

**CARING, CONTROL AND COMPLIANCE: NURSING'S
STRUGGLE TO BE AUDIBLE**

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Abstract

There are many situations in healthcare delivery in the UK where nurses are the dominant workforce or have expert practitioners working directly with clients, yet rarely are they involved in national healthcare policy development nor do they have significant input into how they are expected to practise.

Given the sheer numbers of nurses and the long history of the profession it is not immediately clear why this should be the case. Talking to colleagues though one is left with the impression that this situation is somehow embedded in our history. One clue here is the perception that nursing is women's work and there appears to be a strong parallel between the historical treatment of women in society and the status of nursing. The lack of value ascribed to the skills of the woman nurse can, I believe, be found in our Christian heritage

In this work I have explored this phenomenon by examining the development of nursing through history to try and identify and expose the barriers to nursing being able to lead in public healthcare policy determination.

I have used an historiographical approach to review the literature using, where possible, contemporaneous accounts. Through this approach I have highlighted the historical, impact of Christianity on the status and value of women in society overlaid with the struggle nursing has had with the enduring legend of Florence Nightingale.

The exposure of nursing's history and the roots of the embedded attitudes offers the expectation that nurses through nurse education can work with them to better prepare future practitioners to take on the challenge of influencing national healthcare policy in Britain.

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Introduction

While undertaking a period of professional development in an area of highly specialised practice, I discovered that the group of nurses with which I was working, who had over time amassed significant knowledge and skills, believed they had no direct input into the development of the national policies that governed their practice. The result of this was that they thought they were being expected to implement procedures that often had little basis in the reality of their day-to-day work and that they believed were flawed and sometimes damaging to their client group.

Their perception matched my own experience of the processes of developing public policy in this area. However, the apparent lack of a feedback loop to monitor the accuracy and effectiveness of the policies as used at the point of delivery was of concern and surprised me as I am aware that senior nurses both work within government and attend policy briefings with Government departments. Why then were they not speaking up sufficiently for nursing practice or, if they were, why was what they were saying not apparently being heeded?

It is also apparent that this problem is not limited to this country as this phenomenon was recognised by the International Council of Nurses (ICN) when in May 2011 – as the representative federation of millions of nurses worldwide – they passed an emergency resolution demanding that the Director General of the World Health Organisation (WHO) empower and finance leadership positions throughout the organisation claiming “it makes no sense for WHO to advocate for nurses to fully participate in the health care team at the clinical level, yet exclude them from playing their full role at the policy table” (ICN 2011).

In 2004 in the USA the Nursing Organisations Alliance (NOA) expressed its concerns that nursing was not being properly represented in national healthcare

policy development. However they seem to lay the blame for this at the feet of nurses themselves, expressing concern that nurses were not a united group speaking with a powerful voice (NOA 2004).

My own experience of undertaking work at Government level in the UK that bridged the gap between the practitioners and policy-makers highlighted for me the divisions between these two groups and also revealed a powerful hierarchy of perceived relative importance, and therefore influence, of different healthcare professional groups. The contrast at the Department of Health in England between the treatment and assigned status of medical staff, and to an extent social work staff, and that of nursing staff was stark. But this was not a simple case of how doctors perceived and therefore behaved towards nurses, this was also a matter of a third party – a Government department – working in a way that was complicit in compounding this hierarchical and differential treatment. Alarming, this behaviour was written into their policies and procedures and, significantly, was apparently accepted by all parties as being normal and natural.

This normalcy would tend to suggest that these practices have been part of healthcare culture for some time and this is noted in work in the UK by Fagin and Garelick (2004), Radcliffe (2000, 2006) and Salvage (1985, 2000) with a very similar position summarised in the USA by the NOA, who in their report highlighted the barriers in nursing's past that have prevented the creation of a united focus (Grindel 2006). These barriers, they believe, are still affecting nursing's ability to respond to the realities of the future and need a concerted effort to break down. In the same vein also in the USA Cardillo, (2011) states that nursing is not sufficiently contributing to healthcare policy development although it is ready to and to rectify this she thinks all it needs to do is learn from its past. Accad (2008), considering nursing's challenge to contribute to a new era of healing, highlighted nursing's historical subjugation to medicine being the reason for its oppression and therefore inability to contribute properly to

healthcare policy development. She too believes that nursing is ready to take its place at the table (of healthcare policy development) but needs to re-identify with its own culture.

But this may not be a simple task. New Zealand is a country with a very similar history of, and modern structure of, nursing as the UK and where in the late twentieth century nursing had gained a place at the table but following repeated political reforms and the introduction of a market approach to healthcare delivery the nursing representation at Ministry level became significantly reduced (Brinkman 2006) leaving it compromised and heavily outflanked by medicine. So the message here may be that nursing's place at the policy table is not yet guaranteed even in countries where the attitude towards nurses is often perceived as being more enlightened than our own. In a more pressured commercial health service old attitudes towards the profession can re-emerge where nurses are still considered as part of a workforce and the service they provide still only a commodity. If this is the case then the need to be able to understand the roots of those attitudes and develop arguments and strategies to robustly challenge them becomes more crucial.

I have chosen to examine this topic as I have become aware that although my own field of nurse education is becoming more sophisticated, the practice of nursing appears to be still misperceived and undervalued outside the profession and nurses do not appear to be able to have their professional voice heard, whether this is due to an inability develop and use political expertise or a failure to 'fit' nursing to match others' expectations. And old values, as discovered in New Zealand, are not far from the surface. Or are there significant external obstacles to nursing's voice being heard?

It is worth noting here that in the process of constructing this piece of work I have read widely through literature chosen for its relevance to the core themes

of the work. Inevitably some of the material consulted has not been written primarily about the British nursing system. It is important, therefore, to consider whether there are sufficient similarities between nursing in these other countries and nursing in Britain to justify its inclusion. My conclusion is that it is the culture, philosophy, aspirations and mission of nursing that is of interest here and while caution should be exercised with regard to how nursing is practised within the different healthcare delivery structures there is evidence to show that the structure of educational preparation for nursing in the USA, Canada, Australia, New Zealand and Ireland is almost identical to the UK (Robinson and Griffiths 2007), leading to the assumption that there are likely also to be significant similarities with other aspects of nursing. However, for clarity I have indicated in the text where the literature, and its commentary, is not of UK origin.

A recurrent theme in the literature is that the roots of the barriers to nursing's proper contribution to healthcare policy development are largely historical and poorly understood even by nurses themselves. This has highlighted the need to re-examine these barriers in the context of their development, understand them and offer routes to their resolution – one of which may be through nurse education.

It is important to emphasise that this work is presented as one plausible account of the issues surrounding the historical roots of nursing's lack of voice and apparent lack of authority, while recognising that there may be other accounts. I have selected and accessed literature sources to support this account based on their contribution to the central themes of the story – nursing's apparent powerlessness and lack of voice - and used a historiographical approach to examine the history of nursing as a healthcare activity in Britain, from its very earliest roots through to its emergence as a profession, in an attempt to highlight and understand the discourses that are influencing its voice. This

commentary will also draw on work from North America, Australia and New Zealand, countries where the British – post Nightingale - model of nursing is still evident in their structures and organisation (Egenes 2009). The work will include a discussion on the contribution this understanding of nursing's history can make to nursing education practice development.

The popular images of nursing in Britain since the end of the nineteenth century have been those of a predominantly female workforce, although around the mid-twentieth century the truth of this imagery starts to blur with many more men joining the profession, the relationship between women and nursing is still, I believe, highly significant in understanding its development. My thesis is, therefore, that an informed understanding of nursing history and its close association with women's history can provide insights into the perception of the silencing or filtering out of nursing's voice in the British healthcare policy-making arena. And that these insights can inform and contribute to developing a role that nursing education can play in identifying and nurturing the necessary skills and knowledge to allow nurses to promote nursing's input into healthcare policy development.

Consideration of the enigmatic presence of Florence Nightingale has been given a section of its own. In her own lifetime and ever since she has been seen as the epitome of the ideal nurse and therefore her impact on how nursing is perceived both within and outside the profession cannot be ignored and should not be underestimated. However, her often difficult persistence may owe more to political manipulation than actual activity thus contributing to a possibly covert discourse about the nature of nursing.

There is a tendency in historical research for the narrative to move in waves and to take unexpected turns and potential diversions from the main theme, and in an attempt to limit this movement I have restricted consideration of what might

be considered 'side' issues to those that make a significant contribution to the core narrative – for example the impact notions of physical damage have had on the development of women's education.

Chapter 1: Method

In the very early stages of this work a combination of general database searching, examining the better known literature and conducting informal discussions with relevant staff from nursing and other healthcare professions revealed that this perceived problem of lack of voice is not limited to one area of practice in nursing and any particular staff/client group but is indicative of a much bigger issue in nursing. It appears to be linked to a way of thinking or discourse that is deeply embedded not only in the culture of nursing evidenced within the profession but also in the perception of nursing and nurses by employers, other health professionals and the wider population. The evidence gathered through the early literature searches was also indicating that the basis for this discourse was not immediately obvious, but as it appears to be strongly rooted in nursing's historical past an historical investigation was the method of choice.

The broad historical sweeps in the work encompass the development of attitudes towards and perceptions of nurses and nursing through early history, the establishment at the latter end of the nineteenth century and early twentieth century of a more recognisable (by today's standards) nursing and healthcare service, followed by the later struggle by nursing to rationalise its position and status through its attempts to develop and demonstrate its professional credentials.

The decision to include a wide historical view while no doubt contributing to the complexity of managing data is quite deliberate. It is wrong to assume that nursing begins in the late nineteenth century and therefore starting an account of nursing's history at that point would provide not only a distorted view of nursing but also fail to provide a proper context for the nature of nursing as attitudes towards women were well-established by that time. As Celia Davies

(1980 : p175) notes in her commentary on Margaret Connor Versluysen's work (Versluysen 1980) on women healers, starting our analysis further back than the 19th century allows us to ask about, not take for granted, the sexual divisions which became established then. However, it is recognised that the evidence about early history is limited and largely speculative, but working from a speculative position is generally accepted within historical research and, by using a mix of knowns and presumptions, move to construct an account that is available for further interrogation. This approach of 'gap filling' was highlighted by Foucault (1978) who was concerned that any 'gaps' in (known) history should not be ignored but used to provide a sense of historical perspective, and speculative positions (such as Versluysen's) that offer an alternative theoretical position can, according to Davies (1980), help keep us alert.

As it is through the narratives of nurses that we can begin to understand the impact of the 'silencing' discourses, the challenge for this work is to create a structure within which nursing's available narratives can be placed in a historically logical form and examined by overlaying the relevant social, political and economic influences and contexts, in an attempt to illuminate the underpinnings of the discourses. The parameters of this work are determined by the definitions of nursing contained within the published sources reviewed. Importantly these definitions have largely been created and applied by others from outside nursing and therefore I have examined the historical and social basis for the relationship between nurses and these others, including other health professions, and the significant impact on all this of the arrival, presence and influence of Florence Nightingale. The importance of Nightingale in shaping the understanding of nursing in Britain cannot be underestimated; therefore understanding not only her physical presence but also her presence in the social,

economic and political context of the time can provide some insight into the continuing persistence of her influence.

For many of today's nurses the struggle in Britain one hundred years ago for nurses' registration may hold little interest but its impact in terms of the internal and external perceptions and extent of the political control of nursing is still very relevant. The focus, therefore, of the selection of evidence has been on works or narratives that explore the changing interpretations of those events through time (Furay and Salevouris 2010) . Using this historiographical approach, to study the writing of nursing history and of written histories of nursing is for some a contested method and historiography itself has been criticised for being too narrow, too anecdotal and lacking in statistical verification (Monkkonen 1986), but for this work concerned with investigating the historical development of a caring (for and about people) profession it has several advantages as it can be focused on a single coherent story, be descriptive rather than analytical, is concerned with people not abstract circumstances, and it deals with the particular and specific rather than the collective and statistical (Stone 1979).

As a research method it is not as Remenyi et al. (2004) note, concerned with the primacy of facts, it is an individualistic approach and highly interpretist. Part of the difficulty for the researcher is identified by Mansell (1999) who notes that inevitably the historical evidence from documents about developments in nursing tends to be considered from only one perspective, that of the leaders who were writing at the time. In order for a more complete picture to be gained the researcher would need evidence from the ordinary practising nurse but the likelihood is that she didn't write it down or it is contained within diaries and journals kept privately with family memorabilia. It is necessary therefore throughout this work to recognise the biases contained within the primary sources and be aware of how those biases could influence perceptions of nurses. In spite of the inherent difficulties in its research knowledge of nursing history is

still important. For example Sarnecky (1990) believes that the dimensions of nursing are discoverable through its history, Maggs (1996) talks about knowledge of nursing history creating occupational cohesion and exclusivity and Lynaugh (1996 :p1) describes it as "our cultural DNA".

While Christy (1978) would agree that the process is undeniably subjective and the sources of evidence can be any authentic and credible source (O'Brien et al. 2004) or plausible account, she believes that this does not detract from its validity as a method nor from its potential to provide academic rigour (O'Brien et al. 2004). In fact, as Christy (1978) points out this subjective weaving together and synthesizing of information from a diversity of sources is a process that produces meanings and highlights significant relationships; and it is the examination of these relationships – both with each other and between historical events and issues and the present – that is the strength and legitimacy of historiography as a research method in nursing.

Sarnecky (1990) reviewed the historical method in nursing from the position of key researchers in the field (Christy 1978, Newton 1965, Matejski 1979, Abdellah and Levine 1979, Lynaugh and Reverby 1987, Polit and Hungler 1987) and found a general agreement among them that historical research is a process of putting data from the past to some pragmatic use for the present and future. More cautiously though Wittgenstein, in his *Tractatus Logico-Philosophicus* (Pears and McGuinness 1961), was concerned about investing too much in the idea that the history of an issue or situation not only informs the present but also in some way dictates our current or future attitude or policy towards it. So while the intention of this work is to use historical knowledge to give solidity to the understanding of the present (Elton 1989), Wittgenstein's concerns about the (often) destructive result of not being able to put history to rest are justified and manifest themselves in the tangible tension in current nursing that appears to derive from the persistence of and a lack of resolution of historic events and

issues. A point Lewenson (2008) appears to support when she states that an understanding of nursing history can provide nurses with a sound knowledge base from which to understand their practice; yet, she notes, nurses appear not to take account of their history when making decisions. She cites Nelson and Gordon (2004) and their concept of the 'rhetoric of rupture' where nurses continually distance themselves from their past meaning every new situation requires a re-invention so the understanding of what nurses do on a day-to-day basis is lost to not only current and future practitioners but also others who seek to understand nursing better. Writing during the latter years of the 20th century Keeling and Ramos (1995) were also clear that in order to critically evaluate information, nurses in the 21st century will need to be sensitive to historical contextual variables and this formed the basis of their argument that nursing history must form an important part of the curriculum on nursing courses.

This sensitivity to historical context is important, even crucial as Sayer (2000) argues for explaining nurses' behaviour. For example Lewenson (2008) raises several very pertinent questions about the impact of 19th century nurses' relationships with medical staff on how they made decisions about care, and where they derived their evidence for these decisions; the tension between professional autonomy and social status for the lady nurses, and the need to keep the support of politicians during the registration debate and the suffrage movement by acting less assertively. The review of the historical accounts should therefore include, alongside the historical narrative, analysis of structure and mechanism (Sayer 2000).

As Remenyi et al. (2004) note historiography is essentially interpretist so it is necessary to determine what approach will help structure or frame the interpretation of the material under review. The hermeneutics or understanding and interpretation of texts, historical periods and other people offered in this thesis is one layer of this structure, but in order to comment more specifically on

the findings for the purposes of influencing nursing practice another layer of structure must be added. A common approach to nursing research, or more accurately research about nursing, is to combine hermeneutics with phenomenology (Cohen et al. 2000), but some consideration is needed of the applicability of this approach to this thesis. Phenomenology is a method used to understand meaning; for example a piece of phenomenological research would seek to understand how men feel about their prostate cancer, or diabetes etc. It would not be primarily concerned with the pathophysiology. One phenomenological question for this piece of work might be 'is being a nurse a lived experience – something nurses have instinctive feelings about?' Answer; yes possibly, but in answer to the more specific question of 'does every nurse have the same lived experience of nursing's history?' I would argue not. I think that the focus of this work lends itself better to being discovered through a more grounded theory approach where basic social processes such as assimilation, socialisation, civilisation, marginalisation and professionalisation are studied in context. However, it should be recognised that the accounts, the texts and the people under consideration are not absolute facts. Historiography is a study of interpretations – and interpretation of interpretations.

In seeking to successfully identify the discourses that contribute to the perception of nursing's lack of voice and powerlessness it is necessary to define, from the outset, the concept of discourse. This is generally defined as the conversations and the meaning behind them by a group of people who hold certain ideas in common. According to Callaghan (1995) it is a term that has a variety of meanings and usages but there are common rules that cut across all operations, she refers to Foucault who held discourse to be the acceptable statements made by a certain type of discourse community but also considered it to be complex and contradictory – at once an instrument of power and a

hindrance, but the discourse, in impeding and exposing the power, renders it also open to challenge (Foucault 1978).

This work, therefore, will seek to find, within the documentary commentary on the main themes identified for study, evidence of the relations between disciplines and disciplinary practices (Foucault 1978) and how institutions are supported and power relations reproduced (Callaghan 1995) and the practical expression of ideologies (Lupton 1992). For example, the dominant discourses constructing gender may be found to be expressed in the male voices of the social elites (Yuginovich 2000).

In order to provide structure I have taken note of Austin's (1958) definition of history as a written record of past events and historiography as a synthesis of the history and its interpretation. It is in this element of interpretation that the inconsistencies may lie but if the alternative is a search for objective truth then there are, according to Sweeney (2005) three main hurdles or dilemmas to be overcome: firstly, the problem of interpreting historical material using a modern lens; secondly, does the spread of evidence adequately represent and verify events, and; thirdly, is the evidence fact or is it more likely to be a probability or possibility and is it derived from differing interpretations of reality? So, Sweeney concludes, citing Church (1987), determining what constitutes knowable truth in historiography relies upon some interpretation. Platt (1981) refers to this process as making an informed judgement and Lusk (1997) proposes that researchers should create mental reconstructions, add in the evidence they have and interpret the story they see playing out in front of them.

Although, as Lusk (1997) points out, historical research does not generally follow a rigid, set methodology, she does cite Burns and Grove (1993) and Glass (1989) who note that there are stages in historical research that appear to be common to nearly all studies. To provide suitable scholarly rigour to the study

Hewitt (1997) recommends the use of the guidelines developed by Streubert and Carpenter (1995). Streubert and Carpenter's four categories of data generation, data treatment, data analysis and interpretation of findings are largely consistent with the work of Cooper (1984, 1988) and Sarnecky (1990) who indicate the key questions that need to be posed to guide the construction and writing of a review of the literature, and how to frame those questions logically. An important part of any piece of research is how the literature is reviewed and used within it. Consideration of related research sets the study in the context of the larger framework of the topic and the organisation of the review should support the intent of the piece of work remembering, importantly, that there is an implied thesis (Hewitt 1997) in this work that understanding nursing's past has present value.

Both Cooper (1984) and Sarnecky (1990) highlight that the first stages in the process are to decide what evidence should be included and how that evidence can be found. For this work the data required to investigate the phenomenon of nursing's voice will be from accessible written materials, including both primary sources – 'first hand' accounts and secondary sources – accounts usually somewhat removed from the original events. In the very early stages of the work conversations with practitioners from other professions were interesting and enlightening but unfortunately on further reflection their comments provided little useful insight and so have not been included in this work.

Initial searches in the main nursing literature databases - Cumulative Index of Nursing and Allied Health Literature (CINAHL), EMBASE from Elsevier and Medline using very specific search criteria produced a very small number of relevant articles; for example searching for 'nursing's voice' in all three databases produced one relevant piece of work. In order to provide a sufficient quantity of data to carry out a study the search terms were widened to include concepts peripheral to nursing's voice in public health policy determination and

the range of databases searched was increased. By contrast searches for material relating to the 'history of nursing' produced large numbers of relevant and interesting works and highlighted the need to make searching in this area very specific indeed. This was primarily achieved by limiting the time span and defining specific events. Searching for books and papers associated with the commonly identified key players in the history of nursing e.g. Ethel Bedford Fenwick, Henry Burdett and Florence Nightingale also produced much useful material.

Using a standard internet search engine such as Google offered the potential for many thousands of useful and relevant articles, books and websites. However, these tools cannot distinguish between the valid and the spurious so it was necessary to narrow the searches and sift carefully through the results. The use of the Google Scholar adjunct to the main Google search engine was useful in filtering out the less academic results.

Limited resources of time and money have prevented access to the entire population of currently available data and criteria (Sarnecky 1990) and materials not written in English have been actively excluded as I do not have the necessary skills to translate accurately from other languages. Throughout the data collection materials discovered have been subjected to a sifting process to ascertain what is 'of value' and will be used; what is 'mildly interesting' and will require further examination and what is 'irrelevant' and therefore discarded at that point. According to Sarnecky (1990) it is also necessary at this point to try and test the validity of the data uncovered. This is a process more commonly associated with the positivist perspective of quantitative research studies (Golafshani 2003) where the validity of a study offers some comment on the accuracy of the construct being used to underpin it. Its use, therefore, in naturalistic or qualitative research studies where the researcher observes and reports upon the phenomenon unfolding and the impact of the researcher is part

of the study rather than a variable to be excluded, warrants some explanation to allow a re-definition. For example Pyett (2003) considers that as qualitative research does not seek to measure but more to understand and explain phenomena, its validity lies in its attempts to be accurate and truthful in its representation of its account. One approach to this, she proposes, is to ensure a constant checking of the commentary against other sources, a reflexive approach that she believes will increase confidence that the representation offered is accurate.

As my inclusion criteria embraces any authentic and credible text that offered comment on and provided further insight into the chosen topic and I have been concerned to hear the authors' stories rather than focus a critique on their sources or styles of writing, increasing the range of similar stories to compare and contrast would contribute to Pyett's concept of confidence, so I have chosen to critically accept all authors' relevant opinions, if they resonate with the concept of the core thesis and help to validate the work of others.

Nursing has history before Nightingale and themes and beliefs that are still important today have their roots in very early times so it has been necessary to include many older, even ancient, texts to be considered alongside more contemporary works. The purpose was always to explore widely, accessing primary and secondary sources as appropriate. One problem that was identified here was that of chronology. For this piece of work the logicity of the data organisation is not always demonstrated in a strict linear progression as it has been necessary to follow some narratives out of sequence. So although the story flows more or less chronologically the need to access primary sources and then apply external and internal criticism (Streubert and Carpenter 1995) using secondary and other sources has meant that the dates of the works used have on occasion 'jumped' backwards and forwards giving a rather disjointed impression. A different approach to data treatment may resolve this problem.

The need to determine the strength of the evidence in terms of fact, probability and possibility is important and Sarnecky (1990) suggests that the strength of the relationship between primary and secondary evidence sources in agreement with each other will further enhance the validity of the study. However this is not necessarily an objective process and should be carried out with due regard for the consideration of the evidence as a whole and how the story fits together. An important key function of the researcher is to attempt to uncover new data from known sources.

The final stages involve the organisation, integration and analysis of the data into a logical sequence (Sarnecky 1990), and the application of the increased understanding of the historical events and issues in nursing to future actions in nursing education. Streubert and Carpenter (1995) warn that the historian must guard against analysing past events from a present day perspective as this can introduce bias but it is arguable that this is inevitable if the thesis includes the need to recognise how nursing's past is continuing to influence its present, and in the case of this work, its future.

Chapter 2: Literature Review

In order to provide an academic basis to the research, clarify my ideas and findings and seek out data and research methods I chose to search the published literature for evidence using, initially, three broad themes. For this piece of work these were stated as:

- (a) the perception of nursing as women's work,
- (b) the subordinate status of women in society, and
- (c) the influence of powerful external (to the profession) discourses.

Searching the published literature is an essential first stage and important part of the academic communication process, allowing connection into a scholarly chain of knowledge, but also allowed me to consider how my work fits into a wider context. However the early searches highlighted that while these three areas are fundamental to any consideration of 'voice' in nursing they are also very broad themes and the searches were producing large volumes of interesting material often with very tenuous relationships to the central theme of 'voice', and it was necessary to re-consider the process in order to reduce the amount of material and ensure its relevance. Although, as a piece of historical research this piece of work is not 'required' to have a stated hypothesis; outlining a research question for myself proved useful in identifying a more methodical approach to searching. I started therefore with a loosely framed question that incorporated my original thesis – 'How has the perception of nursing as women's work contributed to a discourse that renders nursing apparently powerless and voiceless'?

Framing my searching in this way allowed me to further break down the question into themes, for example the relationship between women and power, the historical derivation of nursing and why it is perceived as women's work, the

concept of voice etc. I was also able then to define, to an extent, the limits and boundaries of my searching by identifying keywords that could be used as search terms.

For the initial broad themes a minimum of five keywords to be used as search terms were identified for each concept:

Broad theme: (a) the perception of nursing as women's work

Concept: nursing

Keywords: nursing, nurse, nursing education, nursing image, caring, nursing recruitment, history of nursing, stereotypes, empowerment, power, femininity and masculinity, sex roles

Concept: women's work

Keywords: work based gender bias, work based and educational discrimination, women and career, image of women's work, self-esteem, gender differences, power and control, men in nursing

Broad theme: (b) the subordinate status of women in society

Concept: subordinate status

Keywords: gender studies, gender sensitivity, patriarchy, minority group, sexuality, oppression, the Church, Christianity, good character

Concept: women in society

Keywords: status, gender, domination, oppression, inequality, institutions, cultural practices, rights

Broad theme (c) the influence of powerful external (to the profession) discourses

Concept: profession (nursing)

Keywords: profession(al), influence, religion, politics, history, education, training, Florence Nightingale

Concept: discourses

Keywords: discourse, culture, politics, social norms, Church and Christianity, ideology

The effective use of the databases and search engines requires a search to clearly define what it is trying to find. This involves using specific keywords and an awareness of issues such as different spellings, synonyms and alternative ways of combining words and concepts to produce new ideas and ways of looking at issues. Searching is often cyclical in nature and even searching for one specific concept often took several turns through the cycle, using slightly different combinations of the search terms to produce a reasonable amount of usable data. Using a systematic approach was leading to the discovery of too much material as it was widening the boundaries and it soon became clear that a more focused approach was needed to keep the connection between the data and the central themes. I found that using a citational approach – following leads from found books and journals to discover new material – produced the most useful information.

