Nursing History and Humanities

Who cared for the carers?

A history of the occupational health of nurses, 1880–1948

DEBBIE PALMER

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Nursing History and Humanities

This series provides an outlet for the publication of rigorous academic texts in the two closely related disciplines of Nursing History and Nursing Humanities, drawing upon both the intellectual rigour of the humanities and the practice-based, real-world emphasis of clinical and professional nursing.

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For my husband, Jamie, my parents, Wendy and Keith, and my children Jack, Harriet, Charlie and Lucy

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List of abbreviations

AJN	*American Journal of Nursing*
AWA	Asylum Workers' Association
BCG	Bacillus Calmette-Guerin vaccine
BJN	*British Journal of Nursing*
BMA	British Medical Association
BMJ	*British Medical Journal*
BNA	British Nurses' Association
CLA	Cornwall Lunatic Asylum
CMH	Cornwall Mental Hospital
CRO	Cornwall Record Office
HIV	Human immunodeficiency virus
HMWC	Health of Munitions Workers Committee
IHRB	Industrial Health Research Board
IIAC	Industrial Injuries Advisory Council
MPA	Medico-Psychological Association
MRSA	Methicillin resistant staphylococcus aureus
NAWU	National Asylum Workers' Union
NCW	National Council of Women
NHS	National Health Service
NUWW	National Union of Women Workers
PRO	Public Record Office, London
PUTN	Professional Union of Trained Nurses
PWDRO	Plymouth and West Devon Record Office
RBNA	Royal British Nurses' Association
RCN	Royal College of Nursing

RLH	Royal London Hospital
SDEC	South Devon and East Cornwall Hospital
TB	Tuberculosis
VADs	Voluntary aid detachment nurses

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Introduction

In 1890, the *Pall Mall Gazette* argued that 'to help a million sick, you must kill a few nurses'. The deaths of eight nurses from The London Hospital over the preceding two years were confirmation, according to the *Gazette*, that illness was an inevitable consequence of nursing in the late nineteenth century. 'Are nurses sweated?' the newspaper enquired and, in response, nurses described the detrimental effects on health of long working hours, poor diet and high patient-to-nurse ratios.[1] However, the cause of the rising mortality rate, the *Gazette* concluded, was as much about the way nursing was managed as it was about poor work conditions: nurses were dying because there was something wrong with The London Hospital's 'administration'.[2] The newspaper raised an important question that shapes the focus of this book: how did the management of nurses between 1890 and 1948 shape nurses' experience of ill-health?

To answer this question, this book compares the histories of psychiatric and voluntary hospital nurses' health from the rise of the professional nurse in 1880 to the advent of the National Health Service (NHS) in 1948. In the process, it reveals the ways in which national ideas about the organisation of nursing impacted on the lives of ordinary nurses. It explains why the management of nurses' health changed over time and between places and sets these changes within a wider context of social, political and economic history. The purpose of the introductory chapter is, firstly, to establish why this question is important and, secondly, to set out the analytical themes that underpin its subsequent discussion.

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Managing nurses' health today

The management of nurses' sickness has recently been targeted as a crucial way in which NHS trusts can save money. The cost of sickness absence nationally for nurses and health care assistants is approximately £141 million and rising. Since 2007, the amount the average NHS trust spends on agency staff to cover sickness has risen from 2.9 per cent of its staffing budget to 5.1 per cent.[3] To tackle the problem, the Department of Health commissioned an independent review of the health and wellbeing of NHS staff in 2009, led by Dr Steve Boorman.[4] The review found that the direct cost of all NHS staff sickness absence is £1.7 billion, and recommended a target decrease of £555 million. 'Now is the time', it advised NHS trusts, 'to make your workforce's health and wellbeing a priority so you meet your financial targets and improve patient care.'[5] The management of nurses' health care has become part of trusts' business strategies to meet targets and measures set out by the government against which they are publicly measured. Such an approach is justified, according to the Boorman review, by the 'clear relationship' between measurable outcomes such as patient satisfaction, absence rates, agency spend, the number of MRSA cases, patient mortality rates and staff health.

