Thomas’s Nurse Graduated in 1903,’ HI/ST/NTS/Y23/9, LMA.
probationers were systematically coached and mentored for the pivotal position of ward sister. Special probationer programmes in nurse training schools in prestigious hospitals thus helped to keep clear lines between nursing and medicine by channelling interaction with senior medical staff, as assistants to ward sisters and advanced pupils in theoretical discussions, to the relatively few nursing students who were expected to become ward sisters. While ordinary probationers could become ward sisters and even hospital matrons, special probationer programmes specifically set out to train nurse leaders for ward and hospital positions. As ward sisters they would be the ones to interact directly with the senior doctors.

By the 1870s there were five categories of probationers at St. Thomas’s. The probationers in four of these categories signed a contract saying that they would serve for four, later three, years wherever the Committee sent them. These four categories were: the ordinary probationers who were paid a salary of 10 pounds a year, probationers who were ‘Free Specials’ who were not paid a salary, ‘Free Specials’ who were paid a small salary and ‘Specials’ who paid 30 pounds per year for room and board. The last category, who were not required to serve the hospital after finishing their training, were ‘Specials’ who paid 52 pounds per year. Baly stresses that contrary to the statements of some nurse historians, the money paid by

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special probationers was for room and board and that none of the pupil nurses paid tuition for their training.\textsuperscript{53}

Not all hospitals had special probationer programmes. In 1899 24.3 per cent of London hospitals had special probationer schemes as did 11.1 per cent of hospitals in the remainder of England and Wales.\textsuperscript{54} \textit{Cassell’s Science and Art of Nursing}, a four volume set of books with chapters written mostly by matrons of large British hospitals in the early years of the twentieth century, included a chapter by Lilian Maule on training schools with descriptions of their requirements and programmes.\textsuperscript{55}

There was no date of publication printed in the books, but the first chapter was a short explanation of ‘Nursing, Past and Present’ which outlined major milestones up to the ‘present’ ending with Florence Nightingale receiving the Order of Merit in 1907 and the introduction of legislation for nurse registration in 1909.\textsuperscript{56} Maule included a ‘representative but not exhaustive’ list of specific requirements and programmes for seventeen London ‘general hospitals,’ of which twelve had special probationer programmes. Those schools with special probationer programmes included most of the large voluntary hospitals including Guy’s, King’s College, Middlesex, London, St. Bartholomew’s, St. Thomas’s, and University College. General hospitals listed which did not have special probationer programmes included Great Northern Central and St. George’s. Maule also included information about 78

\textsuperscript{53} Baly, \textit{Florence Nightingale and the nursing legacy}, p. 56.
\textsuperscript{54} Brooks, ‘Structured by Class, Bound by Gender,’ pp. 13-21.
general hospitals in the provinces and other parts of Britain, of which 28 had paying probaterion programmes.57 Those nurses who graduated from London voluntary hospitals had the most prestige, followed by graduates of provincial voluntary hospitals, with graduates of poor law hospitals having the least prestige.58 Special probationer programmes tended to be at the most prestigious London hospitals.

The great majority of pupil nurses in Britain were regular probationers. Though small in numbers, however, special probationers made a major impact on nursing development. In the most prestigious British hospitals it was generally special probationers who were assigned to be ward sisters and it was usually from the ranks of ward sisters that nurses were promoted to the position of matron.59 According to Abel-Smith lady pupils became ‘missionaries in the nursing reform movement’ for Nightingale as they became matrons for hospitals throughout Britain and abroad.60 Baly disputes the purported impact of Nightingale School trained nurses.61 However, McDonald argues that despite a predictably rocky beginning, hundreds of graduates of the Nightingale School became hospital matrons in various parts of the world.62 Baly recognises that many of the ‘specials’ did become important and influential pioneer matrons, including Angelique Pringle and Rachel William who presided over

57 Maule, ‘Training Schools and Other Nursing Institutions,’ p. 66-68.
60 Abel-Smith, A History of the Nursing Profession, p. 24.
61 Baly, Florence Nightingale and the Nursing Legacy.
a highly successful nurse training programme in Edinburgh. According to Baly, special probationers who became matrons were successful mostly because they were ‘both educated and highly motivated.’

While the introduction of lady probationers may have moved the cause of trained nursing forward, they brought with them new problems. In various ways, lady nurses could be troublesome both in training schools and in private practice. While some lady probationers became excellent nurses it was not uncommon for them to behave in rather obnoxious ways that indicated they considered themselves to be superior to those around them. They were accustomed to deference, special treatment, and often expected to be waited on. Comments arose about higher class nurses needing many footmen. A late nineteenth century popular magazine carried an article about difficulties with higher class nurses who were not only expensive but haughty. The author stated that ‘Many persons…object to the sense of superiority exercised by the nurse over them,’ specifically citing a nurse who liked to talk about going hunting with her groom behind her and making comments about her father’s butler, implying that she was boasting about her privileged background. This article was widely condemned by private duty nurses who considered it to be a ‘vicious attack’ on all nurses practicing in private homes. The article elicited a defence from Ethel Fenwick which was published in the following issue of the magazine which

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63 Baly, *Florence Nightingale and the Nursing Legacy*, p. 159.
64 Abel-Smith, *A History of the Nursing Profession*, p.66; Baly, *Florence Nightingale and the Nursing Legacy*, p.159.
65 Abel-Smith, *A History of the Nursing Profession*, p. 66
66 Lady Priestley, ‘Nurses a la Mode,’ *The Nineteenth Century*, 28 (Jan 1897), p. 36.
corroborates the idea that many people perceived a tendency of higher class nurses to flaunt their superiority.\textsuperscript{68}

In regard to relationships between doctors and lady nurses, doctors were sometimes intimidated by them and were annoyed by their tendency to put religious concerns above medical treatment. Many doctors were wary of lady probationers who came from higher class backgrounds than they did, worrying that their authority would be undermined by high class women with wealth and social connections.\textsuperscript{69} Their fears were not unfounded. Before the advent of nurse training schools doctors reigned over both patients and nurses from the lowest classes and there was no question about who was in authority. Introduction of lady nurses could not fail to cause concern among the doctors, and it is no wonder that nurse leaders were constantly reassuring them that their authority over medical matters was inviolate.\textsuperscript{70} In addition to issues of social hierarchy, lady nurses tended to be devoted Christians who were inclined to put the patients’ spiritual needs above their physical needs and doctors’ orders. In cases where the lady nurse believed that the doctors’ treatments were in conflict with the patients’ spiritual needs, the treatments might be left undone.\textsuperscript{71} According to Maggs it was difficult for doctors to know how to deal with special probationers in regard to both etiquette and authority. Should the doctor stand for the lady or should

\textsuperscript{68} Ethel Fenwick, ‘Nurses a la Mode, a reply to Lady Priestley,’ \textit{The Nineteenth Century} (Feb 1897), pp. 325-334.

\textsuperscript{69} Maggs, \textit{The Origins of General Nursing}; Abel-Smith, \textit{A History of the Nursing Profession}, p. 27.


\textsuperscript{71} Baly, \textit{Florence Nightingale and the Nursing Legacy}, p. 159.
the nurse stand for the doctor? He also discusses the lady pupil’s propensity for standing on her social status and behaving as sisters’ deputys rather than as nurses in training.  

There were other issues. The ‘Specials’ at St. Thomas’s Hospital tended to associate together to the exclusion of other probationers. According to Baly this bothered Nightingale and was one reason she did not want an ‘officer class’ of nurses. In addition to lady probationers being aloof from other pupil nurses, according to Baly, Mrs Wardroper found them to be intimidating. Baly states that Wardroper was afraid of them and didn’t think she could control them. Maggs notes that special probationers were probably ‘more trouble than they were worth’ in terms of monetary income and that although they had served an important purpose, when the lady pupil programmes were phased out there was little sorrow at their passing.

Maggs states that the purpose of the special probationer programs was to raise the ‘moral and class tone’ of the nursing profession, but perhaps more important was their purpose as a means to produce effective ward sisters and hospital matrons. The advantage to assertive, self-confident special probationers was that they tended to make strong self-confident ward and hospital leaders. There were probably exceptions to this rule, but evidence supports the likelihood that graduates of special probationer programmes would not be likely to tolerate anything but respectful

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73 Baly, Florence Nightingale and the Nursing Legacy.
74 Baly, Florence Nightingale and the Nursing Legacy, p. 157.
treatment. There is evidence that this was not the case for head nurses in at least one major Philadelphia hospital. Nancy Tomes explains that head nurses at the Pennsylvania Hospital from the last years of the 1890s through the first years of the 1900s were often subject to disrespectful treatment from the pupil nurses. She states that hospital records indicated that ‘being rude, impertinent, disrespectful, or disobedient to a head nurse was a common misdemeanor (sic).’ At the same time, the pupils would not have dared to be rude in any way to the superintendent of the school. ⁷⁷ The superintendent, Lucy Walker, was a former special probationer at St. Bartholomew’s Hospital in London. A strong superintendent or hospital matron was essential to the implementation of Nightingale’s vision of nurses being under the control and supervision of an expert trained nurse head.

The British Matron

Hospital ward sisters were supervised by the chief nurse in the hospital, known as the matron or lady superintendent. ⁷⁸ After the first years of the Nightingale School at St. Thomas’s, matrons were trained nurses who had generally served as ward sisters before being appointed to administer the hospital nursing service. Nightingale had insisted that it was essential to have the hospital nursing service under the supervision of a trained nurse, not hospital governors, chaplains, or medical staff. ⁷⁹ Separating the nursing service from the medical service was not an easy endeavour,

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⁷⁸ Moore, A Zeal for Responsibility.
and the matron had to be strong willed, tactful, and persevering to maintain control over the nurses.

One of the most difficult aspects of separating the nursing service from the medical service was securing the role of disciplining the nurses for the matron. Under a combined medical/nursing service, the doctors had taught and disciplined the nurses. With the ‘new nursing,’ nurses attended formal lectures from doctors but most of the responsibility for teaching pupil nurses was carried by the ward sisters under the supervision of the matron. In some large London hospitals special nursing staff, ‘Home Sisters’ and later ‘Sister Tutors,’ were assigned to look after the pupils and help with the teaching.

At St. Thomas’s Hospital there was a great deal of tension between Nightingale and the matron, Mrs Wardroper, about teaching the student nurses on the wards. Wardroper, who was not a nurse, did not want her authority undermined in any way on the wards. Unfortunately, student diaries at St. Thomas’s in the 1860s indicate that students spent a great deal of time unsupervised on the wards and did not receive much instruction from the sisters. Dingwall, Rafferty, and Webster state that the

80Helmstadter, ‘Old Nurses and New,’ pp. 43-70; Helmstadter and Godden, Nursing Before Nightingale, 1815-1899; Margaret Lonsdale, ‘The Present Crisis at Guy’s Hospital,’ The Nineteenth Century 7 (1880), pp. 677-683.
81Margaret Lonsdale, ‘The Present Crisis at Guy’s Hospital,’ The Nineteenth Century7 (1880), pp. 677-683; Helmstadter, ‘Old Nurses and New,’ pp. 43-70; Abel-Smith, A History of the Nursing Profession; Lees, Handbook for Hospital Sisters; Luckes, Hospital Sisters and their Duties; Maggs, The Origins of General Nursing.
sisters on the wards were not doing much in the way of teaching, which was widely recognised as a problem.\textsuperscript{83}

In the 1870s trained nurses were at last employed to teach student nurses at St. Thomas’s. The first nurses specifically employed to train the probationers were called Home Sisters. Nightingale invented the term ‘Home Sister’ in order to avoid upsetting Wardroper. According to Baly, the latter would have been disturbed if Nightingale had designated the position ‘Mistress of Probationers,’ which would have been a more appropriate title. In the beginning, the Home sister was responsible for the welfare of the students, but only the doctors supplied formal lectures.\textsuperscript{84} Brooks argues that doctors consciously wanted to keep control over the content of nurse education and nursing practice by controlling nurse education, and the Home Sister spent a great deal of her time setting up the doctor’s lectures and then marking the students’ notes.\textsuperscript{85} Later on the Home sisters began to give formal instruction to students. Education of pupil nurses consisted of ward instruction by the hospital sisters, the Home sister’s instruction, the report book and taking case notes, and students’ keeping diaries of everything that they did on the wards. Matrons also gave some formal lectures to pupil nurses. The Home sisters’ instruction consisted of ‘tutorials and improvement classes’ in nursing and moral matters.\textsuperscript{86} According to

\textsuperscript{83}Robert Dingwall, Anne Marie. Rafferty, Charles Webster, \textit{An Introduction to the Social History of Nursing} (London: Routledge, 1998).
\textsuperscript{84}Baly, \textit{Florence Nightingale and the Nursing Legacy} , p. 157.
\textsuperscript{85}Jane Brooks, “Women in-between” (Strathern), 1995,’ pp. 169-175.
\textsuperscript{86}Helena Riddick, Letter from St. Thomas’s Hospital (1888), HI/ST/NTS/Y18, LMA; Miss D. S. Doode, responses to a questionnaire about experiences at St. Thomas’s Hospital, dates of training 1899-1902, HI/ST/NTS/Y13/14/5, LMA; Reminiscences of a Nightingale probationer of 1899, HI/ST/NTS/Y13/4/13, LMA; Eva Luckes, \textit{Lectures on General Nursing, Fourth Edition} (London:
Baly, it would be many years before there would be an instructor along the lines that Nightingale wanted at St. Thomas’s.\textsuperscript{87}

During the first years of the new nursing, strict discipline—proverbial in nursing—was necessary to keep lower class nurses under control. But continued strict discipline which persisted after nursing pupils were coming primarily from higher working classes and the middle classes has been puzzling.\textsuperscript{88} As one explanation for this phenomenon, Helmstadter argues that strict discipline made hospital nursing services less expensive to run, which was very important for hospitals always struggling to maintain financial solvency.\textsuperscript{89} Strict discipline was also necessary in order to maintain decorum between the new young, respectable nurses and male hospital staff.\textsuperscript{90} Another explanation may be that stern discipline by the chief nurse, which continued into the second and third generations of trained nurses, was necessary in order to wrest the discipline of the nurses from the medical staff. In order to transfer authority over the hospital nursing service from the doctors to the chief nurse, the chief nurse had to tighten her grip on it. This would help to explain why discipline became stricter in the 1880s even though the quality of nurse recruits had improved since the first generation of secular trained nursing began in the 1860s.

\textsuperscript{87} Baly, \textit{Florence Nightingale and the Nursing Legacy}.
\textsuperscript{89} Helmstadter, ‘Building a New Nursing Service,’ pp. 590-621.
\textsuperscript{90} Brooks, ‘Structured by Class, Bound by Gender,’ p. 17.
Under the old system, ward sisters had been responsible for supervising assistant nurses on the wards, under the direction of the doctors, and had little supervision from the matron, who was not a nurse. Doctors worked with ward sisters and nurses to teach them how they wanted the patients to be cared for and how to carry out doctors’ orders. The doctors disciplined the nursing staff when they were not satisfied with their work, but generally had congenial relationships with them. It would have been easier to interact on a more friendly personal level with older nurses from the char-woman class than with nurses from higher classes because they were not suitable for matrimony and had less respectability to lose.

One contemporary medical man’s perceptions of the differences between relationships between doctors and the old nurses as contrasted with the new nurses is illustrated in Edward Berdoe’s novel, *St. Bernard’s: the Romance of a Medical Student.* The old style nurse, Mrs Podger, has a motherly, friendly relationship with the medical students at St. Bernard’s Hospital. She takes tips from medical students and in return teaches them various clinical skills, does not stand in the way of their medical experiments, and makes sure they are left alone if they want to be. For instance, if accident cases arrive at the hospital when the students are in the middle of a card game. The well-being of ‘her boys’ takes precedence over everything else. In contrast, the new-style nurse, Sister Agnes, is a deeply religious young woman whose top priority is the well-being of the patients. When she thinks

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that some of the medical experiments being tried by the doctors are ‘needless and dangerous’ she rebels and does what she can to see that they are stopped. According to Berdoe’s novel, the old style nurse was a close ally to the medical students, while the new nurse was an advocate for patients who kept a professional distance even as she did what she could to assist the doctors. The relationship of the medical staff to nurses and ward sisters before the advent of nurse training schools is further illustrated by actual events at Guy’s Hospital.

In 1880 the nursing and medical staffs at Guy’s Hospital were at loggerheads over the appointment of a new matron who was implementing what they called the ‘new nursing.’ Records of the controversy include repeated claims from the doctors that the new nursing was taking away the ‘autonomy’ of the old ward sisters. Although the official rules at Guy’s stated that the matron was responsible for all female hospital staff, it is clear from the discussion between the doctors and the governors that making the sisters answerable to the matron and making her responsible for their discipline was a new development. The doctors expressed outrage that the sisters, who had previously been in sole charge of their wards were, under the new nursing, required to regularly report to and take instruction from the matron. They were also expressed shock that hospital administrators and the matron were discussing the hospital nursing service as an entity separate from the medical service. It appears that the medical and nursing staffs had previously been assumed to be under one

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94 Berdoe, St. Bernard’s, p. 164.
95 Letter from Acting Medical Staff of Guy’s Hospital to the Governors, with responses from the Treasurer, H9/GY/A/219/018, LMA.
96 Letter from Acting Medical Staff of Guy’s Hospital, H9/GY/A/219/018, LMA.
hospital service. Under the old nursing doctors and nurses had assumed that carrying out doctors’ orders was an important nursing function, so the doctors were not implying that the nursing staff had previously been autonomous in regard to patients’ medical treatment, rather they were saying that ward sisters had previously been autonomous from the hospital matron and answered only to the doctors in matters of patient care. Regular, constant supervision and discipline from the matron in regard to patient care was a new development.

The trained nurse matron who supervised and disciplined the nursing staff was one of the most radical aspects of the new nursing, and successfully taking over this role from the doctors required a great deal of skill and tact. At the end of the century the role of trained nurse matron could still be recognised as an important source of tension between hospital nursing and medical staffs. One doctor argued that much of the ‘friction’ between nurses and medical men was rooted in the relationship between matrons, nurses, and doctors. He declared that one important difference between the education of nurses and medical men had to do with the involvement of the matron in nursing education. He stated that medical students were essentially on their own while nursing students were under the constant supervision of ‘the awful figure of the matron, who is the absolute despot by right of her position, in this world as it at present exists.’