Sarnecky (1990) highlights this as a problem with historical research and recommends that the researcher asserts the assumption that the sample of data they have used – that is, that which has been most practically available from the entire population of data, is adequate.

The central theme for this piece of work is the concept of voice. However, searching deliberately and specifically for 'voice in nursing' produced little useful

material, so the result of a broader search for the 'concept of voice' was used to identify sub-themes that would offer some insights into its component parts. One of the most respected authors on this concept is Hirschman (1970), who considered Voice and Exit as the two major action options for members of an organisation to deal with perceived problems within the organisation. So, for example, if an employee within a company is unhappy with the quality of work they can either resort to Exit – they leave the company; or they can resort to Voice – they speak up and out about their unhappiness. Hirschman defined voice as 'any attempt at all to change', leaving the way open for the expression of voice to be other than solely vocal. But this doesn't really advance our understanding of the nursing voice. The perceived problem here is not simply about nurses speaking up within their own organisation but more importantly making themselves heard in external arenas. But on second thought it is also about why nurses may not be heard in any arena. However there is no evidence to support the notion that nurses, frustrated at not being heard, resort to Hirschman's notion of Exit and leave their jobs and the profession in large numbers. Does this suggest therefore that for nursing there may be a third behaviour –No Voice but No Exit?

Using Gambarotto and Cammozzo's (2010) work to develop this notion, the concept of *silence* is added. It is interesting to note that they do not define silence as merely the opposite of voice; instead, they believe, silence is active, intentional and strategic. Silence can therefore be considered a proactive self-protective behaviour – a deliberate silencing of voice. If, as Gambarotto and Cammozzo propose, this is a strategy adopted by organisation members in response to perceived risk, or an active discouragement of voice by managers or others, then this would appear to reflect the situation for nursing. Nursing has a history of being controlled by men; and a workforce that appears, either through deliberate choice and/or through an expectation of cultural feminine passivity to

have suffered from a silencing of voice. These ideas appear to resonate with the sociology of professions and the concept of emotional labour.

Feminist Literature

Accessing the feminist literature in this area has offered other useful perspectives throughout this work. However it has also been noted that in the past the relationship between nursing and feminism has occasionally been obscure and difficult. According to Bunting and Campbell (1990), this has hindered the incorporation of feminist thinking into nursing literature or nursing theory, meaning possibly that nursing has not, over its history, benefited from the progress in achieving equality for all engendered by the feminist movement. But an alternative approach to this concept is the notion that the isolation of nursing has provided for women a safe haven where they can excel. One prolific and significant feminist author in this field, Carol Gilligan believes we should be wary of only taking one perspective. Described as the founder of 'difference feminism' Gilligan (1982) was concerned that part of the problem lies in the theories about development and world view that have traditionally assumed that men and women occupy the world and express themselves in the same way. However if this is not the case and men and women do express their positions differently could it be that nursing does have a voice and does express itself but the failure to hear is due to the way in which the voice is heard? Although not written specifically with nursing in mind nursing Gilligan's work does appear to have a particular resonance for the profession, and Harbison (1992) suggests that "Gilligan's emphasis on caring and relationships accords with the common experience of the nurse" (p202), However Gilligan's work is not without its critics and one of the most fervent has been Sommers (2001) who has claimed that while Gilligan's findings are highly influential on public policy and spending in the US her data are flawed. Sommers also believes that Gilligan's promotion of an anti-male agenda hurts both males and females and

that it is not helpful for girls and women to be told that they are diminished or voiceless. This may be a little harsh as Gilligan does not necessarily promote an anti-male agenda. A closer reading of her work fails to clearly demonstrate any claims for superiority of either sex instead she appears to be claiming that the different experiences of each sex leads to the adoption of a different perspective on morality. Interestingly, according to Harbison (1992), neither does she claim that a caring perspective is exclusive to women, indeed she believes that both men and women display caring attributes but, importantly for this work, women have a stronger tendency to speak with a caring moral voice.

Voice and visibility

Star and Strauss (1999) explore the concept of visibility of women's work and how that leads to role stereotyping which in turn may create expectations of voice and silence from women's occupational groups. Simpson and Lewis (2009) add a complication to this argument by suggesting that paradoxically visibility produces powerlessness. If we apply this to nursing, do nurses lose power when they try to articulate what is nursing – in other words when they try to make visible what has been deemed invisible, possibly through its historical association with the domestic? For one explanation of how the domestic became invisible see Folbre's (1991) review of the evolution of census categories in England and the US during the nineteenth century showing how the status of wives and mothers became 'downgraded' from productive to unoccupied and finally dependent, a situation also mirroring the Victorian attitude to family. But it was an important move, the non-productive domestic activities of women in the home were thus not perceived as contributing to the economy. In simple terms the concept of being invisible here does not mean that women cannot be seen but that what they were doing had no value – it didn't count. There is though an apparent contradiction here. Nursing is a productive occupation, it is marketable and it does contribute to the economy so surely it, and its

practitioners, should be, by that definition visible? Again it appears that visibility and invisibility are being determined by the association with women rather than the activity.

The reaction from the medical profession and the hospital administrators in the late nineteenth century to the attempts by the lady nurses to professionalise or to make visible the women's work of nursing appears to have been to try and subjugate them further.

Sub-themes for searching

Examination of these supporting arguments suggested sub-themes to be searched that could provide useful material to develop a central argument more relevant and specific to nursing's voice. So it was decided to narrow the searches to within three major search areas:

- i. Historical roots of nurses' (as women) subjugation
- ii. Gender issues and nursing
- iii. The development of nursing as a women's profession

It should be noted here that throughout the early searching and reading it became clear that the influence of Florence Nightingale in and on nursing could not be ignored nor easily dismissed. It has been necessary therefore to devote a part of this thesis to trying to unravel the nature of her impact on not only the development of professional nursing but also the persistence of her perceived relevance into present day nursing practice and theory. But in doing so further insight has been gained into how nursing understands itself and is understood by significant others outside the profession.

Historical insights

The need to, albeit briefly, explore the historical roots of the subjugation of nurses' (as women) became more important as the initial work on building this thesis progressed. The history of women and the associated history of nursing are both large and complex subjects and it is beyond the scope of this work to consider them in any detail. It was necessary therefore to identify those aspects of these histories that relate most closely to and comment upon nursing's voice and having identified those I have attempted to subject them to a re-analysis via the more obvious feminist texts. This approach was not without its own problems. For example, as Group and Roberts (2001) identify, published literature specific to gender and professional roles of nurses prior to 1975 is difficult to find, in contrast to extensive sources on female physicians, women as healthcare consumers and sexism in healthcare. This is due in part, they believe, to a combination of the women in nursing themselves not systematically documenting the relationship – and interrelationship – between gender and professional roles; and also the paucity, at least in the early 20th century, of feminist studies in this area. A problem compounded at the time by the apparent lack of dialogue, based often on mistrust and misunderstanding, between feminist scholars and nurses. In many cases in this work, therefore, it has been necessary to try and extrapolate the issues relevant for nursing from texts that do not appear to offer immediate relevance. One significant exception is a more in-depth consideration of Celia Davies' *Gender and the Professional Predicament in Nursing* (1995) – a work considered by some to be pivotal in our understanding of the relationship between gender and nursing professional roles.

One of the major themes of this piece of work is seeking to understand why nursing does not appear to have a significant voice in the determination of public

health policy when it does have a significant role to play in the execution of that policy.

Work so far seems to indicate that many individual nurses have achieved great things and some have received public accolade for their work, but nursing as a whole still seems to struggle to have its voice heard. A question here, therefore, might be what is it about nursing that it seems almost to suppress itself?

In her work Davies examines the ways in which nursing is understood and how that understanding is gendered and to do this she draws significantly on the work of Nancy Chodorow a sociologist, Carole Gilligan, a psychologist and Roslyn Bologh, a political scientist. This book, published in the mid-1990s, builds on Davies' work from a decade earlier (Davies 1980) when she and others (e.g. Lagemann 1983) were starting to examine the attempts being made to revise nursing history, moving away from its traditionally descriptive narratives that largely ignored parallel issues in social and women's history, into a social history format with its emphasis on race, class and gender (D'Antonio 1999).

This gap in time between the 1980s and 1990s represents an interesting period in the development of this 'new' understanding of nursing history. In the US James (1984) in her review of the work of the time in this area points to works such as Christopher Maggs' 'Origins of General Nursing' (Maggs 1983), highlighting how he revisits familiar views of nursing and nurses but provides new emphases on demography, social class and gender stereotyping, concluding that Maggs has revealed some of the tensions contained within nursing's own view of itself; and Barbara Melosh's 'The Physician's Hand' (Melosh 1982) in which she emphasises nursing's workplace culture; and Celia Davies' own *Rewriting Nursing History* (Davies 1980). James concluded from her examination of these and other texts of the time that the future of nursing history looked promising with the growth of cross-disciplinary working and writing. To an

extent she was right and over the next decade, as D'Antonio notes, nursing narratives started to include considerations of gender, class, race and professionalism, and raised important questions about whether nursing is defined by gender or transcends sex-based stereotypes; whether the heterogeneity of the nursing workforce was strong enough to provide a defence against race, class, gender divisiveness; and the impact of professionalization on the craft of nursing. But exciting though the prospects of these new lenses were, by the end of the 1980s D'Antonio notes that a "certain complacency" (p270) had crept into the field and the debates from earlier in the decade were little refined or reconsidered, and important assertions were still being left unchallenged. This is a really interesting point and begs the question of whether it is not a case of either/or – either descriptive narrative accounts of nursing history, or social and women's history but a more complex mix of the two. Were the new lenses missing the essence of nursing, that very intangible of the relationships between people that has ensured the survival of nursing as an occupation?

Celia Davies' 1995 work marks an important chronological point in re-awakening interest in this debate and perhaps trying to re-establish a dialogue, or cross-disciplinary reciprocity, between those embedded in the historical traditions of nursing, often with a background in nursing, and those, like herself, more exclusively grounded in the arts. To do so Davies, in contrast to similar works of the same time that tended to concentrate on institutional policy and the labour market (see for example Freidson 1994), focuses on professions and the gender division in the organisation of nursing work. Using this focus she has built an analysis of how the gendered world of social institutions can devalue and diminish nursing. But what distinguishes Davies' work from the 'mainstream' feminist debate is her move away from the difference issue – comparing how

women are treated differently to men - to examine the cultural 'baggage' of gender and how masculinity and femininity are exposed in daily life.

In order to better understand the significance of this it may be worth re-visiting our understanding of the concepts of gender, masculinity and femininity. In the 21st century gender has developed quite a contextual meaning, the World Health Organisation (WHO) is of the opinion for example that gender "refers to the socially constructed roles, behaviour, activities and attributes that a particular society considers appropriate for men and women" whereas sex "refers to the biological and physiological characteristics that define men and women" (WHO 2012). So male and female are sex characteristics and masculinity and femininity are gender characteristics. Confusingly however, in everyday speech 'gender' and 'sex' are often used synonymously and not all gender theorists would agree with the clear cut definitions above, arguing for example that gender roles are themselves defined by both biology and culture.

For this examination Davies' develops three main themes in her work: firstly, by using Gilligan's work she highlights how developmental assessments of the thinking and reasoning abilities of young children can demonstrate two ways of problem solving - one, considered the male perspective tending towards independence, and the other seen as the female perspective tending towards devotion; secondly she considers how masculinity gains its own coherence by the denial or repression of the qualities expressed as femininity; and thirdly; how masculinity is hegemonic in silencing certain ways of thinking and acting by regarding them as feminine.

The importance for this work of considering Davies' work in some detail is two-fold. Firstly it lays out a very similar pathway and secondly by bringing together some fairly wide-ranging ideas into one coherent essay it provides an

opportunity to try and understand the influence of a gendered organisation approach on the development of nursing.

Davies' work is seductive, it appears to lay bare a set of discourses that could at first sight explain the 'problems' in nursing today, and also extends Salvage's question from a decade earlier about the basis for and appropriateness of nursing's quest for professionalism by looking at how this could be defined in terms of the positive aspects of nursing care and by giving proper recognition to the range of skills involved in delivering this care. What Davies does not do is answer the question of why this definition and recognition has not happened before. The debate has been on-going for nearly one hundred years and a lot has changed politically, socially and economically in that time so why are we apparently no nearer a resolution, what barriers or discourses are we failing to recognise? Disappointingly Davies really only offers a similar response to many others which is based around an appeal to nurses themselves to play a more prominent role in their own futures and take their places at the public policy debate table.

While Davies' work is considered pivotal, challenging as it did the assumption of gender neutrality as one of the great blind spots of twentieth century organisational theory (Rothschild and Davies 1994) it should be viewed as one perspective and not **the** explanation. There has been over recent years a rising concern about the way gender studies as an academic discipline has been developing. Criticisms have included the bias towards feminism and women's studies, the marginalisation of alternative views thus rendering them to a less credible status and the rejection of criticism (Liinason 2011).

What is also not clear from Davies' work is why the lens is automatically represented as masculine which she describes and defines as 'active and powerful'; or feminine which she describes and defines as 'passive and

marginalized'. There is almost an imperative to accept these perspectives as being natural – givens not open to challenge. This may derive in part from Gilligan's work on early moral development but that opens another debate about whether Gilligan herself was ever that prescriptive or definite in her work.

Usefully Group and Roberts (2001) identify several key feminist texts on sexism and nursing and these form a sound basis for further investigation in this area. For example Ehrenreich and English (1973) consider the historical relationship between the dominant Christian church and early nurses in the person of women healers. Where many historical texts document the visible presence of nurses in the mid-medieval period (around the 10th Century), they also note the 'disappearance' of mention of nurses as an organised group until probably around the early to mid-nineteenth century, but make no effort to explain why this should be the case. Ehrenreich and English attempt to fill this gap by highlighting that the increasing power of the Christian church across the western world at that time was, through its teachings about Eve and original sin, ensuring the subjugation of women, and therefore their role as healers was coming under particular scrutiny at a time when health and illness were perceived to be solely in the hands of God. Ehrenreich's and English's conclusion is that the Church, in an attempt to control these women used the label of witch to exact terrible punishment on them, effectively wiping out their practices and neutralising the nursing role of women by bringing it under the auspices of the religious orders.

Ashley (1976) reveals how the problems of sexism and subordination that dog current nursing have deep-seated roots in the history of nursing, but importantly she considers how nurses themselves have virtually created and certainly contributed to the insignificance of their own profession. The combination of the social programming of women and the desire of (male) physicians and (male) hospital administrators to control the female nursing workforce not only created

an obedient servant class but has also created a discourse that has served to maintain that obedience, and there are identifiable points in the history of nursing where the profession has not only failed to take advantage of but actively rejected opportunities to embrace change and move closer to autonomy. Ashley also comments on nursing's cynical and rather paranoid treatment of its own heroes when they have achieved their notoriety by stepping outside the accepted norms of their era(s).

Susan Reverby (1987b) examines the development of nursing in America between the mid-19th and mid-20th centuries and focuses in particular upon the cultural, political, economic and ideological constraints placed upon nursing and nurses in their efforts to provide 'care'. But Reverby goes one step further and examines the consequences of caring for nursing; stuck as it is in between its definition as women's natural role and familial duty; a societal expectation; and a professional occupation, where nurses are expected to represent high moral virtue and are idealised as 'ideal women' but the service they offer – caring – is of low value and low status.

James (1992) in her work on the emotional labour of nursing also considers this relationship between nursing, women and low status work and notes the "confusion of rhetorics that have accumulated around the notion of care" (p489) and postulates that if the notion of care is problematic so is that of carer. James' develops an interesting argument examining the links and close relationship between nursing care and domestic care – the traditional domain of women.

This resonates very much with Lawler's concept of the problem of the body (Lawler 2006). In her work on the place of the body in nursing she attempts to understand how in a patriarchal society the practices that involve bodily intimacy, such as washing, feeding and dressing etc. – called basic nursing care

by nurses - are deemed to belong in the domain of women and are traditionally considered women's work.

Sullivan (2002) highlights how nursing was largely unaffected by the 'first wave' of feminism in the late nineteenth century and early twentieth century but was placed in turmoil by the 'second wave' when feminists were actively encouraging bright young women away from nursing because of its perceived lowly status – a phenomenon Group and Roberts (2001) also note. While the intent may have been laudable – demanding women's equal entry into the so-called higher (and more lucrative) professions - the impact was negative and is still being felt over fifty years later. For feminists nursing remains perceived as a traditional, oppressive women's occupation (Vance et al. 1985) with any claim to being a profession still tenuous. Sullivan criticises those feminists within nursing for remaining silent in the face of the demands placed on nurses for so little respect or reward.

The work of Bedford Fenwick and the Royal British Nurses Association (RBNA) to gain professional status and respect for nursing was undeniably an important stage in the development of nursing. However, while their efforts appear to conclude with the introduction of a prescribed period of training and state registration by state examination, the debate about nursing's professional status is, to a large extent, on-going, it is important therefore to acknowledge some of the many key texts in the sociology of professions including Abbott (1988), Burrage and Torstendhal (1990), Abbott and Meerabeau (1998), Allen (2001), and Magali Larson (1977) for historical completeness (see below). Even a brief analysis of these pose more questions for nursing to consider about its claim to being a profession and the benefits of such a title than they answer. I have not attempted to explore these concepts in great depth in this work as they may divert the discussion too far from its central thesis; nonetheless this is an interesting field of study worthy of attention in a future piece of work.

Although Larson's (1977) original work is over thirty years old, and thinking about professions has moved on, her ideas do still offer a valuable insight into the history and development of organizational life and her key text *The Rise of Professionalism* has been recently re-published with a new introduction to bring it into the 21st century (Larson 2012). It is also worth noting that Celia Davies (1995) in the presentation of her new model of the professional as a reflective practitioner nods back to these early theorists when she acknowledges that her concept is derived from viewing the historical model through a gender lens to reveal the flaws of the masculinist vision that created it.

Evetts (2012) notes the difficulties that sociologists have had in defining 'profession', particularly when trying to identify what makes professions different to other occupations. Part of the problem here has been the change of professional work where professionals are increasingly employed within organisations with the result that control of their work and discretion has passed to others. Interestingly, until the 1980s, the sociology of professions was an almost exclusively Anglo-American field of studies as many European languages do not have words that distinguish 'profession' from 'occupation' – German, French and Italian equivalents use terms that relate to the middle class (Sciulli 2005), so a profession equates to a middle class occupation - leading to the argument that any distinction between health professions and occupations is merely an artefact of the vocabulary of sociologists (Riska 2001). It has been important though to work from a stated broad perspective of what is a profession or perhaps more pertinently, what it means for an occupation to define itself as a profession. I have chosen, therefore to use elements that are common to the majority of the literature and these include some notion of the relations between occupational groups, their theoretical knowledge and the possibilities for practitioners within the occupational group to exclusively apply such knowledge within their occupational practice.

In common with the experience of Group and Roberts (2001), the relative lack of straightforward scholarly sources has, in this work, forced the review of many and diverse materials from scholars in other disciplines and their analysis for possible relevance to the area of concern. For example, in their work Group and Roberts (2001) found that gender stratification and sex discrimination are common themes in health occupation literature where about seventy per cent of workers are female, leading them to conclude that understanding sexism is particularly important in understanding the development of nursing.

Any researcher considering the history of nursing is bound to consult the key, standard texts in this field – and carefully consider their contribution to the debate. In chronological order the earliest comprehensive and authoritative text on the history of nursing in Britain was produced by Brian Abel Smith in 1960. Interestingly and unusually Abel Smith (Abel Smith 1960) was not writing from inside the profession – traditionally a position from which occupational histories have been written. He was an academic specialising in political analysis. In his work he makes no attempt to understand nursing from a nurse's point of view – as he highlights early on in the work; it is a discussion about the politics of nursing. Although the original book is now over fifty years old it still has value as a nursing history source.

In her own work, *Rewriting Nursing History*, Celia Davies (Davies 1980) notes the lack of significant further work on nursing since Abel Smith's contribution and also recognises the influence he has had on the contributors to her own collection. This is an interesting comment as Monica Baly (Baly 1973) first published her work on nursing and social change in 1973. This was extensively revised for the third edition in 1995 (Baly 1995). Baly's book could have been more accurately entitled 'Social Change and Nursing' as she identified how social change creates health needs and then explored how nursing evolves to meet those needs.

Other key texts that provide interesting insights not only into the history of nursing but also the developing genre of the writing about nursing history include Rafferty, Robinson and Elkan's work on Nursing History and the Politics of Welfare (Rafferty et al. 1997), Chris Maggs's two works from 1983 and 1987 respectively (Maggs 1983, 1987), and some of the very early works originating from the USA notably Lavinia Dock's Short History of Nursing from the Earliest Times to the Present Day (Dock and Stewart 1938) and the rather longer History of Nursing in three volumes that she co-wrote with Mary Nutting (Nutting and Dock 1907-1912); Isabel Stewart's review of nursing history from ancient to modern times (Stewart and Austin 1962) and slightly more obscure historical texts such as Sellew et al 1955 History of Nursing (Sellew et al. 1955) and Walsh's 1929 version (Walsh 1929). Vern and Bonnie Bullough have produced a work that charts the history of nursing by looking at constructs of sickness and historical developments in the care of the sick (Bullough and Bullough 1979).

Dingwall, Rafferty and Webster (1988) undertook a re-evaluation of previous versions of nursing history and, from a fairly eclectic range of sources, revealed a potentially more accurate vision of not only how nursing has developed since the beginning of the nineteenth century but also the interdependence of nursing and the hospital system in Britain through the nineteenth and twentieth centuries. It should be noted that although some of these very early texts are now out of print but the internet still provides access to most of their content.

An initial broad search of the University's online catalogue for items relating to the history of nursing also identified biographies and other material about the life and times of Florence Nightingale that are useful as sources of information on nursing's history and development. Importantly it also highlighted that any consideration of the development of nursing, nursing philosophy, nursing

culture, nursing practice and how nursing (and therefore nurses) is perceived both from within and without the profession would not be complete without at least a basic understanding of the impact of Nightingale on nursing both during her lifetime and beyond.

Nightingale's story is well told by a succession of, although relatively few, biographers, each changing the story slightly to suit the context of the time. To try and understand why unlike anyone in nursing before or since Nightingale has become so important this work has sought to find a middle path through her biography by consideration of many of the more easily recognised works about her life and times, including Edward Cook (1913), Lytton Strachey (1928), Ida O'Malley (1931) Cecil Woodham-Smith (1955), Hugh Small (1998) and latterly Mark Bostridge (2008). And in order to try and understand how her upbringing, status in Victorian society and activity worked together to produce her iconic status – and in turn how that has endured - I have drawn significantly on the work of Geoffrey Cubitt and Allen Warren (2000).

Chapter 3: Voice

It would appear that nursing does not have a significant presence in national healthcare policy groups and this absence may be representative of a wider lack or denial of nursing's 'voice'. But what does it mean to have 'voice' and how does this impact on nursing's opportunity and ability to influence not only the focus of its own practice, but also others' expectations of nurses?

One notable example of an important policy making body in the UK where nurses do not feature significantly is the National Institute for Health and Clinical Excellence (NICE). NICE is currently the government body dedicated to producing national guidance on public health, health technologies and clinical practice in the UK but, at the time of writing, does not count a single nurse on its board or among its senior management team (SMT) where medical staff occupy a third of the seats. This situation is not numerically representative of the way in which healthcare is delivered in this country where there are just under two registered nurses for every registered medical practitioner (HSCIC 2012). However it would appear that medicine is the profession with the most influence on healthcare policy and this mirrors the situation in healthcare practice where the reality is that medicine, although fewer in numbers, is perceived as the dominant profession.

One answer to nursing's absence from policy development could be that nurses don't want to be there. However, a more likely response is that they are not able to be there and if this is the case it then begs the question of how they are prevented from being there and contributing to the debate by any direct or indirect actions of others including the dominant group. This concept of nursing as a group with a history of domination by other, external, groups – in particular medical practitioners, is an important theme that recurs through this work.

The related concepts of voice and silence appear frequently in the literature and may be important in not only describing the problem of nursing's apparent invisibility but also in uncovering the reasons why nursing has such a low professional profile when it appears to have a very high public profile. From the North American perspective according to Bartholomew and Cohen (2008) nursing may be the most trusted healthcare profession – possibly more so than doctors (Gallup 2008), but in the health policy arena nurses are not taken seriously and in Western healthcare systems in general this lack of 'voice' makes them the most invisible of the healthcare professions. It is important here to clarify what Bartholomew and Cohen mean by (in)visibility as this is a different version of the concept than the one examined previously in this work. This manifestation of invisibility is very closely aligned with the concept of voice and is concerned with the ability, opportunity and expectations of nurses to contribute to health care policy debates.

Bartholomew and Cohen (2008) note that in this political arena nurses are not taken seriously which given that these authors are writing about nursing in the early 21st century is disturbing. There appear to be several factors at work here which include nurses' image and identity; nursing's perceived scientific foundations through research maturity; nurses' proven knowledge base and demonstrated political skills.

Nursing - Image and Identity

In order to achieve such a high rating in a national opinion poll in the USA (Gallup 2008) nurses there must have a high public profile, they and their work have been open to scrutiny and they have been reviewed separately to their healthcare professional colleagues, therefore they cannot be deemed to be invisible. However while the public may say they love nurses they are often bemused and unsure about their role and for whom they work. Unfortunately this perception still appears to be informed by an understanding of nursing as

women's work. Nursing globally is still, in spite of years of equal opportunity legislation, a female dominated profession; currently the ratio of men to women in nursing in the UK is still only about 1 to 10 (NMC 2008). This has allowed the perception of all nurses being women to become quite firmly embedded in popular culture. In speech, for example, it is common in everyday discourse to find that nurses are usually referred to as 'she'. Paradoxically, the ratio of men to women in medicine is almost 1 to 1 (GMC 2011) but doctors are still commonly referred to as 'he'.