This new financial focus on the care of the health of nurses emphasises the need for managers to understand the links between health and organisational performance and, as a result, to remodel their provision of occupational welfare to include a much stronger preventative emphasis than in the past. Nurses, and other NHS employees, are to be supported to reduce their risk factor of disease by, for example, losing weight, increasing exercise and stopping smoking.[6] Managers have also been advised to give a much higher priority to mental health issues and to tackle stress, bullying, harassment and the deep-seated culture of long working hours. The Boorman review sets out a number of models of ideal mental health care including Tower Hamlets Primary Care Trust's policy which trains managers to deal with staff's mental health and Addenbrooke's Hospital's 'Life' scheme which offers staff poetry and painting competitions, book clubs, manicures and back massage.[7]

High rates of sickness absence in the nursing profession attract increasing criticism. Nurses take more days off sick than private

sector employees and most other groups of public sector workers.[8] The average rate of employee sickness in Britain is 3.64 per cent with teachers (4.6 per cent)[9] and social workers (4.94 per cent) rates higher.[10] Nursing staff had the third highest sickness rates (5.21 per cent) in the NHS between 2009 and 2011, with health care assistants and support staff ranked top (6.46 per cent) and medical and dental staff bottom (1.26 per cent).[11] (Rates have been calculated by dividing the full-time equivalent number of days side by the full-time number of days available.)

Nurses face a high risk of physical illness from the basic tasks of the job (such as lifting or exposure to body fluids), infection or, increasingly, from violence especially in accident and emergency departments and psychiatric wards.[12] They are also vulnerable to mental illness, stress and suicide.[13] There is no statutory NHS occupational health service and wide variations occur in the quality of care offered. NHS trusts generally are not giving priority to staff health, the Boorman report concluded, with many displaying behaviours 'incompatible' with high-quality health services. Staff health is not seen as a priority at either organisational or management level.[14] The drive for change, to raise the importance attached to staff health, may be better understood by informed comparisons with the past.

Intentions

At the centre of this book is an exploration of the management of nurses' health in the first half of the twentieth century. It asks: who was responsible for nurses' health and why did this change over time and between places? Today, the trend is for government policy makers to set national policy, which is implemented by health service managers. But what parts have hospital managers, doctors and nurses played in the past? The ability to influence policy entails significant power and, thus, the theme of power underpins this history of nurses' health.

This book is also concerned with how occupational health policy and practice varied between different types of hospital and between different groups of nurses. Its focus is limited to unpicking the differences between the voluntary hospital and the psychiatric hospital and does not cover, for example, the expanding and lower-grade

hospitals in the Poor Law system. The decision to restrict its remit was made on the grounds that the significant disparity between asylum and voluntary hospital nurses regarding social class, gender and training produced very different systems of occupational care that warranted careful consideration. Some of the most important differences include the fact that asylums employed an almost equal number of men and women from working-class backgrounds compared to the all-female nursing staffs of voluntary hospitals who were drawn from more diverse social backgrounds. Furthermore, whilst voluntary hospital nursing was classed as women's work in the late nineteenth and early twentieth centuries, looking after the male insane was regarded as men's work despite the equal ratio of male to female nurses.[15] Another significant difference concerns formal nurse training which was introduced in the 1880s to the voluntary hospitals studied and over thirty years later to the Cornwall Lunatic Asylum (1918). Asylum and voluntary hospital nurses' choice of occupational representation also differed, with the former group selecting trade unionism and the latter the College of Nursing. Moreover, asylums were subject to a different legislative framework from that of the voluntary hospitals, and this inevitably produced a distinctive culture.

The themes of social class and gender frame the book's examination of nurses' health. One of its aims is to trace the shifting cultural meanings of social class across time and assess the impact of change on the construction of nurses' health. Social class, according to Barbara Harrison, explains why some groups of women workers and not others were subject to state intervention in the regulation of work between 1880 and 1914. She argues that intervention was often made on the grounds that there were peculiar problems resulting from women's work, particularly the neglect of domestic and maternal duties.[16] Such ideas carried currency in a climate of debates about infant mortality and industrial efficiency. Anxiety about a declining birth rate and concern about the health of the working classes, based on Britain's need for a fit, imperial race, not only placed great emphasis on women's reproductive ability but reinforced the idea that employed mothers were failures for being in paid work. For example, working-class women formed most of the cotton industry labour force and enjoyed a reputation for independence, a counterweight in

a period when a woman's place was defined by an ideology of domesticity. This reputation was a problem for some medical officers who criticised female cotton workers' alleged immorality outside work in debates about the health risks of 'shuttle kissing'.[17]

In the late nineteenth century, nursing was emerging as one of the new 'professional' occupations for middle-class women, Harrison suggests, and escaped state regulation because 'it seems that middle-class women's work in particular was rarely considered to pose occupational health problems or to require intervention'.[18] Harrison's contention that class explains the regulation of women's work is important to this book because it prompted my initial interest in explaining the relationship between the image of nursing and attitudes to occupational health. Indeed, it raises one of its key questions: what part did the notion of class play in the professionalisation of nursing and how did it shape attitudes to nurses' health? As time went on and nursing faced recurrent recruitment problems, how did the changing image of nursing affect attitudes towards nurses' health?