Unfortunately the writer did not elaborate on how matrons were related to conflict between nursing staff and medical staff, but further light is shed on this subject through comments made by John Shaw Billings, an American doctor planning for the establishment of Johns Hopkins Hospital in Baltimore. Billings studied hospital nursing in Britain and did not approve of the ‘independent female hierarchy,’ which he found there. He was concerned that if a similar hierarchy were established in America its members would also ‘consider from the very commencement that one of its main objects is to endeavour to be independent of all males, who are to be considered as the natural enemies of the organisation.’ Both writers acknowledged the strong position of the matron under the new nursing. Billings’ perception was that there was a strong nursing hierarchy which was not only separate from but independent of the medical hierarchy. He also had made up his mind to avoid establishment of a similar arrangement at Johns Hopkins.

At the top of the nursing hierarchy was the hospital matron. Many of the new matrons had been special probationers. Women from the higher classes were recruited for special probationer programmes partly because they already had experience running large households and therefore had experience with directing and disciplining others. Good matrons ensured that patients received optimal nursing care through enforcement of standards by means of a formal chain of command. The matron directed the ward sisters who in turn taught and directed the nurses and

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98 James, ‘Isabel Hampton and the Professionalisation of Nursing in the 1890s,’ p. 208.
99 Abel-Smith, A History of the Nursing Profession; Maggs, The Origins of General Nursing.
probationers.\textsuperscript{100} With this arrangement, working relationships between the matron and the nursing staff took on fundamental importance.

Contemporary nursing journals regularly published articles and stories about working relationships between matrons, sisters, assistant nurses, and probationers. In 1905 the \textit{Nursing Times} published several articles about interactions between various members of the nursing staff. One of these discussed the difficult life of matrons and suggested that nurses should be more kind and considerate to their matrons.\textsuperscript{101} Rebuttals followed which claimed that the idea of exchanging pleasantries with one’s matron was preposterous, and that matrons were usually so formal, strict, and brusque that any attempt at being pleasant to them was likely to be met with disdain.\textsuperscript{102} Maggs discusses a situation in which probationers were not allowed to speak directly with the matron—if a probationer needed to communicate with the matron, even in her presence, she should speak to the staff nurse, who would speak to the sister, who would convey the message to the matron.

Not all matrons were so fearsome. Another writer described three matron types which were quite different from each other. The first was beautiful, understanding, sweet, and got married. The second was formidable, never said good morning, and was very strict about all the rules, believing that anyone who would be late for

\textsuperscript{100} Nightingale, ‘Sick Nursing and Health Nursing,’’ p. 28.
breakfast could be of no use to anyone. The writer stated that both of these were excellent matrons, but the best matron was one who was quiet, not ostentatious, and could discern which probationers would not be good nurses and did not keep them. The best matron had great powers of observation and could also recognise those probationers who would be good nurses no matter how clumsy they were at the beginning of their training. All of these matrons maintained discipline, the hallmark of a good matron. One probationer described arriving back at the hospital after a holiday at home and along with unpacking her collars and cuffs, unpacking ‘Dame Discipline.’ ‘Discipline’ was a clearly recognised entity for probationers in nurse training schools.

Ward sisters who had their eyes on gaining a matron’s post had to maintain strict discipline. One new ward sister lamented the necessity of imposing ‘a new and rigid code of etiquette’ with her nurses after finding one of them leaning out of a window in order to have an amusing conversation with some housemen on the veranda. She found the role of night sister very pleasant, but the worst appointment was that of assistant matron, with too many nurses to deal with, no ‘patients of one’s own,’ and ‘ever so much too much matron!’ Maintaining order and discipline in the absence of the matron was also challenging, however. When the matron went on holiday, the assistant had to take over and then ‘the kitchen boiler blows up, the cook goes off, every delicate nurse goes off sick—and their mothers swoop in on you if you don’t

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104 Anonymous, ‘Extracts from the diary of a probationer,’ *Nursing Mirror* (October 5, 1907), p. 10.
properly care for them.’ She lamented that is was too bad the telephone ‘did not also stop working!’

A short story in the Nursing Mirror illustrates the intimidation felt by probationers toward ward sisters and especially matrons, but also the humanity of the matron. A new probationer finds that she is struggling to perform all of her duties adequately. When she makes mistakes, she is mortified to be reprimanded by the sister in the hearing of the patients and ward maid. An incident in which she accidentally injures a patient with a hot water bottle—an error unfortunately discovered by a doctor with his flock of students—makes it necessary for her to have an audience with the matron. The suspense in regard to this dreadful meeting is skilfully developed by the author. The probationer also agonises over her relationship with the sister, who never liked her because she is shy and timid. The relationship between the two is more strained not only because of the mistake, but because the sister regrets the doctor’s confidence in her has been undermined by the incident. Before the probationer’s appointment with the matron, the sister assigns her to watch a confused typhoid patient at night. She is exhausted and drifts off to sleep for a moment. She comes to and finds that her patient is outside, climbing a ladder up to the roof of the hospital. She hurriedly climbs out the window and, risking her own life, follows the patient up the wall to save her. After recovering from injuries associated with this episode, the probationer finally goes to the matron’s office with fear and trembling for her audience. She is

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sure that she will be dismissed, but the story ends with the matron reaching out her hand in pity and sympathy.\textsuperscript{107}

The author of the story found it plausible that a pupil nurse would climb a tall building in pursuit of a delirious woman with little thought, but would be terrified by the prospect of meeting with the hospital matron. In this way the author emphasised the tremendous fear and trepidation which matrons inspired in pupil nurses. The author also, however, forcefully made that point that this matron was a compassionate human being.

Accounts of actual matrons who maintained discipline while also demonstrating kindness also exist. At St. Thomas’s hospital in the mid 1890’s the highly respected matron, Miss Gordon, described as \textsuperscript{108} ‘severe-looking’ woman with a ‘great air of authority,’ had to undergo surgery and asked one of the ward sisters at the hospital to be her nurse. The sister was intimidated by the prospect until the matron kindly told her not to think of her as her matron but as a patient in need and to please tell her everything that she needed to do to safely recover from the procedure.\textsuperscript{109} Another probationer was called to the same matron’s office and her senior probationer told her with glee that she was going to be severely reprimanded. The probationer was reprimanded by the matron, but as she went out the matron leaned forward and told

\footnotesize{\textsuperscript{107} E. Margaret Fox. ‘A Christmas of Clouds’ \textit{Nursing Mirror} (Dec. 14, 1907), pp. 161-165. \\
\textsuperscript{108} E. Lees, ‘Probationer Recollection,’ St. Thomas’s Hospital, HI/ST/NTS/Y23/6/2, LMA. \\
\textsuperscript{109} E. M. Vezey, Memoir of her experience as a probationer at St. Thomas’s Hospital 1895, HI/ST/NTS/Y23/1, LMA.}
her that she had not been a particularly good probationer herself, which the probationer found profoundly endearing.\(^\text{110}\)

While the character of individual matrons may have been complex, it is evident that they were all expected to maintain firm discipline. This was not easy. In their ‘daily trials and worries’ they were ‘often-maligned,’ ‘much criticised,’ and ‘sometimes envied’ while persevering through ‘great loneliness and grave responsibilities.’\(^\text{111}\) Nightingale once commented to a newly appointed ward sister that she would find much to enjoy in her new position, but that if she were to take on the post of matron, it would be a lonely one.\(^\text{112}\) While medical officers had colleagues, the matron had peers only outside of her hospital.

Nightingale insisted that the matron be responsible only to hospital administrators, not medical staff, thus forming a nursing service separate from the medical service and placing the chief nurse on the same plane of authority as the chief medical officer. An early twentieth century incident related to efforts to place matrons under chief medical officers at workhouse infirmaries suggests that by the first years of the twentieth century, British nurses expected that the matron and the medical superintendent would be in positions of equal authority. In 1907 the Metropolitan Asylum Boards (MAB) proposed to put the matrons of their hospitals under the authority of hospital medical superintendents. Nurses gave the MAB the benefit of

\(^{110}\) Lees, ‘Probationer recollection,’ St. Thomas’s Hospital HI/ST/NTS/Y23/6/2, LMA.


\(^{112}\) E. M. Vezey, Memoir of her experience as a probationer at St. Thomas’s Hospital 1895, HI/ST/NTS/Y23/1, LMA.
the doubt in regard to their motives. They stated that the MAB were probably not maliciously attempting to weaken their authority but only trying to simplify the situation by having only one person in charge. They did, however, strongly object stating that placing matrons under control of the medial superintendent would result in the ‘depreciation of the position and influence of their matrons.’ If the MAB were successful, the new regulations would ‘undermine the office’ and it would become much more difficult to find suitable women who would be willing to take the position of matron.113 Nursing leaders including Isla Stewart and Ethel Fenwick publicly protested the MAB’s proposal stating that the proposed action would ‘degrade’ MAB matrons from ‘first to second class officers.’ They argued that not only would the proposed change affect nurses, it would have a detrimental effect on the equality of men and women.114

Nursing leaders of various philosophical persuasions, such as Nightingale, Stewart, and Fenwick, agreed that the hospital matron must have control of the nursing service. The matron needed to have control of the nursing staff, and in order to do so would have to maintain strict discipline, and by the end of the nineteenth century the large London teaching hospitals were turning out graduates who became successful hospital matrons. For example, Eva Luckes, who had been a paying probationer in London’s Middlesex Hospital, was matron of the London Hospital for 39 years where she oversaw the training of many future matrons.115 Luckes, known for her

114 Anonymous, ‘Protests Against the MAB’s Action,’ Nursing Mirror (October 26, 1907), p. 948.
ability to maintain discipline, received her share of criticism but also received a great deal of support from hospital administration and her graduates in the face of that criticism. At Guy’s Hospital, the resolution of the controversy between doctors and nurses resulted in the doctors’ obtaining a place at the table to regularly discuss medical issues with hospital administrators, but the matron succeeded in securing the matron’s place in control of all matters pertaining to the nurses. McInnes argues that at St. Thomas’s Hospital, the three matrons who followed Sarah Wardroper, the first matron of the Nightingale School, maintained Nightingale’s vision of the matron’s place at the head of the nursing service. In spite of setbacks, some exceptions, and a slow beginning, nurses in authority in large London hospitals had to a great extent achieved control of hospital nursing services by the end of the nineteenth century.

According to Vicinus, the lady probationers who achieved roles of authority in the early years of trained nursing were characterised by high social position and ‘indomitable will.’ It was also helpful that Nightingale was willing to put her considerable influence at the disposal of new matrons. According to Abel-Smith, ‘In the event of serious trouble they could appeal…to Miss Nightingale…She was often

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117 Vicinus, Independent Women; Moore, A Zeal for Responsibility.
119 Hawkins, Nursing and Women’s Labour in the Nineteenth Century.
120 Baly, Florence Nightingale and the Nursing Legacy.
121 Vicinus, Independent Women, p. 95.
able to use her influence with doctors or hospital governors to ensure that the matron got her way.¹²²

**Superintendents in America**

In America there were no lady probationer programs. While successful American hospital nurse training schools were functioning by the 1870s, until the end of the century even some of the most prominent American hospitals struggled to find effective training school superintendents to direct hospital nursing services. Authorities in some of these hospitals accomplished their objectives in regard to establishing successful nurse training programmes by appointing superintendents from Britain.

At Bellevue Hospital in New York a group of conscientious women of high social status were attempting to improve general conditions and nursing care in the early years of the 1870s. They encountered a great deal of opposition from hospital administrators and many of the doctors. With the support of a few of the doctors who enthusiastically supported the ladies’ efforts, they were eventually able to set up everything necessary to start a school for nurses—except a superintendent. As part of their preparations the ladies had studied the written works of Florence Nightingale. A sympathetic member of the medical staff had also spent three weeks in London studying the nursing school at St. Thomas’s Hospital and had personally corresponded with Nightingale. They believed that in order for the school to be successful they would need to have a strong, experienced woman in charge of the

¹²² Abel-Smith, *A History of the Nursing Profession*, p. 28.
nurses. The position was filled when a British nursing Sister volunteered for the post.\textsuperscript{123}

Sister Helen Bowden belonged to a Protestant nursing sisterhood in England which had taken over the nursing service of a large London hospital. She possessed all the necessary qualities and experience to maintain discipline, improve the quality of the nursing, and train new nurses and she was very successful at Bellevue.\textsuperscript{124} Nursing sisterhoods had established formal nurse training before Nightingale, and much that was subsequently successful in nurse training was modelled on the sisterhoods.\textsuperscript{125} Nightingale’s vision of secular nurse training, however, was meant to avoid significant problems experienced by sisterhoods contracted to provide the nursing in individual British hospitals.\textsuperscript{126} At Bellevue, the organisers, so careful to set up their school after Nightingale’s ideals, found a successful superintendent in a member of a nursing sisterhood who had never had anything to do with the Nightingale School.\textsuperscript{127} Nevertheless, although she was an active member of an Anglican sisterhood and in America for the purpose of establishing a nursing sisterhood in Baltimore, Sister Helen did not attempt to form a sisterhood in New York. She organised the training

\textsuperscript{125} Helmsdader and Godden, \textit{Nursing Before Nightingale, 1815-1899}; Aeleah Soines, \textit{From Nursing Sisters to a Sisterhood of Nurses: German Nurses and Transnational Professionalisation, 1836-1918} (University of Minnesota Dissertation, 2009).
\textsuperscript{126} Moore, \textit{A Zeal for Responsibility}
\textsuperscript{127} Helmsdader and Godden, \textit{Nursing before Nightingale 1815-1899}.
school at Bellevue as a secular project under a strong chief nurse appointed individually by hospital authorities, as Nightingale had advocated.\textsuperscript{128} 

Johns Hopkins Hospital and its school of nursing both opened in 1889. At Johns Hopkins, where the nurse training school was an integral part of the hospital’s plan from its inception, the successful first superintendent of the school, Isabel Hampton, was from Canada and trained at Bellevue. She then worked for two years with British trained nurses in Rome. According to James, Hampton’s goal at Johns Hopkins was to train nurses to the ‘best British Victorian standards…’\textsuperscript{129} John Billings, a physician, had opposed a separate nursing hierarchy such as he had found in Britain when helping to plan the nurse training school for Johns Hopkins. But when the hospital was organised other events resulted in the hospital being divided up into independent departments including a nursing department. According to James, Hampton worked amicably with the medical staff and one of her favourite sayings was a quote from Billings that ‘the hands of the nurse’ were the ‘physician’s hands lengthened out to minister to the sick.’\textsuperscript{130} 

In Philadelphia, nursing services at the Philadelphia General Hospital, the Presbyterian Hospital, Pennsylvania Hospital, and the Hospital of the University of Pennsylvania had British superintendents. Lucy Walker, first at the Presbyterian and then at the Pennsylvania, Caroline Milne at the Presbyterian, and Nightingale nurse, Alice Fisher, at the PGH tightened discipline of the nurses under the trained nurse

\textsuperscript{128} Hobson, \textit{Recollections of a Happy Life.}

\textsuperscript{129} James, ‘Isabel Hampton and the professionalisation of nursing in the 1890s,’ pp. 201-44.

head and improved the quality of patient care. The Hospital of the University of Pennsylvania also appointed an English graduate of the Nightingale School, Charlotte Hugo, to set up their training school for nurses one year after the arrival of Alice Fisher at the Philadelphia General Hospital.

Descriptions of conditions at the Philadelphia General Hospital in the days before and after Alice Fisher became the first superintendent of the nurse training school are similar to descriptions of nursing in general before and after the advent of Florence Nightingale. What had been miserable, sordid, and disorderly became therapeutic and well organised. Dr William Osler felt that working with her was one of the highlights of his work at the PGH and that her example showed that nursing was a ‘suitable field for women of the highest culture and intelligence.’ Even taking into consideration the hagiography surrounding Alice Fisher after her early death from heart disease, indications are that conditions at the hospital were significantly improved under her leadership. Fisher had trained as a special probationer at St. Thomas’s Hospital in London and had served in several leadership positions in various British hospitals before going to Philadelphia to take over the nursing at the PGH in 1884. She remained in that position until her death in 1888, after which

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generations of pupil nurses made yearly pilgrimages to her gravesite. American trained nurses took over the reins after her death.

According to contemporaries who wrote about her, Fisher and her assistant, Miss Horner, whom she brought with her from England, were able to accomplish great improvements at the PGH. Nevertheless, a review of hospital rules indicates that both before and after her tenure, the chief nurse was not on an equal organisational level with the chief medical officer. The medical officer was ultimately responsible for the discipline of the nursing staff. Hospital rules from 1869 and 1883 state that any ‘dereliction’ on the part of the nurses was to be reported to authorities by the medical officer, not the nurse superintendent. Rules from 1887 and 1902 state that the chief medical officer had ‘control and general management of all the nurses…’ The rules changed somewhat by 1908 when the chief nurse was to have control over the nurses, ‘under the direction of the Chief Resident Physician.’ Thus, in 1908 the nursing service at the Philadelphia Hospital, one of America’s oldest, largest hospitals was under the official direction of the doctor in charge of the resident medical staff. Details about how Fisher made changes and maintained discipline under these circumstances is not apparent in the data. It is possible that she was

134 Printed biographical article, re: Alice Fisher, c1889, MC 71, II, 4, f.5, CSHN; In Memoriam: Alice Fisher, Chief Nurse of the Training School for Nurses, Philadelphia Hospital, c1889 MC 71 II, 4, f.6, CSHN; Alice Fisher Alumnae Club Illustrated Souvenir Book 189, MC 71, IV, 6, f.1, CSHN.
136 Guardians of the Poor, Rules for the Government of the Medical Board of the Philadelphia Hospital, 1870, A-5431, 35-3-7.27, PCA; Guardians of the Poor, Rules for the Government of the Board of Guardians of the Poor in the City of Philadelphia, 1887, A-5431, 35-3-1.4, PCA; Guardians of the Poor, Rules of the Department of Charities and Correction for the Government of the Bureau of Charities, Philadelphia, 1902, PCA.
given de facto control of the nurses, but strong wording in the 1887 hospital rules, three years after Fisher’s arrival, do not corroborate this view. The record suggests that there was a single medical and nursing hierarchy with doctors at the apex.