The public may derive their understanding of nursing and perceptions of nurses from a variety of sources including personal experience, but importantly media portrayals may also be highly influential. These can often be sexist and negative with the media's persisting stereotypes of the sexy nurse and doctors' handmaiden or, for men, a job that is somewhat less than 'manly'. Whether these stereotypes are in themselves problematic is open to debate and even the over-sexualised portrayals could be shrugged off as irrelevant if they were the sole problem. But the danger is that the complacent and passive acceptance of these distorted views of nursing by the public and profession alike may lead to their internalisation naturalisation. Darbyshire (2006) believes that the end result could be that not only does nursing fail to understand itself but the public fails to understand the true nature and complexity of nursing. Without this proper understanding, Darbyshire believes, the service risks losing the support it needs to secure necessary social and financial resources. But if nursing fails to challenge these distorted perceptions and take itself seriously it should come as no surprise that others do not take it seriously. There is a presumption here, of course, about the homogeneity of nursing. The nursing population is complex and diverse and it is likely that each section or division has a different view of what is nursing. However the title 'nurse' is shared across all branches and the public and media may not discriminate.

Voice

The concepts of 'voice' and associated 'silence' are, I believe, useful in furthering our understanding of the autonomy and authority of nursing.

Hirschman's (1970) work, *Exit, Voice and Loyalty*, which is now considered a classic of social science literature, on three alternative options for an individual facing a dissatisfying situation was conceived of as a general formula for human behaviour (Hoffman 2008). As a general formula it has applicability across several disciplines but for nursing it can be interpreted in the following way: *exit* occurs when dissatisfied nurses leave the profession and take up a different occupation; *voice* describes nursing articulating discontent which, according to Hirschman, can be anything from "faint grumbling to violent protest" (Hirschman 1970: 16); and *loyalty* is the status quo where nursing neither voices discontent nor do nurses leave the profession through dissatisfaction - but this does not necessarily mean that nurses are content. For Hirschman these 'choices' are not compatible - it is one path or the other - but he suggests that the accessibility of each affects the resultant action. For example, if the opportunity for *exit* is present and relatively easy, then the likelihood of either protest or loyalty is lower. For nursing this is an important concept, and it is particularly evident in the early 20th century when working and living conditions for nurses were poor and the attrition rate very high but there is no evidence that the employers were overly concerned by so many leaving probably because without changing anything they could easily recruit more staff. It is also possible, of course, that those leaving did not voice any complaint, so employers were given no cause to make improvements. Interestingly Hirschman himself makes the point that "the presence of the exit alternative can *atrophy* [my emphasis] the development of the art of voice" (Hirschman 1970: 43), which suggests that the choice of many nurses to avoid the risks of complaining by taking the easier option of *exit* was

impacting on the wider profession's ability to learn and develop the skills of the use of (its) voice.

This concept of the use of voice carrying some risk is very pertinent in nursing – maybe more so in the early life of the profession, but the re-percussions of those early years are still being felt today. The nursing workforce in the late Victorian era and for a significant part of the early 20th century comprised almost exclusively of women, a group who had little or no social or political power, a state that surely must have also had significant influence on nursing's opportunity and ability to express itself. While there is significant literature on voice much of it appears to concentrate on the effects or impact of voice or what improvements have been brought about by the exercise of voice, but little has focused on how or why opinions and ideas have or have not been voiced - in other words what is the process of voice? (Islam and Zyphur 2005). If voice behaviour is that which desires change then clearly it will, in some situations, carry risks as well as benefits, and one of the significant variables that can increase or decrease risk in this situation is power. According to Fiske (1993) virtually all social interactions contain an element of power, but power itself is quite a difficult concept to define. Most studies tend to consider it either in terms of status or the control of resources – two concepts that can be very closely identified with nursing and therefore run as themes through this work.

Hirschman (1970) viewed loyalty as a tempering factor. Where members feel bound or attached (loyal) to a group then the resort to voice or exit is depressed or delayed. Although Hirschman, in his own work, never really explored this third behaviour in the same detail as the other two, loyalty is clearly an important category, ranging as it does from unconditional identification and enthusiastic support to passive acceptance, inertia, or even submissive silence (Hoffman 2008). And it is this apparently 'action free' end of the spectrum that I think is particularly important for nursing. While inertia may be a relatively

easily understood state in many groups, submissive silence is not and yet from the outside looking in this may be how many observers of nursing would describe the nursing workforce. But does nursing choose this silence or has it just accepted it as part of the discourse that says only weak, incapable nurses leave the profession and only bad nurses complain about their own dissatisfaction? However, this does seem a rather negative scenario and in reality the silence of nursing may not be simply a neutral behaviour. There is also a dilemma forming here – if nursing's non-use of voice, in Hirschman's terms, maintains a powerful silence throughout the profession then could it be argued that nursing prevents itself from being represented? In other words, does nursing suppress its own voice?

Silence

Gambarotto and Cammozzo (2010) in reconsidering Hirschman's work on voice develop his ideas further by rethinking the notion of silence. For them silence is not merely the opposite of voice or the alternative to voice; instead silence is active, intentional and strategic. Silence can therefore be considered a proactive self-protective behaviour – a deliberate silencing of voice. This may, according to Gambarotto and Cammozzo, be a strategy adopted by organisation members in response to perceived risk, or an active discouragement of voice by managers. This is an interesting point and raises several questions about the active and passive nature of voice in nursing. Does nursing actively choose to keep silent because of some discourse that suggests that there is power in deliberate silence or is it actively discouraged from using its voice?

Not all authorities are convinced that nursing lacks voice or chooses silence. For example, from the feminist perspective the American psychologist Gilligan (1982) offers us the notion that nursing does have voice but it is a voice that is ignored simply because it is the voice of women. This is not to say that individual nurses do not speak from a position of sound professional knowledge,

do not have developed political acumen and cannot articulate well researched nursing perspectives; what is missing according to Gilligan is the reception of the collective voice.

Simpson and Lewis (2009) suggest therefore that 'voice' comprises not only the physicality of expression but also the process of listening and giving attention – actions that they feel are driven by political motivations. Ferguson (1994) suggests that simply bringing more voices into the conversation would resolve these issues but Simpson and Lewis (2009) are concerned that this does not address the deeper issue of the process of silencing that occurs. But surely in order to silence something it has first to be audible; Gilligan et al appear to be saying that nursing's voice is audible but there is an unwillingness to listen to it. Who then, has the power to ensure that nursing's voice is rendered inaudible?

Gilligan (1982) is clearly concerned that there are gender tensions inherent in the hearing of or suppression of women's voice. In her work concerned with uncovering the gender bias in developmental theories, she proposes that women view the world in a different way to men and therefore voice their concerns differently. Importantly she believes that men view the world in terms of sets of hierarchical principles of right and wrong – corresponding to an ethic of justice; whereas women, relating through an ethic of care, voice their concerns in terms of conflicting responsibilities and their effect on relationships with others. As Gilligan notes this failure to hear the difference in women's voices stems in part from the assumption that there is a single mode of social expression and interpretation (Gilligan 1982). This is interesting and does pose the question of whether nursing's voice, the voice of an organisation still largely dominated by women, is not being heard because it is being listened to through, perhaps translated by, male filters. So ultimately the dominant discourse becomes one of right and wrong as that of responsibilities and relationships gets filtered out.

There is an inevitable next stage in this argument – if nurses’ voice can be considered irrelevant does that mean that ultimately nurses themselves are irrelevant? I don’t mean that nursing – what nurses do – is irrelevant but who does the nursing and what they have to say is unimportant. Do nurses become invisible in the delivery of nursing?

Invisibility

Star and Strauss (1999) take the concept of voice one stage further by examining this relationship between silence and visibility, or invisibility, in work – particularly women’s work. They conclude that no work in itself is inherently visible or invisible but perhaps the workers are, and the traditional selection of indicators through which we view the activity involved in work – including the default perception of visibility as the defining state - have allowed women’s work to appear invisible, with an associated expectation of silence. For example the unpaid labour of domestic work such as cleaning the family home or raising children – has traditionally been seen as an informal activity of women deriving from an act of love or the expression of a natural role. The degree of muscle or brain activity involved, often how ‘work’ is defined, is not acknowledged and therefore the work and the person doing it become invisible. But this does raise the question of who defines what work is. Star and Strauss’ proposition that definitions belong to the definers not the defined appears to resonate with the experience of nurses whose work activities have long been defined by others, often with different motivations to the defined.

If visibility is defined as a state of being that isolates the doer from the dominant group – then it brings with it its own expectations and pressures. Feminist writers (eg Kanter 1977) have highlighted how visibility demands conformity to stereotypical roles which embody their perceived differences – for example women may be forced into the role of mother, wife, seductress, nun, battle-axe and for nurses – angel. This heightened visibility creates stress and the desire

for further invisibility is demonstrated by avoidance of conflict, low-risk behaviour and fear of success (Simpson and Lewis 2009).

So it would appear that women can be powerful when undertaking their invisible work (Star and Strauss 1999) simply because they are part of the mass of women undertaking this work. However, as Simpson and Lewis propose, if it is visibility that creates the circumstances for powerlessness, then do nurses only lose power when they try to articulate what nursing is – in other words when they try to make visible what has been deemed invisible largely through its association with the domestic?

This idea would appear to resonate with Star and Strauss' (1999) work which warns of the downside of nurses' attempts to make nursing more visible by categorising nursing interventions. As Wagner (1995) demonstrated, more visibility means more surveillance and a consequent increase in bureaucracy. Equally the de-construction of nursing into lists of tasks allows for the eradication of discretion, knowledgeable intuition and professional judgement – areas of ambiguity and discretion that are at the very heart of the art of nursing, but possibly the antithesis of visibility (Star and Strauss 1999) because nursing care does not lend itself easily to being broken down into a series of measurable interventions. For example, while it is relatively easy to record that one has spoken to a dying patient and their family it is virtually impossible to capture the understanding of the situation, the skill of the approaches, the words used that are only relevant to that situation at that point in time and the compassionate way that they are used.

Simpson and Lewis (2009) have also highlighted that it appears to be only women who suffer these negative consequences; for men in an organisation, visibility and tokenism have positive consequences, and it is this ability of men to draw on the privileges of their sex and benefit from their observed, token

status, even when the numerically dominant group is women, that has allowed men to quickly ascend the hierarchy in nursing. This leads Simpson and Lewis to conclude that visibility is largely about difference while voice is about absence, neglect and a failure to recognise female perspectives. But this does raise another question of why, when there is an increased presence of men in nursing, and particularly in the higher ranks, this appears to have little impact on the status of the profession as a whole. Does this make some comment about the wider perception of the title 'nurse' rather than the messenger or the message? Interestingly, Sargison (1997) writing about the New Zealand nursing situation during the latter part of the nineteenth century, highlights how doctors won the power struggle with trained female nursing and became able to dictate the role and functions of the new workforce and thus maintain their supremacy. But while at face value it appears that this was a struggle about the domination of the male medical profession and their perceived qualification to speak with supreme authority on healthcare matters Sargison (1997) is concerned to note that although gender was an issue during this transition period, it was ultimately less important than doctors' roles, suggesting that the issue was about the perception of the relative importance of nursing and medicine rather than simply a gender struggle between men and women.

Gambarotto and Cammozzo (2010) also attempted to understand the relationship between the discourse of the organisation and the intensity of voice, by examining the organisational climate, which they defined as a product of organisational learning – how the organisation understands itself - and concluded that the two are synonymous. If this idea is applied to nursing where the organisational climate comprises a culture that values humility, loyalty and obedience and a set of work activities that render the workers invisible then the intensity of nursing's voice is weakened. Gambarotto and Cammozzo (2010) also found that silence due to fear of powerful others is less important than the

silence due to a fear of sharing knowledge and information with peers and colleagues. For nursing this suggests that its troubled and subordinate relationship with its closest working colleagues in the workplace, the medical profession is only part of the problem and nursing's 'relationship' with itself is also a factor in its apparent lack of voice.

This chapter has highlighted the complexities of voice within organisations and in focusing on nursing has demonstrated that there are a range of influences at work that all impact on nursing's opportunity and ability to contribute to the healthcare policy debate, including discourses within nursing itself. It has been suggested that not only have gender tensions had a large part to play but also the tensions between the expectations and perceptions of the relative importance of gendered roles and job titles.

In the next chapters I intend to examine how nursing became identified as women's work with the associated perceptions of status, and the role of Florence Nightingale – someone arguably still universally considered the benchmark for all nurses - in creating and perpetuating the relationship between nursing and the virtues of the ideal woman.

Chapter 4: Women's work

Why should the perception of nursing being women's work or a woman's job mean that it is denied a voice or its voice is unheard? What circumstances have made it possible for this work and the people who do it to be seen as unimportant?

Most authorities believe that women's association with nursing grew out of the domestic nurturing role that is apparently traditionally associated with women. However, this alone surely cannot explain the low status given to nursing. It appears that there are several factors at play here including the low status of women in society and the low status attached to the work women do.

Addressing the issues is a bit like answering a riddle – is the work of nursing viewed as low status only because it is women's work or is it that women are only subjugated because of their association with work that is invisible, menial and domestic?

While the main focus of this work will be on that period in British history between the mid to late nineteenth century that is commonly considered the time when organised, recognisable formal nursing was starting to develop, and the present day, there is a whole previous history of the treatment of women in our society that cannot be ignored as it formed the foundations for the attitudes that are largely extant today. Likewise and closely related to this history of women, there is a history of nursing, as performed by women that can help our understanding of the current prevailing attitudes and values in the profession.

For the very early history of the domestic nurturing role of women there is little verifiable data so the theories are largely speculative, often no more than a best guess. But there is occasional contemporaneous literature that would appear to support the speculation. This work will, therefore, attempt to follow a line of best fit from the 'proposals' of Collière (1986) through to the more supported history

of the Victorian era, whilst always recognising the possibility of alternative interpretations. A route proposed by Margaret Versulyen in her alternative approach to addressing nursing history (Versluisen 1980) which she argues offers a more adequate theoretical position to begin. In her commentary on Versluisen's work Celia Davies (1980) emphasises the importance of such critiques in keeping us alert.

From motherly nurturing to nursing

For the purposes of this piece of work I am proposing that the early history of nursing witnessed an evolution from 'caring' into 'nursing'; where caring remains a core function and 'nurse', together with the definition of what nurses do, that is 'nursing', become the formal titles given to an occupational form of caring.

It has proved difficult to identify the point of the transition of nursing from this domestic family activity to the formal work activity that would be recognised today. Part of the problem has been the conflation of nursing and medicine in history – including the identification of nursing as a para-medical occupation, making historically identifiable separate roles difficult to isolate. The concept of formal caring or nursing as a devotional art and science, as distinct from medicine, starts to appear in the historical records during the better-documented period in history of around the early Middle Ages - earlier mentions as far back as the Romans have apparently been recorded but the literature is extremely limited. In particular, the advent of the Crusades in the Middle East in 1096 brought this kind of work to our attention, and the joining of the activities of the Knights Templar and the Hospitallers, around one century later are important in our understanding of the development of early nursing.

However, while it may be convenient to begin the quest for the so-called 'birth of nursing' in the 11th / 12th centuries, to do so would leave still unanswered any question about what went before. It is highly likely that a form of formal nursing

existed before the Middle Ages but with the inherent difficulty in defining nursing *per se* creating its own problems in deciding a starting point, this piece of work will take as its beginning, a speculative position in history at which women became identified almost exclusively with a 'caring for others' role. And in particular the work of Marie-Françoise Collière, a nurse who has written extensively about "the different knowledges and sources of power that (mis)inform healthcare practices and that keep nurses' knowledge hidden and their work despised." (Lawler 1998 :p124), has been useful in providing prospective insights into these early roles.

Collière (1986) proposes that care lies at the very root of women's history and that women's destiny is largely woven around care. As the main focus of their activity it has had a profound influence on who they are and what has been expected of them and so closely entwined are they that even for those women who do not want to take on the burden of caring, it still shapes their destiny.

It is likely that even in very early history survival will have meant 'taking care' of all the components necessary for it; with particular attention paid to two aspects:

1. the giving of care to newborns and their mothers – this was expected of women; and,
2. taking care of the territory and repelling danger – this was expected of men. (Collière 1986)

Other authors such as Devereux and Weiner (1950) have considered those components of the need for care expressed by those seeking or demanding care, for example children, the ill and the infirm and concluded that both were not just physically weak and helpless but also psychologically dependent. Thus, they argued, it was natural to assume that women, as mothers, or potential mothers, caring for or about to care for children were also 'qualified' to care for the sick. Collière (1986) feels, however, that it was not, or not just, the actual natural relationship between women and birth but also the perceived natural relationship

between birth and death that linked women to the care of the sick, aged and dying. Collière (1986) also proposes that early women's caring role centred around two main activities – Body Practices and Feeding Practices. Through feeding practices women gained knowledge about plants, discovering not only their food properties but also their medicinal properties. They created a form of pharmacology and achieved a role as sage or wise woman and healer; and through body practices, including feeding, washing and touch, women gained an extensive knowledge about the body and its reactions (Collière 1986).

As discrete family groups joined to form tribes which in turn became ordered social groups, a phenomenon Burgess (2007) believes is the dominant factor in human progress, the care these women gave and the potent knowledge they possessed, traditionally transmitted by word of mouth and by apprenticing each new generation, became part of the rural exchange system which fostered survival for the whole community. But as communities became larger and the modes of knowledge transmission became more complex – particularly the development of writing between about 3200 to 2700 BC (Wilford 1999), as a solution to problems of mass communication - women started to lose control of the passing on of their ancient knowledge and wisdom

Many authorities (see Wilford 1999) believe that historically writing was used by the dominant elite to control the masses who were, in the main, illiterate.

Savescu (2006) argues that early writing was also used for religious purposes and socio-political functions, and was often so revered that its origins were ascribed to myths and deities, and this perceived divine nature ensured that writing became much more than a tool for recording information. As writing, and therefore reading, developed, initially in the temples and tombs of early religions and later to translate the Bible, its use and understanding apparently became restricted to the male priests and scribes, thus enabling them according to Collière (1986), to 'confiscate' women's knowledge by writing it down,

Importantly though, by doing this and in assimilating it to their own understanding they also changed its meaning.

The impact of Christianity on women

The close relationship of humans to their environment and their dependence upon it for their survival had encouraged the worship of nature spirits and gods, which included a significant number of female representations. As the nature of the means of production changed from women cultivating and men hunting to men cultivating, the status of women started to diminish. This was mirrored by the transition of worship to the more specifically male-based and organised religions such as Hinduism, Buddhism, Confucianism, Taoism, Islam, Judaism and, importantly for this work, Christianity (Johnstone 1988).

The global advent of Christianity in particular appears to have had quite an impact on women. Not only is there evidence of their status diminishing as their usefulness to the community was downgraded but this was further compounded through the teachings of the Christian Church's Bible which expressed a profound mistrust of women. The Bible has been traditionally interpreted by the wise and holy men and the perception has been built that to challenge them is to challenge God. Conversely, to unquestioningly accept their authority on these matters is to accept the truth of the Bible.

Groothuis (1999) develops an interesting argument by comparing and contrasting the claims of Darwinists and Traditionalist Christians to possess the truth about the 'creation' and status of men and women. She uses this to examine how representatives of the dominant ideology use a number of predictable rhetorical strategies to control public discourse. While she is concerned to note that ideology is not by definition necessarily false unless it is being maintained through falsehoods and suppression of counter argument. And when the arguments are subject to close examination, according to Groothuis,

certain premises are proposed to be accepted unquestioningly as the foundations for the major theory, for example, she says, the doctrine of women's subordination to men as ordained by God is not easily found in the Bible unless traditional gender stereotypes of the roles and status of men and women are used as a framework to interpret the texts. Other authorities have expressed concerns about the subtlety of language and cultural interpretations of the relevant texts in the Book of Genesis and how they have been used as the basis for this doctrine. Grootius is concerned that the real argument is about whether women are actually significantly inferior to men, and until we have the courage to address that debate, we cannot and should not be prepared to accept any notion of a gender hierarchy – whatever its source (Grootuis 1999).

One ploy that has been developed to deflect perceived criticism of any interpretation of the Bible that supports gender hierarchy is to claim that men and women are equal in being but not in function. But as Rorty (1989) observed merely changing the description of a bad thing may make it, on the surface, appear good, but it doesn't change its nature - so too with the Bible interpretations of gender hierarchy. But the impact of these interpretations of the teachings of the Bible should not be underestimated. In the Middle Ages there was no opportunity for alternative interpretations, the Bible, as interpreted by the Church, prescribed worship and daily life and informed the law. In 1140 AD, Gratian, a lecturer in Church Law in Bologna, produced the *Decretum Gratiani*, a compilation of church canons and rules about the 'right' treatment of women including how women were not to be given liturgical office in the Church; they may not become priests or deacons nor teach, baptise or distribute communion and that the word 'woman' signifies weakness of mind (Friedberg 1879). The *Decretum* remained the fundamental text of Church laws for the next nine centuries, until at least 1917 and it is worth noting how still, nearly 100 years further on women are still subject to similar taboos and stigma.

These rules, however, are a little hard to reconcile with the original words in the early parts of Genesis, the first book of the Bible (The Bible 1611): "So God created man in his own image, in the image of God created he him; male and female created he them." (Genesis 1,27). This would appear to suggest that men and women were created equal by God. But, perhaps the more influential (for women) aspect of the Genesis story is that of Adam and Eve, and in particular the behaviour of Eve. She ignored God's instructions and listened to the serpent – an action that condemned her and all women to eternal punishment for original sin. It is notable though that Adam's part in this story and his consequent bad behaviour remains largely ignored.

The apparent disappearance of any mention of the traditional women healers as nurses from the historical records available is probably explained by the combination of the changing roles of women, the changing status of women in society and the growing influence of the Christian church. Possibly the earliest comprehensive records of an identifiable, formal nursing service date from the Middle Ages, with the activities of the Knights Templar and the Hospitallers who founded hospitals for pilgrims and the poor in the Eastern Mediterranean and around the Holy Land. The motivation for the Knights Templar to care for the sick and needy was based, according to McCleery (2007), on an ancient Christian tenet of the devotional relationship between nursing/caring and the Church. As the Knights Templar was an exclusively male organisation, it may appear that this early nursing is exclusively the domain of men, and many authors have used the records of the Knights Templar to demonstrate that early nursing was originally commonly executed by men and not women. But women were not excluded as the Rules and Statutes of the Teutonic Knights, Book of the Order Rule 31 (ORB 1969) shows in its recognition that there are some services for the sick in the hospitals and also for the livestock which are better performed by women than by men. However there were to be strict controls over the

admission of women and their physical presence in the hospital, for example they had to be housed apart from the brethren and lights were to be left burning.

While this Rule may represent an early 'official' mention of women performing a formal caring or nursing role, it also subscribes to the notion that nursing is the natural function of a woman. However what really stands out in this rule is the comment it makes about women and their visibility. Clearly they could not be admitted as members of the Order, but they could occupy a servant's role; and, importantly, it was believed that their mere presence posed a threat to the safety of the chastity of the brethren. This notion that women are in some way seductively dangerous, or at best untrustworthy, appears to be a theme to be found running through the Christian belief system. The Teutonic Knights' Rule may confirm that women still had a role in healing but it is apparent that now it was firmly subject to the attitudes of the Church towards women.

The relationship between the Church and healing/caring was complex. The philosophy of early Christianity was that of a religion of destiny – things occur in a specific way because that is God's will. The basic principle was the belief that everything, people included, was God's creation and God's creation is essentially good. Everything comes from God and is, therefore, part of some greater plan where everything happens for a reason. So any sort of illness or suffering should be accepted and not questioned for it may be necessary for some (future) greater good. At a time when little was known about the causes of sickness and the workings of the human body, few could challenge the rulings of the Church which had divine authority over all things (Amundsen 1996).

Scholars have generally asserted, therefore, that the Church would have opposed any form of medical (in its widest sense) intervention for interfering with God's work. However, Amundsen (1996) makes a strong argument to counter these claims, pointing to primary literary sources demonstrating that

from the Crucifixion (circa AD 30) through to around AD 1600, Christianity for the most part welcomed the healer as a servant of God to provide healing. However the healer in their position as a servant of God also needed to ensure that not only was the physical body cured of the sickness but the soul, also, cured of the sin. Healing, therefore, took place through the co-operation between the spiritual and the temporal, indicating that there was an acceptance of the concept that not all healing came directly from God (Amundsen 1996). However medical interventions could only be provided under strictly controlled conditions and the Church provided the rituals and incantations to be used during healing and also set out ethical values, drawn from an eclectic mix of classical ethics and a newer Christian philosophy to guide the healers. The healing included the use of plants and other natural substances – the stock in trade of the traditional women healers, and although the Church disapproved it was obvious that unlike most of the treatments used by the approved medical practitioners of the time, these pagan 'folk' remedies were often very effective. This created a philosophical tension - Christian (good) medicine was often not as effective as pagan (evil) herbal medicine, clearly therefore some healing was as a result of evil. The Church eventually reconciled this tension by ordaining that while these herbal remedies were being applied only Christian incantations could be used.

For the Church the control of healing offered a complete control over the physical and the spiritual – literally power over life and death. So sensitive was this that non-Christian religions were banned with harsh penalties for those who flouted the ban. Pagan rituals were forbidden and non-formally educated healers were viewed with extreme suspicion, with those who flouted the draconian law of the Church by continuing to care for their fellows by using their skills as healers, being assured of a terrible punishment. But the Church needed the assistance of the State to legally enforce these restrictions and penalties, as, according to (Willis 1911), Canon law restricted clerics to ascertain the fact of the blasphemy,

any punishment could only be administered by civil government. So any behaviour of which the Church disapproved could be judged by them and punished harshly by secular courts, including often the use of the death penalty. There is nothing in the teachings of the Catholic Church that forbids the infliction of capital punishment and the writings of the theologians and biblical sources have given the State power and authority to administer this ultimate punishment (Willis 1911).

It would appear that one group that particularly attracted the attention of the Church in this way was the traditional women healers. In an age when academic medicine was uncertain, its ability to cure limited and its availability restricted to the rich in the cities, many people continued to consult these local folk healers for their remedies. The knowledge and skills of these healers, passed down through the generations and therefore well tested, provided an extensive 'database' of empirical facts based on perspective, concrete and accurate observations (Collière 1986), and importantly, their healing generally worked. The level of medical sophistication achieved by many of these wise women was allegedly quite significant, and given the likely efficacy of their pharmacies it is no wonder that they were the source of much speculation about their abilities and religious loyalties. Ehrenreich and English (1973) highlight how many drugs that we still use today have their roots in what they call the "witch-healers' repertoire", including for example Ergot, which they used for the pain of childbirth at a time when the Church held that pain in labour was the Lord's just punishment for Eve's original sin.