Gender is another crucial theme and, like the concept of social class, is key to understanding how the health of nurses was constituted and represented. The central question raised is concerned with how the changing concept of gender, between 1890 and 1948, shaped understandings of nurses' health. The period witnessed significant social and cultural change for women including widening educational and employment opportunities plus enfranchisement in 1918 and 1928. But, according to Patricia D'Antonio, the notion of gender ultimately constrained nurses' opportunities. She argues that late nineteenth-century nurse leaders' embracement of the gendered meaning of nursing – the notion that the ideal nurse was domesticated, maternal and thus qualified to care – initially allowed nurses to step out of 'or perhaps more importantly up from the traditional conventions of their particular starting place' but also 'created boundaries that were often simultaneously both a source of strength and a dam around their ambition'.[19] This book argues that occupational health was such a boundary: to ignore the hazards of nursing was initially a source of pretended strength but the extent to which this strategy limited the development of a comprehensive occupational health service for nurses needs addressing.

Structure and sources

To assess how nurses' health was managed, this book adopts a two-tiered approach. Firstly, it uses government-sponsored reports and nursing and medical inquiries into the organisation of nursing to provide an overarching political framework. Although reports were often initiated in response to political problems such as a shortage of nurses, the restructuring of the health service or a need to manage manpower in response to war, solutions increasingly involved nurses' health. Secondly, in order to place the individual nurse's experience of illness within this context of political reform, the book focuses on primary sources drawn from the archives of The London Hospital, a large metropolitan teaching hospital, the South Devon and East Cornwall Hospital (SDEC), a smaller provincial voluntary hospital, and the Cornwall Lunatic Asylum (CLA), a large rural asylum.

There are several reasons why these hospitals were chosen but most importantly they allow me to contrast the individual asylum nurse's experience of illness with that of his or her voluntary hospital counterpart and explain how and why that experience changed over time. Furthermore, because the matrons employed at these three institutions held different political opinions about the professionalisation of nursing, it is possible to trace the relationship between matrons' politics and occupational health policy. Chapter 1 examines the impact of the late nineteenth-century debate about nurse registration on ideas about the health of nurses. Between 1888 and 1890, the mortality and morbidity rates among The London Hospital nurses dramatically increased and critics alleged that its cause was linked to matron Eva Luckes's increasing power and political opposition to nurse registration. Using evidence from the inquiry called to investigate the problem, this chapter contrasts Luckes's ideology about the organisation of nursing and the care of sick nurses with that of Harriet Hopkins, matron of the SDEC and a staunch supporter of nurse registration. The disparity between these women's ideas is then contrasted with those of the CLA matrons who expressed no interest in the politics of nursing and enjoyed little power.

Another reason for my choice of case study institutions is to explore the relationship between nurses' choice of occupational representation and their health care. Chapter 2 explains why CLA nurses

chose to join a trade union and take strike action in 1918, at the end of the First World War, by relating their choice of occupational representation to the terrible deterioration in their health and working conditions. Indeed, seven CLA nurses died from infectious diseases in 1917 and 1918, all under the age of thirty. The chapter compares the impact of the war on nurses' health at the SDEC and examines whether these voluntary hospital nurses' lack of interest in any form of occupational representation can be explained by the fact that they experienced little day-to-day change between 1914 and 1918. Brian Abel-Smith and Christopher Hart locate the reason for voluntary hospital nurses' choice of the College of Nursing and asylum nurses' decision to join trade unions within a framework of gender and class.[20] This chapter assesses how influential these factors were at the SDEC and CLA and suggests that further analysis must include nurses' occupational health issues.

The theme of the professionalisation of nursing and its impact on health is continued in Chapter 3, which examines the Nurses' Registration Act of 1919. This is an important episode in the history of the health of nurses because it was an opportunity for state legislation to regulate nurses' work conditions. Early twentieth-century nurse leaders predicted that they would be able to stipulate conditions once professional status had been achieved. They reasoned that if nurses were better educated and more highly trained then improvements to economic conditions would follow. Yet their prediction failed to materialise, and although asylum nurses achieved standardised work conditions by 1919, voluntary hospital nurses' work remained unregulated despite the award of professional status. This chapter questions why nurse organisations failed to achieve improvements revealing their attitudes towards the regulation of work conditions and the treatment of nurses' health.

The focus of Chapter 4 shifts away from the professionalisation of nursing to examine the rising incidence of tuberculosis (TB) among nurses in the 1930s and 1940s. Such was the attention given to the problem by nursing and medical journals that TB was presented as the only occupational health problem nurses faced in the interwar period. Why, this chapter asks, did TB emerge as a health problem for nurses at this point in time and not before? Furthermore, it also investigates how the changing conception of TB as a disease, between

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