According to Lewenson, American superintendents of nursing schools faced a great deal of opposition from hospital administrators, often businessmen or doctors ‘who knew next to nothing of nursing or the proper education of nurses.’ At some of the nurse training schools the nurse superintendent had complete control of nursing education. At other schools, the training of the student nurses was controlled by administrators who did not have any nurse training. At a superintendent’s meeting in 1898, Linda Richards said that this was an intolerable situation which would not happen to any other profession.  

Richards was opposed not to medical involvement with nurse training but to control of nurse training by lay administrators. The author of the introduction to her memoirs emphasised that Richards firmly believed medical control of nurses’ training to be not only benign but beneficial and desirable. According to the introduction, early training schools had been officially independent of their associated hospitals while providing nursing services for them. This had caused a great deal of ‘disharmony’ which was overcome when training schools were officially integrated into the hospitals. In order to bring this to pass, the training schools—and thus the nursing services—were put under medical control. The author of the introduction stated,

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...The first training schools, being organised for work in the hospitals by outside associations, did an admirable service that was needed in the crude conditions of lay management...The alternative was to make the nursing service a constituent part of the whole hospital business, without external encumbrances...With clearness of insight...[Richards] accepted at once the principle of unity of institution control... No argument was needed...She saw no reason against subjecting the head of the department of nursing to the larger coordinating medical control. There was no pride of authority, no thought of personal sacrifice...¹³⁸

The author makes clear that this pattern of medical control over hospital nursing services became the norm. The introduction notes that the nursing superintendent was responsible for the ‘conduct and discipline’ of her subordinates, but does not go into detail about what this means.¹³⁹ Nevertheless, if the nursing service was ultimately under ‘medical control’ it would seem that the superintendents’ decisions could be appealed to the presiding medical officer, and unlike London matrons, American superintendents could not turn to Florence Nightingale for support. Celia Davies and Ann Bradshaw suggest that Nightingale’s presence in Britain and her absence in America made a difference in the way nursing education developed in the two countries.¹⁴⁰ Her absence may also have contributed to medical control of hospital nursing services in the United States.

Susan Reverby has elaborated on the medical control of hospital nursing services in America. Reverby argues that both doctors and hospital administrators recognised the potential power of a strong superintendent of nursing in charge of an independent

nursing service, reporting only to the trustees. She discusses the ‘power of the nursing superintendent’ as one of the most important issues regarding hospital authority between 1873 and the first part of the twentieth century.\textsuperscript{141} She argues that in response to the threat of the powerful nurse superintendent doctors and hospital administrators set out to curtail the superintendent’s power by ensuring that nursing remained dependent on both the administrators and the doctors.\textsuperscript{142} According to Reverby, doctors used their official control of nursing services to impose their authority on the nurses and nurses’ training. She uses the example of nurse superintendent Francina Freese. In 1905 Freese had a disagreement with the hospital’s chief medical officer regarding pupil nurses’ learning to catheterise male patients. Freese felt strongly enough about the issue to ‘go over the physician’s head’ to report the dispute to a member of the board of trustees. When the trustees deliberated the issue it was ‘assumed’ that the physician ‘knew best what nurses should do.’\textsuperscript{143} As time went on the doctors’ authority grew to the point that decisions that had previously been made ‘on moral grounds by the trustees’ were increasingly ‘made on medical grounds by the doctors.’\textsuperscript{144} The de facto control of hospital operations had shifted from the trustees to the medical staff.

Some nurse leaders, such as Lavinia Dock and Lilian Wald, realised that integrating training schools into hospitals under medical control would end any dreams of maintaining schools based on the Nightingale model. In addition, Wald pointed out

\textsuperscript{141} Reverby, \textit{Ordered to Care}, p. 71.
\textsuperscript{142} Reverby, \textit{Ordered to Care}, p. 70.
\textsuperscript{143} Reverby, \textit{Ordered to Care}, p. 74.
\textsuperscript{144} Reverby, \textit{Ordered to Care}, p. 71.
that if the nursing superintendent were hired by the chief medical officer, she would have to put more effort into supporting the medical staff than into her other responsibilities.\textsuperscript{145} Wald’s concern is important in regard to the present discussion. Putting the superintendent of the nursing service under direct control of the medical officer fundamentally changed the nature of the superintendent’s work, making her more focused on nurses’ responsibilities to assist the medical staff with their work. This would detract from the superintendent’s responsibilities regarding nursing’s other major category of work based on core nursing and the training of nurses in this sphere. It is clear that Wald recognised that nurses had important nursing responsibilities which were not part of ‘supporting the medical staff.’ Ultimately, these objections were disregarded and nurse training schools were generally integrated into hospitals under medical control.\textsuperscript{146} Reverby notes that at Johns Hopkins Isabel Hampton Robb was able to implement a ‘better educational program’ but that both the hospital and the training school at Hopkins were unusual.\textsuperscript{147}

If hospital nursing services generally came to be under medical control in the United States, American training school superintendents turned to channelling significant energy into independent organisations outside of hospitals. In the 1890s, while British nurses were debating nurse registration and the value of organisation on a larger scale than individual hospital organisations, American nursing activists united to form two national organisations, the American Society of Superintendents of Training Schools in the United States and Canada, which would eventually become

\textsuperscript{145} Lavinia Dock, ‘Hospital Organisation,’ \textit{National Hospital Record} 6(1903), p. 414.
\textsuperscript{146} Reverby, \textit{Ordered to Care}, p. 72.
\textsuperscript{147} Reverby, \textit{Ordered to Care}, p. 76.
the National League of Nursing Education, and the Associated Alumnae of the United States and Canada, which would become the American Nurses’ Association. In her comparison of nursing in Britain and the United States, Davies argues that the formation of the American Nurses’ Association was a uniquely American action related to the importance of forming a nursing organisation for all nurses that would operate on ‘democratic lines.’ Davies attributes the ‘stock taking’ and self-consciousness involved in the development of this organisation to basic American values of individualism, independence, material gain, belief in equality and achievement, relatively open social mobility, localism, and dislike of government intervention. The general nurse’s organisation in particular would espouse these principles.  

Susan Armeny discusses the relationship between newly formed nurses associations at the end of the nineteenth century and upper class philanthropic women. According to Armeny, nursing organisations shared the ‘sanitary ideal’ with wealthy early nineteenth century women philanthropists. Armeny argues that the sanitary ideal, a combination of ideas from Nightingale and the Civil War Sanitary Commission, held the nurses associations and women philanthropists together. Nursing leaders did not often explicitly express what their ‘social vision’ was but when they did, they emphasised expertise, collective purpose, and discipline—ideas which were

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consistent with the sanitary ideal.\(^{149}\) In the context of Armeny’s discussion, late nineteenth century nursing organisations could be seen to some extent as compensation for losing the hope of independent training schools on the Nightingale model. This concept may be worthy of further research.

In addition to forming professional organisations, American nurses looked outside of hospitals to collegiate institutions for development of nursing education. Nineteenth century nursing leaders Adelaide Nutting, Isabel Stewart, Lillian Wald, Isabel Hampton Robb, and Lavinia Dock persistently promoted collegiate education for nurses. This was an ambitious goal at a time when most nursing students were not high school graduates.\(^{150}\) Davies argues that the battle for nurse education was fought in the United States instead of the registration debate that was taking place in Britain.

According to Davies, differences in the trajectories of nursing education in Britain and the United States were rooted in American values such as individualism, self-improvement, and social mobility. She maintains that this helps to explain the openness of education in the US, including nursing education, compared with education in Britain. In America, as in Britain, there was a constant battle between the need to educate the students and the need to supply labour for hospitals.\(^{151}\) But

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\(^{151}\) Reverby, *Ordered to Care.*
nursing leaders in the United States perceived a need for higher education in nursing whilst their counterparts in Britain did not.\(^{152}\)

Lewenson also discusses early American nurse leaders’ taking nursing education into the university setting in order to better prepare nurse educators and nurse managers. She notes that papers presented at the 1898 annual convention of the Superintendents’ Society called for better preparation of nurse superintendents. None of the nurse training schools had a curriculum that prepared nurses to be in charge of nursing education and management. It was suggested that a post-graduate programme should be implemented for the purpose of providing this kind of preparation. A committee drawn from the society was formed which worked to implement the suggestion, and in 1899 two students were admitted to a course in hospital economics at Teachers College, Columbia University under the direction of nurse Adelaide Nutting.\(^{153}\) Nursing services in American hospitals were under medical supervision, but nursing education in institutions of higher learning under the direction of nurse educators had been implemented. University education for nurses and nursing associations provided venues for nurse directed activity for nurses outside the hospital setting.

Although hospital nursing services were under medical control, hospital training school nurse superintendents still had room to manoeuvre, and a strong superintendent could set and achieve institutional goals. Miss Lucy Walker at the

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\(^{152}\) Celia Davies, ‘A Constant Casualty: Nursing Education in Britain and the USA to 1939,’ in Celia Davies (ed.) *Rewriting Nursing History* (London: Croom Helm, 1980).

\(^{153}\) Lewenson, *Taking Charge*, p. 81.
Pennsylvania Hospital is an apt example. In 1888 the managers of the Pennsylvania Hospital were looking for a new chief nurse and superintendent of the training school. Applicants for the position referred to the post in various ways: one applied for the position of ‘Matron,’ another ‘chief nurse,’ another ‘Superintendent of Nurses.’ Several applicants were from England—one having trained under Alice Fisher in Cambridge. A letter of recommendation for one Josephine Dumkee, a graduate of Blockley, remarked on her many fine attributes and then noted with emphasis that ‘besides her other excellent qualities, she is an American.’

A chief nurse was appointed, but in 1891 the managers were looking for another. In that year the managers appointed the ‘substitute’ chief nurse to the position, which she filled until 1895. In 1894 hospital authorities expressed concerns about the nursing stating that the pupil nurses were not being well instructed, the nursing care was unorganised, and the superintendent did not have the ‘confidence’ or ‘respect’ of the pupils. In 1895 Walker left the matronship of Philadelphia’s Presbyterian Hospital to take the position of superintendent of nurses at the Pennsylvania Hospital.

Lucy Walker trained as a special probationer at St. Bartholomew’s Hospital in London. Recollections of Sarah McMullin, one of the pupil nurses at Pennsylvania Hospital indicate that Miss Walker tightened the discipline and turned the training

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154 Letters of application for the post of chief nurse, MG 3.3, 106, PHHC. Emphasis in the original.
155 A Chronology of Nursing and Nursing School. PA Hospital School of Nursing. MSG 3.1, ff28, PHHC.
156 Letters of application for the post of chief nurse, MG 3.3, 106, PHHC.
157 A Chronology of Nursing and Nursing School. PA Hospital School of Nursing. MSG 3.1, ff28, PHHC.
school into one of the best in the country.\textsuperscript{159} McMullin stated that although the changes that Walker made were difficult to get used to at first, they were for the best. The morning work was ‘speeded up,’ the wards in ‘good order’ by nine o’clock. Rules such as those regarding taking exercise during off duty hours were strictly enforced. A morning ‘service’ was implemented which improved the general tone. The pupil nurses were divided into four classes according to how much time they had been in the nursing programme, and classwork, which had apparently been spotty until then, was begun ‘in earnest’ and ‘did take place.’ Each class of students had its own table in the dining room at which strict ‘decorum’ was maintained and the food was ‘much improved.’ One of the most difficult aspects of the transition for the pupils was dealing with one of the assistants that Walker had brought with her to the job, another British nurse named Miss Manly, who had an annoying way of implying that they were ‘far superior’ to the existing nursing staff.’\textsuperscript{160} The resources do not give details about Manly’s educational background, but if she was also a special probationer, her air of superiority would be consistent with British accounts of nurses who had been lady pupils. Nevertheless, it is possible that Manly’s purported deportment was related to her association with former special probationer, Lucy Walker.

Walker had taken over leadership of the school of nursing with the title of Superintendent of Nurses and subsequently took over as Matron as well. The two positions had previously been occupied by two individuals who, according to Tomes,

\textsuperscript{159} Memoir of Sarah McMullin (class of 1895), PA Hospital School of Nursing History, MSG 3.1, ff8.
\textsuperscript{160} Memoir of Sarah McMullin (class of 1895), PA Hospital School of Nursing History, MSG 3.1, ff8.
often argued about who was responsible for various parts of the work.\textsuperscript{161} When Walker combined the two positions into one and assumed responsibility as matron she acquired an assistant to look after the ‘housekeeping.’ At some point, she changed the textbook used at the school from Clara Weeks Shaw’s to Hampton Robb’s. Students had lectures for three hours a week and Walker gave weekly quizzes. One of her top priorities was to fill nursing supervisory positions with graduates of her training school. As supervisory positions in the operating room and the wards were filled with graduates of the school, rather than nurses whom Walker had brought with her, and the students came to understand Walker better, the ‘atmosphere’ improved and McMullin concluded that morale was excellent. When McMullin went as a delegate to the ‘American Association of Nurses’ convention in New York in 1898, she ‘got up’ and told those in attendance about the great improvements that Miss Walker had implemented at the Pennsylvania Hospital. Isabel Hampton Robb commented on McMullin’s remarks which pleased Walker very much.\textsuperscript{162}

Walker demonstrated the indomitable will of a London trained special probationer. On one occasion a doctor questioned the way she disciplined one of the pupil nurses and told the pupil so. Walker suggested that she should resign. She did not resign and the discipline was enforced.\textsuperscript{163} On another occasion, Walker dismissed a student nurse for slapping a patient. In support of the student involved, another student wrote

\textsuperscript{161} Toomes, “Little World of Our Own,” p. 512.
\textsuperscript{162} Memoir of Sarah McMullin (class of 1895), PA Hospital School of Nursing History, MSG 3.1, ff8, PHHC.
\textsuperscript{163} Lucy Walker and James Magee correspondence, Training School Committee, meeting minutes and correspondence, 1894, MC 35, I, 218, f.25, CSHN.
to Miss Walker to say that if the first student were dismissed then many of the other students should also be dismissed because nearly all of them had done the same thing at one time or another with very difficult patients. Walker summarily dismissed the second student. After several unsuccessful attempts to overturn the decision by appeals (and flowers) to Miss Walker, who responded kindly but firmly, the second student hired a lawyer and sued the hospital for re-instatement, but Miss Walker’s decision was upheld.\(^{164}\) According to a former pupil she was ‘a great organiser and strict disciplinarian,’ but she ‘had much sympathy in dealing with cases she deemed deserving it.’\(^{165}\)

Early in her tenure Walker wrote to the medical staff a letter, ‘stating a few of the troubles that have hindered me in my efforts to have the work of the wards run smoothly and systematically and asking for their co-operation.’ She hoped ‘to receive from them a favourable reply.’\(^{166}\) She reported her correspondence to the hospital managers and went on to say that overall things were going well in the training school and that the ‘Nurses,’ as pupils were called, were ‘learning to work methodically and carefully.’ They were ‘obedient and well-behaved,’ and they knew ‘that only by doing well, can they expect to remain here.’\(^{167}\) A reply to Walker’s letter from representatives of the medical staff made clear that if they had any difficulties or questions regarding ‘ward management’ they would consult the

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\(^{164}\) Marianne Wood File, Section 1, Series 1, Board of Managers, PHHC.

\(^{165}\) Speech given by Miss Alice Garrett, MSG 3.3, ff41, PHHC.

\(^{166}\) Report of the Training School for Nurses 24 July 1896, Lucy Walker Donnell, MG 33, ff61, PHHC.

\(^{167}\) Report of the Training School for Nurses 24 July 1896, Lucy Walker Donnell, MG 33, ff61, PHHC.
superintendent of nurses about them.\textsuperscript{168} Official hospital records indicate that there was little difficulty between Walker and the medical staff. According to Tomes, although many incidents of conflict between nurses appeared in hospital records, none were recorded about conflict between nurses and doctors.\textsuperscript{169}

One of Walker’s most difficult challenges when she started in her position as superintendent of nurses was maintaining discipline among the head nurses. She had to ‘part with’ several of them because they ‘could not or would not carry out’ her ‘methods.’ Apparently Walker’s methods were significantly different from the methods that the existing head nurses were used to. From McMullin’s account, it appears that Walker’s methods involved tighter organisation and discipline for the pupils, which would have made the head nurses responsible for teaching pupils to be more careful and methodical, tightening the ward routine, and attending religious services. Walker was sure that the work would not be well ‘settled’ until she had her own graduates in supervisory positions.\textsuperscript{170} But that would take time. She felt that the length of the training programme should be increased to three years in order to have good senior pupils on the wards to help with ward work and supervision of the newer pupils.\textsuperscript{171} Experience as third year pupils would also make the graduates more ready to take over a permanent head nurse role.

\textsuperscript{168} Report in response to LW’s letter of 7/6/1896, Lucy Walker Donnell, MG 3.3, ff62, PHHC.
\textsuperscript{169} Tomes, “Little World of Our Own,” p. 515.
\textsuperscript{170} Report of the Training School for Nurses 24 July 1896, Lucy Walker Donnell, MG 33, ff61, PHHC.
\textsuperscript{171} Memoir of Sarah McMullin (class of 1895), MSG 3.1, ff8, PHHC.
Walker was unable to get good head nurses from the ‘best hospitals’ because the salary was too low, and declined to hire some available ‘first-class English Nurses’ because she felt that it was important for American Nurses to ‘know that they had the preference.’ This need to reassure American nurses that they were preferred over British nurses, along with the doctors’ remark about the desirability of hiring an American nurse as superintendent and McMullin’s comments about haughty nurse Manly, indicate that sentiments regarding British nurses was a serious issue. There had been strong opposition to bringing Alice Fisher to Philadelphia from England both because of the cost of bringing her, her demands for a higher salary than hospital managers were used to paying, and because of desires to appoint a Philadelphian to the post. It was only after one of the hospital authorities had put up the money to cover the extra cost of her salary and had convinced others that a ‘Nightingale nurse’ would do much to overcome a recent corruption scandal at the hospital that Fisher was appointed.

In addition to her work at the Pennsylvania Hospital, Walker participated with other active nurse leaders such as Adelaide Nutting and Lavinia Dock in establishing nursing education at Columbia University. She was one of the teachers for the courses in Hospital Economics which inaugurated nursing education there.