This juxtaposition of women and healing was something that the Church was keen to control. Interestingly Ehrenreich and English (1973) introduce the concept of the 'witch' healer, but this notion of these healers acting as witches, with all the stigma attached, is difficult to understand. And according to Halsall (1996) there has been much recent discussion of whether witches actually

existed, but he does note that some authors have argued that there were indeed groups of people who regarded themselves as witches and how witches and witchcraft were very real phenomena to the writers of the fifteenth century and later. While the works of these writers may tell us much about their thought worlds, and also, importantly, their attitudes towards women (Halsall 1996), this assumption that witches were exclusively women is also open to question. For example Briggs (2002) points to evidence from France where there were also many men accused of being witches. Given the numerous fantastic stereotypes that abounded (Briggs 2002), it could be argued that the Church had applied the label 'witch' to criminalise these people. Nonetheless the witch hunts that continued for nearly 400 years are seen by some authors, for example (Larsen and George 1992, Ehrenreich and English 1973) as quite purposeful executions that were supported by the Church and the medical profession and used to eliminate the advancing knowledge and skills of – predominantly female - lay healers (Kane and Thomas 2000).

This does raise the question of why the Church was so at odds with these women folk healers. It had, apparently, reconciled the tension inherent in the healing practices of folk healers. The answer appears to lie in the fact that they were women and as such their possession of skills and knowledge and the practice of their arts were completely at odds with the very core of the preaching of the Church and therefore it was fearful for the mortal souls of its followers (Ehrenreich and English 1973).

Clearly women were a problem for the Christian Church; they were not to be trusted, through Eve they were responsible for the first recorded sin and therefore responsible for the need for death; as healers whose practice was based in empirical study (Ehrenreich and English 1973) and therefore not derived directly from God they were 'witches'. For the Church, the healing of the soul of the sufferer was as important as treating any disease or injury, and lay women

could not (be allowed) do this. By contrast, under the protection of the Church, male healing/healers generally prospered. Medicine became a subject to be studied at the highest academic level in universities, but by men alone as women were excluded from higher education. It is at this point in history that we begin to see the paths of men healers and women healers starting to diverge. Men could study medicine in university to become physicians to diagnose and treat, whereas women healers, stripped of their access to knowledge of healing, deprived of education about healing and fearful to practice healing were becoming restricted to the 'domestic' role of nursing. Even when the Church embraced the practice of nursing, but notably not healing, as a more formal role for women, they were not permitted to be autonomous in that role. Their opportunities and ability to provide nursing care were subject to the stringent control of the Church - in particular, they had to demonstrate through their behaviour their total devotion to God and the Church.

By seeking to control knowledge and subordinate women, Christianity, and specifically the Church, was responsible for the institutionalisation of the role of women as care providers (Collière 1986). But one is struck immediately by an apparent contradiction - how could the Church which had denounced women as evil and the source of original sin then countenance the employment of women to perform its charitable imperative? Collière (1986) offers us a clue when she examines the eclectic nature of Christianity's inheritance: the superiority of the spirit over the inferiority of the body; the contempt of this mortal life; and, how eternal happiness can only be achieved through a life of misery and, for women but not always for men, total sexual continence. This history gave rise to a central tenet of the Christian Church that proclaims the body, and especially women's bodies, as the source of all evil, sin and fornication. Therefore, for women, purity and freedom from sin as evidenced by their abstinence from sexual activity and behaviour, was the route to higher status. Members of

religious sisterhoods were set above other mortals by their proclaimed life-long virginity and renouncement of the world and all its evil – particularly sins of the flesh. This made them suitable, and acceptable, as nurses.

However, as the Church had defined the boundaries between men and women and dictated how normal relations between the two were to be conducted, nursing, dealing as it does with conditions of helplessness and vulnerability requiring body contact was bound still to violate societal norms of intimacy between men and women. Relief was to be found by dealing with this situation as an act of charity i.e. something one is called to do. This approach protects both the status of the nurse and the adult recipient. Performing such work sacrificially sanctifies and consecrates both task and person (Williams and Thrift 1987).

However, these nurses were subject to further precautions to ensure that their passions and 'womanly emotions' were kept under control, including the complete denial of their 'wicked' femininity. The uniform that they wore was made from a rough material and was long and shapeless, designed to cover the body entirely leaving only the face and hands on show. They were not allowed to marry and were kept sheltered out of sight from the world in closed convent communities.

The primary imperative to fulfil their spiritual calling meant that the healing role practised in the convents by these women, became increasingly limited. The emphasis on the superiority of purity and the ethereal over the bodily meant they had lost their traditional means of learning about bodily functions and sickness through touch and massage. The role of the nurse became centred on offering spiritual care for the purpose of salvation, rising above the base physical needs of the sick to prepare them for their heavenly destiny. While providing physical care it was important for this consecrated virgin to preserve her own purity by restricting, or placing certain interpretations, on her contact with

others' bodies. One powerful example of this was the perception of engagement with the body of her patient as an act of devotion to Christ, with the carer 'tending the wounds of their heavenly bridegroom'.

According to Morrison (2004), the end of the medieval period was marked by a well-established tradition of institutionalised Christian care for the sick, and thus the inseparable identification of nursing with the religious life. However, she notes that it was a tradition lacking intellectual rigour and driven by a religious discourse that promoted an ambivalent attitude to the body, and it was this marriage of lack of knowledge with uncertainty about the proper attitude to the body that had a significant negative impact on the development of nursing. Collière and Lawler (1998) express this much more forcefully in their 'conversation' about Collière's work on the invisibility of care, in which they describe nursing's ancestry as 'troubled', it being the bastard child firstly of nuns and priests and then, as doctors replaced the priests, the bastard child of nuns and doctors (Collière and Lawler 1998).

This remained the situation for nursing for about four hundred years but by the mid nineteenth century in Britain the sectarian sisterhoods were becoming quite advanced and some, for example the sisters of St John's House in London, were starting to extend their field of practice beyond the boundaries of their own institutions into the more public arena of the voluntary hospitals. This coupled with the increasingly formal organisation of philanthropy towards the poor and sick – for example Elizabeth Fry's Society for the Sisters of Charity - dispensed largely by ladies from the middle and upper classes created the right circumstances for respectable women to enter hospitals not just as kindly visitors but as care-givers, and paved the way, by the 1870s, for nursing to be publicly considered an acceptable and respectable occupation for ladies (Young 2008).

Almost in parallel with these social developments, chance political decisions regarding the medical care for soldiers fighting in the Crimean War a few years earlier had also brought a new focus on nursing resulting in the emergence of nursing's most iconic, influential and popular figure, Florence Nightingale. No consideration of the culture, imagery and perceptions of nursing can ignore the influence of the mythology surrounding Miss Nightingale and the next chapter will explore the impact her near deification had on the development of nursing at the time and also the long shadow it has continued to cast over nursing for over one hundred and fifty years; a shadow that may well be responsible for, if not the silencing, at least the distortion of nursing's voice.

The life, times and influence of Florence Nightingale occurred at a time when social, economic and political developments and issues were having a significant impact on the development of nursing as an emerging and recognised profession. It is important therefore to consider all these changes and their relationships with each other and then situate Nightingale within the context of their impact.

Florence Nightingale is synonymous with nursing but what is important for this work is how that relationship has been manipulated to create and reinforce an identity for nursing. It could be argued that Nightingale is a nursing discourse in herself and the story of how she became so during the early attempts to establish nursing as a profession against a background of changing social norms such as the breaking down of the class and gender barriers is useful background to understanding the relationship between her and nursing. A relationship made more complex by her not being just a philanthropic gentlewoman but one whom actively sought technical nursing knowledge and skills.

It is possible through the next section of this work to identify the recurrent powerful themes in Nightingale's life and work that mirrored the late Victorian

concept of the ideal woman – humility, obedience to authority, Christian, temperance etc. - and therefore why the Victorian establishment would be persuaded to engineer her public persona and publicise her virtues to present her as a suitable role model for all women.

Chapter 5: The iconic Miss Nightingale and the political manipulation of nursing and its voice

For many Florence Nightingale is identified as the first iteration of the 'modern' nurse and her impact on nursing and how nursing is perceived by nurses and others alike has both exceeded her contribution and long outlived her presence – very few people in any field of human endeavour have a reputation that has been quite so enduring, so what was so special about her?

Looking at her life there appears to be little out of the ordinary to discover. The story of Florence Nightingale's life is well told, but in each successive telling, slight variations in emphasis serve to re-establish her credentials as the inspiration for the next generation of women and nurses, making it important to note the time period within which each author is writing to better understand the different perspectives expressed.

Superficially the biography of Florence Nightingale is that of an educated upper middle-class young woman who wanted to be a nurse – a desire that is alleged to have caused outrage in her family. However it is difficult to ascertain the facts of her life and as it is beyond the scope of this work to cover all that has been written about her it is suggested that a composite picture using material from her supporters - often ardent, sometimes blinkered - her detractors and those who have sought 'objectively' to uncover the truth, will provide a narrative of her history while recognising that within historical research attempts to uncover any objective 'truth' will encounter significant hurdles not least of which is the partiality of the authors of these texts. This narrative therefore is worked from themes that appear common to all her biographies and have been reported in a

similar manner but even these may only represent successive authors repeating the same misinformation.

I think it is important to recognise that Florence was not an 'ordinary' woman. The Nightingale family was wealthy and she and her sister, Parthenope, had a privileged upbringing surrounded by all the trappings that wealth and social status could bring in mid-nineteenth century Britain. She was also very well educated, having been taught at home firstly by a governess and then by her father. Florence, by 19th Century standards, received a 'man's' education meaning that she was considered to be over-educated, a concept that apparently concerned the Victorians as highly educated ladies in Victorian society had no useful role (Small 1998).

In 1837, just before her 17th birthday, Florence had her first 'visitation from God', during which, although the words are not recorded, He "energised her to work very hard among the poor people with a strong feeling of religion for the next three months" (Dossey 2000). Florence had a relatively traditional religious upbringing with religion featuring significantly in her childhood and her beliefs continued to play a pivotal role throughout her life and work. According to her biographers, during her life Florence claimed to have been visited by God three times in all. These direct 'conversations with God', as Smith (1982) notes, may have caused some consternation, even suspicion, among her own family.

Without doubt these divine interventions were a significant motivator for Florence's future endeavours and what she did as a result of them may offer a more meaningful insight into the forces that shaped her beliefs about nursing, than possibly endless dissection of her life. But it was another six years later, in 1843, that Florence began to become aware of the life of people outside her own social circle - in particular the agricultural workers and weavers who lived in Holloway, a village near to Lea Hurst, the Nightingale family summer residence

in Derbyshire. Florence, motivated by what she witnessed of the conditions in which these workers lived now started to believe that nursing, in the form of caring for the poor and sick such as those she had seen at Holloway, was what her 'call from God' really meant (Bostridge 2008). This does, however, seem a rather romantic view and there are no doubt other interpretations, but there appears to be a consensus among her biographers about her early leanings towards nursing manifesting in this way. However she would not have had easy access to role models or examples of how she might pursue what she now apparently regarded as her vocation.

The organisation and delivery of nursing care was very different at that time. Hospitals, now regarded as the spiritual home of nurses and nursing, were not the focus of medical activity they are now. The voluntary hospitals found in the bigger cities, were run as charities, providing free care and treatment but only for the sick poor who were lucky enough to be nominated by benefactors. The middle and upper classes – Florence's social group – would not have gone into hospital for their medical and nursing care as this would have been delivered in their own homes often by nurses contracted out, for a fee, from the voluntary hospitals and significant numbers of these nurses would be members of religious orders. Nurse training was only provided by and within the voluntary hospitals or by some of the larger sectarian sisterhoods. Florence's parents had refused to give their permission for their daughter to study nursing at Salisbury Infirmary and the only other route, and not easily open to her, was to become a member of one of the, predominantly Catholic, sisterhoods.

Kaiserswerth

Florence's determination to fulfil her perceived destiny to nurse led her to investigate a good example of nursing made respectable for secular middle class women. To this end she eventually attended for a short period, Pastor Fliedner's institute at Kaiserswerth in Germany (Higgins 2005). The Kaiserswerth Institute

had been founded by Pastor Theodor Fliedner, a Lutheran minister, in 1836. His vision was for young women to be trained as Deaconesses in theology and nursing and then to travel to seek out and care for the needy sick. This approach appeared to offer the avenue Florence needed to both keep her bond with God, avoid the social censure often attracted by 19th century middle and upper-middle class women who ventured out to work in the public realm (Marshall and Wall 1999) and not have to become a member of a religious order with a diversely different belief system to her own.

Florence's writings at the time offer an interesting insight into her motivation and what she felt nursing, particularly the diaconate approach, could offer her and women like her. This was, she felt, an occupation in life that they could develop and call their own (McDonald 2004). In a letter to Samuel Gridley Howe in 1852 Florence wrote about her experience at Kaiserswerth and expressed the wish that the system could be introduced in England where, she believed there were thousands of women have nothing useful to do and where the hospitals are staffed by a class of women nurses not fit to be household servants (McDonald 2004). This comment is noteworthy because it is typical of many she makes in her writings about the attitudes and behaviour of women in her own social class and their lack of social utility. However Florence did not attend the institute for the full three year training and did not become or fulfil the role of a Deaconess. Arguably she was little more than a guest of the Pastor's and this visitor role gives little credibility to any claim or bestowal of the title nurse and rather undermines her later refusal to allow anyone not trained as a nurse to join her at Scutari.

The Crimea and Scutari

Following her time at Pastor Fliedner's Institute, Florence became the Superintendent of the Establishment for Gentlewomen during Illness in Upper Harley Street, London – a position procured for her through her father's

influence. But in a life that was not that out of the ordinary the one unique event that distinguished Florence Nightingale was her appointment by the Government to supervise the nursing effort for the soldiers at Scutari during the Crimean War and within three years she was a British hero and one of the most famous women in the world.

To try and understand this phenomenon we need to consider the very complex relationship between who she was, what she represented, what she did and the social and political ethos and climate in which all this happened. By reference to a 'template' for examining the processes by which heroic reputations are made and acquired (Cubitt and Warren 2000), we can start to see how the combination of these factors and situations were manipulated to create this most iconic and enigmatic influence on nursing.

The Government needed nurses at Scutari for political as well as medical reasons. I would argue that they didn't necessarily set out to have a Nightingale but her espoused passion for nursing that drove her determination to improve people's health and conditions of living; her personal circumstances that allowed her to stay focused on her task and her personal philosophy of duty and loyalty coupled with her background and strong religious convictions made her an important political asset to a weak government running a changing and unstable country, where one significant 'problem' was the increasing voice and influence of women. This was a woman whose loyal qualities could be used to create a role model for all women; a shining public example of the qualities expected from the ideal, dutiful daughter, mother, wife and citizen.

The Crimean War was a military campaign fought in Turkey and the Balkan states between 1854 and 1856 and became the defining event in late Victorian Britain that focused the British public's attention on nursing. Prior to this engagement Britain had not been at war for some time so this was a military

campaign that captured the public's imagination but events highlighted in the media soon also stirred the public's indignation. From a military and political point of view the Crimea campaign was rather pointless, so the only newsworthy item was the immense loss of life early in the engagement, with significant numbers of soldiers dying for reasons unrelated to the battlefield.

Malnourishment and lack of suitable accommodation, exacerbated by the incompetence of the Commissariat charged with the responsibility of providing the raw materials to keep the army fed, watered, sheltered and fighting, contributed to the spread of debilitating and often fatal diseases such as Cholera, Typhus and 'Ague' (an acute fever). At times during the campaign the sickness roll – usually around eight thousand men - contained more names than the roll of men fit to fight (Shepherd 1991). This coupled with the arrogant incompetence of many of the officers, led to a complete breakdown of the service almost as soon as the British soldiers landed (Hibbert 1961).

The medical provision fared little better. The head of the medical staff of the Expeditionary Army at the time was Dr John Hall a man whom Hibbert (1961) describes as bitter, influential, hard and self-satisfied, and who was disliked by Lord Raglan the supreme commander of the British troops. Dr Hall had reported the hospitals at Scutari as having been put 'on a very creditable footing', with nothing lacking, but Florence Nightingale arrived soon after and described them as 'destitute and filthy' (Hibbert 1961). In fairness it is difficult to judge whether Hall himself was negligent, or the victim of political intrigue and incompetent deputies. He was well qualified to do the job asked of him but he was dealing with new phenomena in this war –the establishment of base hospitals that, due to the intense pressure of informed public opinion in Britain, had to be copies of the better civilian institutions back home (Shepherd 1991).

With no military heroes emerging – apart from arguably all the working class soldiers - the press focused its attention on the deaths and news of this angered

the British public who, manipulated by the media, held the British aristocracy leading the army and ran the government to blame. This morbid publicity in turn heightened public awareness about the need for nurses and it was noted that the French had despatched five hundred Sisters of Mercy to tend to their troops. Bowing to public pressure led by Robert Peel and The Times newspaper, the Government dispatched a small group of British nurses led by a Miss Florence Nightingale out to the battlefields.

The reasons behind the choice of Florence Nightingale to spearhead the Government's nursing response are unclear. Nightingale was a friend of the Minister for War, Sidney Herbert, and his family and as such he had long been aware of her nursing aspirations. It is possible that from his relationship with her he quite genuinely believed she was the only suitable person to undertake this task which would require a strong character or maybe he cynically thought that if the venture failed she could sink back into anonymity and his political reputation would suffer little damage.

Whatever the rationale, on Oct 19th 1854 The Times announced Florence Nightingale's appointment to "organize a staff of female nurses" (1854d). It is worth quoting this in full as it offers some further insights into situations that occurred following her arrival and during her time overseas. For example, the creation of a married status for Florence - was this simply an error or a calculated deceit to make her appear more respectable and therefore acceptable?; the fact that she was to be subject to the authority of the chief medical officer; the selection of nursing staff by FN and the need for certificates to prove that her staff possessed "the knowledge, experience, and general capacity requisite for duties so difficult and so responsible" (see below).

"We are authorized to state that Mrs.[sic] Nightingale, who has been for some time acting as superintendent of the Ladies'

Hospital, at No.1, Upper Harley-street, has undertaken to, who will at once proceed with her to Scutari at the cost of the Government, there to act under her directions in the English Military Hospital, subject, of course, to the authority of the chief medical officer of the establishment. Mrs. Nightingale will herself select the persons who will accompany her, and will recommend them to the War-office for certificates, without which certificates, of course, no one will be admitted to the hospitals. After her departure, arrangements will be made for the granting of certificates upon the recommendation of persons to whom Mrs. Nightingale will have delegated the duty, to such additional number as, may, from time to time, be forwarded to Scutari upon her requisition. By this arrangement it is hoped that much confusion and disappointment may be prevented, it being obviously impossible in any hospital, but especially in a military hospital, to admit as nurse any persons offering themselves, without any proof or evidence of their possessing the knowledge, experience, and general capacity requisite for duties so difficult and so responsible, and the willingness to submit implicitly to the regulations of one central authority." (The Times 1854d)

While Florence's call to travel to the hospital at Scutari appears to have been a sudden random event, many of her biographers report that she had also simultaneously volunteered her services to Sidney Herbert but the letter to him crossed in the post with his letter to her.

Media interest and heroic status

Klapp (1954 :p57) defines a heroes as "personages, real or imaginary, who are admired because they stand out from others by supposed unusual merits or attainments", and in his review of studies examining the role of heroic narratives in the propaganda of both empire and the construction of 'Britishness', Lieven (1998) builds on that by highlighting that heroism is definitionally public – in other words the clever, brave, self-sacrificing person only becomes a hero when he or she is declared to be one. The foundation for this declaration is a dramatic narrative that binds together what Lieven calls the 'epic myth' and reality. But heroes are rarely declared as such without their own acquiescence and collusion in creating their own heroism. Interestingly Lieven's work is focused on the Anglo-Zulu War of 1879 and so reflects well the mechanisms that would have also been in place in Nightingale's time and the processes of making the heroes of this war resonate well with those of the creation of Nightingale's own heroic status during the Crimean War. Equally though, all war heroes to that point had been men.

The way the world's attention became focused on the Crimean campaign and Florence Nightingale's role in it meant that she and nursing became synonymous. While she was at Scutari, the press, having apparently shamed the Government and secured the services of a female nursing service for the troops overseas, maintained a close interest in her work and this extra publicity clearly served to promote her reputation further. Although media 'spin' is usually considered a late twentieth century concept it is interesting to observe how even in the mid-1850s it was the actions of the media at home and abroad that kept Nightingale so effectively in the public eye, and how, in spite of inconsistencies in the stories of what she may have achieved and even what she represented, only the positive images prospered. For example, despite very different reporting from the two apparently opposite political and religious positions

vested in *The London Times* and *The Belfast News-Letter*, two newspapers whose archives are readily available for review online, Nightingale was still promoted in the public's eyes into near sainthood. This situation is noted by Lieven (1998) when he notes that even in the criticisms of the war and the anti-imperial attacks made in the press, the status of any identified war heroes was preserved. But it is not only the journalists' reporting that is of interest. The archives of these and other newspapers also include letters sent to the editor by the public and these provide a valuable contemporaneous insight into how the people were thinking and reacting to the reports they were reading. It is through a combination of public opinion as voiced by the public and public opinion as dictated by the editors that a picture of Florence Nightingale began to emerge. The strong press interest in her was certainly a powerful factor in elevating her profile, and given her notoriety for speaking her mind when criticising her military colleagues it is likely that she kept the journalists interested in her. However, as Klapp (1948) believes, heroes do not become visible through self-promotion, although this is a feature, but via rational routes into public acclaim. These may include formal selection – for example by canonisation or military decoration and/or by becoming the poetical creation of dramatists, story-tellers and writers. However and possibly more importantly, the person needs to have been chosen by the public, a choice which may manifest itself through spontaneous popular recognition and homage and the gradual growth of urban legends. A more recent study by Cramer et al (1981) confirms that the press, as informer of the public, still plays a powerful role in the creation of heroes by emphasising and de-emphasising selected attributes in the focus of their writing. Interestingly Elkin (1955) hypothesised that there are differences in how hero objects are perceived by men and women on different social classes; and that the public tend to seek to find within likely hero figures some resonance with their own thoughts and feelings about the world.

Other considerations for the recognition of heroes are whether recognisable villains are needed in order to put the heroes into stark relief (Klapp 1954), and the importance of the attribution of worthiness to people to be considered as heroes. In Florence Nightingale's case the press cast in the role of villain the politicians and bureaucrats who appeared to work to frustrate her attempts to provide good care for the sick and wounded. I think this is an important point. Nightingale provided, for a politically manipulative press, the ideal antithesis to an army run by an incompetent aristocracy answerable to a weak government. It is arguable that the journalists were not interested in nursing *per se*, nor particularly were they interested in Florence Nightingale but the tension between her and the army chiefs was newsworthy.

Nightingale's growth as a popular legend was assisted in no small part by the writing of Times journalist William Howard Russell. Russell was the most influential of The Times' correspondents at the Crimea. According to Russell's epitaph in St Paul's Cathedral he was "the first and greatest" war correspondent. First and greatest may be open to debate, what is not in dispute is the title war correspondent. His coverage of the Crimean War marked the beginning of an organised effort by the media to report a war to the civilian population at home using the services of a civilian reporter (Knightley 2000), and Mowbray Morris, manager of The Times, aware of the potential for increasing readership following the unexpectedly huge surge of patriotic passion from the British public to the declaration of war, sought quickly to reassure readers that The Times alone would provide accurate reports from the war by employing their own reporters situated on the front line, (The Times 1935-1952). The circulation of The Times at the time was greater than that of all its rivals put together, so the potential for it to exert considerable public and political influence was enormous.

Nightingale and her nurses were undoubtedly newsworthy - the use of female nurses in British military hospitals was unprecedented and contentious - for

many in the military their presence was unacceptable. The establishment of military base hospitals was unique to the Crimean War, prior to this medical facilities would have been provided in field units set up along the front line (Shepherd 1991). The fact that at first these nurses didn't make a significant difference to the health and well-being of the ill and wounded and that the death rate at Scutari continued to rise after Nightingale's arrival goes unacknowledged in the reports, but, according to (Cubitt and Warren 2000), this separation of fact and fantasy is a classic feature of the development of an heroic reputation. Lieven (1998) also found several cases where officers declared heroes during the Anglo-Zulu War had possibly achieved the accolade through less than heroic actions, but because the end result of what they did matched the 'criteria' for model British military behaviour, for example saving the regimental colours from the enemy, their faults were generally brushed over. In fairness to Nightingale, the circumstances of many of the deaths recorded as occurring at Scutari at this time probably owed more to military decisions than to sanitation, welfare or her nursing.

Mary Seacole

Merely appearing in the hearts and minds of the public does not automatically guarantee everlasting iconic status, however; other required or acceptable conditions must apply. For example another prominent name latterly associated with nursing during the Crimean War, Mary Seacole, also generated a fair amount of press interest - but not until after the event, and she did not achieve the lasting iconic status afforded to Nightingale.

Seacole did not work in the formal, organised environment of the military hospitals. Her presence in the Crimea was not officially sanctioned or recognised. She took her healing skills right onto the battlefield, she offered comfort and succour and was apparently loved and respected by all the soldiers, officers and other ranks, she encountered. Yet Seacole's name and reputation has not

endured like Nightingale's and in spite of the restoration of her name and deeds to the history books in the latter part of the twentieth century she cannot, unlike Nightingale, be said to have had any significant influence on the history of nursing.

One commonly held view is that the Government's refusal to sanction Mary Seacole's passage to join Florence Nightingale in the Crimea was as a result of racism. However, the Government statement announcing Nightingale's appointment to the war effort indicated that she had personally chosen the nurses who would accompany her and had left instructions about the criteria to be used to choose those who followed, including the need to show "proof or evidence of their possessing the knowledge, experience and general capacity requisite for duties so difficult and responsible" (Times 1854e), something Seacole, like many others who offered their services including Lady Maria Forester, daughter of the 3rd Earl of Roden who had originally offered to fund the expedition, did not possess. Also, like Forester, Seacole was a Catholic, which does beg the question, given the distrust of Catholics at the time, whether she was more likely to have been subject to discrimination on those grounds. The sensitivities of this should not be under-estimated. Given the recent history of revolution in neighbouring countries the British government was anxious to quell any signs of social unrest in this country and the fear of popery and a return to Roman Catholicism was still fairly universal. The reports from the Belfast News-Letter offer an insight into the depth of feeling, in some quarters, about the perceived continued threat from Rome in the form of the Government's choice of nurses sent to the Crimea (The Belfast Newsletter 1854a).