Lucy Walker had many ‘ups and downs, many worries’ and was seriously ill several times, but according to McMullin and others she was effective, and when she retired

172 Memoir of Sarah McMullin (class of 1895), MSG 3.1, ff8, PHHC.
173 D’Antonio, American Nursing, p. 24
174 Lucy Walker Donnell Papers, MG 3.3, PHHC.
after twelve years as superintendent, she received a flood of mail expressing gratitude and praise for her work.\textsuperscript{175} A decade after her retirement, the Surgeon General asked her to go to Washington to help select nurses for service in military hospitals when the United States entered World War I.\textsuperscript{176} When Lucy Walker took over the nursing at the Pennsylvania Hospital, her assistant, Miss Caroline Milne, took her place at Presbyterian Hospital. Miss Milne had travelled to America from Britain with Miss Walker and became a respected superintendent in her own right, serving at the Presbyterian until 1920. Two decades later a nursing student award was established in her honour. American trained nurses took over the post after Miss Milne.\textsuperscript{177} Tomes concludes that Walker ‘transmitted a heritage of British methods’ then turned the hospital over to American trained nurses.\textsuperscript{178}

Conclusion

Nightingale’s vision of nursing was based on a strong central nurse authority figure who was ultimately answerable only to hospital administrators and on an equal organisational level with the medical staff. In Britain matrons filled this role. A strong matron independent of the medical staff was necessary for several reasons, one of which was to take control of the nursing from the medical staff. Large London teaching hospitals had such matrons at the apex of nursing services on a hierarchy separate from doctors. Strong character, solid social standing, and special probationer programmes for ladies at prestigious hospitals aided them. Special

\textsuperscript{175} Memoir of Sarah McMullin (class of 1895), MSG 3.1, f8, PHHC; Letter from Mary Porger Dressler (class of 1899), MSG 3.1, f8, PHHC.

\textsuperscript{176} Lucy Walker Obituary Bulletin—Philadelphia, Thursday, March 19, 1942, MG 3.3, PHHC.

\textsuperscript{177} Presbyterian Hospital Alumnae Association Report, 11 February 1939, MC 35, V, 199, CSHN.

\textsuperscript{178} Tomes, “little world of our own,” p. 530.
probationer programmes in nurse training schools in prestigious hospitals also helped to keep clear lines between nursing and medicine by channelling interaction with senior medical staff to the relatively few nursing students who were expected to become ward sisters. While ordinary probationers could become ward sisters and even hospital matrons, special probationer programmes specifically set out to train nurse leaders for ward and hospital positions. As ward sisters they would be the ones to interact directly with the senior doctors. The higher class background of some matrons and sisters, and the reflected prestige that they lent to others, helped to strengthen their position and maintain control of hospital nursing services.

Special probationers who became matrons, though relatively few in number had a significant impact on nineteenth century nursing. There were no special probationer programmes in America, and authorities at various major American hospitals turned to British matrons to establish or reform their nurse training schools. British nurses were met with some resentment by Americans. This was at least partly because some of the British nurses were perceived as pretentious, a common attribute of special probationers, who were associated with higher social classes. Class distinction was explicitly integrated into nursing programmes in Britain, but in America more democratic principles are evident in nurse training and in the formation of American professional associations. In order to lessen tensions regarding British nurses, Lucy Walker, British superintendent at the Pennsylvania Hospital, went out of her way to appoint American nurses over their British counterparts to show preference for Americans.
British training school superintendents in America succeeded in tightening discipline in the training schools but did not separate hospital nursing services from medical control. Outside of hospitals nursing leaders in America did set out to take nursing education into institutions of higher learning and succeeded at Columbia University. At least one British nurse superintendent participated in that endeavour. American developments in nursing education can be seen as compensation for loss of the hope of having independent hospital nursing hierarchies as advocated by Nightingale.

Celia Davies and Ann Bradshaw suggest that Nightingale’s presence in Britain and her absence in America made a difference in the way nursing education developed in the two countries.¹⁷⁹ Perhaps her absence in America contributed to the lack of an independent nursing hierarchy in American hospitals despite the presence of strong Nightingale trained superintendents in many large American hospitals. This possibility needs further investigation.

Differences in institutional relationships between hospitals and the first nurse training schools in America and subsequent efforts to smooth those relationships also influenced the development of medical control over nursing services. Not only the absence of Nightingale but the presence of nurse leaders such as Linda Richards, who did not have qualms about medical control of hospital nursing services, influenced this aspect of American hospital nursing. Richards had prestige as

‘America’s First Trained Nurse’ and her sanguine attitude toward medical control would have been influential.

This study raises other questions in regard to interaction between nurses and doctors in Britain and America which provide starting points for further historical research. One of these questions is related to the ward sister or head nurse position in hospitals. The position of ward sister in large British hospitals was a permanent position filled by nurses who had experience as staff nurses. Until the last decade of the nineteenth century many if not most head nurse positions in American hospitals were assumed to be temporary positions filled by senior pupil nurses. It appears that ward sisters were generally well respected while there is evidence that head nurses in at least one major American hospital were not. More research is needed to discover if this situation was general in America and if so to understand if the relationship between experienced, assertive, socially advantaged ward sisters and the medical students and doctors they worked with were the same or different from relationships between American senior pupil head nurses and the graduate doctors they worked with. Interacting exclusively with qualified medical staff could have made it easier for inexperienced American nurses to be impressed by the activities of the medical staff. Consequently, not only did American nurses have more opportunities to perform medical work, they could have been more inclined to be drawn into nursing in order to be involved in impressive new scientific medicine. Understanding how these relationships between nurses and doctors may have influenced the development of nursing in the two countries is a tantalizing prospect and invites further research.
CHAPTER VI

HARMONY AND DISCORD

Nurses and doctors worked amicably side by side in hospitals both in Britain and America. Their interactions also involved tensions and conflict. While British nurses believed that doctors should be in charge of the medical care of patients and that the nurses’ role in that endeavour was to assist the doctors, they acted to ensure that hospital nursing services would be under official institutional subordination to their own trained nurse heads and hospital governors, not doctors. This process did not occur without angst on the part of doctors who worried that their authority was being undermined. Anxiety on the part of doctors and determination on the part of nurses and hospital administrators resulted in serious conflict. One of the most publicised cases of such conflict occurred at Guy’s Hospital, which culminated in a crisis in 1880. Examination of events at Guy’s helps to understand the interaction of nurses and doctors at that time, including aspects of hospital work which were prone to tension between doctors and nurses. Examination of the records of the conflict at Guy’s also helps to illuminate how nurses conceptualised differences between nursing and medicine.

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Harmony and discord

Interaction between nurses and doctors in both America and Britain involved both conflict and harmony regulated within societal norms. In order to safeguard the moral standing of young single members of the nursing staff, rules were in place to regulate social relations between nursing and the medical staff. Probationers at St. Thomas’ Hospital, for example, were not allowed to speak to the dressers except when necessary for patient care. But rules could go only so far to keep nurses and doctors from relationships outside of professional boundaries. St. Thomas’ Hospital probationer Laura Wilson remarked that although the nurses were ‘not supposed to have anything to say’ to the medical students except what was necessary for doing their work, when standing over a patient together for extended periods of time it was only natural to talk to each other. Hospitals in the United States also laid down strict rules to regulate social interaction between nurses and doctors which could be just as difficult to enforce. An article in an American nursing journal decried over-regulation of nurse-physician social relations arguing that nurses and interns should be able to court and marry each other if they wanted to. The author of the article pointed out that if the rules were not so stringent, nurses and doctors would not have to resort to ‘clandestine meetings’ in parks and grocery stores. Famous examples of nurses and doctors who did court and marry, after they had finished their training, included Ethel Gordon and Dr Bedford Fenwick in Britain and Isabel Hampton and

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2 Rafferty, *The Politics of Nursing Knowledge.*
3 Laura Wilson letters from St. Thomas’s Hospital 1876, HI/ST/NTS/Y17/2, LMA.
4 Laura Wilson letters from St. Thomas’s Hospital 1876, HI/ST/NTS/Y17/2, LMA.
Dr Hunter Robb in the United States. Other nurses also married doctors after finishing their training.  

Sometimes when nurses became sick they needed the professional attention of the doctors. Miss Wills, another St. Thomas’s nurse, recounted that while she was visiting fellow probationers who had come down with measles and were admitted as patients on one of the wards, one of the resident doctors checked on the nurse patients and they smoked cigarettes together—which caused some consternation to the matron who walked in on them. Miss Wills also noted that she thoroughly enjoyed working with Dr Seymour Sharkey, who ‘was perfectly delightful, so friendly and natural.’ Some situations provided opportunities for nurses and physicians to help each other out of personal difficulties. Mary Cadbury, a pupil nurse and nursing staff member at St. Thomas,’ recounted an occurrence in which one of the doctors took over cleaning up a kitchen disaster for her so that she could go to a Christmas party. A graduate nurse at St. Thomas took pity on an errant resident physician who was late for breakfast and against the rules cooked eggs for him to take away.

Along with cooperation, antagonism between nurses and doctors also occurred. According to a nurse who wrote an article published in the American journal The Trained Nurse and Hospital Supplement in 1888, doctors were often domineering

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7 Miss Wills, ‘Recollection of a St. Thomas’s Nurse Graduated in 1903,’ HI/ST/NTS/Y23/9, LMA.
8 Mary Cadbury letters, HI/ST/NTS/Y16/1, LMA.
9 Horaries of special probationers at St. Thomas’s Hospital, HI/ST/NTS/C39, LMA.
and disrespectful. She complained especially about the house staff. As an example, she related that a house surgeon requested that a particular nurse be moved to a different ward because the nurse had refused to smuggle food. She stated that the doctor’s word was taken over that of the nurse and that the hospital authorities always looked at things ‘through their eyes,’ continuing that ‘in every way the will of the doctors was law exercised arbitrarily and unkindly.’ She referred to an incident in which a nurse had resigned because of bad treatment by medical staff and that this forced resignation had resulted in the resignations of several other nurses.\textsuperscript{10} Unfortunately, any rebuttals by the doctors were not available for examination. In Britain, complaints were made about arrogant lady nurses\textsuperscript{11} as well as some merely irritating trifles such as a complaint from Dr Duckworth that nurses’ veils should be eliminated because they were useless and ‘flap in people’s faces when the nurse is outside taking exercise.’\textsuperscript{12}

Discord between doctors and nurses on an institutional level also occurred. According to Monica Baly, one reason that Sarah Wardroper, matron at St. Thomas’s Hospital, did not allow the Home Sister to instruct students on the wards was that the matron wanted to avoid trouble with the doctors. Some of the doctors did not want the new nursing system, and Wardroper wanted to minimise disruption of the wards. The doctors were used to working with the ward sister, who functioned as the

\textsuperscript{10} Experience, ‘Dominance of Doctors,’ \textit{The Trained Nurse and Hospital Supplement} 2 (1899), p. 224.
\textsuperscript{11} See Chapter 5 of this thesis.
doctor’s assistant. Putting other women on the wards to teach the probationers would create too much conflict, and Wardroper wanted to keep the peace.\footnote{13}

According to Eva Gamarnikow, tension between doctors and nurses was a result of no one knowing where medicine ended and nursing began.\footnote{14} Patricia D’Antonio argues that as nurses and doctors struggled to find practical spheres of influence, conflict was inevitable. She reasons that the conflicts that developed between nurses and doctors were about more than deciding who would do which tasks, they were about finding new ways to provide care for the sick when the old ways no longer worked.\footnote{15} When trained nurses and their trained nurse matrons were introduced to hospitals in the latter part of the nineteenth century, nurses and doctors had to work through what this meant for hospital care of the sick as well as their working relationships with each other. The process was not easy.

\textbf{Dispute at Guy’s Hospital}

A well-documented conflict between nurses and doctors at Guy’s Hospital in London serves as a conduit for understanding relationships between nurses and doctors at that time as well as for understanding contemporary ideas about nursing work. In 1880 Margaret Lonsdale, a nurse at Guy’s Hospital sparked public discussion about conflict between doctors and nurses when she wrote an article about a tense situation

between nursing and medical staff at Guy’s Hospital which was published in a popular magazine. This conflict and controversy at Guy’s Hospital is discussed extensively elsewhere in regard to underlying social dynamics. Judith Moore discusses the conflict in terms of class and gender, arguing that the nurses involved were not docile spineless persons. Carol Helmstadter argues that the dispute was primarily based on tensions related to the position of doctors in British society and the doctors’ desire for the ‘status and power of professionals.’ Keir Waddington also looks at the dispute from the doctors’ point of view, arguing that doctors’ fear of loss of authority was central to the conflict and that although the governors proved themselves to have ultimate authority in the hospital, in the end the doctors were able to expand their power by gaining a formal means of discussing their concerns in regularly scheduled meetings with the governors. The incidents will be examined here in regard to what may be learned about the influence of the interaction between nurses and doctors on the development of nursing and nurses’ work.

At the end of the 1870s the long-time treasurer of Guy’s Hospital retired and Edmund Lushington took over the position. The treasurer, who was the de facto administrator of the hospital directing the day to day operations of the institution, was elected from among the members of the board of governors and served on a voluntary basis. The board of governors did not include any physicians in its ranks.

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For some time various members of the hospital community, including members of the medical staff, had felt that the nursing of the hospital should be improved. When the matron of the hospital, who had served for several decades in that capacity, retired a few years after Lushington took office, he took up the task of improving the nursing at Guy’s. In order to do this, he invited Margaret Burt to take over the position of hospital matron and superintendent of the nursing school. Burt had served very successfully in these positions at Leicester Infirmary, and the medical staff there were reportedly her ‘firm’ life-long friends.19

Lushington had full authority to appoint a new matron and did not involve the medical staff in the recruitment of Miss Burt.20 When the medical staff learned about the appointment of the new matron, many of the doctors became upset and decided that they would not work with her. As Burt’s tenure progressed the situation became worse. The doctors complained that new rules which had been implemented by Burt were getting in the way of the functioning of the medical school and that the new matron had a religious agenda.21 Other reasons for the reaction of the medical staff to Miss Burt’s appointment did not become clear until later, during an official inquiry. Over time it became apparent that the medical staff had worried that the new chief ‘lady’ nurse would try to enforce her authority on an equal or superior basis in relation to the medical staff. This concern was magnified when the new matron took on the new title of ‘Lady Superintendent.’ Up until this time the only person who had

21 Moore, A Zeal for Responsibility.
the title of ‘superintendent’ was the physician in charge of the medical staff, Dr Steele.\textsuperscript{22}

According to Moore, the medical staff at Guy’s had prepared to defend themselves from any nursing interference even before Burt arrived to fill her new position at the hospital.\textsuperscript{23} When Burt arrived at the hospital most of the medical staff refused to have anything to do with her. Many of them would not speak to her. Undaunted, she set about to improve the nursing by proposing new rules regarding the nursing routine on the wards, the uniform worn by the nurses, and the movement of nursing pupils from ward to ward. In accordance with practices in other hospitals where schools of nursing had been established, the pupil nurses were to be moved periodically in order to ensure their well-rounded education and provide for rotating nursing coverage during the night. Lushington approved the new rules and they were subsequently implemented. Several of the ‘old’ nurses at the hospital were not happy about the new regulations, particularly the rules regarding nurses’ dress. They complained bitterly to the medical staff, their old allies, and some of the nurses resigned their posts and left the hospital. New staff members were appointed in their places. The medical staff commiserated with the old nurses and continued to refuse to work with the new lady superintendent.\textsuperscript{24}

\textsuperscript{22} Moore, \textit{A Zeal for Responsibility}; Waddington, ‘The Nursing Dispute at Guy’s Hospital 1879-1880,’ pp. 211-230.
\textsuperscript{23} Moore, \textit{A Zeal for Responsibility}.
\textsuperscript{24} Moore, \textit{A Zeal for Responsibility}; Waddington, ‘The Nursing Dispute at Guy’s Hospital 1879-1880,’ pp. 211-230.
This was the situation when Margaret Lonsdale, one of the new nursing staff at Guy’s, wrote an article about the dispute between the nursing and medical staffs for the popular magazine, *The Nineteenth Century*. In her article, Lonsdale stated that the ‘crisis’ at Guy’s hospital between the nursing and medical staffs was a result of the medical staff not wanting to allow the ‘new system of nursing’ into Guy’s Hospital. She outlined the differences between the ‘old system’ of nursing and the ‘new system.’ The old system consisted of nurses who were, for the most part, former patients with little or no formal training in nursing and a very low level of refinement. Any training which they received was from doctors, not nurses. The new system consisted of refined, educated women of high moral standards who learned nursing from expert nurses. Lonsdale came to the conclusion that in light of the doubtless benefits of the new system, the opposition of the doctors could not be based solely on the introduction of the new system. She argued that there must have been other reasons for their resistance. She began by contending that the medical staff were opposed to the new nursing for more nefarious reasons.25

Lonsdale explained that doctors and nurses under the old system were in positions analogous to ‘head and under servants in a large household.’ In this relationship it was to their advantage to be sure that people outside of the institution were not made aware of any family secrets.26 She then declared that doctors and their students were engaging in medical experiments on patients and that the doctors did not want the public to be aware of them. According to Lonsdale, nurses under the old system

would probably not talk about these experiments, but even if they did, no one of consequence would pay attention to them because of their lowly status in society. On the other hand, if a reputable lady made such activities known, the repercussions could be substantial. She emphasised that not all doctors engaged in such activities, that the medical profession was full of men of high moral character, and that ‘many’ members of the medical profession would never practice anything on a hospital patient which they would not try on one of their private patients. But she implied that there are many who would—and did.\textsuperscript{27}

Lonsdale then stated that another reason for medical staff resistance to nursing reform was the effort required on the part of the doctors to suppress their naturally ‘uncouth’ behaviours in the presence of lady nurses. She argued that it was ‘against this, as much as anything else that they are now, at Guy’s Hospital, resisting with all the might they possess.’ She further contended that the doctors were more concerned about the medical school than they were about the patients or the welfare of the nurses. Lonsdale stated that the medical students were ‘often a hindrance of a serious kind to the nurse’s work.’ They were inconsiderate, thoughtless, and increased the amount of work the nurses had to do by expecting to be waited upon and by leaving behind clutter which the nurses had to clear away.\textsuperscript{28} Lonsdale believed that Doctors should have ‘supreme authority’ over medical matters, and nurses must faithfully and intelligently carry out their orders. But, she insisted, nurses should have the same

\textsuperscript{27} Lonsdale, ‘The Present Crisis at Guy’s Hospital,’ p. 682.  
\textsuperscript{28} Lonsdale, ‘The Present Crisis at Guy’s Hospital,’ p. 683.
authority in their own sphere, a sphere containing much knowledge and skill which doctors did not know.\textsuperscript{29}

Many members of the medical staff of Guy’s Hospital were incensed at much of Lonsdale’s assessment of the situation. However accurate she may have been, she did not use a great deal of tact. Angelique Pringle, St. Thomas’s graduate and matron at a large hospital in Edinburgh, decried this lack of sensitivity in an article published in the \textit{Edinburgh Medical Journal}. She lamented a ‘young nurse’s’ tactless and inappropriate magazine article, without mentioning any names.\textsuperscript{30} This was not the first time that Lonsdale had demonstrated lack of tact. Not long before going to Guy’s Hospital, she had written a biography of the famous nurse Sister Dora.\textsuperscript{31} In her book she portrayed the working class people of Walsall, where Sister Dora practiced, in such an uncomplimentary light that they were infuriated. Doubtless she wrote what she believed to be a truthful account, but when the people of Walsall erected a statue of Sister Dora in 1886 and Lonsdale attended the unveiling, she had to stay out of sight in order to avoid ‘insult.’\textsuperscript{32}

In addition to insight into relationships between nurses and doctors, some important aspects of nursing work come to light in Lonsdale’s article. According to Lonsdale, refined women nurses served to temper the rough atmosphere of hospital wards and the unruly ways of medical students. She also argued that the new nurses did their

\textsuperscript{29} Lonsdale, ‘The Present Crisis at Guy’s Hospital,’ p. 683.
\textsuperscript{31} Margaret Lonsdale, \textit{Sister Dora, a Biography} (Boston: Roberts Brothers, 1887) from the sixth English edition, first edition 1880.
best to assure that the patients were safe from questionable medical practices. She emphasised that nurses provided expert nursing care which was different from medical care—nursing work which doctors did not know. Furthermore, according to Lonsdale, it was not the nurses’ job to wait on medical students or clear up after them.\(^{33}\) The large numbers of medical students working on the wards could generate a significant amount of this kind of work. Some doctors complained that under the new nursing medical students would always be ‘found too numerous’ and ‘to be always in the way.’\(^{34}\) Lonsdale evidently agreed with this assessment.

Keeping the wards in order was an important part of nursing work.\(^{35}\) Keeping the medical staff and students from being ill-mannered on the wards would have been an important part of keeping order, and there is evidence that medical students needed this kind of reining in.\(^{36}\) In his autobiographical novel about a London medical student, Edward Berdoe devoted a large amount of space to describing the antics of medical students both in and out of the hospital. He also developed the character of an old style nurse who disregarded improper behaviour on the part of the medical students and contrasts this character to that of a refined lady nurse who would not

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\(^{33}\) Lonsdale, ‘The Present Crisis at Guy’s Hospital,’ pp. 677-684.
\(^{34}\) Letter from Acting Medical Staff of Guy’s Hospital to the Governors, with responses from the Treasurer, H9/GY/A/219/018, LMA.
\(^{35}\) Pringle, ‘Doctors and Nurses,’ pp. 1048-1052.
tolerate it. Charles Dickens’ Bob Sawyer in The Pickwick Papers was the consummate badly behaved medical student. In Of Human Bondage Somerset Maugham implied that Dickens exaggerated Sawyer’s uncouth behaviours, nevertheless, Maugham admitted that medical students were a ‘mixed lot’ with a few who were ‘exceptionally brilliant’ and who moved through the ranks of hospital appointments until they became ‘prosperous, eminent, and titled,’ those who were ‘industrious young men of the middle-class’ that became respectable country doctors, and ‘some who [were] lazy and reckless.’

In Philadelphia, Arthur Bliss wrote about high spirited American resident physicians. Another contemporary American, Elizabeth Hobson, described medical students as a ‘rough lot,’ and recalled that refined nurses had a civilizing effect on both doctors and medical students. But medical students were not involved in patient care in Philadelphia hospitals nearly to the extent to which they were involved in London. In large London teaching hospitals large numbers of medical students worked with patients on the wards and hospital rules referred specifically to responsibilities for keeping medical students under control. While American nurses may have had a useful civilizing effect on visiting doctors, keeping large numbers of medical students under control on the wards would have devolved on nurses in Britain significantly more than in America.

40 Bliss, Blockley Days, MC71, III, 5, CSHN.
41 Hobson, Recollections of a Happy Life, p. 102.
Lonsdale was also concerned about medical experimentation on hospital wards. Physicians on both sides of the Atlantic referred to hospital patients as ‘clinical material’ and boasted about hospitals that were able to provide a good variety of ‘cases.’\textsuperscript{42} Clearly, it was important for doctors to learn about various kinds of medical problems and to have as much experience with them as possible. Having many patients with various medical conditions in one place made this learning convenient, so the ability to provide varied clinical material was most helpful and desirable. In order to ensure the best possible clinical material, doctors screening patients in out-patient settings had guidelines for admitting patients to hospital wards which included instructions to admit patients with interesting illnesses in preference to those with more mundane conditions.\textsuperscript{43} Abraham Flexner noted that for one British hospital, ‘Not every patient is educationally valuable. Fortunately, material is, as a rule, so plentiful that the useless can be freely discarded.’\textsuperscript{44}

Lonsdale’s concern was that doctors were experimenting with the unsuspecting patients turned clinical material, and as Moore points out, in all of their subsequent remonstrations against Lonsdale’s assertions, the doctors did not specifically deny...


\textsuperscript{43} Bliss, Blockley Days, MC 71, III, 5, CSHN.

this one.\textsuperscript{45} In addition to Lonsdale’s assertions, there is other evidence that medical experimentation was taking place on hospital wards. Berdoe’s novel dwells on this matter in particular. Berdoe was an avid anti-vivisectionist who was adamantly against experimentation on animals and hospital patients.\textsuperscript{46} In his novel Berdoe described gruesome physiological experiments on animals and made his villain a doctor who performed experimental procedures which imposed intense suffering on patients. This villain carried on these experiments knowing that while the results of the treatment might lead to personal fame for his scientific discoveries, they provided no benefit to the experimental subjects.\textsuperscript{47} In a companion book to the novel, Berdoe claimed that this aspect of the novel was taken from his own experience in actual hospitals and gave references to corroborating information.\textsuperscript{48}

Sources indicate that medical experimentation was also taking place in American hospitals and that some nurses saw medical experimentation in a positive light. One nurse noted that ‘experimentation’ in hospitals was necessary for advances in medical treatment and that although hospitals were originally established to care for the sick, the founders would be happy to know their institutions were instrumental in the advancement of medical science.\textsuperscript{49} Another nurse advised new nurses to ask doctors about treatments that they didn’t understand, but also advised them not to worry if the doctor did not want to talk about his treatments, as he might not want to

\textsuperscript{45} Moore, \textit{A Zeal for Responsibility}, p. 58.
\textsuperscript{46} Obituary of Edward Berdoe, \textit{British Medical Journal} (11March 1916).
\textsuperscript{47} Berdoe, \textit{St. Bernard’s}.
\textsuperscript{49} Anonymous. ‘The Relation of Hospitals to Medical Education.’ \textit{The Trained Nurse and Hospital Supplement}, 2 (1889), p. 139.
discuss ‘a delicate experiment.’\footnote{H.C.C., ‘Ethics of Nursing No. IV. The Doctor,’ \textit{The Trained Nurse and Hospital Supplement}, 2 (1889), p. 82.} Another nurse, however, did not have such positive attitudes toward this kind of research and warned other nurses that ‘wily’ doctors might try to entice women with ‘a high order of intelligence to the Training School to aid [their] medical experiments by scientific care.’\footnote{One of the Owls, ‘The Real vs. the Ideal.’ \textit{The Trained Nurse and Hospital Supplement}, 4 (1890).} Lonsdale would probably have agreed to the use of a sinister tone in this context. Because nurses had continuous interaction with hospital patients, they could not escape some involvement with various kinds of medical treatments, including those which were being tried on an experimental basis. As a result, nurses would have been involved, wittingly or not, in medical experimentation in the course of their work.

Not surprisingly, Lonsdale’s article caused a great deal of agitation in the London medical community, and numerous rebuttals to the article were published in subsequent issues of \textit{The Nineteenth Century}, \textit{The Times} newspaper, and professional medical journals. They dismissed her accusations of unethical conduct. In addition, several of the medical men who responded to Lonsdale’s article said that the idea that doctors would not know every detail of good nursing was preposterous. They argued that nursing was no more than a tool of medical treatment like medications and dressings, and that doctors knew more about it than anyone else.\footnote{Samuel Habershon, ‘The Nursing at Guy’s Hospital,’ \textit{The Nineteenth Century} (May 1880), pp. 884-901; Octavius Sturges, ‘Doctors and Nurses I.’ \textit{The Nineteenth Century} (June 1880), pp. 1089-1096; Seymour J. Sharkey, ‘Doctors and Nurses II,’ \textit{The Nineteenth Century} (June 1880), pp. 1097-1104; A Correspondent, ‘Government of Hospitals,’ \textit{The Times} (London: 27 July 1880), p. 4; Thomas Bryant, ‘Guy’s Hospital.’ \textit{The Times} (London: 7 Oct. 1880), p. 11; Anonymous, ‘The dispute at Guy’s Hospital.’ \textit{The Times} (London: 18 Oct. 1880), p. 9.} Some of the doctors recommended that if nurses wanted to be in charge of the care...
of patients, they needed to become physicians and that this was a good and desirable aspiration for able women.\textsuperscript{53} Lonsdale answered her critics with a second article in \textit{The Nineteenth Century} which reveals some important ideas about nursing from a nurse’s viewpoint.

In her second article Lonsdale firmly upheld her allegations, but apologised for any unintended offence she had given to the doctors. She emphatically repeated that the doctors were in charge of the patients, that they were indeed, ‘in all ways, and at all times and seasons, the master and controller of both nurse and patient…’\textsuperscript{54} She clarified what she meant by the nursing which doctors did not know about by saying that nursing consisted of ‘small details of nursing,’ and that ‘…nothing is small where the comfort of a patient is concerned…’\textsuperscript{55} If the doctor had left an order for a patient not to be moved, but the patients sheets required frequent changing, the nurse would not ask the doctor how she would change the patient’s sheets because the doctor would be the first to say that knowing how to do so was the ‘nurse’s business,’ not his. In ‘thousands of little ways’ such as this, nurses had to employ their unique knowledge and skill.\textsuperscript{56} As another example of the difference between medical and nursing work she stated that while the treatment of bedsores was the province of doctors, the prevention of bedsores was left up to nurses.\textsuperscript{57} These explanations of unique knowledge and functions echo those of Nightingale and

\textsuperscript{53} Sturges, ‘Doctors and Nurses I’; Sharkey, ‘Doctors and Nurses II.’
\textsuperscript{54} Margaret Lonsdale, ‘Doctors and Nurses III.’ \textit{The Nineteenth Century} (June 1880), p. 1105.
\textsuperscript{55} Lonsdale, ‘Doctors and Nurses III,’ p. 1105.
\textsuperscript{56} Lonsdale, ‘Doctors and Nurses III,’ p. 1105.
\textsuperscript{57} Lonsdale, ‘Doctors and Nurses III.’ pp. 1105-1108.
correspond with concepts which her friend Eva Luckes taught in her lectures to probationers at the London Hospital, later published and widely read in book form.\textsuperscript{58}

The controversy at Guy’s Hospital continued through the summer of 1880, gaining momentum through an incident at Guy’s in which one of the nurses, Louisa Ingle, allegedly forced a patient to take a long, tepid bath as punishment for soiling her bed. The patient died some days after the episode and the nurse was tried for murder. Several members of the medical staff at Guy’s blamed the incident on the new nursing system even though it was not difficult to show that the nurse responsible was not a pupil nurse and the head nurse of the ward where the incident happened, and who had approved the bath, was one of the ‘old sisters.’\textsuperscript{59} Dr William Gull, a distinguished former member of the medical staff at Guy’s and a supporter of nursing reform, testified that the patient had tuberculosis of the brain and that it was this that caused her death, not the bath, but Ingle was convicted of the crime. Margaret Lonsdale believed that Nurse Ingle was at fault, but that Margaret Burt and the new nursing system had nothing to do with the incident.\textsuperscript{60}

Some pieces in \textit{The Times} regarding the controversy at Guy’s and the Ingle case include remarks about nursing work. One piece specified that baths given for medicinal reasons needed to be done under medical orders and supervision while

\textsuperscript{60} Lonsdale, ‘The Inquest at Guy’s Hospital,’ p. 7
baths given for cleansing purposes could be done on a nurse’s initiative. Another doctor explained that nursing involved carrying out physicians’ or surgeons’ directions regarding patient positioning, personal cleanliness, feeding, giving medicine, and ‘other such matters’ with ‘care and gentleness.’ He gave more detail in two examples regarding feeding and bathing, noting that when giving food nurses should be sure not to put too much food in the patient’s mouth at once and that nurses should know how to bathe patients using ‘water of a proper temperature’ and without uncovering too much of the patient at once. His comments indicate that doctors knew about what constituted general nursing care, but this does not necessarily mean that doctors knew about the essential ‘little things’ in nursing care that Lonsdale had discussed in her article in *The Nineteenth Century* and were painstakingly elaborated by Luckes.

At one point in the dispute at Guy’s Hospital, the head of the medical staff, Dr Habershon, and the head of the surgical staff, Mr Cooper-Forster, sent a letter to the hospital governors outlining their grievances. That the hospital treasurer, Mr Lushington, was highly distressed by the complaints is evidenced in a letter to the treasurer from Dr Gull. Gull reassured Lushington that it was understandable for him to be upset and that clearly the quality of the nursing was as important to the treasurer as it was to the doctors. He also stated that he believed the doctors’ complaints to be based more on ‘sentiment’ than anything else. Gull reinforced the

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61 Anonymous, ‘Charge Against A Guy’s Hospital Nurse,’ p. 12.
necessity of providing ‘a more educated and more highly trained class of women’ to care for the patients and lamented that the doctors would be an impediment to their introduction in the hospital.\textsuperscript{64} Gull’s most significant statement in regard to the concept of nursing work as separate from medical work was that the doctors were complaining about ‘a matter which falls but little within their province.’\textsuperscript{65} The implication was that the treasurer had the authority to appoint a matron, the matron had the authority and expertise to take charge of the nursing, and that the doctors did not have this expertise or authority. Some doctors at Guy’s noted that the governors considered nursing to be a hospital service separate from the medical staff and opposed the idea. These doctors stated that if the nursing went out of their hands and under the control of a ‘central authority,’ meaning the matron, patient care would be severely affected for the worse.\textsuperscript{66} That Gull agreed with the governors indicates that there was dissention among the doctors in regard to the appropriateness of separating the nursing service from the medical service at Guy’s. While some of the doctors believed that the nursing of patients should be under the direction of the doctors, not all of them did.

As the controversy at Guy’s deepened, the doctors submitted a list of grievances. The Treasurer wrote answers to each of the doctors’ grievances and sent a copy of the original document along with his responses back to them. The Treasurer’s response included comments about ‘misstatements’ which had been made to the medical press.

\textsuperscript{64} William Gull, Letter to Mr Lushington in regard to the controversy at Guy’s Hospital, 1880, H09/GY/A/220/004, LMA.
\textsuperscript{65} William Gull, Letter to Mr Lushington, H09/GY/A/220/004, LMA.
\textsuperscript{66} Anonymous, ‘The Dispute at Guy’s Hospital,’ p. 9.
and a rebuke about a ‘vulgar lampoon, ridiculing the Treasurer…and the Matron’ which had been published in the *Guy’s Hospital Gazette*, a student news magazine, and ‘promoted’ by some of the doctors. Copies of ‘this rubbish’ had been disbursed by the sister of one of the wards during visiting hours. This incident corroborates Berdoe’s accounts of disorderly medical students and complicit ‘old style’ nurses. According to the Treasurer, several of the ‘old Sisters’ had also been telling untruths to the doctors, who chose to take their statements at face value.⁶⁷

One of the reasons that the new matron had been brought to the hospital was that for some time the doctors had been unhappy with the nursing. In their document the doctors complained that sweeping changes were being made to the nursing when what they had wanted was improvements in the ‘details’ of the nursing, another possible reference to the concept of nursing as numerous important ‘little things’ which was part of contemporary discourse about expert nursing care. They had ‘complained much’ about the nursing in the hospital in the past but had expected changes to be made in the details of nursing rather than the overhaul which they felt was occurring. In order to make their point they described the long standing system of nursing at Guy’s. In this system the ward sisters and nurses were each attached to one ward where they worked for years. The doctors found this advantageous because the nursing staff got to know their way of doing things which helped them carry out the doctors’ instructions and made them responsible to the medical staff. The nursing

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⁶⁷ Letter from Acting Medical Staff of Guy’s Hospital, H9/GY/A/219/018, LMA.
staff were essentially the physicians’ and surgeons’ personally trained assistants.\textsuperscript{68} The medical staff complained that under the new system the sisters and nurses were responsible not to the medical staff, but to the matron.

Lonsdale had explained that under the new system the nurses learned from expert nurses not doctors. The expert nurse in charge of the training school for nurses was the matron. When the nursing school was established, the offices of matron and superintendent of the nursing school were combined into the position of lady superintendent. The medical staff were so opposed to this title that as a concession to them, the title was dropped and the position was again called ‘matron.’\textsuperscript{69} Whatever the title, it was apparently understood by both medical and nursing staff that with the establishment of the nursing school, nurses would be trained by nurses and the nurses expected the nursing service to be separate from the medical service in the hospital. The Treasurer responded to medical staff concern about these issues by stating that the female staff of the hospital had always been under the supervision of the matron.\textsuperscript{70} The medical staff, however, perceived fundamental differences between the way things worked before Burt’s arrival and afterward.

Another point of contention addressed in the governors’ response to the doctors’ complaints was the administration of medications. The doctors explained that under

\textsuperscript{68} Letter from Acting Medical Staff of Guy’s Hospital, H9/GY/A/219/018, LMA; For more on the ‘ward system’ see Carol Helmstadter and Judith Godden, \textit{Nursing Before Nightingale} (Farnham: Ashgate, 2011).