From her early life and involvement with the British military in Jamaica and her time in the Crimea Mary Seacole had developed a sufficient reputation to warrant coverage in The Times and this allows some insight into her situation and importantly some measure of public and establishment attitudes towards

her – at least after the war. On her arrival in Britain after the war she was fêted by the aristocracy and royalty. Most of what is known about Mary Seacole comes from her own autobiography written after her return from the East and therefore difficult to substantiate, not least because it was written in a semi-fictional style. *The Wonderful Adventures of Mrs Seacole in Many Lands* (Seacole 1988) was written to raise funds to support her as the sudden end to the Crimean War had left her bankrupt.

William Howard Russell had originally noted Seacole's arrival in the Crimea with a degree of cynicism, noting that Mrs Seacole from Jamaica was to set up and run a hotel at Balaklava and speculating about her attracting "excursion visitors" to view the siege in the summer (Russell 1855b). Following those initial few lines Seacole is only briefly mentioned in *The Times* for the rest of the war. However, Russell seems kindly disposed towards Mary in the few comments that he does make (Russell 1855c). Nightingale attracted far more coverage in *The Times*, but this is hardly surprising as the paper, through its agent, John McDonald was using the money raised from its readers to fund much of her work. Following the war and her arrival in Britain Seacole did attract significantly more press interest than she had during the hostilities.

In many ways what Seacole did in the Crimea was 'heroic' but the lack of recognition she received for her work demonstrates the potential artificiality of the label.

Characteristics of the hero

This presentation of Nightingale as a hero was unusual for the time and possibly represents the need of the British Government at the time to establish the 'rightness' of the Crimea campaign. As Lieven (1998) points out military campaign heroes in the Anglo-Zulu War were portrayed as young, white, public school men, fearless in their defence of the Empire. If in reality they were not

then reports of their actions were manipulated to make them seem so. Political cartoonists at the time used a grand allegorical style (Quartly 2005) in which male heroes with perfect bodies battled monsters for the control of the body of the state – usually personified as female for example Britannia. But these heroes were officers, leaders or politicians not working class men or lower ranks. But Nightingale was none of these and could not be portrayed in this way, which begs the question of the function she was to serve. Elkin (1955) states that the hero symbolises the values of the group to which they belong; strictly speaking the group to which Nightingale belonged was that of the upper class, wealthy Victorian lady but the role she played at Scutari was not typical of that group, so whose values was Nightingale symbolising – were they those of nursing, of women, of Victorian society? However the hero makers perceived Nightingale the end result of their work was to have a significant and lasting impact on the development of nursing from that point.

It would appear that the characteristics of the hero are necessarily value laden, the moral goodness or badness is not a natural feature, it is determined by reference to the prevailing values of what is good and bad, and commonly, to the product or outcome of the act(s) in question. And, according to Stengel (1999) these judgements are not vague, they are very clear cut, leading him to conclude that those who make the grade, as he calls it, are not morally ambiguous nor do they have anything suspect in their background. According to Klapp (1948) a clamouring for heroes tends to emerge in a society that is in turmoil and seeking a focus for social re-orientation. Victorian Britain was according to Hunt (2001) an age of instability. The collapse of faith was viewed by the government, having witnessed recent events in France, as inextricably linked to revolution (Hunt 2001), the more scientific dialogue of the time was starting to challenge the dominant religious ideology, and the inevitable space created was being filled by a popular form of social progress commonly called

Socialism. To counter this turmoil the Victorians were looking to their past for more ordered times and confirmation of the very roots of 'Britishness'.

In Britain, in the early part of the century, socialism was tangled up in notions of charity, beneficence and philanthropy – possibly to keep it at arm's length from the vested interests of the wealthy - so it did not emerge as a potent social force until after the 1880s when, rid of its political agenda it could be attached to notions of civic pride and morality.

In spite of the perceived diminution of faith at the time it is still possible to observe strong moral themes threading through the culture of Victorian Britain, for example: faith, character, self-negation, self-discipline, sense of humour, responsibility, helpfulness to others, loyalty, patriotism and the virtues of honour, loyalty, duty, courtesy and obedience. In particular, the Victorians believed that good citizenship, the glue that held the fabric of society together, could be manufactured or nurtured through the acclaim of an exemplary life and its promotion as an aspirational goal. They were not interested in producing heroes as objects of devotion, they had to be productive, demonstrating worthy features that, if emulated would help mould good citizens. These heroes were to be role models for the people.

For Cubitt and Warren (2000) however, the straightforward copying of a hero is not necessarily how the modelling process works. They propose that it may be a more oblique process involving the embracing of the ethical or existential truths embodied by the exemplary existence.

It is probably safe to say that Florence did little hands-on nursing during her time at Scutari. Most of the changes she made for the better were achieved by bringing into play her skills of organisation and administration. But she went there as a nurse, the press promoted her as a nurse – in fact the representative of all the nurses and nursing - and that is how the public chose to, and were

encouraged to, understand her. So her initial heroic reputation was constructed around 'nurse' Florence Nightingale. But a heroic reputation takes on its own life and to an extent moves away from the flesh and blood in which it is initially invested. As Cubitt and Warren (2000) note, it is not just the endowment of a high degree of fame and honour on the person but what they call the 'special allocation of imputed meaning and symbolic significance' that induces the collective emotional investment in them. They describe how this means that heroic reputations grow and develop to eventually comprise merely the representations of heroes, and importantly the concept that their lives and personalities are imaginatively constructed and embellished, both during and after their own lifetimes. So we become less concerned with Nightingale's life and achievements, including her nursing, in themselves and more with the ways in which her life achievements were celebrated, remembered, narrated, mythologized and politically exploited, both during her lifetime and after (Cubitt and Warren 2000). In other words any truth of Nightingale's slightly flawed perfection becomes lost in the celebration and adulation of what she represents.

What is important therefore is not the heroic action but the heroic image and how that is then put to cultural and political usage. The heroic reputation is a cultural construct, one woven within and around moral and historical discourses and one that works on such concepts as 'exemplary life', Christian sanctity and genius, and reflects the values and ideologies of the societies in which they are produced. Cubitt and Warren (2000) propose that human societies have turned the selection, promotion and celebration of heroes into fairly formalised procedures and the tangible celebration – for example naming of streets, images on banknotes etc. and in Nightingale's case storytelling, literature, mass media, gossip, propaganda - is a powerful tool controlled by political or religious authority and, occasionally, a hegemonic social elite. This allows for the manipulation of the heroic image to suit certain political, religious and social

motives. In other words they become associated with or representatives of the values on which society is or ought to be based.

The powerful symbolism of the 'Lady with the Lamp'

Another 'problem' for the construction of Nightingale as a hero during a military campaign is the issue of her being a woman in a patriarchal society where the concept of feminine is paramount. In her famous speech to the troops at Tilbury Queen Elizabeth I used any perception of feminine weakness to great effect, for Nightingale this incongruence was dealt with by Henry Wadsworth Longfellow, poet, educator and linguist from Maine, USA who in 1857 wrote and published a poem, *Santa Filomena*, that he dedicated to Florence Nightingale (Longfellow 1857). This popular poem is awash with the sentimental, historic and religious imagery so popular with the Victorians, and within it he apparently not only introduced the concept of the 'Lady with the Lamp', but also in juxtaposing Nightingale and Saint Philomena he reinforced the containing images of Nightingale as not only the ideal nurse but also the ideal representation of ideal woman, the angel of mercy and the bedside Madonna.

If the war reporting in *The Times* marked a revolution in written journalism, the work and methods of *The Illustrated London News* and its field artists were breaking new ground in the field of pictorial journalism. According to Bostridge (2008), one of the most enduring and iconic images of the nursing profession made its first appearance on 24 February 1855 when the depiction of Florence Nightingale as the Lady with the Lamp was published as an engraving in the *Illustrated London News*. This date appears to conflict with the idea that it was Longfellow who first used that label, however, one explanation for this may be that the image first appeared in the press but Longfellow reinforced the associated symbolism.

The power of this image and its associated symbolism should not be underestimated. It was, as Bostridge (2008:p252) describes it, "a potent visual metaphor for the ideal of Christian womanhood she [FN] had come to represent." One key element of the symbolism contained within the picture is the mysterious substitution of the Turkish 'fanoos' lamp, carried by Nightingale during her rounds, with a Grecian style lamp. The symbol of the lamp and the light it emits is central to the development of the Christian imagery surrounding Nightingale. The same style of lamp features in a picture by William Holman Hunt first exhibited in 1854. His painting of *The Light of the World* shows Jesus holding a lantern and knocking on a door, symbolically asking to be let into the heart of the viewer. For the Victorians, with their love of powerful religious and moral messages mixed into easily accessible media, the painting was an instant hit, with millions of copies sold - the image hooked into their need for affirmation of Christian religious belief in an age of perceived moral decay.

What appears to emerge from the work of successive biographers, painters sculptors, film-makers, playwrights and historians of Nightingale and the legend that has built up around her over many years, is that the icon that has endured is not Florence Nightingale but *The Lady with the Lamp*. For the Victorian public during the Crimean War Florence Nightingale was the lady with the lamp; for the 21st century *The Lady with the Lamp* was Florence Nightingale. The difference is subtle but important. If this otherwise potent symbol of nursing was merely a nineteenth century woman, its message, fixed in time and convention, would have lost its impact with the ending of the Victorian age. But the image of the ideal nurse represented by *The Lady with the Lamp* endures – not a realm of fixed and timeless meanings but presenting changing definitions and shifting constructions (Cubitt and Warren 2000) through a set of Christian values overlaid with powerful Victorian virtues and endlessly re-invented to suit each new situation.

Certainly over the last century Florence's history has been rewritten many times. However, although indisputably famous she has had relatively few biographers (Small 1998). But then, according to Crowther (2002) every time Florence Nightingale's story is told from original material, each historian has re-invented her in the context of their own time:

- (i) Cook (1913) writing in the early 1900s concentrated on the Christian heroine and the ministering angel;
- (ii) in the 1920s, when Freudian psychotherapy was very much in vogue, the 'neurotic and manipulative' Lytton Strachey (1928) redrafted Florence Nightingale in very much the same style;
- (iii) in the 1930s Hollywood showcased her in a film *The White Angel* (Shairp 1936), (Crowther 2002);
- (iv) in the 1950s, Cecil Woodham-Smith's *Nightingale* was an aristocratic yet resourceful organiser of the military, although not lacking in motherly instincts – a suitable heroine for women who had endured the Second War and were still poised uneasily between the claims of work and home;
- (v) since the 1960s several historians have discussed Nightingale as trouble-maker, religious iconoclast, committed professional or feminist prototype; they have also speculated about her sexual orientation (See Baly 1986) (Crowther 2002).

At the end of the war, Florence Nightingale returned quietly to Britain and almost immediately went into self-imposed isolation. While, through friends and other contacts, she maintained close contact with the outside world and continued to write prolifically, she never returned to hands-on nursing. Yet her reputation grew and persisted even without her visible presence, while other

names, even those who remained longer in the public eye, have disappeared into obscurity.

Chapter 6: Nursing seeks a professional voice

As nursing left the sectarian institutions and became more acceptable as an occupation for women why did it still struggle to organise itself?

By the end of the 19th century in Britain nursing had become a popular choice of occupation for women and, importantly, women with social standing. Yet nursing was still burdened with commodity value and no status in the developing health care system and the expansion of the workforce was starting to highlight class differences. Many of the lady pupils socially 'outranked' their employers and the doctors they worked with, but at work they were expected to show the same deference as the nurses from a lower class background. In an attempt to bring some exclusivity and greater recognition to their new occupation, and in the process raise their own standing with their colleagues, these lady nurses started to seek a more professional grounding for nursing by introducing more rigorous selection processes for admission to training and a national nursing register to limit the legitimate practice of nursing to those who had met the selection and registration examination requirements. By the 1880s the 'battle' for professional status through state registration had become a major issue for nursing.

Nightingale, by now very influential in all nursing matters, opposed the move to registration as she believed it was the complete antithesis of the moral stature requirements she placed at the very core of any assessment of suitability for the job.

The story of the quest for state registration is so often presented as a great triumphalist history with the embattled nurses finally winning out against all the odds. But to view it solely as a group of nurses seeking proper public recognition for their work would be to miss the complex social and political developments at the time of which it was just a part. This 'battle' was a class and gender issue

that also encompassed hospital organisation and patient care ramifications. According to Young (2008) nursing had, around the mid-nineteenth century, become a contested field of endeavour, with the debates about it becoming increasingly public. The discussion in the media, she argues, had influenced societal norms and paved the way for the acceptance of genteel women taking it up as an occupation. Initially this would have still been attached to notions of charity but eventually that would change to it becoming an acceptable paid occupation for these women. The appearance of the iconographic Miss Nightingale had an impact – not necessarily on changing these attitudes but more perhaps on giving the changes a seal of approval. While Nightingale focused public attention further on nursing there were other influences on it that were moving it forward. Externally the expanding voluntary hospitals and advances on medicine demanded a large skilled workforce, and internally the lady nurses wanted an elite profession – freed from its association with domestic service and the servant classes - within which they would have status, autonomy and recognition for their specific skills.

Nursing spent nearly thirty years struggling to achieve what its leaders perceived as its holy grail, and while chronologically this action mirrors that of the fight for women's suffrage it does not lend itself to be easily understood in any simple terms of the paramountcy of men versus the obedience of women and their place in society and the workplace. Abel Smith (1960) defines it as essentially a dispute between nurses and the employers of nurses for control, with nursing desiring to create a new profession for women and the employers needing a large number of skilled hands at the bedside (Dingwall et al. 1988).

Nurses as a commodity

Nurses were seen by the employers as a commodity, to be bought and sold as with other goods and services. As Dingwall et al (1988) point out, the voluntary hospitals, the major employer of nurses at that time, were under significant

financial pressure. Their costs, in particular nursing costs, were rising sharply. White (1978) estimated that between 1860 and 1890 hospitals saw a four hundred per cent increase in nursing costs per patient. Hospital governors, seeking a way to manage their costs became aware that they could realise a return on their investment in their nurses by renting them out for private duty care (Dingwall et al. 1988), and for many hospitals the hiring out of nursing staff was a resounding financial success. For example, in 1905 the London Hospital was returning a significant annual profit of nearly £2000 using this system (Abel Smith 1960).

But the hospitals were also jealous of their reputations and this system, profitable as it may be, left them feeling vulnerable. Unlike their private agency competitors they could provide their patients with some sort of reassurance in the form of a hospital certificate about the quality of the product they were supplying. But they had no such guarantee from the nurses themselves that they would uphold their employer's standards. The hospitals' honour and reputation was in the hands of (untrustworthy) women working outside the hospital and therefore not within its direct control (Rafferty 1996) and the fear primarily was that unscrupulous, unsupervised nurses could exploit their vulnerable patients. Or worse still they could revert to the philosophy of their sectarian roots and neglect the treatment of the patient to concentrate instead on their moral welfare. Ultimately, though the hospitals had no option but to trust their staff, as the surety of good behaviour and scrupulous nursing care could be provided only by the nurses themselves. The response of the employers was to return to the benchmark of the sectarian nursing institutions and seek to employ only women they deemed to be of good character and subject them to a training that emphasised and inculcated the virtues of moral purity, modesty, chastity, loyalty, vocation and obedience with the expectation that these virtues

would be internalised and demonstrated by the nurses in their behaviour and practice.

It would appear that in many ways attitudes towards nurses and nursing, even as it moved from the sectarian to the secular, remained largely unchanged. This emphasis on moral virtue as a precondition for nursing very much derives from the Church's view of women as 'unclean'. However, it also formed the basis of a powerful argument that was to undermine the attempts by the lady nurses to establish nursing as a profession for women. Fundamental to this quest was the need to introduce a properly premised scheme of training for all nurses but there was opposition from both within and outside nursing to the use of educational achievement to discriminate.

One concern Florence Nightingale expressed was that only women from the middle and upper classes would be sufficiently well educated to cope with the training and pass the exams thus excluding 'good girls' of strong moral character. A demonstration of her thinking is contained in this rather cryptic comment in one of her regular letters to the probationers at the Nightingale School, "It is not the certificate which makes the nurse or midwife. It may unmake her" (Nightingale 1888). But Nightingale's objection was to exams and certificates not the education of women which she valued. Looking at the situation in the wider picture of girls' education at the time she had a point. The debate aroused strong emotions. In 1874 Mr Beresford Hope, MP for Cambridge University, expounded his views on the suitability of educated women as nurses. In a way typical of the time, he strove to demonstrate how educating women beyond a certain level was bad for them, thus any perceived oppression was perpetrated in the best interests of women. During his speech he explained how God had sent women to be "ministering angels, to smooth the pillow, minister the palliative, whisper words of heavenly comfort to the tossing sufferer."

(Hansard 1874), on behalf of women's dignity he protested against attempts to educate them beyond the Diploma of the nurse claiming that would pervert women into feeble and deteriorated men.

This perception – later to be developed into a scientific 'fact' – that too much education was debilitating for girls and women was gaining momentum at the same time as education and education as a route into work was opening up for women.

Women's education and work

The relationship between education, in particular further and higher education, and work and as a route into work, is a relatively modern concept that really only comes into existence, and then uneasily, in the later Victorian period (Schwarz 2004). However, the expansion of education for young men as the 'new' way into paid employment did have a positive knock-on effect for women and formed the background for the expansion of female education. But as Schwarz (2004) rather cynically comments, parents' desire not to have unmarried, "surplus", daughters on their hands, may also have had a significant impact on the access to continuing education and exams by young women. Moralists at the time, though, raised objections to exams for girls on the grounds that they "involved improvement of the understanding rather than of the heart" (Cohen 2004), believing that in girls one could only be achieved at the expense of the other.

Where schooling for boys had been quite easily available for some time, wide-scale schooling for girls was a relatively new phenomenon in the nineteenth century; however it is important to consider schooling at the time in the context of its purpose. It was not a homogenous process; it was gendered, with a split between schooling as education, generally for boys; and schooling as training, generally for girls.

The initial limited provision of mainstream education and schooling for girls was not a Victorian phenomenon. A century earlier Mary Wollstonecraft, famous now as the author of *Frankenstein*, wrote about it in her 'Vindication of the Rights of Women', a tract that is recognised today as an early feminist text. In 'Vindication' Mary draws on her experience as a self-taught teacher of girls to express the view that the girls she and her sister Eliza were attempting to enlighten were already enslaved by a social training that subordinated them to men. A phenomenon she described as "a false system of education, gathered from books written by men who have been more anxious to make of women alluring mistresses than rational wives." (Wollstonecraft 1792). However, on closer examination even her proposals for creating 'rational wives' also included limiting girls' education to appropriate instruction for domestic employment and to make them rational nurses of their infants, parents and husbands (Wollstonecraft 1792). This does seem to be at odds with her later reputation as a tough advocate for women – she was known, according to Hughes (2008) as a 'hyena in petticoats' and is commonly thought of as the mother of feminism, it appears, though, that she did not claim across the board equality for women – rather a set of different – but equally valued - roles for the sexes.

This approach to girls and their education persisted for most of the next century. In 1857 Harriet Martineau, a contemporary and friend of Florence Nightingale, set up an Industrial School for girls in Norwich (Austin 1857). But again by definition this was a place to 'educate' girls to become servants. While the curriculum comprised scripture and other reading, writing, arithmetic, grammar, geography, part-singing, outline drawing and English history, the particular arrangement of the building was also an important feature of the school. It retained the servants' arrangements found within a large house with the intent to establish in the girls' minds and habits a permanent relationship between things

and their allotted places – a relationship that was also considered a necessary part of training for servants (Austin 1857).

By the latter part of the nineteenth century, just as the professionalization debate for nursing was starting to gain momentum, girls' education was clearly becoming too big an issue for Parliament to ignore. However comments made by MPs during various debates highlighted the conceptual struggle the issue was causing them. During a debate on the Endowed Schools Bill in 1869 Mr G. Gregory wanted to point out to the House "that the great business of their [women's] lives lay in: the domestic circle, and in things which could not be taught in schools" (Hansard 1869). Similarly Mr Beresford-Hope, Member for Cambridge University, was of the opinion that it was a matter of common sense and this showed that "while the necessity for female education was as great as the necessity for male education, the education required for girls was less extended than that which ought to be imparted to boys" (Hansard 1869).

For most girls at this time, it would appear, education was unlikely to continue beyond primary school level. This most probably reflected the expectation on the part of their families that girls did not need to be educated beyond learning to read and write and an associated unwillingness to educate girls *per se*. The education of women, certainly up to the mid-nineteenth century, continued to be one designed to equip them to function in their community and fulfil their domestic functions. It was not designed, even for the higher classes, to educate them beyond certain 'accomplishments'. And, according to Petersen (1987) most middle class girls at this time would have been educated at home by a governess – often untrained or by a 'lady' – again untrained, in a small, private school or by some combination of both.

In 1867, as the Government was setting up an inquiry into the state of girls' education, Florence Nightingale published a pamphlet with Henry Bonham-

Carter, friend to Nightingale and Secretary of the Nightingale Fund (Bonham-Carter 1867) commenting on the need for any reform of the current system of hospital nursing to be focused on the substitution of trained for untrained nurses and highlighting the need for all nurses, including the most senior, to undergo some form of recognised training. In many hospitals at the time it was often the case that the Matron, the most senior female position in the hospital, was not a trained nurse. Although this was the position coveted by the Lady Pupils, traditionally they had been chosen from the ranks of gentlewomen – comfortable with running a household and dealing with servants. While acknowledging the desirability of that office being filled by a lady of education, Bonham-Carter stressed the need for that person also to have undertaken a regular course of training as a nurse. Nightingale did not apparently dispute the need for nurses to be trained, what she could not agree with was the need for examinations and associated registration to prove competence. Nightingale was herself a highly educated woman but here she seems to be downplaying the need for 'ordinary' girls to be educated beyond a level that would fit them to be trained as dutiful nurses.

This sentiment certainly resonated with the Government's concerns. In 1868 the Schools Inquiry Commission, considering secondary education, received much evidence about girls' eagerness to learn and their earlier mental maturity than boys. This led the Commission to express concern about the danger of overwork and overstrain for girls. By 1874 this concern had been given scientific credence following the work of Clarke (1873) in America and Maudsley (1874) in Britain, who warned that "Education would deplete the nervous energy women needed for menstruation and pregnancy and cause a range of disorders from madness to sterility" (Sengoopta 2004). In 1874 the Government established a Commission of Inquiry into the state of schooling in Britain with one of its briefs being to examine the pitiful state of girls' education (Project 2003). However, in

common with other Victorian endeavours, the provision of schooling funded from the public purse was not without its value conditions. The Commission declared that there was no reason to encourage "indiscriminate gratuitous instruction", an idea that they compared in its mischief to the indiscriminate donation of alms to beggars (Project 2003). By 1899 major advances had been made in the establishment of children's rights and moves were being made to include in that portfolio the right to a proper education. Legislation had been passed liberating very young children from the drudgery of factory work and other industries. However, the amount and level of education required by girls in particular still seemed to be exercising the politicians. During a debate on the Education of Children Bill in the House of Commons in May 1899, Mr. William Tomlinson, MP for Preston, proposed that girls' schooling should be limited to part-time to allow them to assist with the domestic work of the household. This he felt would be of lasting benefit to them, in contrast to education, which, if carried beyond a certain point tended to unfit them for domestic duties and domestic life (Hansard 1899).

It appears that the ethos of girls' education continued to be rooted in the preparation of good wives and mothers into the early 20th century. The 1902 Education Act opened up elementary schooling to the working classes but the education was often of a poor quality. By 1918 the leaving age had been raised to fourteen years but this made little difference but in the years following the First World War, the uptake of schooling by girls had improved enormously and by 1920 the number of girls receiving secondary level education had risen almost ten-fold compared with the turn of the century (Kamm 1971). But the concerns about the debilitating effects of education on girls persisted and in 1923 girls' options were narrowed to protect them from themselves and their own ambition (Cohen 2004). However, it had also been recognised for some time that given the right educational circumstances girls could become high achievers. In fact as

early as the seventeenth century, a study comparing girls and boys learning languages had noted that girls learned faster and better than boys and Cohen (2004), basing her ideas on this work by John Locke, has developed and used an analytical model of gendered achievement (Cohen 1998) to inform the debate on the organisation and deployment of the discourse of achievement that has allowed and promoted, through history, the differential treatment of girls and boys in the education system, where boys' achievement is due to the nature of their intellect but their failure is due to poor teaching. However, for girls the discourse changes, and it is their intellect which is the cause of their failure and external factors such as teachers, are responsible for their successes (Cohen 2004). Cohen's argument is that traits or learning styles attributed to girls are constructs "elaborated at specific moments of history, within specific discourses, which are recast again and again, and saturated with new meanings." (Cohen 2004). For example, John Locke over three hundred years ago highlighted girls' achievement while simultaneously making it invisible therefore re-establishing the correct hierarchy of intellect. Girls were not more clever but their method of learning was easier Cohen (2004). In real terms, though, the majority of working class girls would not achieve something approaching equality of opportunity in education until the 1944 Education Act which opened up free secondary education for all children.

The impact of this slow but steady improvement of working class girls' education was surely a good thing for nursing who could now potentially recruit from a pool of numerate and literate young people to train to deliver what was becoming a more complex service. But it is likely that the 'powerful' nurses of the time felt threatened by its contribution to the breaking down of the traditional class barriers that ensured their superior positions.

Registration and the Employers

The dispute, as Abel Smith (1960) defines it, was now between nursing represented by its new self-selected leader - Mrs Ethel Bedford Fenwick, née Manson, nurse and lately Matron of St Bartholomew's Hospital in London, and the employers represented by hospital administrator Mr (later Sir) Henry Burdett (Rafferty 1996). And through it one can see acted out the gender relationships between the (male) employers' representative and the (female) nurses representative.

Like Florence Nightingale, Ethel Bedford Fenwick had come from a well-to-do background and a family that was surprised by her determination to enter nursing. She had trained at Nottingham Children's Hospital as a paying probationer then undertook further training at the Manchester Royal Infirmary. During her training it was clear to others that she was clever and motivated within her chosen career and she moved to the London Hospital as a Sister and in 1879 at the age of 24 she became Matron at St Bartholomew's (Barts). She had, according to Helmstadter (2007) a will of steel and Florence Nightingale considered her to be unscrupulous (Bostridge 2008) but she was a successful Matron at Barts. In 1887 she married Dr Bedford Fenwick and according to the conventions of the time she had to leave nursing.

It is interesting how during an historical period prior to suffrage when the political attitude towards women was possibly perceived to be at its most patronising and demeaning two very strong women emerge as international nursing figures.