\textsuperscript{69} Letter from Acting Medical Staff of Guy’s Hospital, H9/GY/A/219/018, LMA; Margaret Lonsdale, ‘The Present Crisis at Guy’s Hospital,’ pp. 677-683.

\textsuperscript{70} Letter from Acting Medical Staff of Guy’s Hospital, H9/GY/A/219/018, LMA; Margaret Lonsdale, ‘The Present Crisis at Guy’s Hospital,’ pp. 677-683.
the old system the Sisters knew the patients and gave them their medicines. In their letter to the Governors the doctors’ stated that in the past only the sister of the ward had administered medications to patients. They felt that this was desirable because medication administration could be dangerous and should be carried out by the most responsible nurse on the ward. They stated that under the new system ‘lady pupils’ were giving medications to patients and expressed concern that as students they were inexperienced and therefore unqualified to give medications.\textsuperscript{71}

In response to the doctors’ apprehensions regarding medication administration the Governors stated that the practice had been modified. They also noted that in the past medications had been administered not only by ward sisters but also by other nursing staff. They stated that various nurses had routinely been given the responsibility for administering medications as long as the sister was present.\textsuperscript{72} Clearly, giving medications was considered to be a highly skilled activity which was the responsibility of the nursing staff, normally the sister. There was little indication in any of the sources examined for this study that anyone assumed that anyone but the nurses should be administering medications. Even Florence Nightingale had previously insisted that medication administration should be a nursing function.\textsuperscript{73} Administering medications, like administration of other medical treatments, was an activity which required doctors’ orders and participation in medical therapy rather than independent nursing action. Talking about separation of nursing and medicine

\begin{itemize}
\item \textsuperscript{71} Letter from Acting Medical Staff of Guy’s Hospital, H9/GY/A/219/018, LMA.
\item \textsuperscript{72} Letter from Acting Medical Staff of Guy’s Hospital, H9/GY/A/219/018, LMA.
\item \textsuperscript{73} Florence Nightingale, \textit{Subsidiary Notes as to the Introduction of Female Nursing into Military Hospitals in Peace and in War; Presented by Request to the Secretary of State for War} (London: Harrison and Sons, 1858).
\end{itemize}
was certainly easier than putting it into practice, and the incongruity of advocating separation of nursing and medicine while insisting that nurses should implement doctors’ orders was not discussed.

Another aspect of nursing care discussed in the governors’ document was that of patient activity. The doctors repeatedly expressed concern that under the new system the nurses got the patients out of bed too early in the morning in order to make the beds before the day nurses arrived on the wards. They claimed that the new nurses were more concerned about their routines than they were about patient welfare. The Treasurer answered that after thorough investigation it was found that only those patients who were awake and strong enough were taken out of bed early in the morning to allow some of the beds to be made before breakfast.\textsuperscript{74} The discussion of this issue suggests that under the new system the nurses needed more time to accomplish patient care activities. This, in turn, suggests that under the new nursing the nurses were either less efficient or were doing nursing care of higher quality.

Another incident involving Margaret Lonsdale and one of the doctors helps to elucidate the quality of nursing at Guy’s Hospital before full establishment of the new nursing. While working on one of the medical wards in the hospital Lonsdale had observed some conditions which she found unacceptable. According to Lonsdale, at least two patients on one of the wards had serious bedsores due to ‘filth and neglect.’\textsuperscript{75} She did not have confidence in the sister of the ward and did not feel

\textsuperscript{74} Letter from Acting Medical Staff of Guy’s Hospital, H9/GY/A/219/018, LMA.
that it was her place to approach the physician in charge of the ward, Dr Moxon, about her concerns. Because she did not feel that it was her place to approach a consulting physician herself, she decided to write a letter to her mother describing conditions on the ward and asking her to contact Moxon to inform him of the situation. Moxon received the letter from Lonsdale’s mother just as he was getting ready to attend a meeting of the Governors. He took the letter with him to the meeting where he read it to those assembled and vigorously denied that this kind of care would have occurred on the ward in question. The ward was the ‘clinical ward’ where, he claimed, patients were carefully looked after by the best senior medical students, each of them having only five patients to care for. He stated that he had personally examined the patients in question and had found no sores. Lonsdale wondered how he could have examined the patients when he had left his office and gone immediately to the meeting. She stood by her statements, insisting that she would never be able to deny what she had actually seen. If Lonsdale’s statements were accurate, even the most experienced medical students in conjunction with nurses on the old ward system did not provide adequate nursing care. The medical staff either intentionally neglected their patients or did not know how to ensure good detailed nursing care. Since none of the documentation charges the medical staff with pointless or malicious desire to harm patients, the latter is more likely. Like the larger dispute at Guy’s, discussion of this incident made its way into the public press.  

76 C. Hilton Fagge, ‘To the Editor of The Times,’ The Times (London, England), Saturday, Jul 31, 1880; pg. 8; Lonsdale, ‘Guy’s Hospital,’ p. 10; Moxon., ‘Guy's Hospital,’ p. 6.  
77 Fagge, ‘To the Editor of The Times,’ pg. 8; Lonsdale, ‘Guy's Hospital,’ p. 10; Moxon., ‘Guy's Hospital,’ p. 6.
Problems with the nursing had also been reported within the hospital administrative structure. In their letter to the Governors the doctors accused the new nurses of espionage because some of them had been writing about substandard conditions on the wards and reporting their observations to others. The treasurer responded that cases of ‘apparent neglect and carelessness’ had been reported to the matron, put in a journal, and reported to the superintendent. The new matron had been implementing practices which were standard at other hospitals which had embraced the new nursing. Following the lead of the Nightingale School, the lady probationers had been keeping journals of their activities on the wards. The superintendent made it clear that the purpose of the journals was to help the pupil nurses to learn, not to spy on the doctors.  

In addition to their pedagogical application, however, the journals did serve to document inadequacies in the nursing care.

After a thorough inquiry into the ‘crisis’ which included listening to hours of testimony from the individuals involved, the Governors concluded that Margaret Burt had done all that she was asked to do and that the trouble between the medical and nursing staffs was primarily due to the refusal of the medical staff to talk with her, let alone work cooperatively with her. The governors were willing, however, to make provisions for better communication between the treasurer and the medical staff and offered to have representatives of the Board of Governors meet with representatives of the medical staff monthly. The medical staff, who would not be placated, refused this method of collaboration with the governors and insisted that if

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78 Letter from Acting Medical Staff of Guy’s Hospital, H9/GY/A/219/018, LMA.
Burt remained in the hospital they would resign. In the process they blatantly insulted the governors in the public press. The exasperated governors asserted their authority and told Dr Habershon and Mr Cooper Forster that they were dismissed. Because Habershon and Cooper Forster had been representing the entire acting medical staff, the dismissal of these two men essentially meant the resignation of the entire medical staff. At this point, the doctors relented, apologised, and were retained at the hospital.  

Miss Burt also remained at the hospital until her marriage a few years later and continued to supervise implementation of the new nursing. That the nursing improved after the implementation of the new nursing is evidenced in articles in *The Times* some years later. In 1886 F. W. Pavy stated that

> Nursing, it must be owned, was not always a strong point at Guy’s; in this it was only like other hospitals. In recent years great improvements have been effected…Lady nurses will not be content with the appliances which satisfied the nurses of former days. Cleansing is more frequent and thorough, food is more appetizing and better served in accordance with modern ideas; atmospheres have now to be cleansed as well as floors…

Pavy, who had been the doctor caring for the unfortunate patient in the Nurse Ingle case, clearly believed at this point that striking improvement in the nursing at Guy’s was brought about by lady nurses under the new nursing. According to Helmstadter, by the end of the nineteenth century patient care had improved to the point that ‘doctors no longer allowed feeding, posture, therapeutics, ventilation, and sanitation to be done haphazardly, but required that they be carried out with scientific

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precision.\textsuperscript{81} No doubt the doctors were very pleased to see improvements in the nursing which had been brought about by the new nursing, improvements which the doctors had not brought about themselves. The doctors had wanted improvement in the nursing, so desire was not lacking, but they did not have the expertise to bring it about. They had turned to the hospital governors to find a way to accomplish their goal, and the governors had turned to an expert nurse.

Six years after the governors’ difficult introduction of the new nursing, Pavy declared that the medical staff and nursing staff at Guy’s Hospital were working together ‘with the greatest unanimity’ and that he was sure the rest of the medical staff would agree that ‘the nursing staff was everything that could be desired.’\textsuperscript{82}

Across the Atlantic, institutional conflict and resolution also took place in the United States. Lewenson quotes American nurse Linda Richards saying that in the beginning trained nurses were not wanted by doctors, hospital administrators, or untrained nurses.\textsuperscript{83} Armeny notes that in the early days of trained nursing, nurses in military hospitals had to deal with distrust from the military doctors and the obstinate attitude of enlisted hospital corpsmen.\textsuperscript{84} But according to Lewenson, by the end of the century trained nurses were considered very desirable, and conditions at Bellevue, Blackwell’s Island, and other hospitals improved after the implementation

\textsuperscript{82} Pavy, ‘Guy’s Hospital,’ p. 8.
\textsuperscript{83} Sandra Lewenson, \textit{Taking Charge: Nursing, Suffrage, and Feminism in America.} (New York: Garland, 1993).
of trained nursing. In addition to other improvements, Melosh suggests that the new trained nurses had a civilizing influence on the doctors and the infamous medical students. Nancy Tomes states that after a thorough examination of historical records at the Pennsylvania Hospital she found many instances of conflict between nurses and other nurses but virtually no evidence of conflict between nurses and doctors.

It is possible that there was more conflict in nineteenth century London hospitals than in Philadelphia hospitals, perhaps because nurses in London hospitals were working to separate their hospital nursing services from medical control while nurses in America put their energy elsewhere. Further research into conflict at other British hospitals and other American hospitals is indicated in order to shed light on this topic.

**Conclusion**

Nurses and doctors had harmonious and discordant interactions as they worked side by side in hospitals. Precise rules regulated day to day interaction in order to preserve order and moral decorum in the hospital. Rules were sometimes stretched for nurses and doctors to help each other out of exigent circumstances, and romances did occur in spite of rigid rules designed to prevent such relationships.

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85 Lewenson, *Taking Charge*, p. 76.
Examination of conflict between nurses and doctors helps to understand the development of nursing during the study time period. Examination of well documented conflict at Guy’s Hospital in 1880 provides an instructive case regarding areas of tension between doctors and nurses. By magnifying points of contention between the governors, the medical staff, and the nursing staff, the crisis at Guy’s Hospital illuminates relationships between hospital administrators, nurses, and doctors as well as the work done by nurses at that time.

Doctors at Guy’s wanted control over the nursing of patients and claimed that they were the only ones qualified to decide what constituted good nursing. They wanted improvements in the details of nursing without changing the ward system under which nurses were essentially trained and supervised by doctors. Under the ‘new system,’ nurses were to be taught and disciplined by the matron turned lady superintendent, an expert nurse. Although the matron had always had official oversight of the nurses, with the new nursing matrons gained control of de facto supervision of nurses on the wards. Doctors worried that their authority was being undermined. Nurses emphasised that doctors were the supreme authorities over the medical care of patients and that nurses were loyal in carrying out their orders and providing assistance to them. One of the nurses, Margaret Lonsdale, explained that in addition to helping the doctors, nurses had unique nursing work which required a distinct body of knowledge and skill. She argued that it was nurses who had to deal with these details, nurses who had to use their ingenuity to master them, and therefore nurses who knew how to do them, not doctors. After the conflict had been
resolved and the new nursing implemented, all parties agreed that the nursing at Guy’s Hospital was much improved. Nursing supervised by an expert trained nurse head resulted in better nursing than had been provided under the supervision of doctors.
CHAPTER VII

NURSES, DOCTORS, AND PHYSIOTHERAPY

As ‘scientific medicine’ gained strength in Britain and America in the latter part of the nineteenth century respect for doctors and their treatments also grew. Doctors were increasingly regarded as the experts in all things associated with health and sickness. Against this background, and as trained nursing became a mainstream endeavour, nurses claimed unique expertise in hands-on administration of therapies to patients. In addition to other direct ministrations such as feeding, bathing, and emotional support, massage and exercise were considered to be important aspects of nursing care in both Britain and America. In Britain, as massage and exercise became widely accepted as legitimate treatments, larger numbers of respectable massage experts were employable, making training in massage more attractive as a nursing specialty. Massage and exercise as a specialty eventually developed into the basis for a separate profession, physiotherapy. This chapter examines the development of physiotherapy out of massage and exercise within nursing in Britain and out of a different background in America. The chapter focuses on how nurses and doctors, and the interactions between them, were involved in these developments.

For secondary material this chapter relies heavily on Jean Barclay for Britain and Wendy Murphy for America. According to Thomas Terlouw, there were very few secondary sources for the history of physiotherapy in 2000 other than these two books. In a more recent article he again laments the lack of historical research on this topic. Fortunately, Beth Linker’s work has expanded scholarship in regard to American physiotherapy and is also used in this chapter. Primary material for this chapter comes from various sources in regard to the development of physiotherapy in America, and for Britain primarily from the British nursing journal *Nursing Notes*, which carried a regular column called ‘Massage Notes’ during the 1890s and early 1900s. ‘Massage Notes,’ which was firmly embedded in a nursing context, contains on-going documentation of the formation and development of a formal organisation of nurse masseuses which eventually became the first organisation of physiotherapists in Britain.

**Specialisation in Nineteenth Century Nursing**

In the last half of the nineteenth century allopathic scientific medicine was gaining strength in Britain and America and edging out other forms of medicine such as homeopathy and osteopathy. Major developments in allopathic medicine such as

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5 Beth Linker, ‘Strength and science: Gender, physiotherapy, and medicine in early-twentieth-century America,’ *Journal of Women’s History*. Fall 5 (2005), pp. 105-132.

vaccination, bacteriology, antisepsis, and anaesthesia, which literally opened new surgical frontiers, solidified medical authority. While some people pushed back against experimentation on laboratory animals and hospital patients turned ‘clinical material,’ the public increasingly relied on doctors to ensure that only the most rigorous and up to date treatments were employed. As the authority of the doctors expanded, any kind of treatment outside of that provided by doctors became more and more suspect as ‘quackery.’ One of the hallmarks of trained nursing was strong emphasis on carefully following doctors’ orders, and the respectability of the new trained nursing depended on this association with authoritative scientific medicine. Without the endorsement of authoritative medicine, nurses could be classed with other quacks. Another reason to seek the support of the medical community was that As Kathryn McPherson has explained in regard to private duty nurses in Canada, nurse masseuses who took cases referred to them from doctors needed doctors’ recommendations in order to practice successfully.

In addition to their authority as guardians of scientific medicine, doctors had for some time considered themselves expert in all aspects of patient care. The early and mid-nineteenth century doctor examined patients, diagnosed illness, and produced many of the medicines that he prescribed. By the end of the nineteenth century

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specialists in the manufacture of medicines were taking over that aspect of medical care, and the production of pills, lotions, and other medications became the province of pharmacists. While medication production passed to other providers, various specialties developed within the diagnostic and prescriptive provinces of medicine. Reputable doctors were expected to obtain a general medical education before focusing on increasingly sophisticated specialties such as neurology and laryngology.¹⁰

Specialties in nursing also developed. Nursing specialties which antedated the new nursing included monthly nursing (care of post-partum women and their babies), midwifery, and nursing the insane.¹¹ At the end of the nineteenth century, nurses could talk about ‘various branches of nursing.’¹² In their efforts to find niches for themselves in what was often a competitive atmosphere, graduate nurses embraced nursing specialties which were taught in training schools, but they also specialised in areas outside of standard nurses’ training. For example, some nurses specialised in musical therapies for patients.¹³

At least one American nurse specialised in nursing care of the hair. After working at the bedside for many years, this nurse was tired and wanted to do something different while remaining in nursing practice. She thought of an aspect of nursing

¹² Anonymous, ‘Massage Notes,’ Nursing Notes (September, 1895), pp. 119-20.
care which she especially enjoyed—caring for patients’ hair—and approached a
doctor who specialised in medical care of hair (and who was, incidentally, bald). She
found that the doctor was remarkably receptive. He told her she could get as much of
that work as she could manage and referred several of his patients to her. She was
very successful and reported that one patient told her that she would rather be treated
by a nurse than a masseuse who knew nothing about hygiene.\(^\text{14}\) This account
suggests that the doctor had previously referred his patients to one or more
masseuses who were not nurses.

**Massage**

Massage was a standard component of the curricula in nurse training schools in
Philadelphia and courses in massage were available to probationer nurses in London
in the late nineteenth and early twentieth centuries.\(^\text{15}\) A small group of British nurses
who were passionate about exercise and massage began a movement which led to
massage and exercise as a nursing specialty area and eventually to the development
of a separate professional occupation: physiotherapy. How these nurses navigated
through a medical climate which required the blessing of doctors in order to maintain
respectability while maximizing their own autonomy illuminates relationships
between nursing and medicine at that time.

\(^\text{15}\) Monthly reports, Presbyterian Hospital. MC 35:II:430, CSHN; Letter to student from Miss Milne.
Presbyterian Hospital MC 35:II, CSHN; ‘Report of the Superintendent of Nurses for the year ending
April 1899,’ MG 3.3 ff65, PHHC; ‘Course of Study 1900-1901 Pennsylvania Hospital Training
School for Nurses,’ MG. 3.3 ff6, PHHC; Barclay, *In Good Hands*; Margaret Palmer, *Lessons on
Massage had been a part of medical therapeutics for centuries. Medical practitioners from Hippocrates in Greece to Galen in Rome to Weir Mitchell in nineteenth century Philadelphia formulated treatments using therapeutic exercise and massage. Dr Silas Weir Mitchell, who worked with Lucy Walker at the Pennsylvania Hospital, devised a treatment regimen used mostly for women with nervous complaints which consisted of rest, large amounts of dietary intake, passive exercise, electricity, and massage. His treatment became very popular in America, Britain, and Europe and contributed to a ‘revival in massage’ which became a widespread phenomenon in the last decades of the nineteenth century, not only as part of the rest cure but for many other ailments as well. For example, bicycle riding, also much in vogue in the late nineteenth century, and the large number of associated accidents, provided ‘much work’ for masseuses.

Nursing and Physiotherapy in Britain: an ‘angel with a cast iron back…’

In 1894 scandalous reports about London massage parlours, dens of vice for the middle and upper classes, were published in The British Medical Journal. The story was picked up in the popular press and the reputation of anyone engaged in massage work was badly damaged. Several nurse masseuses, some of whom were members of the Trained Nurses’ Club in London, commiserated with each other

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16 Barclay, In Good Hands, p. 1; Murphy, Healing the Generations.
17 Letter from Dr Silas Weir Mitchell to Lucy Walker, Feb 16, no year, MSG 3.3, PHHC.
19 Murphy, Healing the Generations; Barclay, In Good Hands, p. 13.
about the situation and eventually determined to do what they could to make therapeutic massage respectable. They decided that the best way to achieve this goal was to organise a professional organisation for masseuses that would set high standards for practice and moral integrity, the same requirements set for trained nurses several decades before. The Society of Trained Masseuses would offer written and practical examinations for masseuses who had completed an approved course of training and who could provide impeccable moral references. Those masseuses who paid the fee, passed the exams, and met the moral criteria would receive an official certificate from the society.\textsuperscript{22} The society began as a small group but grew steadily. After three years the society had approximately one hundred members,\textsuperscript{23} by 1914 a thousand members, and in 1918 the society had a membership of 3641.\textsuperscript{24}

Not all masseuses were trained nurses, but the founders of the Society of Trained Masseuses (STM) believed that massage and exercise was a valid specialisation for professional nurses and that being a nurse made one a better masseuse. Before the organisation of the STM, an article in the British nursing journal \textit{Nursing Notes} argued that all masseuses should maintain professional behaviour like nurses, and that masseuses who were not trained nurses should at a minimum study written materials on nursing.\textsuperscript{25} One of the founders of the STM, Lucy Robinson, called ‘rest combined with exercises and massage’ a branch of nursing work which required

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\item \textsuperscript{22} Anonymous, ‘Massage Notes,’ \textit{Nursing Notes} (February 1897), pp. 23-5; Barclay, \textit{In Good Hands}, p. ; Patricia Young, ‘A Short History of the Chartered Society of Physiotherapy,’ \textit{Physiotherapy} 55 (July 1969), pp. 271-8.
\item \textsuperscript{23} Anonymous, ‘Massage Notes,’ \textit{Nursing Notes} (June 1897), pp. 83-4.
\item \textsuperscript{24} Barclay, \textit{In Good Hands}, p. 50.
\item \textsuperscript{25} Anonymous, ‘Hints to Masseuses,’ \textit{Nursing Notes} (May, 1892), p. 49.
\end{itemize}
special study and commented that some massage cases ‘make us ardently desire that we could be that ideal nurse, ‘an angel with a cast iron back…’26 The January 1st, 1895 edition of Nursing Notes published the first of what became a regular column devoted to a new organisation for massage experts under the title, ‘Massage Notes.’ The author explained that the purpose of the new organisation would be to establish standards in this important ‘branch of the nursing profession.’27

Contributors to ‘Massage Notes’ repeatedly argued that professional masseuses should be trained nurses. They argued that the masseuse should know how to make a patient as comfortable as possible and be capable of implementing ‘the numerous details of sick-room management.’28 She should be able to tell when a patient was suffering from fatigue or when the treatment was causing some emotional or physiological problem with which the non-nurse masseuse would not be familiar. She should know how to interact with doctors and how to report important information to them. She should know how to avoid ‘stupid blunders’ which could thwart the efforts of doctors and nurses and be able to accurately monitor the patient’s temperature, pulse, and respirations.29 The need for non-nurse masseuses to have skill in bandaging was thought to be great enough for the Council to establish a bandaging course at the society.30 Another contributor stated strongly, ‘…”Some

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26 Anonymous, ‘Massage,’ Nursing Notes (March, 1894), pp. 30-1.
knowledge of nursing is indispensable, or you cannot handle sick people, and after all, the majority of massage patients are sick people in some way or other’ and called her work, ‘this branch of the art of nursing.’

According to some of the same contributors, doctors were increasingly looking to engage only nurse masseuses for their patients. Weir Mitchell recommended that when applying his treatment, doctors should employ ‘refined and cheerful, gentle but firm, intelligent’ nurse-masseuses to assist them. In his medical textbook, Dr James Anders devoted three pages to the treatment of neurasthenia which included a description of the Weir Mitchell treatment and the importance of engaging a nurse who was also a well-trained masseuse.

As the society became established, increasing numbers of trained nurses took the society’s examinations, and the STM became a valuable resource for nurse training programs looking for qualified persons to teach massage to student nurses. For instance, when The Queen’s Hospital, Birmingham, wanted a massage instructor for their nurses, they applied to the society which sent a qualified masseuse, Miss J. Manley. The society was also an invaluable resource as a reputable examination and certification body. In 1898 the society reported that two large London hospitals

33 Barclay, In Good Hands, p. 13.
sent their masseuse-nurses to the society for the certificate. St. Thomas’s Hospital kept a record of their nurses who received the certificates of massage and Swedish remedial exercises (SRE) from the ISTM (the STM had by that time been incorporated). Examinations in SRE had been implemented at the ISTM in 1909. The record indicates that in 1913 all of the pupils registered in the Physical Exercises & Massage Department had received ISTM certification, except a few pupils who had left the program. A few of them had also received the SRE certification. By 1915 nearly all of the pupils had received both certificates. At least one 1903 graduate of the Nightingale School, Alice Smith, who ‘Left Home’ on May 3 was appointed as a ‘Ward Rubber’ at St. Thomas’s.

The massage program at St. Thomas’s was begun in 1911 with Minnie Randell, a trained nurse-masseuse and prominent member of the ISTM, as the first principal. She remained in that position until 1945. A Physical Exercises Department had been organised in 1898 and a Dr Timberg began instruction there in 1906 (Mr Timberg in the medical school prospectus). The London Hospital had organised a department of massage in 1891 with one of its objects to teach student nurses. Several of the original founders of the STM had been trained in this program.

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39 St. Thomas’s Hospital Register of Pupils Physical Exercises & Massage Department Year 1913-1915, H01/ST/PS/C/07/001, LMA.
40 St. Thomas’s Hospital Nightingale Training School report for 1903, HI/ST/NTS/A3/17, LMA.
41 Barclay, *In Good Hands*, p. 34.
42 Saint Thomas’ Hospital: Physiotherapy School Administrative History, H01/ST/PS, LMA.
43 St. Thomas’s Hospital Medical School Prospectus and Directory, 1907 & 1908, HI/ST/MS/A5/8, LMA.
including Margaret Palmer, who wrote a standard textbook on massage.\textsuperscript{44} Massage training was even older at Guy’s Hospital where some instruction had been given since 1803. Massage teaching there was carried on in earnest from 1888, but a massage department was not established until 1913.\textsuperscript{45}

While courses on massage were available for nurses at these large London teaching hospitals, they were not compulsory at all hospitals but were, rather, considered to be an available specialty. Interested nurses went through the course of training in massage and physical exercises and were then eligible to take the certification exams at the STM. A nurse who had graduated from St. Thomas’s recalled that as a probationer she had decided to ‘join’ a massage class which was taught by Miss Haig-Brown, a ‘trained masseuse’ who was also the home sister at the time.\textsuperscript{46} Massage was a widely used therapy\textsuperscript{47} and having ‘a certificate in massage’ was believed to be ‘almost essential’ for a fully trained nurse.\textsuperscript{48}

Doctors had for some time referred massage work to nurses. The first column of ‘Massage Notes’ included a warning to nurses undertaking massage cases to be wary

\textsuperscript{44} Barclay, \textit{In Good Hands}; Palmer, \textit{Lessons on Massage, Fourth Edition}.
\textsuperscript{45} Barclay, \textit{In Good Hands}, p. 34.
\textsuperscript{46} Miss Wills, ‘Recollection of a St. Thomas’s Nurse Graduated in 1903,’ HI/ST/NTS/Y23/9, LMA.
of self-professed doctors requesting that a nurse take male massage cases.\textsuperscript{49} One of the three original rules of the society was that members of the society would not undertake any case except those referred by a doctor. In her article, Robinson discussed the importance of being loyal to the doctor who had referred his cases for therapeutic massage. When the founders made a circular describing their society, they sent printed copies to medical men, matrons of hospitals, and surgical homes, all of whom might provide referrals and employment for masseuses.\textsuperscript{50} When asking for character references, the society requested that applicants send names of doctors ‘for whom they have massed [sic], who will vouch for their professional efficiency.’\textsuperscript{51}

An important turning point occurred during the society’s first year. The society had received positive mention in \textit{The Hospital}, a widely read professional medical journal, and in at least one other monthly medical journal. One of the journal articles suggested that ‘in order to give a standing to the society’ one or two medical men should be added to the society’s governing Council. The members of the Council, made up of the society’s founders, very tactfully explained that they had given much thought to the issue and had discussed it with ‘medical men whose advice we sought when we began to organise our Society.’ They continued,

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…we thought it best to wait till we could prove our \textit{bona-fides}. If at the end of a year’s work we can say ‘we have examined so many candidates, all of whom we have ascertained to be of irreproachable character and all of whom have signed our rules,’ we should have more reason for our request that a certain number of medical men should signify their approval of us by perhaps
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\textsuperscript{49} Anonymous, ‘Massage Notes,’ \textit{Nursing Notes} (January, 1895), pp. 8-9.
\textsuperscript{50} Anonymous, ‘Massage Notes,’ \textit{Nursing Notes} (March, 1895), pp. 37-8.
allowing their names to be placed on an Advisory Board or Reference Council or something of that sort. The matter will be discussed by the Council when it again meets, and we shall be most pleased, and it will help us very much, if those interested in the improvement of Massage will send in their views…

The Council made it clear that they appreciated the good wishes of the medical community, and were careful to avoid offense as they declined to add doctors to their governing body. By keeping doctors out of the governing body, the Council members retained control of the organisation in the hands of nurse masseuses. Two years later they reflected on their beginnings and were happy to report that while progress was slow at first, they had ‘made no false steps’.

The founders wished to maintain good relations with the medical community. As the society’s favourable reputation became established, they continued to court and receive the patronage of the medical community even as they kept control of their organisation. Editors of ‘Massage Notes’ periodically reported that more and more medical men and women were approving of the ‘aims and principles’ of the society and having their names added to the list of society patrons. They were particularly pleased to announce that Sir Francis Laking, M.D., Physician to H.R.H. the Prince of Wales, had approved the society’s ‘aims and objects’ and ‘allowed his name to be added to the list of patrons.’

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53 Anonymous, ‘Massage Notes,’ Nursing Notes (February, 1897), pp. 23-5.
One of the three original rules of the society was that members would not treat patients except under medical direction and the Council often reminded members of their responsibilities to the medical community. Members were frequently admonished to obey doctors’ orders. That this was not always easy to do is evidenced in comments that ‘for some unknown reason’ there was ‘a great tendency with patients undergoing massage treatment to consult the nurse instead of the doctor’ about the kind and length of treatment that they should have. The writer encouraged members to steadfastly avoid falling into usurping the doctor’s role, something which ‘no properly instructed and qualified masseuse’ would even think of doing.\(^{56}\)

The propensity for patients to seek advice from masseuses rather than doctors may have stemmed from masseuses having greater practical knowledge of massage. According to Minnie Randell, before the First World War the great majority of doctors had little knowledge even of how massage and exercise could benefit their patients.\(^{57}\) According to Barclay, when a trained masseuse joined the staff of St. Bartholomew’s Hospital in 1910 one of the surgeons later admitted that he had been afraid of her because she knew so much more than he did.\(^{58}\) In actual practice, doctors often left much of the treatment, including management of diet, rest, and exercise, to the discretion of the masseuse.\(^{59}\)

\(^{56}\) Clare Mackenzie, ‘Massage,’ *Nursing Notes* (January, 1896), p. 5.

\(^{57}\) Golden Jubilee Journal of St. Thomas’ Hospital Physiotherapy School, June 1961 pg. 9, HI/ST/NTS/Y66, LMA.

\(^{58}\) Barclay, *In Good Hands*, p. 34.

\(^{59}\) Mackenzie, “Massage,” p. 5.
A tendency for passing over the doctor was sometimes manifested among prospective massage practitioners as well. When evaluating the written examinations given by the society, one of the examiners lamented that some of those taking the examinations did not so much as mention the medical attendant or what his ‘directions and wishes were.’ Some did not seem to remember that one of the rules of the society was to treat patients only under medical direction and that ‘their duty was always to uphold the doctor’s authority, and themselves to carefully obey his orders.’ Her comments indicate that the masseuse was expected to call on the doctor to find out what his instructions and wishes were. 60 Masseuses were cautioned to ask for instructions from and put any questions to the doctor courteously and in a way that could not ‘possibly give offence.’ 61 The masseuse was counselled not to ‘flaunt her…knowledge in a vulgar, ostentatious way before either doctor or patient.’ 62 These comments support Pillitteri’s suggestion that what has been called the ‘doctor-nurse game’ was evident in nineteenth century nursing. 63 In any working relationship it is sensible for the parties involved to avoid offense, but the need for nurses to avoid displaying their knowledge and the need for doctors to avoid asking for nurses’ recommendations is at the root of the doctor-nurse game. 64

Members of the association were also encouraged to be doctors’ advocates. One of the questions on the written examination dealt with situations in which the masseuse

60 Anonymous, ‘Massage Notes,’ Nursing Notes (September, 1896), p. 137.
should refuse to continue to treat a patient, and examples of important answers included finding out that the patient was, unbeknownst to the doctor, working with other physicians or ‘various kinds of quacks.’ One of the most important reasons that the society insisted that its members follow the rule not to take cases except under medical direction was that the rule gave doctors the security of knowing that the masseuses were not ‘prescribing quacks’ themselves.

The Council continuously worked to maintain good working relationships with the medical community and included doctors in their activities at the society. The anatomy examiner for those taking the STM examinations was Piercy Evans, M.B., who was a Demonstrator of Anatomy at the London School of Medicine for Women. Lady doctors were invited to attend society social functions. At the Lambeth Infirmary, society members were permitted to gain practical experience by providing massage for patients for whom massage had been ordered by the resident medical officers. Many members of the medical profession advised ‘their masseuses’ to become members of the society. The society recommended Weir Mitchel’s book as well as other books by doctors such as Stretch Dowse’s Lectures on Massage and Electricity, and advertised in The Lancet and The Hospital. One

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of the original rules of the society was that members would not advertise except in professional publications.

Nurse-masseuses were not reluctant to learn from doctors. The society regularly announced that doctors would be giving lectures on massage related topics at society meetings. Miss Dove, who gave classes in massage and physical exercises for patients with curvature of the spine was proudly described as having ‘been instructed by’ and having ‘worked for…some of the most eminent surgeons.’ The editor of ‘Massage Notes’ encouraged all masseuses interested in ‘that branch of the work’ to contact the society for further information about the classes.73

Other branches of the work included providing massage for pet dogs (‘canine massage’)74 and the application of light and electricity. The importance of thorough training in electricity treatments was emphasised. One example of the result of practicing without proper training involved a masseuse who applied electrical treatments for weeks before she realised that she had not been connecting the apparatus to a battery.75 Some categories of work done by some masseuses were not considered to be professional and were ‘not undertaken by our Society’ such as face and toilette massage, manicure, chiropody, and hairdressing.76 The society concerned itself only with therapeutic treatment.

75 C.N.S., ‘Concerning Electricity,’ Nursing Notes (October, 1898), pp. 137-8.
By the first years of the twentieth century, the Incorporated Society of Trained Masseuses had become a prestigious, legally recognised accrediting body. When the School of Physiotherapy opened at St. Thomas’s Hospital in 1911, the purpose of the school was to prepare students to take the examinations of the ISTM.\(^77\) When the ISTM changed its requirements for certification in 1916 the Electrotherapeutic Department was established in the charge of W. Rowley Bristow, a fellow of the Royal College of Surgeons.\(^78\) Thus, a department of St. Thomas’s Hospital under the direction of a surgeon was inaugurated to prepare students to take an examination that was given by an organisation run by a group of nurses.

**Nursing and Physiotherapy in America**

In America, nurses were also involved in training in massage in the late nineteenth and early twentieth centuries. Hospital-based training schools conscientiously taught massage as part of general nurse training. Nurses continued to work with patients in massage and exercise through the first decades of the twentieth century but were not directly involved in forming a formal association related to these activities. Physiotherapy developed in America along different routes, and participation from nurses was also different. Because many factors surrounding the development of physiotherapy were different in America and Britain, it would be difficult to say to what extent differences in relationships between nurses and doctors affected the trajectories of the development of physiotherapy in these two countries. Nevertheless, a brief look at the development of physiotherapy in America may shed

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\(^{77}\) Saint Thomas’ Hospital: Physiotherapy School Administrative History, H01/ST/PS, LMA.

\(^{78}\) Golden Jubilee Journal of St. Thomas’ Hospital Physiotherapy School (June 1961), pg. 7, HI/ST/NTS/Y66, LMA.
some light on nursing work and interaction between nurses and doctors at the turn of the twentieth century.

Pupil nurses in Philadelphia studied massage as an integral part of their training. In her report for the month of October, 1897, the superintendent of the Presbyterian Hospital nurse training school in Philadelphia reported that a Miss Ward had begun ‘her course of massage’ which would be taking place twice a week. Subsequent reports indicate that the massage course continued and that all but one of the pupil nurses passed the examination. The student who did not pass was informed that she could not progress from the intermediate class to the senior class until she had re-taken and passed the massage exam. A certain level of expertise in massage was required before a pupil nurse could progress in the nurse training programme.