Henry Burdett and the British Hospitals Association

That same year Henry Burdett had helped to establish the Hospitals Association, later the British Hospitals Association (BHA), as a pressure group to represent

the interests of the voluntary hospitals. This group included among its members many hospital matrons, including Ethel Bedford Fenwick.

Registration as a means of regulation was an important proposition of the BHA, and in May 1887 Henry Burdett wrote in his journal 'The Hospital', "So much good is likely to come from the scheme [registration] that we are surprised that no steps have been taken previously to establish a Register for trained nurses" (Bedford Fenwick 1905). At that time Mrs Bedford Fenwick agreed, and the Nursing and Domestic Management Sectional Committee of the BHA, of which Mrs Bedford Fenwick was an elected member and Chair, proposed a three year training qualification for registration.

This was an interesting decision. Ethel Bedford Fenwick was not one of Florence Nightingale's protégées; had she been she may have proposed the system of training developed at the Nightingale Training School, which had been established at St Thomas' Hospital in 1860 by the Nightingale Fund, and adopted by other institutions. This comprised a one year training with two tiers of entry – tier one, the ordinary probationer who received her training free; and tier two, the middle class lady-pupil who paid for her training. Importantly, it was from this second group, the lady-pupils, that the matrons in the voluntary hospitals were recruited. It is likely, therefore, that the pressure for the longer training proposed by the BHA section committee came from the lady pupils who believed that their professional status was under attack from the increasing numbers of probationers. The argument being that the lower class probationers would be deterred by the prospect of three years without, or with a very low, salary, whereas the lady pupils would easily be able to fund the extra time.

Mrs. Bedford Fenwick and the British Nurses' Association

The BHA, however, driven by the opposition of the voluntary hospitals to any limitations on recruitment, which would have an economic impact, rejected the

section committee proposals, a decision that angered Mrs Bedford Fenwick and the matrons and as a result she and most of the matrons resigned from the British Hospitals Association. Shortly after this Dr and Mrs Bedford Fenwick, together with a group of like-minded fellow matrons founded, the British Nurses' Association (BNA) to fight for nurses' registration and professional status. The repercussions of this revolt of the matrons from the BHA were to be felt for many years. As Mrs Bedford Fenwick later commented, Sir Henry Burdett had taken the formation of the BNA as his cue to embark on a lengthy – ten years – campaign to misrepresent and persecute “those women who dared form an independent opinion concerning their own affairs” (Bedford Fenwick 1905).

But none of the parties in this dispute were being entirely honest about their underlying motives. While on one level the aims of the BNA and its focus on nursing becoming a self-regulating profession with entry restricted and regulated appeared laudable, for example for the support it gave for the removal of the power of the hospital over the career prospects of the nurse (Rafferty 1996), behind these praiseworthy efforts lay other motives. Helmstadter (2007) notes that the articles in the RBNA's official journal, *The Nursing Record*, reveal one of its major, and more sinister, goals – removing working-class girls and women from the ranks of nurses. The BNA believed that with state registration of nurses, along the lines of state registration of medical practitioners, would come instant professional status and social esteem to match that of their medical colleagues, leading to better pay and conditions. In turn this would attract more gentlewomen into the profession. Eventually all nursing students would pay for their training, thus excluding all but the reasonably well off, and ultimately making nursing a profession for ladies, as opposed to women, only.

As an administrator, Burdett's primary concern was the economic welfare of the employing institutions therefore his motivation for regulating the nursing workforce was to find ways to improve its cost effectiveness. And whatever Ethel

Bedford Fenwick may have thought of Henry Burdett's posturing, one very powerful group, the employers, were not generally in favour of the BNA's version of state registration. A survey undertaken by the Hospitals Association – and with which Ethel Bedford Fenwick had been involved – had revealed that, nationally, support for national registration was weak, with less than half of the thirty-four hospitals questioned stating that they were in favour of the proposal. Among the reasons for opposition was the perception among the hospitals that the use of a common register in place of each institution having its own register would dissociate a nurse from her parent school and weaken her loyalty towards her employing institution (Rafferty 1996). However, hidden behind this rhetoric of loyalty was the concern that the BNA's ambitions were actually a threat to the economic interests of the training schools (Rafferty 1996).

Florence Nightingale's contribution to the debate

Nightingale's contribution to this early stage of the debate came in the form of a pamphlet entitled 'Is a General Register for Nurses Desirable?' (Bonham-Carter 1888) written and published by Henry Bonham-Carter, but most likely dictated by Nightingale herself. In this she expresses her concerns about better educated but unfit (for nursing) young women being able to obtain first class certificates and therefore better jobs, whereas the less well-educated and less articulate, although better suited to nursing, would achieve only second class certificates and therefore gain only inferior posts. Nightingale had reason to believe that girls in the late nineteenth century were not well enough educated. Certainly state education for girls in Victorian Britain was limited with free secondary education not becoming generally available until around 1891. But girls from wealthier families were of course privately educated and this, she believed, would give them an inappropriate advantage in any system that valued theoretical achievement over aptitude and fitness. While Helmstadter (2007) maintains that far from dismissing registration solely on these grounds,

Nightingale had other well-informed and intelligent reasons for her opposition – but she fails to clarify what these are. However it is likely that considerations of good character underpin all Nightingale’s objections.

While the main players in the registration debate were the representatives of nursing and the employers, the medical profession was also concerned about the perceived move of nursing from philanthropic venture to career being a threat to their superior position. As Young (2008) notes, initially the medical profession was in favour of nursing reform. The *Lancet* in 1860 was full of praise for the nursing being provided by volunteer lady nurses but by the 1880s many medical men were becoming quite publicly critical of the new style nursing. In that twenty years some doctors were starting to realise that the idea of nursing becoming a ‘profession’ could pose a significant threat to their own position. In 1890 a pamphlet was produced protesting against the proposal to register nurses as it would be “detrimental to the public good and injurious to the medical practitioner” (Nursing Record 1890). One member of the BNA Council, Dr Octavius Sturges, was very clear that the relationship between doctor and nurse was one of natural deference of women to men and while he re-iterated the rhetoric that nursing is monotonous, thankless and ill-paid, he was also anxious to emphasise that any nurse seeking thanks or decent pay had missed her calling and was not fit to be a nurse (Sturges 1889), for him the good nurse was recognisable by her readiness to do as she was told. Interestingly, far from dismissing Sturges’ ideas as demeaning or old-fashioned the BNA appeared to support his viewpoint praising him for his insight into the activity of nursing and wholeheartedly supporting his ideas about loyalty and obedience.

Other doctors were more forthright in their attacks. Supporting what Rafferty (1996) has termed the ‘prevalent medical misogyny’, medical commentators used the power and influence of medical science to ‘prove’ that physical differences made women inferior to men intellectually and that excessive

demands made on their brains could cause serious bodily damage. With the primary function of women perceived to be to reproduce it is hardly surprising that a link was made, by these medical men, between too much intellectual activity and harm to the reproductive organs, thus affecting their ability to produce strong offspring. Throughout this debate, as in so many other arenas, women were infantilised by constant comparisons to children, and how, like children, they needed protecting and educating. However, as previously noted the focus of this education should be on disciplining the passions and exercising self-control (Rafferty 1996).

In spite of this it is likely that the BNA believed that the route to success in their aim to professionalise nursing was to model themselves on the medical profession. The Council used the Medical Act of 1858, which had established a scheme of registration for doctors, as the template for the registration of nurses. However, as Helmstadter (2007) points out, they clearly did not understand the workings of the Act as it did not address the very issues that were at the heart of the BNA's action – the establishment of new licensing arrangements, the outlawing of unregistered practitioners and importantly it would not allow them to exclude practitioners on the basis of their class.

Nurse's Registration Act

By 1919 after a protracted passage through both Houses of Parliament the Nurse's Registration Act finally achieved Royal assent. The 1919 Act required the creation of General Nursing Councils, initially to oversee the registration of all trained nurses in England, Wales, Scotland and Ireland who had achieved an acceptable level of training and practice, but then with a view to establishing a standard training syllabus, setting exams, recognising training institutes and maintaining discipline. Strictly speaking there were three Acts passed and three General Nursing Councils (GNC) formed – one for each of the jurisdictions at the

time. However, there were few differences in the activities of each and commonly all three are referred to as 'the GNC'.

While the agreement for a three year programme of training, which was a major part of the whole dispute, may have been won, the disagreements about the recognised national scheme of registration and who was going to be in charge of nursing were still underway. The opponents remained the same and the arguments were very similar but now the politicians were more directly involved. The interested parties during the passage of the registration Bill through parliament had all wanted state registration for nurses but for different reasons so Parliamentary time had often been wasted up by nit-picking challenges to wording (British Journal of Nursing 1919), convincing the MPs that nursing was not capable of managing itself without Government intervention. Each side also employed a range of tactics outside their political lobbying to undermine the other's case; one notable example was a leaflet that had been circulated by the College of Nursing which implied that the College of Nursing Bill would be the successful proposal and that the provisions of that piece of legislation allowed the College's register to be the first national register under the Act. Thus all nurses already registered with the College would be placed automatically and without further fee onto the State Register (British Journal of Nursing 1919).

However, it is interesting to note that the three year nurse training programme, had not been won by the desires of the campaigning lady nurses of the RBNA working in the relatively wealthy voluntary hospitals where nursing had developed as an occupation for women, nor by the employers in this sector – but by the situation in the institutions where the bulk of the hospital-based care of the sick took place and where the State was directly concerned about the conditions of nursing, the Poor Law infirmaries (Dingwall et al. 1988).

A series of reported deaths of workhouse inmates had caused a public outcry and the consequent public and professional pressure had focused attention on the nature and quality of the staff employed to deliver healthcare in these establishments. Trained nurses were seen as vital tools for the necessary improvements and their recruitment became a priority. As early as 1865 a General Consolidated Order had laid down the duties of a nurse as a paid officer of the workhouse and specified that only trained nurses "of great respectability of character, and of diligent and decorous habits" (Poor Law Board 1865) should be appointed. These criteria again highlight the continued emphasis on the nurses' moral character and how this rather than any demonstration of intellect was what the employer required.

By 1867 the infirmaries had been given the power to set up their own training schools which offered a way to lower their costs and supply a skilled nursing workforce. But these took some time to become established and were generally limited to the larger institutions. In common with the voluntary hospitals, the infirmaries were keen to retain their own trained staff, but smaller institutions without training schools were also required by the Local Government Board to employ trained nurses, so staff mobility was increasing. This in turn caused a recruitment problem in finding suitable probationers and as the demand for nurses rose it was a problem increasingly shared with the voluntary sector. The response from all parties was to lower the entry age – in the voluntary sector this was lowered from 25 years to 23 years, and in the Poor Law institutions this was further lowered to 21 years to give them a competitive edge.

This concern for the supply of nurses in the Poor Law sector caused the Local Government Board to focus its attention on the national regulation of nursing. They believed that a national system of training based on a common syllabus and assessment leading to an universally recognised certificate would increase mobility, leading to more opportunities for promotion, making Poor Law nursing

an attractive proposition and thus addressing the recruitment situation and also easing the staffing difficulties in smaller rural infirmaries (Dingwall et al. 1988). The House of Lords Select Committee on Metropolitan Hospitals adopted the BNA's recommendations on the length of training and in 1892 an order was made laying down a training of three years as the requirement for Superintendent Nurses in workhouse infirmaries. By 1903, however, the sector was still struggling to recruit and retain sufficient nursing staff. The response from the Departmental Committee on the Nursing of the Sick Poor in Workhouses was a proposal to reduce the number of Superintendent Nurses required to have three years' training, allowing the positions to be filled by young women who had only a twelve month training to their credit. An article in the Lancet, while decrying the proposal also noted that the metropolitan hospitals and infirmaries had significant spare teaching capacity that could be utilised to train large numbers of probationers, the only obstacle being the ability of many institutions to provide suitable residential accommodation for the trainees (British Journal of Nursing 1903). And as the voluntary hospitals had already discovered, the improvement of both pay and accommodation was central to attracting suitable staff (Dingwall et al. 1988).

Untrained but registered

Whichever of the two proposals for introducing the scheme of registration were to be adopted the main sponsors would need to demonstrate to parliament that their model was popular and workable. The submission by the College of Nursing Ltd contained a proposal for a period of grace which would allow women without evidence of recognized training but with proof of an extended period of practice, to register. This may well have been a calculated move to not only allow the thousands of Voluntary Aid Detachments (VAD) women 'created' by the war to join the College, and gain access to the nursing register, but also increase the workforce of the employers represented by the College.

Although these VADs were largely a product of the war, the organization itself had been set up pre-war and at that point there had been no requirement for the VAD nursing aides to have any nursing qualifications. The creation of the organization followed a request from the War Office, in 1909, to the British Red Cross and the Order of St John of Jerusalem to provide supplementary aid to the Territorial Forces Medical Service, using volunteers trained in first aid and basic nursing. Between 1909 and the advent of war in 1914 their numbers swelled from an initial 6,000 to over 74,000 (British Red Cross 2009), of which over two thirds were women and girls. During the war VADs took on all kinds of roles but many worked in hospitals where their lack of formal nursing qualifications but use of the title of 'nurse' often led to friction between them and the trained nurses who saw their own status under threat (British Journal of Nursing 1919). By the end of the war there were many thousands of experienced VAD nursing aides who, without formal nurse training, could not be recognised as trained nurses but who could offer a solution to the post-war workforce shortages in British hospitals. A pragmatic response, therefore, would be to put them on the newly formed register under the 'period of grace' provision. And, of course, this would be a highly appealing proposal for both the Government and the hospital administrators who would receive a ready prepared nursing workforce without the associated costs of training them. But it would also dilute the stock of trained nurses and could have potentially made this untrained group very powerful in the profession.

The General Nursing Council

As a means of finally putting the legislation onto the Statute books, the Minister of Health intervened to decide the composition of the first General Nursing Council, and gave the College of Nursing dominant membership (Hallam 2000). The 'interim' Council was charged with the responsibility of creating the first compulsory State Register of trained nurses which was to commence in 1921.

However, by 1922 when less than one thousand of the estimated fifty thousand trained nurses in the UK had been registered by the new GNC, the Council was in chaos and questions were being asked in Parliament. During one rather heated debate Sir Alfred Mond, Minister of Health, let his irritation be known. Having described the whole issue as "the greatest mare's nest that has ever been produced in this House" (Hansard 1922) he then went on to condemn those who continued to obstruct his efforts to get the GNC to work (Hansard 1922). But did the Government need to intervene to 'sort things out' or was this a case of nursing just not being seen to be doing as it was told. Could it be that nursing was struggling to have its own voice heard and not just do what was expected of it, and therefore do Mond's comments contain a subtext of the 'women problem'?

This tension dogged the GNC for the next sixty years. The College of Nursing had, through government favour, become the representative voice of the profession, a position it was to consolidate throughout the 1930s in the face of a growing challenge from the trade union movement (Hallam 2000). It was an organisation dominated by employers and matrons and through its membership it had the confidence of many thousands of working nurses but it also had a rather too close relationship with the Government. To this day the (Royal) College of Nursing treads an uneasy path between professional organisation and trade union and has remained reluctant to confront government over nursing issues. As a result, the GNC, and, by association, nursing, was easily subject to ever more significant external influence and control, both by employers and ministers. Nursing was struggling to have its new voice heard and as the doctors had already discovered, registration and recognition as a profession did not bring with it the instant reward it appeared to promise. As Dingwall & Kidd (2003) note, in gaining the legal accolade of profession, any previously cherished notions of creativity and entrepreneurship give way to the requirement to provide

a standard package of interventions to all clients and the ultimate price to be paid includes allowing others to define your legitimacy.

The GNC had a wider role than just putting names on a register, it also had the difficult task of determining the necessary standards of education and practice for inclusion on the register. In order, perhaps, to better understand the particular problems it faced it may be useful to set the GNC in the changing context of healthcare delivery of the 1920s. The three tier system of healthcare at the time comprised the voluntary hospitals, the local authority public health committees and the Poor Law committees (White 1985b). The majority of nursing at the time was delivered in and from hospitals and there was no 'national' health service as such. These service providers although offering similar services were not in competition. They had different functions, different funding and management arrangements and different levels of susceptibility to political interference and control. But the GNC was charged with the responsibility for defining recruitment, training, discipline, qualification and registration nationally and imposing these national requirements on what were essentially local services ranging from the relatively rich and largely autonomous large voluntary hospitals, through the public health hospitals funded from the local rates to the smaller, often rural, infirmaries and asylums with limited funding and where nursing was often no more than a custodial activity.

The GNC, monopolised by the employers' and matrons' interests and concerned about recruitment and discipline, was not in a position to provide the voice of nursing. The healthcare service in the UK was growing fast and the demand for properly trained nurses was increasing. The problems of recruitment had not been addressed by the registration debate and the persistent shortage of nurses remained an important issue.

Commission on the Reform of Nursing

In 1930 the medical journal *The Lancet* established a Commission on the Reform of Nursing whose terms of reference were to enquire into the reasons for the shortage of candidates, trained and untrained, for nursing the sick in general and special hospitals throughout the country, and to offer suggestions for making the service more attractive to women 'suitable' for this necessary work. The report, finally published in 1932, was 256 pages long and made 61 recommendations, and for some in government it was considered the most important inquiry ever undertaken into the question of nursing and its allied matters (Hansard 1937). But as both Dingwall et al. (1988) and Hallam (2000) note the Commission members were heavily biased in favour of the voluntary hospitals, medical staff interests and the employers.

From vocation to profession

What the Commission report did do, which had not been apparent in other reports, was identify in detail the working conditions of nurses at the time, noting that in over 85% of the municipal hospitals nurses were compelled to work over thirteen hours a day with night shifts sometimes being over 12 hours (Hansard 1937). In 1937, using the data from the *Lancet* Commission report, Frederick Roberts, MP for West Bromwich, introduced a Bill to reduce the working hours of nurses. A strong thrust of his argument was the notion that the long hours were a significant barrier to recruitment into the profession at a time when hospitals were experiencing serious shortages of nurses. Although there was some doubt cast on this measure alone being able to address the recruitment issue there was general agreement in the House about the need to reduce nurses' working hours. However, Sir Francis Freemantle, MP for St Albans, who was one of the last speakers of the day, re-introduced into the debate the notion of the quality of vocation being tainted by concerns of personal discomfort. In his speech he recognised the necessity for a modern health service to meet modern health

needs, but he was also concerned that the sacrifice of the historical spirit of service in nursing would damage the ability to recruit "girls of the highest kind" (Hansard 1937).

During the debate Sir Francis was censured by his parliamentary colleagues for making this point however it was, in many ways, a significant comment. The two decades between 1930 and 1950 saw major sweeping changes in nursing - importantly it was making the move from a vocation to a profession; from duty to service. But it is clear from both Sir Francis' comments and the reluctance of the Lancet Commission to do more than recommend tinkering with many of the more unacceptable aspects of nurses' conditions of service, that the discourse of the womanly virtues being the very bedrock of nursing was stronger than any ideals nurses or others may have had about nursing being a properly administered and rewarded employment. The message was that if the suffering associated with true vocation was somehow eased then the dedication, loyalty and obedience necessary for high quality care would be lost.

The Lancet Commission report also tried to address the problem that the GNC had never really got to grips with, that of the gap between girls leaving school and starting nurse training. Girls leaving the secondary school system did so at around sixteen or seventeen years of age; with those departing the elementary school system leaving at fourteen years of age. The age of entry to nurse training was generally twenty-one years of age, so to enter nursing girls had to wait some time after leaving school. It was believed by many observers that this 'gap' meant that many suitable young women found other jobs and were lost to nursing forever. The Commission's recommendation was to split the Preliminary State Examination into two parts, the first being taken before the probationer enters the wards; the commissioners indicated that this Part could be taken up to two years before she entered the wards - in other words while still at school.

The BNA found this proposal unacceptable and objected strongly however even if adopted it would not have solved the problem as the report of the Athlone Committee in 1939 demonstrated. Recruits to nursing were actually, as they had been since Victorian times, predominantly from the lower middle and 'respectable' working classes, not the middle and upper class young women, who were turning to business, social work and teaching (Dingwall et al. 1988).

It is possible given that the hidden agenda of the BNA's campaign throughout the thirty year struggle for registration had been to exclude the servant-class of women from the ranks of nursing and, by confining admission to the daughters of the higher social classes, ensure that the nurse would be recognised as someone of some importance in the state (Abel Smith 1960) that the gap between leaving school and starting nurse training suited their purpose as very few parents, other than the well-off would be able to afford to educate their daughters up to, or even beyond, the age of eighteen.

The GNC itself did not address the issue of qualifications for entry to nurse training until the early 1930's. Again the motivation to do this came from concerns about shortages of nurses. There had been much speculation about 'wastage' among probationers who dropped out before completing their three year training course and the reasons for this. Although long hours and harsh living conditions were considered primary culprits, there was some speculation that 'suitable' girls with reasonable educational qualifications were being put off nursing by its apparent lack of academic rigour, thus leaving employers with a depleted recruitment pool.

In early 1932 a GNC sub-committee considered the basic standard of education for recruits and recommended to the GNC Education and Examination Committee that the possession of the General School Certificate, or its equivalent should, after June 1st 1936, be the mandatory minimum educational requirement for any

candidate admitted to the GNC preliminary examination. An alternative to possession of the school certificate would be a pass in the GNC test examination in general education (British Journal of Nursing 1936). This was approved by the full GNC in 1935 but could not be put into effect until it had been further approved by the Minister of Health. In spite of some last minute activity from representatives of the Voluntary hospitals who still feared financial loss from any restrictions on recruitment, the Rule was put into effect as planned in 1936, four years after the original proposal.

At last it looked as though the moral character versus intellectual ability debate was being resolved. But the Government, advised and lobbied by the hospital management alliance, clearly felt it was walking a tightrope between raising the academic criteria and standard of nursing and risking falling numbers of recruits to nursing as a result. Among all sides in this debate the 'nursing as a vocational calling for women' discourse was still proving influential.

The Influence of the Mental Health Nurses

When researching and writing about nursing from an historical perspective it is all too easy to become solely focused on so called general nursing or that nurturing activity deriving from maternal and domestic care of the sick and vulnerable that was perceived to be almost exclusively the domain of women. There has, however, always been one other vulnerable group of people in society, the mentally ill who have through time also been subject to both the ministrations of the Church and latterly the state. The care attendants of the mentally ill are also called nurses. Mental illness nursing shares the same early roots as general nursing and initially was practiced by the same people (Carr 2004).

It is beyond the capacity of this work to consider mental health nursing in any historical detail so this section is offered to provide a brief insight into the

historical development of this type of nursing and its influence on the development of professional general nursing. I have used the term general nursing to distinguish the type of nursing that was the concern of Nightingale, Bedford Fenwick et al. from the 'nursing' that was practised in the asylums and madhouses.

Background to Mental Health Care

Towards the end of the 16th century in Britain with the development of the first attempts at social welfare policy and legislation – in particular the first Poor Law in 1601 – it can be seen that the care of the mentally ill starts to become separated from the care of the sick. The Poor Law gave responsibility to the parish for the care of those people in the parish who were incapable of looking after themselves. Previous legislation had already defined how these people were to be dealt with. Often the treatment could be harsh and it is difficult to understand how the mentally ill but physically sound would be distinguished from the idle and undeserving and thus punished for their incapability.

Nonetheless mental illness and insanity were concepts that had been recognised since at least the thirteenth century; and there is evidence from Europe of the first asylums for treating the insane being founded in the very early part of the 12th century. But the tension of understanding between lunacy as an illness and lunacy as a possession by demons continued for many years, and it is not until the early fifteenth century that the first asylums with some tenuous appearance of providing institutionalised medical care start to appear in Britain.

Like the records of other forms of formal care, those of the mentally ill largely disappear from the literature during the reformation between the sixteenth and seventeenth centuries, most likely reflecting the disappearance of the monastic communities that were the primary providers of such care. Unfortunately during this time the demonic possession theory was strong in the Catholic Church and

many hundreds of thousands of insane people were tried before religious courts and burned alive to destroy the devil within them.

The Renaissance saw the re-establishment of the asylums but the understanding of mental illness was limited and these asylums were largely concerned with custody and containment and often the 'treatment' was barbaric. The role of the carers, who were in the majority men, in these institutions was more akin to gaoler than nurse. The asylums were generally privately run and many relied on charitable donations to fund their existence. One of the most famous is probably the Bethlem Hospital in London. More commonly known as Bedlam, this small private asylum supplemented its income for nearly one hundred years between 1676 and 1770 by putting its patients on daily display when the public could pay to watch them much as animals in a zoo.

In 1690 John Locke wrote his masterful Essay Concerning Human Understanding (Locke 1690) and signalled the start of a new way of thinking about the causes of mental illness and its treatment throughout the eighteenth century. As a result of the better understanding of mental illness the treatment of the 'insane' began to improve and the care attendants' role changed to a more caring focus.

As the asylums developed and separated from the workhouses and voluntary hospitals and moved into state control mental health nursing became a speciality in its own right, moving from the traditional custodial role into a new era of therapeutic interventions. Psychiatry was becoming established as a medical discipline and its influence on the development of a mental health nursing curriculum and 'professional' entry gate gave it the beginnings of a knowledge base different to that of general nursing.

Training and Registration of Asylum Attendants (Nurses)

In 1841 the asylum doctors formed their own professional organisation and in 1885, under the group's new title of the Medico-Psychological Association (MPA) and following on from some pioneering work carried out by Dr Clark in the Glasgow asylum, they produced the first edition of their handbook for the instruction of attendants on the insane (Harcourt-Williams 2001). The Red Book as it became known remained in publication until 1945. Five years later, but over thirty years before general nursing had anything comparable, the MPA introduced a two year training, a qualifying examination and registration for asylum attendants. By the turn of the century in excess of five hundred certificates were being awarded each year (Harcourt-Williams 2001). In 1906 the training was extended to three years.

In parallel with these developments the movement for state registration of nursing was gathering momentum and the MPA could not ignore and soon became involved in the prolonged national debate about the preparation and regulation of nurses. The MPA had tried to make early links with Mrs Bedford Fenwick's British Nursing Association but these had not proved successful. Later negotiations with the GNC allowed for the creation of a supplementary state nursing register for asylum trained nurses (Harcourt-Williams 2001) with the GNC eventually taking over complete responsibility for their training, registration and discipline in 1962.

Nolan (1993) however paints a rather different picture, describing the training as superficial and driven by medical needs and practices, the candidates not well selected and the underlying motives of the MPA rather suspect. The truth, he believes, lies more in the impoverished and unscientific nature of psychiatry at the time. The doctors needed to refute suggestions that they were amateurs and that their speciality was scientifically inadequate and having a nursing workforce

that was required to be trained and registered would demonstrate the skilled nature of the work.

By the late nineteenth century the brave new world of therapeutic optimism in asylum care had receded into therapeutic depression and mindless routine, the blame for this failure of care could easily be laid at the feet of a "frail and vulnerable workforce of attendants ... who were ... largely ignorant and down-trodden" (Nolan 1993 p72)

Nolan also believes that the asylum doctors, looking to the perceived respectability of the general nurses from their association with Florence Nightingale and Mrs Bedford Fenwick, thought that their nurses should be associating more openly with this group, thus enhancing their (doctors) own prestige. This attitude only served to feed a greater concern amongst the asylum workers that they would lose their speciality to the new generation of trained general nurses. This is interesting because it appears to be in stark contrast to the attitude of the general doctors who were opposed to a system of training and state registration for nurses because they believed it would undermine their own status.

Chapter 7: Nursing's given public image reinforced

Hallam (2000) highlights the 1930's approaches to publicising nursing with a view to improving recruitment (if only as a subtext), and how the images portrayed subliminally identified with this discourse. The College of Nursing used popular middle class media to spread its message of a profession based on a middle-class ethos. The imagery used reinforced the meaning of the text, with classical references projecting a conception of occupational identity. Presumably the message was designed to be received as aspirational for the working classes and confirming for the middle class families of the suitability of nursing for their daughters. Hallam (2000) contrasts this with a report from a trade union, the National Association of Local Government Workers (NALGO), which was much more to the point about pay and conditions of service for nurses than the College of Nursing material, and notes that the use of 'A Woman's Calling' in the title of the brochure in which it was published – along with associated imagery - was a clever ploy to appeal to vocation-driven nurses, at once convincing them that they deserved better and reassuring them that there need not be conflict between demanding better pay and conditions and the very foundation of their practice. As Hallam (2000) notes, this was essentially a re-run of Bedford Fenwick's earlier campaign, except NALGO were using the same terms of reference in an attempt to achieve equality of access for young women from lower-class backgrounds (Hallam 2000).

The NALGO Charter, promoted by the Trades Union Congress (TUC), was influential in prompting the Ministry of Health to enquire formally and comprehensively into nurses' pay and conditions, and the intervention of the Second World War with its particular requirements for a more mobile national nursing workforce, coupled with further disagreements within the profession

about how this was to be achieved, facilitated the imposition, by the government, of the standardised payments scheme recommended by the Charter (Dingwall et al. 1988). At this time the Ministry of Labour also took over responsibility for recruitment.

Immediately following the end of the Second World War the Atlee Government put in place the necessary legislation to launch the new National Health Service (NHS). The NHS was part of the new Welfare State - one of the sweeping post-war reforms recommended by the Beveridge Report (Beveridge 1942). In his report Beveridge identified and sought to resolve the five 'giants' - Want (poverty), Disease, Ignorance, Squalor and Idleness (unemployment). Although the idea for a health service funded through a national insurance scheme had first been suggested and discussed much earlier in the twentieth century, the social, political and economic turmoil of the immediate post Second World War years demanded a brave new world and a welfare state was at the heart of the Government's response. This was an enormous undertaking involving the bringing together of all the diverse elements of healthcare provision under the auspices of one organisation. However, at its inception it did little to change the day-to-day working practice of nursing. There were no new hospitals to herald the launch of the NHS on 5th July 1948; and importantly no extra nurses to address the seemingly permanent shortage. In fact, according to the Leader in the Nursing Times for November that year, the NHS started its life with a shortfall of 48,000 nurses (Nursing Times 1948).

This was a known. Throughout the twentieth century there had been a perpetual shortage of nurses, yet, as Rivett (1998) notes, there was no provision within the NHS for the training of nurses - the 1946 NHS Act hadn't allowed for it and the organisation had no infrastructure to deliver it. But it wasn't until the eleventh hour, following the passing of this legislation and one year before the NHS 'went live' that the Ministry of Health, mindful of the implications of trying to run a

poorly staffed NHS, commissioned Sir Robert Wood, Principal of University College Southampton, to chair a working party on the recruitment and training of nurses (Wood Report 1947). Disappointingly, but typically, nursing did not have a significant voice - the Working Party itself included two nurses but the Steering Group comprised three medical doctors and no nursing representatives.

The Government had realised that the establishment of the NHS could be threatened by the existing shortage of nurses which would be further exacerbated by the likely increase in demand for nurses from the new service. The Wood working party was rather hastily set up, therefore, to undertake a comprehensive review of the whole nursing service and its problems. Their brief included the need to survey the whole field of the recruitment and training of nurses of all types, how many nurses were required to staff the NHS and how and from where they could be recruited and how wastage could be minimised. The Committee discovered that the wastage rates from all areas of nursing training were between 50% and 70% (Wood Report 1947). They identified "harsh and cramping discipline" (NHS) from the senior staff and matrons as the primary cause of the discontent among nursing students. Unusually the Working Party's conclusions and recommendations were radical. Unlike previous reports they did not merely highlight the inadequacies and appeal to the hospital authorities to change things, they recommended that education and training of students should be removed from the control of the NHS, and importantly that students should be relieved of domestic duties.

Although nursing at the time was able to recruit relatively easily, the attrition rate was very large leading the Working Party to conclude that a combination of improved recruitment processes and improvements to the material conditions in the training environment was urgently required. However, the Report, although offering nursing the opportunity for greater professional autonomy, was not well received by the profession or hospital management who, naturally, perceived a

threat to their large, compliant and low-paid (cheap) nursing workforce. The RCN, at the time quite dominated by the hospital matrons and more concerned with protecting the pay and conditions of the trained staff, opposed the separation of training and patient care delivery, while supporting the notion of student status for nursing students.

It is beyond the scope of this work to consider the detail of the introduction of the NHS into Britain. Several competent authorities have written in depth and with insight – see in particular White's (1985a) work, and it is recommended that other texts are also consulted. For this work what is significant is that the blame for the rejection of what the Wood Report and the Ministry of Health offered nursing as the NHS was unveiled, as White (1985a) suggests, must lie with the representatives of the profession itself due to their failure to understand what the proposals were offering. The much reduced recommendations that did carry forward ensured that the staffing needs of the NHS were dominant over all other considerations, and thus White (1985a) argues, the GNC became an agency for ensuring the 'new' NHS was adequately staffed by nurses.

The disputes that followed the introduction of the NHS mirrored those during the professional project between 1889 and 1919 and the imperative to manage staffing, accepted by the GNC, led to a re-emergence of a vocational ideology suppressing academic debate and allowing Nightingale attitudes and values to re-surface.

Chapter 8: Speaking about caring

Globally nursing has become a large and skilled workforce, recognised for a specific form of care-based healthcare activity, as Kirpal (2004) notes in Europe nursing has become a more flexible, more highly skilled and more mobile workforce with a strong professional identity. This coupled with the public perception highlighted earlier in this work that nursing is a trustworthy and well-like profession would appear to suggest that in the 21st century nursing does not exist in a culture of silence and invisibility. There is also of evidence available in the literature about the difference nurses can make to the health of individuals and communities. So having examined how, even within the discourses that appear to militate against the profession, nursing has developed over time into a large and highly trained workforce that delivers memorable healthcare directly to the community, the argument is that this could not have been achieved without some influencing presence. The proposition now is that nursing does have voice but because of its circumstance, including the discourses of women and caring, and perhaps its own internal tensions, that voice is somewhat undermined. However, as Kirpal points out, we also need to consider the conflicts faced by nurses in their practice whether those be structural – how to deliver good quality care in the face of cost efficiency requirements; or individual – how to balance caring for patients against the often competing demands of administrative work.

Speaking about caring requires us to start to have an understanding not only of what nursing is but also how it is perceived and received by others. The title 'nurse' and the activity of 'nursing' are universal concepts, nurses and nursing can be found in every country in the world and regardless of language, cultural, political and structural differences we tend to be able to recognise nurses and their activities. In the process of constructing this piece of work I have read

widely through literature chosen for its relevance to the core themes of the work. Inevitably some of the material consulted has not been written primarily about the British nursing system, with much of it originating from North America. It is important to consider, therefore, whether this universal understanding of nursing means there are sufficient similarities between nursing in the USA and nursing in Britain to justify its inclusion and the impact it has.

According to a report produced by the National Nursing Research Unit at King's College London and commissioned by the Department of Health (Robinson and Griffiths 2007) to provide information about nursing education and regulation in selected countries, there are many similarities and links between the UK profession and nursing in the USA, Canada, Australia, New Zealand and Ireland, and the data from these countries included in the report shows that the structure of educational preparation for nursing is almost identical.

The decision was made to include this source material, not uncritically and only when written in English, as it was felt that authors working in and describing nursing systems that may have initially derived from a British model but that have been allowed to develop separately within national boundaries – and then have still turned out very similar – can provide useful comparisons for the parallel development of the British system of nursing.

Where appropriate I have indicated when comments made may be more specific to a different country's nursing system.

Caring through competence

Antrobus (1997) is of the opinion that nursing's close relationship with the patient will automatically give it the authority to influence the development of health care policy. Unfortunately this close relationship is also problematic, proving to be something of a double-edged sword. On the one hand the caring aspect of the relationship is devalued due to its association with the domestic

family role of women and on the other the activity of the nursing relationship is so difficult to quantify that the argument becomes lost in the demands to provide the evidence for practice authority. However, it is still a powerful starting point for the debate about developing or recognising a voice nursing can use to challenge deeply embedded values. This chapter will address two main issues arising from this debate. Firstly the problems nursing has encountered in trying to demonstrate or establish its academic credentials and develop a research driven knowledge base for its work , and secondly, the inherent problems for nursing trying to establish an ethic of (nursing) care within the dominant biomedical model of healthcare.

Nursing as an academic discipline

One of the most enduring, and unresolved, debates in nursing has been that of the educational standard of the entrants to the profession (see Chapter 6). In November 2009 the Department of Health announced a major breakthrough in establishing a minimum educational standard for nurses and nursing practice in England. The requirement was that from 2013 all new nurses would be educated to degree level making them better equipped to improve the quality of patient care (Department of Health 2009)

The announcement of this in the media elicited a mixed and often negative response from public and expert commentators alike. This is hardly surprising given the apparent public perception that nursing has never been, nor needed to be, associated with academic achievement –a perception strongly resonating with the legacy of Florence Nightingale. The uninformed inaccuracy of the common argument that clever people can't care coupled with the glaring inconsistency of applying such an argument to nursing alone out of all the healthcare professions is though, disappointingly, never challenged.

A study by Fealy and McNamara (2007) in Ireland, examined discourses concerning the role of the nurse and nurses' professional training and uncovered common themes and continuities whereby "through professional and popular debate, a particular and enduring set of images of the nurse was constructed". This imagery represented the persistence of the belief that higher education for nursing was irrelevant and unnecessary. Interestingly some of the nurses who were involved in this debate themselves demonstrated ambivalence or hostility to the notion of nurses being educated.

The debate essentially was about the relationship between intelligence, as evidenced by having knowledge and practice as evidenced by caring. Further, as Fealy and McNamara propose the widespread and persistent perceptions of nurses as doctors' assistants and as women merely fulfilling their natural caring role create archetypes with an implicit understanding that nurses do not require an academic professional education. Although the authors describe their work as adding an uniquely Irish perspective they do agree that modern nursing in Ireland has developed from the Nightingale model and therefore that nursing discourse reflects international – certainly in the Western world - structures and functions.

But the 'problem' goes much deeper than the consciously constructed chimera of the good nurse (Fealy 2004) and is fed by discourses that have sustained, and to an extent continue to sustain, the dichotomy between the practical and the intellectual in the education of girls and women, and there can be little doubt that this dichotomy has been pivotal in the development of nursing in Britain. Florence Nightingale, for example, opposed state examinations for nurses.

In the UK during the early twentieth century significant attempts were being made to establish nursing in higher education against a background of women's place there still being an anomaly (Brooks 2005). As outsiders looking in, women

were struggling to enter the academy and had to overcome significant hurdles to establish their right to be there. The problem for nursing was compounded by what Fealy and McNamara (2007) describe as a dichotomy between the mental and the manual with continuing concerns from within the profession about the over-education of nurses in universities meaning that a nurse's intellectual ability would be in competition with her caring ability leading to the loss of the spirit (vocation) of nursing (British Journal of Nursing 1923). And this reflection of Florence Nightingale's concerns highlighted the persisting tension between educational requirements and the demonstration of moral propriety and the virtues of obedience, loyalty and vocation in applicants for nursing courses. For example, each nurse applying to enter the State Examination in the early twentieth century still required a Schedule, signed by the matron and the hospital chairman, certifying that she was of 'good character'. When Lorenzton (2003) reviewed the records of trainees at a large London hospital for the period 1876 – 1918, she found that for the nurse probationers little evidence was recorded about schooling prior to training. The emphasis in the nurses' records was on character, valuing such behaviours as loyalty, obedience, carrying out orders and 'a quietly observant attitude'. However, the medical students' records for the same period included detail about the student's education and achievements at school prior to starting the course and on-going notes about the course the student was undertaking and their examination results (Lorenzton 2003).

The 1923 GNC syllabus further reflected this tension between education and training. The priority was to prepare student nurses for practical bedside hospital care, with great importance being attached to teaching being given by matrons, sister tutors and ward sisters, informed by their personal knowledge and practical experience (Bradshaw 2000). So nursing knowledge was learned by observation, nursing procedures were learned by rote. This emphasis, combined with the

apprenticeship model of learning which had at its heart knowledge, skill and attitude, remained clearly evident in successive revisions of the GNC syllabus until its demise in 1979. Bradshaw (2000) also notes that nursing textbooks published between 1870 and 1970 subscribed to the same vision of nursing competence and strove to develop this in four areas: firstly, the moral character of the nurse; secondly, the knowledge and skill needed to provide patient care; thirdly, the apprenticeship model of learning by following the example of trained nurses; and fourthly, a focus on relationships, both with colleagues and patients.

As exams became the norm as an entry into the world of work, nursing had the opportunity to break free from the conventions of selection by reference to moral superiority and legitimately increase its educational entry requirements.

However, this was not without considerable political debate, much of which still has relevance and resonance with current debates. But immediately prior to the Second World War these debates were overshadowed by the Government's recognition that they would need to act to pre-empt a projected shortfall in the numbers of nurses available to staff the health service that would be needed during wartime. Their response was to remove the requirement for any academic qualifications for entry to nurse training; instead all that was required was evidence of schooling. This action, which albeit unknown to the profession at the time, would have a serious negative impact on the future educational elevation of nursing, as far from being a short-term measure to cover the war, this situation lasted until 1965 when the government finally relented and allowed the re-introduction of an academic entry gate. This was set at three GCE 'O' levels, an academic level that was lower than the School Certificate that had been the requirement before the war. But what is more disturbing about this is that in what appears to be another example of nursing seeking to suppress itself much of the resistance to the earlier re-introduction of academic entry requirements after the war had come from within the profession. The twenty-five year gap

between the removal of academic entry restrictions and their re-instatement meant that many of the members of the GNC, who had accessed nursing during this time, believed that nurses, like themselves, did not need educational qualifications to demonstrate fitness for the job.

In Britain by the 1950s however, it is possible to witness a drive to develop a more 'academic' definition of nursing that was intended to direct nurses to their proper function and distinguish their practice from that of other healthcare workers, which in turn it was expected, would demonstrate the 'autonomous profession' credentials. However, the necessary adoption by all nurses for these models and theories of nursing to be effective did not happen. Their use in practice was patchy, fragmented and not well understood and over time and through lack of use and further development their validity and credibility was challenged. According to Wimpenny (2002) the challenge they promised the profession was lost, bringing their value and purpose into doubt. But what were these models and theories trying to change? On one level they appear to be genuine attempts to isolate what nursing is and nurses do and express that as a template, which if followed will demonstrate that nursing is a series of recognisable and easily understood behaviours and actions. On another level though, they appear to be attempts to homogenise the activity of nursing, to manipulate it into quantifiable processes that fit with accepted political and economic definitions of health and illness.

Some authors, for example Graham (2003), have proposed that we need look no further than Florence Nightingale's work to find a guide to the future of nursing theory and practice. In particular her thoughts about the complementary relationship between nursing and nature - "Nature alone cures... And what nursing has to do is to put the patient in the best condition for nature to act upon him." (Nightingale 1992), have been interpreted as an early, accessible definition

of nursing. However, caution must be exercised here as many of her often quoted statements come from her *Notes on Nursing*, a book written as a guide for all women and not as a textbook for nurses.

An ethic of (nursing) care

But there is also a presumption here that models are the Holy Grail that nursing seeks and needs to justify its professional presence, and this needs unpicking. When we look at current healthcare practice and delivery in Britain it appears that arguably the biomedical model remains the dominant and popular approach. It could be that the powerful discourse associated with this model is acting as a barrier to the voice of nursing, but equally it could be that nursing's attempts to appear more credible by trying to define contained ways of knowing what nurses do are supporting the dominance of this approach. In other words nursing is unknowingly ensuring its own domination. In the late nineteenth century nursing was a unique and autonomous practice and contributed to healthcare in a way different to medicine (Wall 2008), but the moves in the early 20th century to formalise nursing education which in itself included an agenda of trying to break the perceived close ties between nursing and 'women's work', most likely had the result of nursing education being driven under the control of physicians (Boutilier 1994).

As Graham (2003 : p346) points out, "British nursing is not defined by nurses but by others who are more successful at marking out professional territory". Here Graham is not necessarily saying that others have overtly stated what nursing is, more that in the absence of the profession being clearly heard to state what nursing is and who nurses are, it has been pushed into roles left by the gaps of other professions' self-definitions. But that in itself leaves opportunity for others to create different definitions of the nursing they want and therefore different expectations of who will deliver it.

Virginia Henderson, considered one of modern nursing's great leaders, in a speech given over thirty years ago highlighted that as long as a multitude of definitions of nursing and nurses persist and as long as nurses undergo different forms of training, undertake different roles and receive different rewards, debating nursing as a concept will remain firmly in our discussions (Henderson 1978). Nearly twenty years earlier, in 1960, Henderson (1960) had attempted to define nursing by illustrating how nurses' skills in caring allowed them to offer a unique service to the community. Putting aside the use of the feminine gender, it is considered a classic piece of work. Importantly, though, it does not appear explicitly to reject the dominant biomedical model of healthcare delivery in this country and thus some critics have asserted that it situates the nurse as the physician's assistant. Others have interpreted it as meaning that the patient is the one required to carry out the doctor's orders and the role of the nurse is to assist them to do that. However both these positions still appear to situate the physician at the top of the 'care' hierarchy.

Almost by definition the biomedical model of healthcare leaves nursing with a mainly passive role in caring, and as a model of healthcare delivery in the UK, Heller et al.(2005) believe that biomedicine dominates contemporary and official understandings of health and certainly forms the basis of the NHS and many other western health care systems. Heller et al (2005) also highlight how biomedical thinking is dominated by the scientific understanding of health and disease and as a model for practice it prioritises professional knowledge, a priority mirrored in nursing models. In Giddens' definition of the biomedical model as a process of seeking out the presence of recognized symptoms in the human body that allow an objective definition of disease that in turn can be treated with scientifically-based medical interventions – in other words the human body is likened to a machine that can be restored to working order with the proper repairs (Giddens 2006) - we can almost see reflected the underlying

philosophy of the National Health Service (NHS). This is a position supported by the Institute of Healthcare Management in 2004, who argue that doctors as the dominant stakeholders in the NHS have, through their devotion to negative and biomedical models of healthcare delivery, moulded the Health Service into a curative or treating service (Ottewill and Wall 2004).

The role of the nurse in this approach becomes assistant, servant, supporter to the doctor by being the person who executes the prescription for cure. It may be that the difference between doctors and nurses – or perhaps more accurately, the difference between what they are perceived to do – is commonly understood as “doctors cure whereas nurses care”, which would suggest that nursing embraces a more biopsychosocial approach. However, according to Castledine (2005) the evidence appears to indicate that nurses base their nursing care on the biomedical model. He identifies how research studies have reported how nurses view their patients as physical beings with medical problems to solve rather than people with personal and individual problems who need nursing and healing care. Castledine highlights a very important point here – nursing is complex and possibly poorly understood even by nurses who can perhaps more easily relate to the logic of biomedical intervention.

Understanding Caring

The challenge is how to understand and communicate the difference of nursing activity within a dominant medical discourse without recourse to an exercise that seeks to break down caring into its component parts in order to identify their objective worth, because following that action to its end appears to defeat any argument about nursing’s unique function and therefore what it can bring to the health policy debate. This is a fundamental issue for nursing, caring for people is at the heart of nursing and it is where nursing’s strength lies according to Antrobus (1997), but articulating this and demonstrating discernible difference from other approaches to caring is problematic.

A significant amount of the commentary on caring in nursing, particularly the earlier material, is drawn from North American literature sources. This does not detract from its validity. Although the nurses may operate within a different model of healthcare delivery the essence of nursing – caring with compassion – is an universal concept.

From the feminist literature (Radsma 1994, Reverby 1987a, Graham 1983) argue that the history of caring has become entwined with the histories of nursing, women and domestic service. They also believe that the professional group called nurses have been given a mandate to care by a society that refuses to value caring and therefore the significance, meaning and function of nursing remains undefined and intangible. This may in part be a feature of some kind of universal definition of caring that makes it a natural human (female) quality rather than a job of work. This does beg the question of whether a person or a nurse can be required or obliged to care or whether this is just presumed to be a given among those who practise nursing.

Barker (2000) notes that starting in the late 1980s nursing theory began to establish itself, with many theorists, for example (Barker et al. 1995, Leninger 1996, Peck 1992, Sourial 1997, Travelbee 1971, Watson 1988) attempting to situate caring as a central or core function of nursing. However, as Barker (2000) notes, it soon became clear that caring may not be a unique or 'exclusive to nursing' function as almost immediately theorists from other disciplines began to emphasise the caring dimensions of their own practice. If caring is not exclusive to nursing then how do nurses distinguish a function uniquely different to other disciplines?

Olshansky (2007) notes that the common answer to what defines a good nurse is someone who is compassionate and caring and that nursing is described as a caring profession. This, however, still leaves open the need to describe caring in

some way that does not just reduce it simply to an innate characteristic of good people, or even just good women. Swanson (1993) used the term 'informed caring' to also indicate that the caring in nursing is dependent on knowledge (see also Koloroutis 2005).

But, as we have seen in other arenas in nursing's history, it has striven to distance itself from those perceived menial activities that could threaten its professional status. One outcome of this is, as Bradshaw (2000) highlights, has been to make personal nursing care into a commodity of lower market value, transferable to less trained workers, leading not only to a 'clouding' of the purpose of nursing, but also suggesting that some nursing is purely routine and there is another, more superior form of nursing. So the argument that it is in this personal nursing care that the art or the very essence of nursing lies is complicated by the perceived move by trained nurses into advanced and specialist areas of (scientific, biomedical) practice, raising the concern that this caring component could become something external or marginal to the profession (Watson 1999).

But nursing is a two-way process and nurses must adjust the care they give according to patient need and response. In a small study, but probably quite representative of larger studies, Bassett (2002) notes the difference between the nurses' perceptions of the care they think they give and the patients' perceptions of the care they think they receive. The nurses in the study seemed to be able to articulate in very similar ways what comprised excellent nursing care and therefore what made a good nurse but the patients seemed to have slightly differing views on what made good nursing. Bassett uses the concept of nursing as 'emotional labour', as defined by Hochschild (1983) (see also James (1992), Aldridge (1994) and Smith (2001)) to suggest that an important part of nursing's caring function is caring for themselves and colleagues in the face of the emotionally arduous nature of caring for patients. Could it be that in the absence

of professional support and for their own self-protection nurses may seek some distance from their patients and here perhaps the biomedical model has some allure?

This suggests that nursing, and therefore nursing education, has two major tasks or challenges; firstly to understand properly not only what is its caring relationship with its clients, but also how to manage that for the benefit of both parties; and, secondly, learning how to influence healthcare policy and the provision of resources in order to ensure that it is able to practise caring for the benefit of the community. To understand where to begin to address these challenges and understand the present the genealogy, or historical context, of nursing it has been necessary to investigate its past. By doing this, some understanding of how the power, knowledge and subjects of nursing are viewed can be gained (Foucault 1980).

This account has taken one route through that genealogy and from that has provided a view of how the combinations of events and people have contributed to the perception of a powerlessness and lack of voice in nursing today. The further imperative of this piece of work is to use that understanding to develop a strategy that has the potential to address the challenges highlighted. As my field of practice is nurse education the proposal I shall outline involves developing educational initiatives to empower and skill nurses to not only recognise and predict the current and future healthcare needs of the community but place themselves in a position to contribute their understanding of these healthcare needs and how they can be met from a nursing perspective, into appropriate national policy planning arenas. It is important to emphasise that this proposal is only one suggestion based on my interpretation of the historical research that precedes it. Others reading this work may well produce different proposals.

Chapter 9: Developing nurse education

This work has shown how, historically, nursing has perceived the achievement of professional status and recognition to be important and has also highlighted how in spite of this achievement there are historical and persistent discourses that continue to dog nursing's ability to have its voice heard in significant places. Part of the problem is that throughout its history nursing has been largely defined by external others including medical staff and employers but it has also been riven with internal divisions that have played a significant part in compromising its professional power and voice; layered onto that are the discourses that have informed the understanding of women and contributed to their (lack of) power and voice in society, so as Brinkman (2009) highlighted in New Zealand, nurses have been unable to get their messages across to one another, let alone the public and the politicians who hold the purse strings. This apparent lack of internal communication and unity is significant. It can be observed quite starkly during the professionalisation 'dispute' with its perceived class agenda; the moral agenda of Florence Nightingale that was so exploited by political and gender considerations and when trying to understand the nature of nursing's voice within Hirschman's work.

McWilliam (2003) believes that as much as nursing has big challenges to meet to secure its future position as a serious contributor to national health, welfare and social policy debates, it is nurse educators charged with the responsibility of developing the professional potential of nursing, who must find the answers to some very difficult questions. The answers lie partly, she believes, in work that will restore nursing's 'spirit' through affirming the value of nurses and nursing which is very much an internal process. When nurses have learned to value each other's contribution then perhaps they can seek to engage and collaborate with external colleagues. For her, the role of nurse education is to provide the

language and culture gained through critical reflection, for nurses to do this. This perception resonates with the work of Hassmiller (2010) in the USA who makes the point that nurse education is central to the development of nurses who can meet the demands of the diverse and changing community healthcare needs, expand the scope of practice, embrace technology, foster inter-professional collaboration and 'be at the table' to contribute to healthcare governance and policy development.