Regular massage courses were also given at the Pennsylvania Hospital. In 1899 Jessie Wald was giving ‘her usual course on Massage,’ and in 1900 a course in general massage, massage ‘in certain Diseases and Injuries,’ and ‘Swedish Movements’ was listed as part of the plan of study for third year nursing students. At that time the course was taught by A. E. Payne, a graduate of the Philadelphia Orthopaedic Hospital School for Massage and Electricity. Ada Payne was a nurse and became superintendent of the nurse training school when Lucy Walker retired in

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79 Monthly reports, Presbyterian Hospital. MC 35:II:430, CSHN.
80 Letter to student from Miss Milne. Presbyterian Hospital, MC 35:II, CSHN.
81 ‘Report of the Superintendent of Nurses for the year ending April 1899,’ MG 3.3 ff65, PHHC.
82 ‘Course of Study 1900-1901 Pennsylvania Hospital Training School for Nurses,’ MG. 3.3 ff6, PHHC.
1907. There was some discussion about having pupil nurses take massage courses at reduced rates at the Orthopaedic Hospital. Massage courses for pupil nurses at the Pennsylvania Hospital were a regular part of the curriculum and were taught by a nurse.

That massage was considered to be an important part of general nurse training in America is also evidenced by the inclusion of massage material in general nursing textbooks. Chapters or chapter sections with elementary instruction in massage were included in major textbooks of the day including those by Clara Weeks-Shaw, Isabel Hampton Robb, and Anna Maxwell and Amy Pope. These textbooks emphasised that the material they contained regarding massage could only be an introduction to basic massage and that in order to be competent in massage a course of lectures and practical work would be required. Even then, these textbook authors emphasised that a course of massage in a nurse training school would make one a competent nurse but not a professional masseuse. Hampton Robb stressed that while a course of lessons on massage in nurse training school would not make one an ‘expert masseuse’ it would be

…absolutely necessary that the nurse should have a good general knowledge of the principles of massage…because such knowledge will enable her to do much for the relief and comfort of almost any kind of patient…as a rule the

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83 ‘A Chronology of Nursing & Nursing School, A bibliography on PA Hosp.’s history,’ MSG 3.1 ff28, PHHC.
84 Letter from Dr Silas Weir Mitchell to Lucy Walker, Feb 16, no year, MSG 3.3, PHHC.
patient will quickly distinguish between an intelligent massage and mere haphazard rubbing.\footnote{Hampton Robb. \textit{Nursing: Its Principles and Practice, Third edition}, p. 531.}

Maxwell and Pope believed that a certain amount of massage training was needed in order to care for patients with ‘nervous diseases’ and diseases which wanted ‘stimulation of the circulation’ and ‘where ankylosis [sic] of the joints’ was likely.\footnote{Maxwell and Pope. \textit{Practical Nursing}, p. 856.}

\textit{A Manual of Nursing} for the training school at Bellevue Hospital had a section on ‘passive exercise’ which included instructions for carrying out the Weir Mitchell method with its distinctive form of massage.\footnote{Committee of the Training School for Nurses Attached to Bellevue Hospital, \textit{A Manual of Nursing} (New York: G. P. Putnam’s Sons, 1878).} A medical textbook author advised that the person performing the massage should be a nurse well trained in massage and ‘thoroughly acquainted with the details of her work.’\footnote{Anders, \textit{A Text-book of the Practice of Medicine}, p. 1182.}

As a rule, nurses in America at the turn of the twentieth century were not expected to be expert masseuses, but they were expected to have some knowledge and skill in massage. While pupil nurses were subject to examinations for massage in their training schools, there is little evidence that nurses in America were submitted to standard certification exams in massage such as the ISTM certification in Britain.

This was the situation when the First World War began. Historians of the development of physiotherapy, later ‘physical therapy,’ in America trace their beginnings to the war. At the time that the nurses at the ISTM were solidifying their authority regarding standards for physiotherapy in Britain, in America physiotherapy developed from a different background. That background was rooted in physical
education and the chief activist was Mary McMillan, an American trained in Britain. McMillan was born in Boston but was sent to live with relatives in England when she was very young. She became interested in physical exercises and worked as an assistant to Sir Robert Jones, an orthopaedic surgeon in Liverpool, England. McMillan later went to London where she received training in therapeutic exercise, massage, and other related courses. When Britain became involved in World War I, she wanted to join the British military but was not accepted because of a physical condition.\footnote{Murphy, *Healing the Generations*; Anonymous, ‘The Beginning of “Modern Physiotherapy,”’ *Physical Therapy*, 56 (January 1976), pp. 3-21.} From 1911 to 1915 she did work at Robert’s clinic, was in charge of massage and therapeutic exercise at Greenbank Cripples’ Home, which was also in Liverpool, and spent time in other parts of England. She then returned to America, and from 1916 to 1918 she was the Director of Massage and Medical Gymnastics and Instructor of Nurses in Massage and Medical Gymnastics at The Children’s Hospital in Portland, Maine.\footnote{Mary McMillan, *Massage and Therapeutic Exercise*. (Philadelphia: W. B. Saunders Company, 1921), title page.}

In order to provide insight into relationships between nursing and medicine this thesis will briefly move outside of the study time frame. When America joined the war and large numbers of wounded soldiers began arriving in hospitals, it became apparent that some kind of service to provide rehabilitation services was needed. McMillan was recruited to head training of ‘reconstruction aids’ for the army and became a much loved teacher at the largest facility for training at Reed College in
Oregon. The army reconstruction aids that McMillan and others trained became the core of what would be called the first American physiotherapists.92

The women who joined the reconstruction aid programme had come, for the most part, from a background of physical education.93 Ninety per cent of reconstruction aids serving in the First World War had been educated in schools of physical education, where students were trained to be physical education teachers.94 Becoming reconstruction aids involved a radical change in career path which associated them with therapeutic intervention and thus with medicine. According to Linker, in the process of changing their career course from physical education teachers to reconstruction aids, physiotherapists ‘subordinated themselves to male orthopaedic surgeons.’95 Linker argues that reconstruction aids who became physiotherapists purposely chose to subordinate themselves to doctors in order to carve out a new profession for themselves in which they would care for injured men rather than the healthy women and children they would have worked with as physical education teachers.

As the new field of physiotherapy developed, one of its most important sparring partners was the nursing profession. According to Linker, in order to further their aim to form a distinct occupation, physiotherapists allied themselves with

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93 Beth Linker, ‘Strength and Science: Gender, Physiotherapy, and Medicine in Early-twentieth-century America,’ Journal of Women’s History 17 (Fall 2005), pp. 105-132.
94 Linker, ‘Strength and Science,’ pp. 105-132.
95 Linker, ‘Strength and Science,’ pp. 105-132.
orthopaedic surgeons and ‘mounted a campaign of professional exclusion against nurses.’ One reason for their animosity towards nurses was rooted in the way that reconstruction aids were brought into the army. They were ‘overshadowed, outranked, and outnumbered’ by nurses. By allying themselves with orthopaedic surgeons, physiotherapists gained support for their cause from officers who were anxious to assert their authority over their more numerous army associates, the general practitioners. When army doctors attempted to place a nurse in charge of physical therapy at one site, the surgeons protested—along with many physiotherapists—and the nurse was replaced with a physiotherapist. When army doctors proposed that all physiotherapists be placed under the direction of the nursing department, the surgeons again intervened on their behalf.

Not all orthopaedic surgeons wanted to exclude nurses, however. Several surgeons who responded to a research survey emphatically stated that they preferred to work with physiotherapists who had nurses’ training. Others also thought that nurses’ training was a better background for physiotherapy than physical education training. Nevertheless, the first leaders of physiotherapy successfully sought official association with medical practitioners and medical organisations.

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96 Linker, ‘Strength and Science,’ pp. 111.
Mary McMillan had some association with nurses—she taught massage and medical gymnastics to nurses in Maine. She also became acquainted with the ISTM while she was in England. When she was elected first president of the American Physiotherapy Association in 1921 she declared that one of their top priorities was to set standards as the ISTM had done in England. She stressed that the association would have to work hard in order to achieve the status that had been reached by the ISTM, and pointed out that holders of the certificates which were obtained from what by then was called the Chartered Society of Trained Masseuses had ‘a recognised standing as professional women.’

**Conclusion**

Mary McMillan paid tribute to the physiotherapy organisation that British nurses had formed, but American physiotherapy leaders purposely set out to develop a profession separate from nursing. The case of physiotherapy demonstrates different conduits for the eventual development of an autonomous profession out of massage, exercise, nursing, medicine, and physical education. In both Britain and America massage was an important part of medical treatment. In both countries nurses were instrumental in supplying that treatment during the last part of the nineteenth century and early part of the twentieth century.

Nurse leaders of the physiotherapy movement in Britain combined massage with remedial exercises and electrotherapy and established an authoritative organisation to

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certify practitioners. They emphasised the benefits of having a nursing background for that practice. American physiotherapy leaders came from a background of physical education and their organisation consciously downplayed the importance of any association with nursing. British physiotherapy leaders purposely minimised formal participation of doctors in the administration of their society. American leaders sought and achieved official, if subordinate, membership in medical organisations. That British nurses could successfully form an authoritative body for certification of widely respected practitioners without official oversight of doctors suggests that they were to a significant extent separate and independent from their medical colleagues.

In Victorian society women nurses had to be respectfully allied with reputable doctors in order to avoid being classed as quacks. The nurses of the ISTM accomplished this while at the same time maintaining a remarkable degree of separation from doctors. The relationship that the society had with medicine was very important to the founders. They believed that massage and exercise made a legitimate branch of nursing. They also felt that it was imperative to secure the confidence and patronage of medical men and women while maintaining their administrative autonomy. This approach was a key component in regard to their ability to maintain control of the society, and through the society their profession, while at the same time avoiding any appearance of quackery.
CHAPTER VIII

CONCLUSION

Nursing in the late nineteenth and early twentieth centuries was based on core or ‘true’ nursing work and assisting doctors. Core nursing work was bed and body work that required specialised nursing expertise. In Britain, Florence Nightingale elaborated on what this kind of work entailed. It was based on focused observation of patients which was used to determine each patient’s specific physical and emotional needs.\(^1\) Interventions were based on expert assessment and were composed of numerous ‘little things’ which together made the difference between life and death. Nightingale also emphasised the nurse’s duty to assist doctors in their work.\(^2\) While both of these aspects of nursing were fundamental in both Britain and America, core nursing was elaborated more in Britain than America.

All good nursing required intelligence on the part of the nurse. Intelligence in regard to assisting doctors meant having a certain amount of medical knowledge. Because nurses were always with patients, they were in a position to observe the development of patients’ illnesses and the efficacy and complications of medical treatments. A nurse practicing ‘intelligent nursing’ would make accurate observations and convey appropriate information to the doctor in a timely manner so that he could make adjustments to the medical treatment. A nurse who was not practicing intelligent

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nursing would unthinkingly implement ordered treatment regardless of the patient’s response or change in status. In order to be able to practice intelligent nursing, a nursing student needed to study a certain amount of medical material. The amount of medical material which a student nurse should study was not easily determined. Too little study of medical material would hamper a nurse’s ability to provide intelligent nursing. Too much study of medical material would tend to blur the lines between nursing and medicine. British nurses and doctors were more concerned about not blurring lines between the two professions, which is reflected in the material they chose to teach to nursing students. In general, British nursing textbooks contained less medical material than American nursing textbooks and more core nursing material. Core nursing work was discussed in depth in the widely used British textbook, *General Nursing*, a compilation of nursing lectures given by London Hospital matron Eva Luckes.³ There is little evidence of a comparable American nursing textbook. A widely used British nursing textbook written by a doctor contained more medical material, but still included significantly less medical material than popular American nursing textbooks.⁴ An American nursing text which was also published in a British edition had more medical material in the American edition than the British edition. The editors of the British edition purposely left out material which they believed excessively blurred lines between nursing and medicine.⁵

Various factors contributed to a more distinct division between nursing and medicine in Britain than in America. These factors included the presence of more medical students in British hospitals than American hospitals and the phenomenon of the powerful British matron.

Large London teaching hospitals had hundreds of medical students working directly with patients on the hospital wards. With so many medical students vying for direct access to hands on care of patients, there was less medical work for the nurses to do. Surgical dressers carried out the numerous dressing changes that were necessary before the development of refined aseptic technique during surgery and the advent of antibiotics. Nurses also did dressing changes, notably during the evening and night hours, but the dressers retained ownership of these activities. With fewer numbers of medical staff in American hospitals, more of this work was left to the nurses. In addition to surgical dressers, London hospitals had large numbers of medical clinical clerks to take patient case notes and provide medical care. Nurses were less involved in this kind of patient care than they were with dressing changes, but the large number of clinical clerks and dressers ensured that nurses interacted with many medical students. Nurses in American hospitals did not have so many medical providers at their patients’ bedsides and would therefore have had less interaction with medical staff and would have been doing more of the routine medical work, which led to less distinction between nursing and medicine.
The formidable British matron was also a factor in more clearly delineating distinctions between nursing and medicine in Britain. A powerful matron could enforce her authority over the nursing staff and maintain a nursing staff subject to a nurse rather than doctors. Having the nursing service strictly separate from the medical service helped to maintain clearer lines between nursing and medicine. One of Florence Nightingale’s most emphatic instructions regarding the improvement of nursing was that hospital nurses should be supervised by a nurse who had sole responsibility for the nursing of patients. She repeatedly reinforced the importance of nurses being governed by one nurse head who reported to hospital administrators and not to doctors or other authorities such as the hospital chaplain. She felt that discipline and morale could not be maintained otherwise. Although the Nightingale School at St. Thomas’s Hospital had a slow beginning, nurse training schools at large London hospitals became important producers of strong hospital matrons. These women worked to keep administration of the hospital nursing service outside of medical control. Nightingale herself helped London matrons to maintain control of nursing services. Her absence in America and the presence of nurse leaders like Linda Richards, who did not have qualms about medical control of hospital nursing services, could have contributed to continuing medical control of nursing services in the United States.

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One of the ways that London hospitals produced strong matrons was to recruit upper middle class women as special probationers. In American hospitals where there were no special probationer programmes, all student nurses in any one programme received the same instruction from doctors. It was also common practice at many American hospitals during the nineteenth century for senior pupil nurses to act as head nurses, a position similar to that of the British ward sister. The temporary nature of the head nurse position, often filled with student nurses would have resulted in a situation in which less experienced nursing staff were dealing directly with fully qualified doctors. While American nurses in training had more interaction with qualified medical staff, they had less interaction with medical students than their British counterparts. The absence of medical students in American hospital wards meant that nurses working in American hospitals, whether as pupils or graduates, would have done more medical work and would have had more reason to be impressed by the opportunities to do so.

Administrators of some American hospitals recognised the effectiveness of strong British matrons and several were recruited to manage the nursing at large American hospitals, including three large Philadelphia hospitals. While in all three of these cases dramatic improvements in the nursing were reported, medical control over the nursing was maintained. For instance, at the Philadelphia General Hospital the nursing service was officially under the control of the doctors after Alice Fisher, a graduate of St. Thomas’s Hospital nurse training school, was gone. According to one source, early twentieth century American hospitals were generally under the
control of hospital medical officers. Nurse leader Lillian Wald expressed concern that if nursing superintendents were under direct control of chief medical officers, their major focus would be on supporting medical staff. While nursing care of patients improved under the new nursing in Philadelphia hospitals as it had in London hospitals, having hospital nursing services under the control of medical officers put a more medical turn on American nursing.

The case of the dispute at Guy’s Hospital helps to illustrate the challenges that nurses faced when implementing control of a hospital nursing service under a trained nurse head. This widely publicised series of events helped to solidify the concept of a trained nurse head being responsible for the nursing service and reporting directly to the hospital managers. The concept of the authority of the hospital managers over the doctors was also strongly reinforced. The well documented proceedings of the case also help to illustrate how these London nurses perceived their profession and their work to be different from that of doctors. Explanations from Margaret Lonsdale, one of the nurses involved in the case, correlate with those of Eva Luckes’ discussions of what is here called core nursing. Luckes and Lonsdale make a solid case for the idea that nurses were developing core nursing into something which was expert nursing, outside the expertise of doctors. Lonsdale also had salient reasons for arguing that nurses had a unique function in regard to reining in excesses of doctors.

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9 Lavinia Dock, ‘Hospital Organisation,’ National Hospital Record 6(1903), p. 414.
and medical students, such as those associated with experimental treatments and indecorous behaviour. The case of the dispute at Guy’s also helps to illuminate the nature of nursing care done by medical students. Medical students nursed patients but as students they did not have a great deal of experience, which was reflected in the poor quality of the care which they gave. The core nursing of Nightingale and Luckes, and described by Lonsdale, developed out of nursing that had been done before, but developed into expertise which doctors did not know.

Another example of the strong position of nursing and relative separation of nursing from medicine in Britain relates to the development of physiotherapy. Physiotherapy as a profession in Britain grew out of an organisation founded by a small group of nurses, the Incorporated Society of Trained Masseuses. The ISTM became the recognised body for certifying professional practitioners of massage, therapeutic exercise, and electrical treatments. The nurse leaders of the ISTM took for granted that the therapies that they provided needed to be ordered by doctors, but they recognised that as trained nurse masseuses they were the experts in the provision of that therapy. Nurse masseuse leaders of the ISTM also provided training in massage, exercise, and electrotherapy, although those desirous of taking the examinations could come from other training sources. In order for a group of nurses to maintain respectability in providing therapeutic treatments to patients, they had to have the approval of doctors. Without medical approval they would have been at risk for being considered quacks. The leaders of the ISTM wanted the approval of doctors but thought carefully about how they would go about building their relationship with
them. At one point not long after the establishment of the society some reputable doctors offered to join the society’s governing body. The nurses did not accept their offer, preferring to keep the administration of the society in their own hands. They tactfully declined the doctors’ proposal and were subsequently able to court their support while maintaining their official autonomy.

Physiotherapy developed differently in America. American nurses learned about massage in their training schools and implemented doctors’ orders for massage for patients. But when physiotherapy emerged mainly from practitioners with a background in physical education, nurses were deliberately excluded. This does not necessarily mean that American nurses were less powerful than their British counterparts, but their experience is useful as an example of an alternate trajectory for the development of physiotherapy. That British these nurses were able to conceive of a relatively autonomous specialty and then develop their specialty to a remarkable level of autonomy also suggests that nursing in Britain had to a significant extent separated itself from medicine.

The major findings of this study are that elaboration of Nightingale’s details of sick nursing, especially as elaborated by Eva Luckes, helped to develop nursing knowledge which was different from medicine. Also, medical students working at the bedside in hospitals and strong trained nurse matrons contributed to a greater focus on core nursing and institutional separation of nursing from medicine in
Britain. Differences in conditions in the United States of America contributed to a more medical focus in American nursing.
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