However, we should be wary of assuming that nursing education does not also have its own problems, and these are possibly very similar problems to nursing practice in terms of accessing and managing the resources necessary to educate future practitioners. What we need to understand here is how aware are nurses of the decision-making processes involved in securing healthcare resources and what is the nature of their participation in these decisions. Falk and Chong (2008), again in the USA, examined the involvement of nurses in the allocation of resources and found that while nurse have considerable knowledge and expertise in the micro-allocation of resources that directly affect patient care their involvement in the macro-allocation of resources is minimal. As healthcare resources become scarce their allocation, at both a macro level – amount of resource; and micro level – who is the recipient, becomes subject to ethical considerations of distributive justice which are informed by knowledgeable experts. But Falk and Chong also found that nursing textbooks and journal articles on the topic show a preponderance of discussion on micro-level ethical issues demonstrating that this disparity is perpetuated in the way nurses are currently educated to always put patient needs first (Falk and Chong 2008).

Applying this to nurse education, Brinkman (2009) noted that the macro decisions made will affect how funds are distributed between teaching, research and the quality of the clinical teaching; and at the micro-level, nurse educators make allocation decisions when supplying students with equipment to practise

their skills. By Falk and Chong's analysis therefore, nurse educators who have most likely come from a nursing practice background, which is significantly the case in the UK, will not be skilled and experienced in prioritising teaching resources but will be more comfortable with ordering skills equipment.

Falk and Chong (2008) contend that effective decision-making related to ethical micro-allocation and macro-allocation of resources should be taught to nurses so they have the tools to take on decision-making responsibility at all levels of the organisation. And, they believe, the benefit of having nurses who are prepared to address all levels of resource allocation in influential administrative and policy positions, beyond the bedside, will be better health care. The same argument could easily be applied to the UK.

Taking on responsibility for the access to and proper distribution of scarce healthcare resources requires facing some issues that may be uncomfortable for nurses for a variety of largely historical reasons. Nursing is, I would argue, still heavily influenced by its religious and disciplined history and the presence of Nightingale with her emphasis on moral integrity is still keenly felt, so activities such as marketing and involvement in political activity with their perceived lack of virtue and outspokenness are felt to be alien to the virtues of humility, obedience, loyalty and invisibility, or being 'seen but not heard' (Brinkman 2009).

But Buresh and Gordon (2006), in their work on nursing moving from silence to voice urge nurses to break away from this outworn culture and wear their brains, not their hearts on their sleeves and relinquish the "virtue script" for one based on their hard-won knowledge. Echoing Antrobus (1997) they are clear that only practising nurses know and can authentically articulate what nursing is and what nurses do, and so, for them, nurses have the responsibility of moving nursing from silence to voice. And this will require every nurse to be prepared to

challenge the structures and culture that deny them their full voice, leaving their work remains hidden and misunderstood. And until this happens Gordon's and Buresh's words, while welcome and wise, will, O'Connor believes ultimately fall on deaf ears (O'Connor 2009).

Nursing's continued lack of involvement in decision-making, it appears, could ultimately have dire consequences for the profession. But getting the message out there requires an understanding of the audience and the medium. In Australia, Sanchia Aranda (Sweet 2008) stated her belief that nurses and nursing have to evolve in ways that are relevant to society or become irrelevant themselves. The message nursing needs to get across to managers and politicians is that nursing workforce planning needs to be based on the needs of patients and communities, not professionals. Effective marketing of messages requires nurses to understand the techniques of marketing but part of the effectiveness for nursing is, as Gordon and Buresh (2008) recognise, for practising nurses to be empowered and supported to contribute to the message. But marketing messages is only part of the problem; nursing still has to get to grips with political analysis and activity. As Brinkman (2009) highlighted in New Zealand, nursing's continuing hesitancy to grasp the nettle of these issues which has threatened patient care through nursing's history may also negatively impact on the profession's future.

It would appear, therefore that the future is clear for many nursing commentators. But what is lacking from their warnings is a clear sense of how to do what must be done.

A good current example of this can be found in the USA where the highly influential Institute of Medicine (IOM) has recently published an extensive report called *The Future of Nursing: Leading Change, Advancing Health* (IOM 2010).

The four key messages in this report are: (1) nurses should practice to the full

extent of their education and training; (2) nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression; (3) nurses should be full partners with physicians and other health professionals in redesigning health care in the United States; and, (4) effective workforce planning and policy making require better data collection and an improved information infrastructure. This report has been hailed as a landmark by nursing leaders in the USA, but they caution that it raises tough issues that demand structural support from the system to enable nurses to take a stronger leadership role in health care reform, and nursing education will also need to include a stronger focus on preparing nurses to be leaders, both in practice and in Government. The semantics of this report are interesting. Out of four recommendations the phrase 'nurses should' appears three times. Is this, therefore not so much a case of nursing being offered the chance to participate but more of nursing being told how to behave – defined by others – in order to be allowed to participate or to have its voice heard? There is an assumption in this work that there is a viable alternative to the perceived perniciousness of the biomedical model of healthcare delivery and that alternative is nursing. However defining the difference has proved difficult and the default position appears to be to engage in a rather circular argument of appealing to the notion that there must be a difference in the caring offered by doctors, nurses, social workers and others simply because they have different job titles. The clarity with which this report appears to offer benefit while the actual impact may mean more control is a warning to nurses in other countries to be wary of political 'solutions' to nursing's 'problems'.

It is important for nurses to know about and understand a history that tells us the working difference between agencies was once much more clear than it is now but it is also necessary to show how that knowledge and understanding can be used to create the circumstances for nursing to use its voice in the

development of healthcare policy and practice. This is the challenge for nurse education.

Caring

In earlier chapters I have discussed how caring, which I believe to be at the very core of nursing, may have become devalued as an occupation through the perception of it as an innate domestic function of women, but it is unclear why this relationship should matter. There is no evidence to support any assumption that caring is an exclusive function of women so nursing is challenged, not to discard caring or distance itself from women's caring – whatever that is – but to unpack caring specific to nursing and defend nursing as a complex and diverse practice of human interaction and management in response to diverse human distress in diverse contexts – with occasional recourse to or use of biomedical technologies.

In order to meet around the healthcare policy table in a context of the biomedical governing discourse nursing has to be able to account for the benefit its form of caring brings to the population – people. Whether that benefit is promoting health and well-being, recovering health and well-being or adjusting to its ultimate loss. The form of managed care we have seen develop in the USA and starting to grow in the NHS merely requires a kind of production-line mentality that is not about the kind of nursing caring to which (should) we aspire.

However, there do appear to be choices to be made. Visibility is available but at a price. As some authorities (Kanter 1977, Simpson and Lewis 2009, Star and Strauss 1999, Wagner 1995) have highlighted, attempting to give a value to caring by breaking it down into a series of objective tasks can lead to the loss of the very essence of the process. The alternative, and this is the challenge for nurse education therefore, is to work with nurses to seek to find a way to understand a form of caring that is specific to nursing and present it in a way

that enhances it as a nursing activity and highlights its strengths as a tool for positive health and welfare promotion – to both practitioners within the profession and politicians and healthcare partners outside.

A significant part of the process here could be the reconstruction of nurses and nursing as an important part of the community's healthcare workforce. As will be shown in the examination of the challenge to enable nursing's voice, nurses cannot continue to accept not being seen or being perceived as less important than other healthcare professions. Darbyshire (2006) highlighted how for too long nursing has failed to challenge negative stereotypes, whenever and wherever they are encountered, leading to both external and internal devaluing of the profession's contribution. Nurse education's role here is to develop the necessary knowledge, skills and attitudes within nurses to empower them to enhance nursing's confidence to promote itself and what it does. I wonder if the question is becoming not 'what is nursing' so much as 'what is it we want nursing to be', the 'we' being the profession itself – resisting the historical recourse to 'what is it external others want nursing to be'. Nursing education already has a repository of tools at its disposal to address this task, such as practice-based research; what it may lack is the confidence in its own ability. This approach may go some way towards tackling the perception that nursing undermines or suppresses its own voice or its own practitioners.

As has been identified earlier in this work, there have been attempts by nursing in the past to create a structure for its poorly understood unique practice through the development of nursing models. However these largely failed to provide the benefits they promised, but in a post-modern analysis this is unsurprising and probably advantageous as models may ultimately undermine the very thing that we are trying to promote. The forced deconstruction of nursing to fit a model presumes a single-voiced profession carrying out a generic set of activities and

so the end results appear vacuous and can make nurses seem intellectually inferior.

It is likely that nursing is significantly disadvantaged by the close adherence to a biomedical approach to healthcare, dominated as it is by medical science thinking. Nurse education with its slight distance from day-to-day practice, is ideally placed to challenge nurses to think about and investigate sustainable nursing approaches for the delivery of nursing care. Perhaps here there is still some value in looking to re-establish the relationship between the art and science of nursing. Importantly any re-evaluation of nursing and the contribution it can make to the health and well-being of the community has to take place within the context of society's future healthcare needs and provision. In creating this future nurses do need to demonstrate the ability to interpret current trends in health and healthcare delivery, be able to imagine the consequences of these in the future and acquire the necessary knowledge and understanding to engage in political debates and through these make clear nursing's contribution to policy development.

Above all nursing needs to challenge its own complacency. With the completion of the all-graduate profession timetable for nurse education in the UK, the curricula in the nursing schools and departments are now well placed to challenge the production-line mentality of healthcare delivery and understand how the generous activity of nursing caring that offers real benefits to people also provides an alternative to the more technical biomedical approach. Unfortunately though nurse education is not autonomous and is subject to its own significant political interference and the challenge for the academic institutions is to try and ensure that their adventurous curricula are not overly diluted by political 'simple solutions' or knee-jerk reactions to health service issues. It is apparent that current political opinion is that all problems within the NHS are amenable to cure through further training. For nursing this has been interpreted as further skills

training, highlighting an agenda appealing to discriminatory values of the past – maybe the Nightingale Effect – that, it could be argued, holds nursing within a simple, practical application that can fit narrow, managed healthcare delivery. Equally though, the argument is not as simple as saying that we either hold to the biomedical model or to a skills model – somewhere between those two positions lies nursing. However, we may not recognise it by current measures as we may not yet have seen it.

It is probably only in the last 10 years or so that nursing research has started to establish an unique and credible knowledge base for nursing practice but by some measures it is starting to demonstrate an enhanced positive impact on patient care outcomes by nurses and specifically graduate registered nurses. For example in the USA Aiken et al (2003 :p1617) found, after adjusting for other variables, “a 10% increase in the proportion of nurses holding a bachelor's degree was associated with a 5% decrease in the likelihood of patients dying within 30 days of admission”. While, for a variety of reasons including the type of nursing interventions delivered by nurses in North American hospitals and the fact that the education system has been embedded in universities for some considerable time, we need to exercise caution when translating these statistics for our use in Britain they do raise some interesting questions for us and our own system. Surely just moving nursing education into higher education and moving the preparation course to degree level does not in itself explain why the degree level educated registered nurse should have any significant impact on patient care outcomes over that of the non-graduate nurse. Should we also be wary of how these outcomes are measured and what they are seeking to demonstrate? If the essence of good nursing is an activity that is difficult to quantify there is the potential, in a healthcare culture fixed in the biomedical model, for this to become of secondary importance to a more measurable activity such as the demonstration of technical competence. But there is no evidence to suggest that

graduate nurses are not also caring, so maybe what we need to consider is that they may bring to their practice a particular attitude and approach that is derived from their experience of studying at a higher level and part of that must be the willingness, desire, ability and confidence to challenge their own and others' practice, and perhaps this is the essence of the knowledgeable aspect of caring.

Voice

From the evidence I have read I have concluded that nursing does have a voice but, as has been considered throughout this work, various factors both external and internal have mitigated against that voice being heard. The challenge for the future, therefore, is to empower nursing's voice.

One of the great puzzles for me during the writing of this thesis has been trying to understand how Florence Nightingale fits into this debate. She has been an enigma and her presence has been impossible to ignore. Only latterly have I been able to clarify for myself why she is so important to the discussion, and to do that I have had to separate Florence Nightingale the woman from the myth or cult of Florence Nightingale. With the benefit of hindsight it has been possible to look back and see that in so many ways Florence Nightingale the woman was almost irrelevant to the development of nursing, but the iconic Miss Nightingale has had a significant impact on the profession. In particular her presence probably distorts what little voice nursing has. In fact, so influential is her presence that it is possible to say that nursing only has a recognisable voice if it fits with the Nightingale view of nursing. And by that I do not mean the view that Nightingale had of nursing but the way that nursing is persistently viewed through a Nightingale filter.

It is important that educational strategies for empowering nursing for the 21st century should include helping the profession to understand and challenge the continuing influence of Florence Nightingale by learning to use her to nursing's

advantage instead of accepting her use by others to determine nursing. A programme of more critical and politically aware professional education informed by a good understanding of nursing's history and underpinned by a robust knowledge base derived from high quality research is required. This latter part will remain a struggle while the research projects more likely to attract large grants are the quantitative studies whereas for nursing the most useful research that will reflect the interactive nature of its work will be qualitative – a discipline that has tended to be less popular with funders. However, there is evidence that this is changing as more and more funders are requiring studies to demonstrate the social impact of their results. Over many years those that govern nursing have colluded with Government and employers to deny applicants an academically challenging route into the profession and even the relatively recent entry into academia has felt tentative as nursing has clung to sub-degree courses in pre-registration education. Importantly the area that has shown significant advance is that of ongoing post-graduate education for its nurses. For the future in England the Diploma level entry courses are being phased out as they have in the other countries of the UK, and nurse education will become more firmly embedded in higher education.

Its placing in higher education is important to the future of nursing for many reasons. For example, Toofany (2005 :p28), talking about the UK nursing situation, quite boldly states that “nurses who have experienced higher education are more likely to participate in policy debates”. This, she believes, is because the experience of higher education tends to broaden their outlook, but she is also concerned that nurses still have difficulty contributing to policy development and also making others aware of their value. There are of course other pressures on or obstacles to nursing becoming more influential in policy creation; significantly the anti-intellectualism within society that invariably is used as the argument for the ‘compassion failure’ witnessed since nursing became more academic, the

narrow biomedical perspective on health and well-being and even within the universities themselves where the emphasis is on positivist, quantitative research methodologies. Cohen et al (1996) note that the political awakening of nursing depends on the education of nurses about health policy. But as Fyffe (2009) points out the inclusion of policy and political education into British nursing curricula to date has been patchy. Part of the problem here is the lack of skills and knowledge among nursing lecturers to develop and provide relevant programmes. However the advantage of the university setting is the accessibility of skills and knowledge from other disciplines.

While education, research and public opinion are important factors upon which the effectiveness of nurses in health policy development depends (Gebbie et al. 2000), it would appear from lessons learned in the USA in the 1980s that the development of leadership skills in the workforce coupled with a recognised 'leader', be that a person or a single representative organisation, play significant critical parts in strengthening and supporting the profession to influence political behaviour with regard to health (Fyffe 2009). Broughton (2001) while noting that certain obstacles and inhibitions have hindered nursing, also highlighted that until the question and issue of leadership are addressed, the profession is prevented from playing a larger role within the health system and within society. Although Antrobus (1997) is of the opinion that nursing's close relationship with the patient will give it the authority to influence the development of health care policy and she is also clear that leadership is a critical enabling factor. The skills of leadership – as distinguished from clinical management - and in particular political leadership are also lacking in the education of nurses.

This is supported by the findings of Williams (2004) in her report to the NHS Leadership Centre. She found that leadership development, if appropriate to the culture and work of the organisation, can have a positive impact on driving organisations forward. However, and this is particularly significant for nursing,

she also noted that the structure and culture of the organisations within which they work may prevent leaders from driving change forward (Williams 2004). This highlights the complexity of the situation for nursing in this country. The majority of nurses in the UK are employed in the NHS, an organisation whose structures and culture militate against nurses moving forward changes in nursing. So although individual nurses may achieve management positions, their opportunities to significantly influence policy from a nursing perspective are limited. As both Gebbie et al. (2000) and Fyffe (2009) highlight although advances have been made in recent years in positioning nurses and nursing as potential influencers of policy and political decision making there is still much work to be done in ensuring consistent and continuing support for nursing in those arenas.

It appears though that while the importance of the need for the support of nurses who will take up the challenge of empowering nursing is apparently well recognised it is, in today's structures, still effectively underplayed and even ignored, as it has been in the past. For example in 1983 the Griffiths Report (Socialist Health Association 1983) was implemented in the NHS and the impact of this was to effectively remove nurses from the management of nurses and by doing this ensured that nurses did not have an equal role in determining health policy. Nursing at the time did not have the political awareness, clout or strength to fight these 'reforms'. As Shrock (1975) had noted some years earlier, not only were nurses not political animals but their own profession ensured that they stayed that way – a statement that appears to resonate with the notion that nursing seeks to undermine itself by its attitude towards those members that participate in public political activity and its failure to support them through united voice.

In the late 1980s the Royal College of Nursing, then under the leadership of Trevor Clay, responded to this perceived lack of political knowledge and

awareness among nurses. Clay was concerned that nursing, power and politics were not generally thought of – both inside and out of the profession – as natural bedfellows. To highlight this and to pave the way for developments in the structure of the RCN to tackle this he published *Nursing: Power and Politics* (Clay 1987). According to Fyffe (2009) it is likely also that this was Clay's response to the stinging criticism of the RCN in Salvage's (1985) earlier work on the politics of nursing. In his work Clay highlighted one of the great failings of the profession, the fact that nursing can remain and has remained either unaware of or has actively disregarded the social, political and economic forces that have shaped and surrounded its practice (Clay 1987), thoughts echoed by others (Gough et al. 1994, Maslin-Prothero and Masterson 1998, Robinson et al. 1992). The historical perception of this active insularity has been that it has given nursing its strength when the reality is very different.

In America, where by the 1980s nurses had come to realise that in order for nursing to be regarded as a unifying force for advancing health (Fyffe 2009) and a powerful influence in determining health care policy, nursing itself had to be seen to be united by a set of values that reflected strong leadership and political knowhow, resulting in the American Nursing Association (ANA) taking on a proactive lead role. In the UK by the late 1990s the RCN saw itself as the guardian of that role and was starting to focus on trying to influence health care policy by employing parliamentary officers and forming a policy unit. But as Barker and Buchanan-Barker (2005) highlight, any progress made was not evident. They note that in spite of the tremendous advances made in mental health nursing education, research and practice in the last forty years, mental health nurses who are the front-line of almost every aspect of psychiatric practice remain largely invisible (Barker and Buchanan-Barker 2005), while the media continue to turn to psychiatrists for informed opinion and also Government agencies such as the National Institute for Clinical Excellence (NICE) continue to

fail to recognise the contribution of nursing to mental health service delivery by choosing to appoint very few or often no nurses to their development groups or review panels, where voluntary sector groups are often far better represented. Why, ask Barker and Buchanan-Barker, have mental health nurses been so silent about their exclusion from this important body? In response to their own question they point out that individual nurses have little in the way of organisational means to bring their understanding of nursing's importance to a wider, public audience but this still does not explain why such bodies as the Mental Health Nurses' Association and the Royal College of Nursing have apparently failed to challenge this state of affairs; and Robinson (1992) and others have indicated that the situation is the same for other branches of nursing.

It is postulated that what is lacking in nursing is unity among nurses and one is moved to ask whether this is the reason for the persisting reliance of the profession on the Nightingale view or values. The global recognition of Nightingale as the leader of nursing has probably provided a form of unity for the profession, but is the attached adherence to her belief that moral virtue is paramount preventing nursing from being and being seen as a meaningful political force in health?

Conclusion

The problem identified in this piece of work is that nursing does not appear to be making a significant contribution to the formation and development of healthcare policy in Britain – its 'voice' is either not being heard or not listened to. Two main aspects of voice have been considered – voice as having something to say and voice as having the ability and opportunity to say it. For nursing this concept of voice can be seen to be operating both internally within the wider body of nursing, and externally on the organisation's ability to deliver its message externally to the wider community – and possibly also externally in terms of the way outside others influence nursing's voice. It appears that it is within both these arenas that the problems may lie, suggesting that nursing, to an extent, may be 'pulling the rug out from under its own feet', an idea that seems to find some resonance with the notion of 'nursing's cannibalism' which is found as quite a common theme in the nursing literature.

But why is nursing being self-destructive, what is it in the construction of nursing that engenders this apparent insecurity? Considering Hirschman's work on Voice has offered some insight into the struggles that nursing has with itself and external others to define itself – give itself Voice. His condition or alternative of Loyalty appears to resonate with nurses' almost universal unwillingness to step up and speak out and the ease, certainly in the early days of modern nursing, with which nurses left the profession rather than fighting the battle of raising concerns may well have had a negative impact on the development of the art of voice. Loyalty would suggest though, a significant degree of unity and collective agreement but these are not necessarily traits easily found in nursing where nurses as individuals are often quick to criticise their colleagues and the closing of ranks behaviour often seen in other professions is not generally seen. However, there may be links to be found here with Florence Nightingale's legacy of the 'nice', 'kind', morally virtuous [young] woman who 'knows her place' – a

prescription for a homogeneity that emphasised humility, devotion and moral stature above academic achievement and aspiration - for Nightingale the nurse was very much Nature's assistant and enabler.

It has been proposed in this work that the roots of this lack of or loss of voice lie in a discourse, or multiple discourses, that focuses on the inseparability of women and nursing and is therefore further compounded by a powerful, deeply embedded and largely negative discourse about the status of women in society that has its roots in and has persisted through history. This work has taken as its premise that the combination of these discourses has created a situation where nursing has been denied the opportunity to become an autonomous profession, and has been unduly influenced and shaped by external sources. And perhaps there is still some underlying and undermining notion that being politically proactive, being outspoken is not something (nice) women do.

This premise has been informed by the observation of nursing being unconfident about its practice which has been largely defined and determined by others who appear to have little understanding of nursing practice and who have subscribed to a view of nursing held by others perceived to be more powerful. Again this is problematic as it could be argued that nursing is powerful in its unique practice and could find its voice in this way but is concerned about this creating the conditions for nursing to be seen as solely a skills based profession which may undermine further its struggle to claim intellectual credibility.

During the writing of this piece of work strong themes have emerged in relation to nursing's lack of voice. Firstly, it is proposed that nursing has evolved through a history that has been closely tied to the history and social evolution of women in Western society. While it is probably safe to assume that women as child bearers were predominantly also the primary carers within a family group and later larger groups of families as communities, the arrival of Christianity and its

teachings saw them vilified as the source of original sin and therefore removed from any active healing roles. This time also appears to herald the development of the persistent discourse that defined women as 'troublesome', a problem needing to be controlled. This perspective does pose so many questions when there are apparently no laws of nature that determine such a discrepancy between the sexes, so for this work I have chosen to focus on how changes in early religious or worship behaviour dictated by changes in food acquisition methods may have set the scene for the different treatment of women – a situation later compounded by what we might call organised religion, in particular Christianity.

It is important to re-emphasise the idea that this thesis offers one perspective or approach to considering these issues and in doing so does not exclude or deny other perspectives. In particular the feminist literature offers an approach to understanding the situation through the lens of a gendered world. The work of Gilligan in looking at the early cognitive development of boys and girls proposes some insight into how they may not only view the world differently but also the way they behave within it. Gilligan's ideas are interesting and ask us to question notions of nature versus nurture. Amongst the literature offering a more specific nursing context the work of Celia Davis is highlighted as providing a well-constructed feminist perspective of nursing's professional dilemma. It is still disappointing though that when put to the test they are still weak on answers. One common and outstanding feature of so much of the literature reviewed for this work is the somewhat tautological advice that the solution to nursing's lack of influential voice is for nurses to develop influential voices.

It is impossible in any consideration of nursing history and its impact on modern nursing to ignore the presence of Florence Nightingale. Whether her practice still has relevance or not, her influence still reverberates powerfully through the profession today, and her emphasis on the moral – as opposed to the intellectual

– stature of nurses is a useful tool for those who seek to oppress nursing. This anti-intellectual stance taken by many – both within and outside the profession – that claims that academic achievement is antithetical to the ability to care has been noted to be just as strong as ever in recent debates about the future of nurse education.

But Nightingale could be as much about the solution as she is the problem and this is why I have chosen to devote a significant section of this work to an examination of her, her work and her reputation. There is an element of knowing the enemy here as the myth of Nightingale seems so deeply embedded in the global culture of nursing that to reject it or her is impossible, so the focus for nursing now is how to work her into a modern scenario where nursing is an academic as well as a practice occupation, driven and informed by research and best practice and where nurses can take their place at the table of policy development thus weakening the use of the influence of her name by others who seek to maintain nursing's unheard voice. One route to this may be for nursing to find a new point of focus to unite it and deliver a single message about nursing and its contribution to health. Whether this point of focus in the UK is vested in a single leader, a 'new Nightingale' accessible and acceptable for current and future practice, or one organisation representing the diverse interests of nurses, along the lines of the American Nurses Association, is an issue open for debate – but we should also be concerned about whether we can afford to continue to avoid having this debate.

The final part of this work has considered whether nurse education might provide one approach to developing nursing's voice. Undoubtedly the lessons that can be learned from nursing's history show that there are powerful discourses at work and it may be that those same discourses impact powerfully on nursing education itself. This review of nursing history has provided some insight into the strengths and weaknesses of the prevailing discourses in nursing and looking at the

experience in other countries whose major nursing structures are very similar to ours provides further useful information. For example New Zealand where nursing made it to the table and then was apparently side lined when healthcare became more commercial and the USA where the olive branch of recent influential national reports commenting on the contribution of nursing to the debate on healthcare may conceal a further hidden agenda of conformity to others' values. These are the key areas where nursing education has an important role to play in the further evolution of nursing. It is, like nursing practice, more than the sum of its parts. Nursing education needs to concern itself with ensuring that the preparation of future practitioners are imbued with the right mix of the practical and the professional and that nurses are not restricted by the historic discourses identified in this work. Nursing courses can encourage focused research and develop political awareness and adeptness amongst practitioners, thus developing future professionals who will be able to speak with confidence in political arenas about nursing issues and demonstrate nursing's vital contribution to health policy development.

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